Bulletin...

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The Pennsylvania Radiological Society

A Chapter of the American College of Radiology

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I. PRESIDENT'S MESSAGE — David S. Buck, MD

Nothing endures but change.
–Heraclitus

I don't read as much as I used to read. Not novels or journals or textbooks. Emails… I read a lot of those. They are very thin of substance and more of a nuisance in the majority of cases. I think I'm busier. I know everyone I have talked with in Radiology is busy. I think I first wished for the 28-hour day in my freshman year of college.

I did, however, sit down one night and start to read through the *Journal of the American College of Radiology* (JACR). As an ACR member, you should get it and I hope you've had an opportunity to read some of its offerings. When I read the March 2007 edition I was struck by the pieces by Arl Van Moore, Jr., MD [1] and Bruce J. Hillman, MD [2]. Editorials that had somewhat opposite-appearing subjects: Quality and Work.

Now, I know I'm working harder. And I like to think I'm doing quality work. It struck me that I don't have a good argument against doing quality work if my purpose is to benefit the person whose image is in front of me. I think that we all would agree in public that that is the name of the game. I would hope that we would all agree in private that quality, and change that improves it, is good.

That is where change comes into play. Some think change is a variable; I think it is a constant. I know that some of my more seasoned and experienced colleagues find some of the things that we try to do now infuriating because it changes a standard protocol of operation that may have been used for a number of years. You have to change your schedules, learn a new way of doing a procedure, or learn how to look at the same old disease process by taking advantage of a different property of the tissues. Maybe one eventually gets tired, at some point, of changing all the time. It seems like you have to work harder too. And it seems we just keep reading more and more studies. The studies are so good, other people want to read them and take them away from us. Now there's a subject that gets me. Not only do my friends the Cardiologists like the 64-slice coronary artery CT angiograms I do, other Radiologists like the CTs and other exams I do overnight. But the goal is to help more patients with better outcomes. If someone else is willing to do it, and do it well, I'm in trouble.

I try to change the tools I use and how I do things. By using my new tools, I can actually be more productive. I change my tools of knowledge by learning new technologies and applying them to my patients. I can provide my expertise to more patients in the same unit of time. I still have a good feeling inside when I "add it all up" and give someone the opportunity for a good outcome. I actually get to do that more often these days.

There is change afoot in how we view the work we had previously been giving away. Lifestyle, income, vacation and work are the pendulums that constantly swing. I think we are approaching the time when doing more work is an imperative. Longer hours, more education, measuring quality. If change is going to happen, I want it to benefit my patients and me. Be prepared to learn about quality measures, because that is one area where the PA Radiological Society and the ACR are trying to lead the way so that government doesn't tell us what quality is. And don't be afraid to use new tools.

They must often change, who would be constant in happiness or wisdom.
–Confucius

1. Van Moore, A., Jr. Quality—Full Steam Ahead. *J Am Coll Radiol* 2007; 4 (3): 141-2.
2. Hillman, B. Everyone is Working Harder. *J Am Coll Radiol* 2007;4(3):143-4.

II. EDITOR'S COLUMN — Thomas S. Chang, MD

The Pittsburgh Roentgen Society had the great pleasure recently of having one of our Past Presidents, Tim Farrell, give the annual Newton and Julia Hornick Lecture to talk about the ins and outs of setting up a local teleradiology network. It was useful to hear how they did it in central Pennsylvania and to learn about the pitfalls to avoid. All in all, it was a fabulous get-together, something I'd love to see us all doing more often. Not only did we have an excellent talk, but we were also blessed with great company, great food, and a great view of downtown Pittsburgh from atop Mount Washington.

As an aside, when we have our Annual Meeting in Pittsburgh this fall, a dinner at one of the Mount Washington restaurants should be on your agenda. For a romantic multi-course repast, Isabela is a gem, though an expensive one at that. My personal favorites are the Monterey Bay Fish Grotto (they have more than just seafood) and LeMont (which is where Tim gave his talk).

Prior to Tim's formal talk, representatives of most radiology groups in town had a round-table discussion about the possibility of setting up a regional teleradiology network in western Pennsylvania. With so many groups using Nighthawk or some other similar teleradiology service, there's a lot of money flowing from Pennsylvania to other parts of the country or of the world. The thinking was: why not keep that money in the local economy, supporting local radiologists? As an added benefit, the local solution would probably be a cheaper one too. Obviously, all the details have to be worked out. But there was a great deal of enthusiasm for the idea. If any of you reading this in western Pennsylvania (even up to Erie) haven't heard about this and would like to get involved, you should contact the president, Jim Backstrom. On a related topic, our lobbyists, the Klines, report that the telemedicine licensure bill is finally moving forward, which is good news to all of us.

