Bulletin...

FALL 2007

The Pennsylvania Radiological Society

A Chapter of the American College of Radiology

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Remember, the ***Bulletin*** is available on the Internet at the following home page: http://www.paradsoc.org/

PRESIDENT'S MESSAGE

David S. Buck, MD

It has been a quiet summer for the Society. We continue to work on some of the issues that carried over from last year. Interestingly, very few critical issues have come forward requiring our attention in the past few months.

I think that we must continue to assess how important it is to maintain a place of high importance with clinicians. I know that where I practice, we are having signs of heavy erosion in the cardiovascular imaging area. But who didn't know that. If you have read the ACR information and our Bulletins, it is clear that we must be relentless in putting forward our position to payers and the government: that imaging is not overpaid. But abuses will abound when clinicians can control how much imaging is done in their own specialties, rather that using consultants with little means to churn the system. Support those who take the fight to those who would take our specialty away. And play a role yourself, either in this Society, the ACR, or as a grassroots voice to your government representatives.

"Support those who take the fight to those who would take our specialty away."

In Pennsylvania, there are changes coming from the state government and we are trying to keep our voice heard when decisions are being made. We have been lobbying for our specialty for years and think that those efforts have been beneficial and worth the cost. And through our own PAC, PaRadPAC, we can be seen and heard with numerous legislators and elected officials. We take our message right into their offices, delivering information face-to-face: a very effective tool. So, if you want to help us to deliver your message, please continue contributing to your PAC. If you have questions about it, please call our main office for information. As you've heard too many times to mention, our opponents like lawyers and specialists who would want to take imaging away (or devalue it) are dumping a lot more money in than we have. And sometimes, money talks.

I want to remind you that Medicare has started its pay-for-performance initiatives and they even want to give you a 1.5% raise. If you don't know what I'm talking about, you or your billing people need to check out the ACR website. A direct link to the information page is http://www.acr.org/SecondaryMainMenuCategories/quality_safety/p4p.aspx . Or go to the ACR site; click the left side menu on Quality & Patient Safety. Then click the left side menu for The American College of Radiology and CMS Pay for Performance Initiatives. There is reference material for you and your billing people, and guidance on what it is you have to do. Their measures are easy to achieve. I wouldn't want to be the one standing between you and a raise.

The summer will end with our Annual Meeting in Pittsburgh this year. It's been a while since the meeting has come to the western frontier. We have planned an informative meeting for both Radiologists and Radiation Oncologists. Please join us at the Omni William Penn Hotel. I am sure that the educational

section with updates on national issues from the ACR, more information on pay-for-performance, PET/CT update lectures, several radiation oncology treatment updates, and a lecture on radiation terrorism will once again please all those who take advantage of attending. And I have asked the Society to honor a great radiologist and teacher from Pittsburgh, Dr. Michael Federle. So please join us in Pittsburgh on October 13 for a great day.

It was an honor being the President of the Society. I thank you for reading this far. I thank all of my friends and colleagues in the Society for the work that they do for our specialty. I would welcome all of you to join and participate in the third largest state chapter in the ACR. We are a very respected voice in the ACR, and I know there are more talented people out there who can help keep Radiology as an important specialty for a very long time.

EDITOR'S COLUMN

Thomas S. Chang, MD, FACR

Welcome Back to Pittsburgh!

As Dave Buck mentions in his President's Message, our upcoming Annual Meeting on October 13 will be held in Pittsburgh for the first time in a long time. We in Western Pennsylvania are eager to showcase the beauty, amenities, and culture of America's "most livable city." This distinction is according to the 2007 25th edition of the *Placed Rated Almanac*.

I did some research on this and found that Pittsburgh is the only city to have garnered the top prize more than once, the last time in 1985, and the only city to have been named to the top 20 in every single edition of the almanac. Having moved here in 1990 for my fellowship (well, actually, the real reason was to be with my new wife, a 1988 transplant to Pittsburgh and a professor at the University of Pittsburgh), I can personally vouch for Pittsburgh as a great place to live, work, play, and raise a family. I like that it's a smaller, manageable city with big-city amenities and pro sports teams. But most of all, I like the friendly people here.

