Bulletin...

SUMMER 2007

The Pennsylvania Radiological Society

A Chapter of the American College of Radiology

Executive Director
Robert P. Powell
101 West Broad Street, Suite 614
Hazleton, PA 18201
Phone: 570.501.9665
Fax: 570.450.0863
E-Mail: rpowell@ptd.net

Please note the new
WEBSITE ADDRESS

www.paradsoc.org

Editor
Thomas S. Chang, M.D., FACR
Weinstein Imaging Associates
5850 Center Avenue
Pittsburgh, PA 15206
Phone: 412.441.1161
Fax: 412.441.9880
E-Mail: tscjiv@verizon.net

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PRESIDENT'S MESSAGE

David S. Buck, MD

I hope that all of you are having a relaxing summer so far.

The Pennsylvania Radiological Society held its Spring Board Meeting in Washington, DC, just prior to the Annual ACR meeting. We again reviewed the activities of the Society and issues that are facing us at the state and national levels. Clearly, the haphazard and illogical changes in reimbursement remain a serious target issue for us and the ACR. Several of the PaRad members spent time on Capitol Hill and reported that amongst the Pennsylvania Senators and Representatives there was sympathetic reception to our issues. We will continue to lobby for fairer approaches to reimbursement. It would help the cause if any or all of you could drop your lawmakers a line and let them know that Pennsylvania is facing some mounting challenges to providing quality radiology because of the traditionally poor reimbursements and the malpractice climate.

This reminds me of a rant I've had in the past. Our governor, Ed Rendell, poses as a friend of doctors by "rescuing" us from the high MCARE fund payments. All you have to do is promise to stay in Pennsylvania for two years or you'll get whacked for the money you saved on the abatement. But that whole process is screwy due to the timing of the application which keeps you in perpetual risk of getting whacked, unless of course you die. The MCARE slush fund does nothing to encourage the legislative system to reform malpractice laws in the state. Certainly,

PRS President David Buck (left foreground) leads the Pennsylvania delegation at the 2007 Annual Meeting of the ACR in Washington, DC

lawmakers have a hard time hearing our arguments and pleas regarding the malpractice environment, and its trickle-down effects on the patients. I think it's hard for them to hear us because we speak softly, carry no big stick, and the plaintiff lawyer's dump trucks make a ton of noise dumping money to get lawmaker's attention. But, from the Department of Incredible Irony, I just can't come to grips with the reality that the MCARE fund is partially funded by a tax on cigarettes. What the heck is that!! I try to avoid this visual: "Mrs. Puff, I need you to keep smoking. It solves the problem of malpractice insurance costs in Pennsylvania." Oh, now that's a fine piece of legislation from the Commonwealth of Pennsylvania. But I now have to figure out how to put my head around it when a close family member or one of my best friends finally stops smoking. Hmmm…

You really can't expect the lawmakers to make the right decisions in a vacuum. That's part of what we try to do in an organized fashion with the PaRad. We need to be there to steer them in the right direction for patients and ourselves. Please support us while we represent you with lawmakers and insurance companies. Make sure that your entire group is part of the Pennsylvania Radiological Society. Find someone in your practice to become part of the leadership of the Society or a Board member or a committee member. It really does pay dividends at multiple levels. And it may just give us that big stick we need.

And now… everyone to the pool.

EDITOR'S COLUMN

Thomas S. Chang, MD, FACR

After attending the ACR meeting in May, I came away feeling like I had emerged from the Franklin D. Roosevelt era. As you may recall from American history class from the good ol' days when we were a little lighter, had fuller heads of hair, or didn't have creaky joints, FDR was known for his Alphabet Soup of various works projects and government agencies.

There is a veritable Alphabet Soup of acronyms and abbreviations that affect our lives as radiologists. Many of these were discussed in detail at the ACR meeting. To survive as a radiologist these days, we all need to know more and more about the economics and business of our field, and that includes these acronyms. So I thought I'd give you a quiz to see how much you really know. Some of the answers can be found elsewhere in this issue.

Give yourself one point for knowing what each abbreviation stands for and one point for knowing why it matters to us. The scoring is as follows: **19 or fewer pts** – Get your head out of the sand. You need to attend more ACR meetings and read your issues of the *Journal of the ACR*. **20-24 pts** – Not too shabby, but there's room for improvement **25-29 pts** – Great job! We need you on our Board. **30 or more pts** – We need you as our President (if you haven't already served as President!). If you spot an error on my part (I'm confused by a lot of these concepts too), award yourself 2 extra points.