As Dave Buck talks about in his President's Message, if we are to survive in this crazy world of third-party strong-arm tactics, turf battles, and perennial congressional slashings, we must keep changing to overcome new difficulties. This includes competing against the Nighthawks (and Dayhawks) of the world. Remember, the field of medicine is not like the rest of the economy. We do not operate under the laws of supply and demand, but rather under the laws of political back-room deals, capitation, and managed care. An experienced, highly skilled lawyer would be able to command top dollar for his or her services. The same goes for architects, home contractors, and advertisers. But that's not the way things work in medicine. An experienced, highly skilled neurosurgeon or interventional radiologist gets paid the same amount as someone just out of training. Is that what we want?

I don't know what the solution is. As Dave says, we just need to keep doing whatever is best for our patients' health. We need to be our patients' advocates when it comes to the most appropriate diagnostic tests. Financial considerations always exist, even for radiologists, but there is no doubt that non-radiologists performing in-office imaging tests do a lot more unnecessary tests than we do. David Levin's research supports this. We are very fortunate to have the smart folks at our parent organization, the ACR, working overtime to address the overutilization problem. Perhaps they'll be successful in getting Congress to repeal the in-office exception to the Stark Rules. They need all the support they can get. So please keep up your membership in the ACR, which automatically makes you a member of our Society also.

Finally, I'd like to remind everyone again that we have a new web site at:

www.paradsoc.org

To access the members-only content, the user name is: members. The password is: Members06. Please let me know how we can enhance the website. What content should we include? Are there any links you find particularly useful in your radiology practice that we should list? Any suggestions would be greatly appreciated.

I look forward to seeing many of you in Washington at our Board meeting and the annual ACR meeting. Enjoy your spring. I love spring, a time for rejuvenation and renewal, and would love it even more if it weren't for my seasonal allergies. I guess we can't have it all. Achoo!

III. CODING Q & A — Eric Rubin, MD

CT Angiography of the Left Atrium

Our department has been receiving an increasing number of requests for CT angiographic studies of the left atrium for patients with atrial fibrillation as a preoperative evaluation prior to left atrial ablation. How should we bill for this study?

CPT directives dictate that a study should be coded in a manner which accurately approximates the intention of the study. Prior to January 1, 2006, the most appropriate CPT code for this type of evaluation was either 71275 (**Computed tomographic angiography, chest (noncoronary), without contrast material(s), followed by contrast material(s) and further sections, including image postprocessing**) or an unlisted procedure code. As of January 1, 2006, however, specific Category III codes for cardiac evaluation became available. CPT 0145T specifically describes cardiac evaluation for morphology (**Computed tomography, heart, without contrast material(s) followed by contrast material(s) and further sections, including cardiac gating and 3D image postprocessing; cardiac structure and morphology**) and is therefore now the most appropriate code for this evaluation.

MUEs

What are MUEs?

MUEs, originally termed *Medically Unbelievable Edits*, have recently been re-named **Medically Unlikely Edits** by the Centers for Medicare and Medicaid Services (CMS). CMS originally created this concept with good intention. They were originally meant to prevent 'unbelievable' billing mistakes for procedures which might be incompatible with life or human anatomy. In the past year,

however, the concept has been vastly expanded and now includes thousands of MUEs. Although many of them remain appropriate, some are clearly 'unbelievable' and almost seem arbitrary. Previously proposed MUEs limited head CT reimbursement to one study a day and more recent proposals would limit them to two a day. This is clearly onerous with respect to critically ill patients. As the caregiver who best knows the patient, it is the ordering physician, not the radiologist, who does and should decide the examination frequency of a study. The MUE concept would place the referring physician and the radiologist directly at odds. Furthermore, CMS has indicated that the decisions have been based on *typical* patient utilization data and not peer-reviewed research data.

With this background in mind the reader should be made aware that CMS, after receiving numerous complaints, have revised their proposed edits and recent communication on their part suggests that they are interested in proceeding further with creating arbitrary caps on services. Stay tuned and I will keep you updated. Let us hope that this and other 'rationing' concepts do not inhibit our ability to provide adequate patient care.

Reference

Duszak Jr, R. Medically Unbelievable Edits: Unbelievable Indeed. *J Am Coll of Radiol* 2007; 4(3):187-188.