Quick Guide to the Best of Pittsburgh

For all you out-of-town visitors, I highly recommend browsing through the www.VisitPittsburgh.com website. There's a wealth of valuable information about things to see and do in this area. Since you will no doubt be interested in finding the best places to eat, the following are *Pittsburgh Magazine's* 25 Best Restaurants (indicated with an *) and Readers' Poll winners (category in quotes) that are located in downtown, South Side, or Mt. Washington:

Downtown

*Bigelow Grille – Contemporary American & Pittsburgh
*Café Zao – Mediterranean fusion, Portuguese
*Eleven – Contemporary American (super!)
*Kaya – Caribbean
*Nine on Nine – French-inspired American
*Original Fish Market – Fresh seafood, sushi
Ruth's Chris Steak House – "Best steak"
*Six Penn Kitchen – "Best American"
*Sonoma Grille – Contemporary Californian
Sushi Kim – "Best Korean"

South Side (active night life)

*Café Allegro – French & Italian Riviera
*Dish Osteria – Italian, Mediterranean
*Le Pommier – "Best French"
Nakama – "Best Japanese," "Best Sushi," "Best Restaurant"
*Restaurant UUBU 6 – Contemporary

Mt. Washington (beautiful views of downtown)

LeMont – Continental, "Most Romantic"
Monterey Bay Fish Grotto – "Best Seafood"

These are About.com's list of "Top 10 Pittsburgh Must-Sees" (http://pittsburgh.about.com/od/attractions/tp/must_see.htm):

1. Mt. Washington and the Inclines (I think you should also drive through the Fort Pitt Tunnel toward downtown at night)
2. Heinz Regional History Center – current special exhibit is about glassmaking
3. National Aviary – "THE" national aviary
4. The Strip – farmer's market/street fair
5. Andy Warhol Museum
6. Carnegie Museums of Art and Natural History
7. Phipps Conservatory & Botanical Gardens
8. Carnegie Science Center & UPMC Sportsworks
9. Mattress Factory: A Museum of Contemporary Art
10. Nationality Classrooms at the Cathedral of Learning, Univ. of Pittsburgh

Bill Poller was kind enough to send me the following "Places to Go!" list, much of which is the same as the previous list:

Phipps Conservatory & Gardens, **Andy Warhol Museum**, **Carnegie Museum**, **Carnegie Science Center**, **Duquesne Incline**, **Heinz Regional History Center**, **Frick Art and Historical Center** (estate of industrialist Henry Clay Frick, called Clayton), **Station Square** (shopping, dining, and entertainment riverfront complex across the river from downtown), **Primanti Brothers** (a Pittsburgh institution, known for its hearty sandwiches complete with French fries on the inside), and the **Original Hot Dog Shop** (popular hot dog and fries eatery on the University of Pittsburgh campus).

Other tours of interest:
Gateway Clipper – boat tours of the three rivers
Just Ducky Tours – land and water tours in an amphibious vehicle
Segway in Paradise – 2-hour Segway tours of Pittsburgh
Fallingwater and Kentuck Knob – Frank Lloyd Wright-designed homes 90 min. from Pittsburgh

For the Cultural District, a complete list of shows and concerts can be found at www.pgharts.org. Here are the highlights for the weekend: **Beethoven's 5th Symphony**, **Madama Butterfly**, **The Comedy of Errors**, and **Circus Oz** (from Australia).

As for sports, sorry, there are no home Penguins or Steelers games that weekend. If the weather cooperates, Sunday would be a good day for golf. The only area course included on Golf Digest's list of Top 100 Public Golf Courses is Olde Stonewall in Ellwood City, which is not that easy to get to. My recommendation for 4-star courses that are easier to reach are Birdsfoot, Quicksilver, or Lindenwood (where I was witness to a hole-in-one by our upcoming Honored Radiologist, Mike Federle). If we have enough interested golfers, maybe we can get an outing together. Let me know.

Well, there you have it, folks. A quick rundown of Pittsburgh's highpoints.