1. ACR
2. FACR
3. HMO
4. CMS
5. CPT
6. TC & PC
7. MOC
8. DRA
9. RVU
10. P4P
11. IDTF
12. HOPPS
13. HIPAA
14. MIRC
15. POS (Those of you with kids should know this one and I don't mean Point of Service. Hint: Think IM.)

Before we get to the answers, I'd like to point out the new layout of the *Bulletin*, which I'm sure you noticed immediately. I hope you like the double-column format. I welcome any feedback and other suggestions for improvement.

ANSWERS

1. The American College of Radiology is, of course, our parent organization and the voice of Radiology. If you're reading this and you're not a member, shame on you and deduct 5 points. 2. If you're already a Fellow of the ACR, give yourself an extra 2 points. This honorary designation is a reflection of one's contributions to Radiology and a great honor to attain. 3. In trying to cut healthcare costs, Health Maintenance Organizations often take the slash and burn approach and end up being our nemesis. 4. The Centers for Medicare and Medicaid Services are the biggest third-party payer. What they decide to pay for certain services usually serves as the basis for other payers' reimbursements. 5. Correct coding using the American Medical Association's Current Procedural Terminology ensures that you get paid for what you do and don't go to jail for fraud. 6. Some experts now recommend billing the Technical Component and Professional Component of various procedures separately, if possible, instead of billing globally. 7. If you're one of the younger radiologists with a time-limited Board certification, you are required to recertify through the Maintenance of Certification process. Other radiologists are encouraged to continue lifelong learning through MOC. 8. The Deficit Reduction Act of 2005 called for significant reductions in reimbursements for imaging services. There is move afoot to postpone implementation of the DRA until its ramifications can be adequately studied. 9. Every procedure is assigned a certain number of Relative Value Units to reflect the time and effort expended to perform that procedure. Reimbursements are based on RVUs, which are continually modified. 10. Pay for Performance is a way for radiologists to get an extra 1.5% in payments for fulfilling certain reporting requirements. This currently affects only a couple of procedures, effective 7/1/07, but will encompass more of Radiology over time. 11. Independent Diagnostic Testing Facilities are facilities that provide diagnostic tests and are separate from hospitals and doctors' offices. There are special rules that apply to IDTFs . 12. For hospital outpatient services, reimbursements are based on the Hospital Outpatient Prospective Payment System, which groups similar services into a limited number of payment categories. Medicare now pays IDTFs the lesser of the HOPPS payment or Medicare fee schedule payment. Since the HOPPS payment is generally lower, payments to IDTFs have declined. 13. The Health Insurance Portability and Accountability Act is the Federal law that dictates, among many other things, how patient-identifiable data have to be secured and maintained. 14. RSNA's Medical Imaging Resource Center is a library of medical information and teaching files that are accessible via the Internet. See http://mircwiki.rsna.org/. 15. If your kids do instant-messaging, you should know that POS stands for Parent Over Shoulder. If you see it, take what's written with a grain of salt.

2007 ANNUAL MEETING BUS TRIP

*If you are planning to attend the Annual Meeting in Pittsburgh this Fall, would a **free bus trip** be of interest? We are planning to have a Luxury Charter leave Philadelphia on Friday Oct. 12 at 7:30-8:00 AM, stop in Harrisburg at 9:30-10:00 AM, and arrive in Pittsburgh at 12:30-1:00 PM. Returning 10:00 AM from Pittsburgh on Sunday Oct. 14 to Harrisburg and Philadelphia arriving at 3:00-3:30 PM. Bus is available to members and guest. If you are interested or for further information, please call 570-501-9665 or email rpowell@ptd.net as seating will be limited to 54 on a first-come, first-served basis.*

PAY-FOR-PERFORMANCE IN DIAGNOSTIC RADIOLOGY

Eric Rubin, MD

On July 1, 2007, the Physician Quality and Reporting Initiative will go into effect. This endeavor was established by the Centers for Medicare & Medicaid Services (CMS) in order to institute pay-for-performance (P4P) measures. These benchmarks are the end result of an issue that came to the forefront in 1999 with the publication of an article by the Institute of Medicine (IOM) called *To Err is Human*. Although this article focused on errors in medicine, the reaction to the article was the establishment of a movement that could ultimately reduce those errors. In doing so, the belief was that medical care could be improved by the establishment of consistent methods of care and, in doing so, might reduce medical costs in the United States which are rapidly spiraling out of control.