IV. HARRISBURG HIGHLIGHTS — Kline Associates Ltd.

Healthcare

Governor Rendell recently delivered his budget address to a legislature that just underwent a 20% personnel change. These new lawmakers were also exposed to the chief executive's "Prescription for Pennsylvania." The plan is a broad approach to some chronic problems in delivery of services across one of America's largest and most diverse states. Some here in Harrisburg jokingly call our fair commonwealth 'Pennsyltucky,' referring to the drastic differences from one of the countries largest metropolitan areas to some counties that still have dirt roads. Infrastructure systems, business and delivery of services are all challenging. Heath care is no different. Part of the plan points to concern for health care delivery in different geographic regions as well as differences by ethnicity. By taking this view, the Governor's Office of Health Care Reform hopes to influence where workforce development financial incentives for healthcare will go. These incentives are designed to attract and retain healthcare providers in underserved parts of Pennsylvania. Incentive determinations are to be made by a commission that will review major expenditures by healthcare organizations. Concern has been expressed by some who view the plan as a restriction on business development but there is a common recognition by all parties to make service delivery better. Many in the medical lobbying field view this as a reemergence of the Certificate of Need program that sunset under the Ridge Administrations. We will closely monitor this "Prescription" to see if it is correct or an overdose.

Budget

As the new faces noted above listened eagerly to the Governor's budget address, senior appropriations staff pored over the numbers and prepared for the annual appropriations hearings, or should we say, dance. This winter event provides select House and Senate members a public forum to question department heads. Respondents explain their individual plans for operations. Sometimes the exchanges are lively. The budget will undergo several iterations before adoption by the legislature. A proposed sales tax increase of 1% is by far the most noticeable feature of the budget. Though many issues need to be resolved, this single proposal may be the only thing needed for a long, drawn out fiscal fight that we predict will last into the summer of 2007. In fact, some department directors have unofficially put their staff on notice that a literal and figurative dry summer awaits them. We shall see.

Winter Blues

Recent weather-related emergencies have cropped up all over Pennsylvania, not the least of which was the "Valentine's Day Massacre." A freak snow, sleet and ice storm ravaged the state and caused closure of three major interstates for days. Not only was traffic stopped, many motorists spent a day or more trapped inside their vehicles along Interstate 78 in Lebanon, Berks and Lehigh Counties. The Pennsylvania Department of Transportation, State Police and the Pennsylvania Emergency Management Agency (PEMA) were caught flat-footed. The response was slow and inadequate. The Governor's fury has led to an independent investigation by a former Clinton-era FEMA official who plans to take a critical look at what happened. Not only was this emergency a show of Mother Nature's fury but reminds us what we already know: our fair state is a life-sustaining artery for transporting goods in and around the Northeast. Disruption of this flow can wreak havoc. Hopefully there will be lessons learned here.

Telemedicine Licensure

We are pleased to report that the Pennsylvania Radiological Society's Telemedicine Licensure bill is being circulated for co-sponsorship signatures. We have met several times with Geri Sarfert, executive director of the Committee on Communications and Technology and staff to Senator Rob Wonderling (R-Lehigh). Mrs. Sarfert has been extremely helpful in streamlining the bill. She

has cleaned the language so that we should have little or no opposition to it from within the Senate chamber. Sarfert had us meet with several interested parties prior to circulating the bill for co-sponsorship. It should go to print by the end of March.

V. RADIATION ONCOLOGY NEWS — Ajay Bhatnagar, MD, MBA & Melvin Deutsch, MD, FACR

New 2007 CPT Codes for Radiation Oncology Expand Freestanding Centers Services

Cancer care continues to evolve into outpatient care outside the hospital, including specialized radiation procedures such as Stereotactic Radiosurgery (SRS) and Stereotactic Radiotherapy (SRT). These procedures, which allow for the delivery of highly localized radiation, will now be available in freestanding outpatient centers with the introduction of new CPT codes for intracranial and extracranial (body) stereotactic procedures.

Traditionally, these procedures have been primarily available in tertiary hospitals for multiple reasons. First, these procedures were associated with only G codes, which limit reimbursement strictly to the hospital setting. Also, with recent advancements in radiation oncology technology, there are now advanced linear accelerators with not only standard external beam radiation functions, but also stereotactic capability. The added functionality make these investments more feasible and practical for community and/or outpatient centers. Finally, recent studies have shown the benefit of adding SRS to standard radiation for local control of metastatic brain tumors, and there is evidence to support effective palliation using SRS or SRT for extracranial tumors such as spinal tumors. As cancer patients continue to live longer with their disease, SRS or SRT may be an effective option to treat previously irradiated areas.

Specifically, three new CPT codes relating to stereotactic radiation procedures became effective January 1, 2007. CPT code 77371 represents the treatment delivery of intracranial SRS using a multi-source cobalt-60 system (such as the Gamma Knife) and CPT code 77372 represents treatment delivery of intracranial SRS with a linear accelerator-based system. CPT code 77373 is for treatment delivery of extracranial (also called body) stereotactic radiation therapy per fraction with multiple fractions allowed. Along with this code, there is CPT code 77435, which represents treatment management for body stereotactic radiation therapy.