Historic Reference Committee at the ACR Meeting

I wanted to bring everyone's attention to the first all-female Reference Committee in ACR's history at last May's meeting. Out of six doctors, two were Pennsylvanians: Beverly Coleman, Chair, and Marcela Böhm-Vélez. Now that's fantastic representation from our state! Thanks Beverly and Marcela, you did Pennsylvania and women radiologists proud.

All-women Reference Committee III at the 2007 Annual Meeting of the ACR. Pennsylvanians on the Committee were Beverly Coleman, MD, Chair (center, front), and Marcela Böhm-Vélez, MD (center, middle row). (Photo courtesy of the American College of Radiology, May 2007)

2007 ACR INTERSOCIETY SUMMER CONFERENCE

Beverly G. Coleman, MD, FACR

The 2007 American College of Radiology Intersociety Summer Conference (ACR-ISC) was held July 27-29 in Annapolis, MD. The topic of the conference was *"The Radiology Report of the Future."* There were approximately 75 conference attendees representing 34 organizations. The registrants attended two plenary sessions and three focus group sessions, culminating in a working breakfast on the final morning. The work group assignments were:

1) Structured reporting
2) Communicating the report
3) Providing images

The mission of the ACR-ISC is to establish communication among the leadership of national radiological societies. Annual meetings have been held since its first meeting in 1979. The goals of the conference are to address significant issues affecting radiologists, improve understanding among organizations, disseminate a summary report to participating societies, publish a final white paper in a major journal, and identify specific action items for the future.

Structured Reporting

It was the consensus of the conference that the radiology report is our most important document and should include patient's demographics, examination protocol, and a detailed interpretation, stating the findings, the most likely diagnosis, any limitations of the study, and recommendations for further evaluation, if any. The radiology report supports billing, documents the activity of the radiologist, and is a medical-legal record. The customers who utilize the services of the radiologists include the referring physicians, patients, the health care system, third-party payers, and the public. Therefore, it is important that all of these groups are totally satisfied.

There was a unanimous vote of attendees that a structured radiology report is the most optimal form of communication and such a report would be good for patient care, would be available for data mining, and is most likely inevitable in the future. The structured report should have a standardized format that follows practice guidelines and technical standards, and includes accreditation and PQRI requirements. The contents should be consistent and have prompts to include all anatomy. It is important to develop a universal lexicon but also to permit a free-text option. To get started, it was suggested that this process should begin incrementally with some of the less complex, common radiologic examinations. It was felt that professional societies, individual groups, and referring physicians could take the lead in the process of beginning to structure radiology reports nationally. There will be vendor issues that will require coordination between the RIS and the PACS, using a DICOM standard. Some of the challenges discussed include autonomy for physicians, potential time constraints, and the need to look at multiple monitors.

Communicating The Report

Discussions were held on how to communicate structured reports, which will require transmission, HIPAA compliance, acknowledgement of receipt of the report, reception, consultation opportunity, and potential auditing. The speed of

transmitting the report will vary depending on whether these are routine cases or are special situations that require urgent action, issues related to unexpected findings, and/or discrepant or changed reports. In the special situation of changed reports, it was felt that the radiologists must clearly distinguish the final report from the preliminary report, state the important differences, provide access to the preliminary report, contact all involved physicians, and provide QA feedback to the initial interpreting physician or physician's assistant. It was noted that patients have a right to review their reports and although some results can be communicated directly with the patient, in most instances, it is preferable to communicate initially with the referring physician who should be in the best position to provide an explanation to the patient. At any time, the patients should be able to speak with radiologists, if desired.