However, there are some issues with these codes that must be mentioned. CPT codes 77371 and 77372 allow only one fraction for intracranial stereotactic radiosurgery, so that a multi-fraction course for intracranial treatment would not be reimbursed past the first fraction. Also, the treatment delivery code and management code (CPT codes 77373 and 77435, respectively) were initially unable to be simultaneously reimbursed. This should be corrected by April 1 through the Correct Coding Initiative (CCI) edits. In addition, there is currently a significant discrepancy in the reimbursement for SRS/SRT between freestanding centers and hospital-based centers, heavily favoring the hospital-based practices, since hospitals can still claim these procedures with the higher-paying G codes. In fact, some are claiming that the freestanding reimbursement is inadequate such that it makes it unfeasible for freestanding centers to afford the premium equipment with stereotactic functions. Clearly, these issues need to be resolved to expand the accessibility of these services further, but hopefully this will be possible with the support of organizations such as the PRS and the ACR.

VI. COMMITTEE ON CONTINUING EDUCATION — Robert S. Pyatt, Jr., MD, FACR, Chair

2007 Annual Meeting

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, and which also meets 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 PET/CT program. Several of the distinguished speakers for this year's program in Pittsburgh will be from the Pittsburgh region. Here is a draft of the possible program agenda:

Morning Program

ACR Leadership (Top ACR official): Hot Topics/Issues Challenging Radiology in 2007 (speaker to be announced)
Billing Fraud and Abuse Update: Richard Duszak, MD (#1 speaker for the last several years)
Pay for Performance Update: Mark Gordon, ACR, and Robert Pyatt, MD, FACR
Nuclear Terrorism
The State of Medicine in PA: Update by Roger Mecum, PA Medical Society
New ABR Requirements for Radiology
Panel Discussion on the morning's topics

Afternoon Program

Radiation Oncology Topics (for Radiation Oncologists)
PET/CT Topics (for Radiologists)
Combined Topic for Radiation Oncologists and Radiologists

Honored Radiologist Evening Program (to be announced)

VII. MEDICARE UPDATE — Gordon S. Perlmutter, MD, FACR

Medicare Coverage for Non-Coronary Intravascular Ultrasound (IVUS)

As of April 17, 2006, Highmark Medicare Services (HMS, formerly HGSA) retired their Local Coverage Determination (LCD) on non-coronary IVUS, LCD 115D, and issued a statement that services would be covered in keeping with the National Coverage Decision (NCD) (Chapter 1, Part 4, Section 220.5) regarding Diagnostic Radiological Services. The NCD states that clinical reliability and efficacy is not proven for B-scan ultrasound for atherosclerotic disease of peripheral arteries and it is therefore not a covered service.

The PA Radiological Society has worked with Highmark Medicare Services and CMS to clarify the NCD language and how it applies to IVUS. Upon recent clarification, it has been concluded and confirmed by Highmark Medicare Services that the NCD refers to routine vascular B-scan for atherosclerotic disease and is not applicable to IVUS (75945 and 75946).

Unlike routine B-scans of the peripheral arteries, there is literature support for non-coronary IVUS. Its clinical uses include evaluating an angioplasty and endograft or stent placement for related complications such as dissection and malposition. It is not intended for or used to diagnose atherosclerotic disease.

As of dates of service 4/17/2006, HMS will cover non-coronary IVUS (75945 and 75946) when performed within such clinically "reasonable and necessary" indications.

VIII. ANNOUNCEMENTS

Breast Imaging - Body Imaging Fellowship (Funded)

The Department of Human Oncology at Allegheny General Hospital has a Breast Imaging Fellowship position. Enjoy the comforts of a 10,000 square foot breast center that is fully digital. In addition, there are two stereotactic units, state-of-the-art ultrasound units, the hand-held Mammotome, the Intact biopsy device, MRI and CAD. Twenty-four thousand (24,000) total breast imaging studies are performed yearly. Flexible year to include dedicated time with surgery, pathology **and body imaging**, if desired. Research opportunities are also available, either with the NSABP (National Surgical Adjuvant Breast Project) or the ACRIN (American College of Radiology Imaging Network) trials associated with breast imaging. There is direct interaction with dedicated breast surgeons who are associated with the NSABP.

For further information, please contact and send a resume and two letters of reference to William R. Poller, M.D., FACR, Allegheny Cancer Center, 5th Floor, Allegheny General Hospital, 320 East North Avenue, Pittsburgh, PA 15212-4772. Telephone: 412-359-8366, FAX: 412-359-8685, Pager: 412-359-8220 ID 4544, E-mail: wpoller@wpahs.org.