Providing Images

It was unanimous that the radiology report should contain annotated images because this would improve patient care, provide added value to the referring physician, and also improve the patients' understanding of his or her medical condition. The improved patient care would hopefully result in fewer communication errors; optimize focusing of the clinician on the area of abnormality, reducing the need for additional testing; and assist the clinician in explaining the results directly to the patient. The referring physician should have no need to review the entire data set of images and can freely use the most important images in patient consultation. It was noted that the patient would therefore have a better understanding of the imaging results and more confidence in the diagnosis. The radiologists would then be perceived, hopefully, as more than an anonymous person who only deals directly with images on a workstation. The most important issue related to annotation of images involves vendor issues. There is an immediate need to improve the technology, which should provide simple, intuitive, and seamless communication between the images and the reports. The process of annotating should be responsive to voice prompts. There are definite challenges to the process of appending images to a radiology report. For one, this would involve additional work on the part of the radiologist. There is a potential for less informative description to be dictated by the radiologists. In some instances, there may be a need to refer to prior reports and occasionally provide comparison images. It was strongly believed that once we achieve the ability to add images to the radiology report, it will not be possible to revert to our current practice of only narrative reports.

Overall, the conference was extremely interesting with excellent brief talks from more than 20 faculty members. There was free and open discussion in the focus groups, which dealt with the issues discussed above. Hopefully, the ACR-ISC will be instrumental in introducing structured reporting in this country within the next 1-2 years.

2007 PRS ANNUAL MEETING

Robert S. Pyatt, Jr., MD, FACR

The 2007 Annual Meeting of the PRS is shaping up to have an excellent all-day program with at least 7 hours of free Category 1 CME credit. These credits also meet the state licensing need for CME in Risk Management and Patient Safety. These CME credits are free to PRS members.

Dr. Mel Deutsch, FACR, is leading the Radiation Oncology Program. Dr. David Buck, PRS President, is leading the afternoon Breast MRI program. Several of the distinguished speakers for this year's program in Pittsburgh will be from the Pittsburgh region. Here is the updated program agenda:

Morning CME Program

- ACR Leadership: Hot Topics/Issues Challenging Radiology in 2007 and Beyond. Arl Van Moore, Jr., MD, Chair, Board of Chancellors
- PET/CT Update, Parts I and II: Linking Diagnostic Imaging and Radiation Oncology. Abass Alavi, MD
- Pay for Performance (P4P) & Quality Initiatives Update. Mark Gordon, ACR (Director, Quality and Patient Safety)
- Panel Discussion on Morning Topics

Luncheon CME Program

The Pittsburgh Regional Healthcare Initiative.
Nancy Zionts, Vice President for Program and Planning, Jewish Healthcare Foundation, Pittsburgh, PA

Afternoon CME Program

- Preparing for Radiation Terrorism. Joel Greenberger, MD
- Break Out Sessions (two separate tracks) for Radiation Oncology and Diagnostic Imaging
  - I. Radiation Oncology Breakout Topics (for Radiation Oncologists), hosted by Melvin Deutsch, MD, FACR
    - a. Innovations in Modern Radiation Therapy: From Functional Imaging to Adaptive Planning. Dwight E. Heron, MD
    - b. An Obituary for Craniotomy for Brain Tumors. Amin Kassam, MD
    - c. Options in the Use of Radioisotopes for Prostate Brachytherapy. Ryan Smith, MD
  - II. Breast MRI Breakout Session (2 programs), hosted by David Buck, MD. Speaker: Jules Sumkin, DO, FACR, Magee-Women's Hospital

Honored Radiologist Evening CME Program

The Future of Continuing Medical Education.
David Lackner, MD, **in honor of Michael P. Federle, MD, FACR**

RESIDENTS AND FELLOWS SECTION

Michael F. Goldberg, MD, MPH

Adam Smith, in his book, *An Inquiry into the Nature and Causes of the Wealth of Nations*, wrote: "The greatest improvement in the productive powers of labor, and the greater part of the skill, dexterity and judgment with which it is anywhere directed, or applied, seem to have been the effects of the division of labor." Smith argued that by dividing the assembly process of pins into individualized tasks, each pin worker could become subspecialized, highly skilled, and therefore more efficient. The end result would be a higher quality product, produced more quickly, and at less cost. The manufacturer, consumer, and overall economy would benefit from this paradigm.

The spirit of Smith's words can be seen in almost every part of our health care system today. Medicine has naturally evolved into a highly subspecialized industry for better handling of the continually growing understanding of the human body, the diseases it suffers, and its appropriate therapies. Even within specialties, many physicians have become *sub*specialized. Adam Smith would be proud if he were to observe a typical orthopedics department, for example—rotator cuff repair experts, hand surgeons, ankle specialists, etc.

So it is in radiology as well. As the field of radiology has grown more complex, we have all witnessed a growing subspecialization with a resultant division of labor. Yet despite this, the method by which radiology residents are evaluated by the American Board of Radiology (ABR) certifies them to be competent *general* radiologists. Further troubling is the growing number of voices to delay the oral boards until 2-3 years after the completion of residency, which seems a step backwards given how our field is evolving.

Gone are the days of the general radiologist reading solely plain radiography and fluoroscopy. Today, radiologists are often subspecialized by organ system and modality. There are radiologists who specialize in breast MRI, musculoskeletal ultrasound, and PET of head/neck cancer, among many others. This makes sense: with an ever expanding body of knowledge and increasingly complex technology, many would argue that it is impossible for a radiologist to excel in all radiology disciplines.

There is another force that is also shaping the division of labor in radiology. As the technology becomes more complex, the images have ironically become easier and more intuitive to interpret. Interpreting a radiograph is literally a game of shadows, trying to *infer* what pathology may or may not be present. For example, the tracheal deviation or high-riding shoulder allows only a skilled radiologist to infer the presence of a goiter or torn rotator cuff, respectively; you don't actually see this pathology, though. Contrast this with cross-sectional imaging, which allows the reader to visualize the pathology, such as the enlarged thyroid or defect in the supraspinatus tendon. No inference is required. As long as one knows the anatomy, the abnormalities can be much easier to detect than they would have been in the days of radiography.

What does this mean for the radiologist in the era of PACS? Because referring clinicians are often subspecialized, possessing an intimate knowledge of the relevant anatomy and pathology, *and* have access to the images, the radiologist must be able to provide an added value to the image interpretation that the referring clinician could have provided alone. Many would argue that only a subspecialized radiologist, with the appropriate training and experience, can provide the higher level of image interpretation demanded by referring physicians.

"Many would argue that only a subspecialized radiologist … can provide the higher level of image interpretation demanded by referring physicians."

Most of radiology has acknowledged these forces and has adjusted accordingly. Most academic radiology departments are highly specialized, demonstrating Smith's benefits of division of labor. Large private groups are becoming more specialized, and teleradiology allows triaging of cases to the appropriate subspecialist. Finally, most graduating residents are pursuing post-residency fellowships.

Yet, despite this great change, the ABR's testing methods remain the same, with each of the 10 sections of the oral boards given equal weight. One could argue that this is an appropriate way to evaluate a resident at the completion of a general radiology residency, but it is difficult to see how this test, in its current form, could be appropriate at the completion of a subspecialty fellowship (in preparation for a subspecialized career). If individuals are truly concerned by the burden of studying for the oral boards that is placed on residents (and their residency) during the final year of residency training, a solution should involve altering not only the timing of the test, but also its content.

REIMBURSEMENT FOR F-18 FDG IN PET AND PET/CT

Gordon S. Perlmutter, MD, FACR

With the passage of the Deficit Reduction Act (DRA), Medicare was mandated to limit the technical component of procedures performed in non-facilities (IDTFs [independent diagnostic testing facilities] and private offices) to the lesser of the Hospital Outpatient Prospective Payment System (HOPPS)

rate or the Medicare Physician Fee Schedule (MPFS). The cost of F-18 FDG contrast under HOPPS is reimbursed to facilities as a separate supply item and is not included in the HOPPS Ambulatory Payment Classifications (APCs). However, in Pennsylvania, the cost of F-18 FDG was bundled by the Medicare carrier into the reimbursement for PET and PET/CT. The net result was that as of January 1, 2007, the DRA provision constraining payment to the HOPPS APCs has adversely impacted on the technical component of 78811-78816, 78608, and 78495, effectively excluding any reimbursement for F-18 FDG since A9552 is paid separately and is not included in the APCs.

After receiving several complaints from practices in Pennsylvania, the Society of Nuclear Medicine (SNM) and the ACR commenced discussions with Highmark Medicare Services (HMS) through its Carrier Advisory Committee (CAC) representatives, culminating in an agreement with HMS to reimburse separately for F-18 FDG under supply code A9552 retroactively to January 1, 2007.

The official communication issued by HMS is as follows:

Update On Payment For PET Scan Radioactive Tracers

(A9552, A9526, AND A9555)
Per recent requests from the American College of Radiology (ACR) and the Society of Nuclear Medicine (SNM), Highmark Medicare Services has updated our payment of PET Scan Radioactive Tracers, specifically HCPCS codes A9552 (Fluorodeoxyglucose F-18 FDG), A9526 (Nitrogen N-13 Ammonia), and A9555 (Rubidium Rb-82).

The pricing methodologies for these Radiopharmaceutical Tracers were developed based on cost estimates for the technical component of PET scans provided to Medicare by PET scan manufactures and retailers several years ago. To that extent, the FDG costs were incorporated into the total PET scan costs, and payment.

However, Section 5102(b) of the Deficit Reduction Act (DRA) of 2005 required a payment cap on the Technical Component (TC) of imaging services. The DRA mandated that the Technical Component of imaging codes in the Medicare Physician Fee Schedule (MPFS) be paid at the lower of the hospital outpatient Ambulatory Payment Category (APC) rate or the rate in the MPFS. F-18 FDG (A9552) is paid separately and not included in the APCs.

Therefore, Highmark Medicare Services, in keeping with the same APC methodology for pricing the Technical Component of PET scans, specifically A9552, will pay separately for A9552 effective with the DRA mandated pricing methodology for imaging services of dates of service on or after January 1, 2007.

In keeping with the CMS Internet On-Line Manual (IOM) Pub 100-4, Chapter 13, Section 50.1 and CMS Transmittal 1270, Change Request 5646, the payment allowance limits for radiopharmaceuticals are not subject to Average Sales Price (ASP) pricing methodology. Contractors are to determine payment limits for radiopharmaceuticals furnished in other than the hospital outpatient department based on the methodology in place as of November 2003. Per these instructions, radiopharmaceutical allowances are to be determined "by report" which has been historically implemented as "by invoice."

Based on the anticipated volume of services for A9552, and in keeping with the Paper Reduction Act, Highmark Medicare Services has worked with the SNM and ACR to obtain a sample of invoices for F-18 FDG in order to establish an allowance and not have to request copies of invoices in order to manually process each claim. Based on this information, we have established an allowance of $210.00 per study dose for A9552.

Codes A9526 (Nitrogen N-13 Ammonia) and A9555 (Rubidium Rb-82) will continue to be individually priced "by report," therefore, "by invoice." Upon request, physicians and providers will be required to submit the following information with the invoice:

- Name of the radioactive tracer
- Dose administered
- Unit cost per dose
- Total charge

This applies to claims for Radiopharmaceutical Tracers for dates of service on or after January 1, 2007. Those claims for Radiopharmaceutical Tracers with dates of service on or after January 1, 2007, that were denied based upon the premise of "re-bundling" should be resubmitted for payment.

Concerns or additional information regarding the cost and pricing of F-18 FDG (A9552) should be sent to:

A. Bloschichak, MD, MBA
VP & Medical Director
Highmark Medicare Services
1800 Center Street
Camp Hill, PA 17089

We again would like to thank the ACR and SNM for their assistance.

ANNOUNCEMENTS

**** August 7-10, 2008**: 26th Annual Pittsburgh Breast Imaging Seminar to be held at the Pittsburgh Convention Center, with all events on one floor, Pittsburgh, PA. Featured speakers to include Stamatia V. Destounis, MD, Beth DuPree, MD, FACS, Michael N. Linver, MD, FACR, Jay R. Parikh, MD, FRCP, Edward A. Sickles, MD, William Poller, MD, FACR. Course Director: William R. Poller, MD, FACR. For further information please call 412-359-4952, e-mail Cheri Jackel at cjackel@wpahs.org or visit www.aghcme.org