So what does P4P mean to you and your practice? CMS has established a specific billing code that can be reported when the specific P4P guidelines are followed. There are a total of seventy-four P4P initiatives that have been established by CMS. Only two apply to radiology. Both apply to neuroimaging and are as follows:

1) **Stroke and Stroke Rehabilitation: Computed Tomography (CT) or Magnetic Resonance Imaging (MRI) Reports** - In patients with signs or symptoms of TIA or acute stroke, if a head CT or MRI of the brain is performed within 24 hours of admission, the radiologist must document the following: presence or absence of hemorrhage, mass lesion, and acute infarction. Each subsequent CT or MRI on that patient must also document the same.

2) **Stroke and Stroke Rehabilitation: Carotid Imaging Reports** - In patients 18 years of age or older, reports for Carotid Duplex Imaging, Carotid CTA, or MRA must include reference to measurements of distal internal carotid diameter as the denominator for stenosis measurement. Such measurements should be reported each time a study is performed on that patient. For CTA and MRA studies, a direct measurement of the internal carotid artery is sufficient. The Duplex Ultrasound requirements, however, are somewhat vague. I am currently awaiting further guidance from ASNR and ACR regarding the specific wording of ultrasound reports. However, for the moment, I would suggest the use of NASCET criteria when reporting stenoses.

The specific coding for these initiatives are beyond the scope of this article (and beyond the capabilities of most supercomputers). I would suggest that you review the specific coding methods with your business manager or billing company. Here is a specific web page link for the coding parameters:
http://www.cms.hhs.gov/apps/ama/license.asp?file=/PQRI/downloads/Measure_Specifications_060107.pdf

If 80% of your reports pertinent to the specific initiatives described above meet the requirements of P4P, then you will be awarded a 1.5% bonus in reimbursement for these examinations. There is, however, a complex formula that may end up bringing the 1.5% number down after all is said and done. Furthermore, if you can understand what I have written in this article then you are eligible for a 10% bonus.

My recommendation is that you should get in the habit of using the specific wording required to qualify for the P4P bonus reimbursement. Consistent use of the terminology is likely the only way to ensure that it makes its way into 80% of your relevant reports. For those of you with digital dictation systems I would recommend creation of standardized template that can be used by all members of your group for reporting of brain CT, brain MRI, carotid duplex, carotid MRA, and carotid CTA.

Finally, I view the P4P initiative as a work-in-progress. There will be bumps along the way as CMS makes its first foray into guiding (dictating?) patient care. Leave it to our government to turn something as simple as reporting blood in the head into a subject that I could barely understand even after reading all of the supporting documentation. Good Luck!

FELLOWSHIP COMMITTEE

Michael B. Love, MD, FACR

Congratulations to this year's Fellows of the ACR from Pennsylvania:

- **Indra Das**
- **Richard Duszak**
- **Keith Haidet**
- **William Herring**
- **Carolyn Meltzer**
- **Donald Mitchell**

They were honored at the recent convocation in Washington, DC.

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, FACR, 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 a draft of the possible program agenda:

Morning 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. Simin Dadvapour, MD
- Pay for Performance Update. Mark Gordon, ACR (Director, Quality and Patient Safety) & Robert S. Pyatt, Jr., MD, FACR, Co-Chair, ACR Imaging Provider Report Card (IPRC)
- Panel Discussion on Morning Topics

Afternoon Program

- Preparing for Radiation Terrorism. Joel Greenberger, MD
- Break Out Sessions for Radiation Oncology and Diagnostic Imaging
  I. Radiation Oncology Breakout Session, 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, Magee-Women's Hospital

Honored Radiologist Evening Program

Michael Federle, MD – Honored Radiologist
Mitchell Tublin, MD – Honored Lecturer

RESIDENTS AND FELLOWS SECTION

Michael F. Goldberg, MD, MPH

In the May issue of the *American College of Physicians Observer*, a monthly journal from the ACP, there was an article about the potential role of handheld/portable ultrasound units in the primary care setting. The idea of internists doing limited ultrasound exams doesn't seem inherently repugnant to me: I am constantly impressed by the power of imaging in diagnosis and I can still remember being frustrated by the limitations of the physical exam. Thus, why not allow an internist to augment his or her physical exam with the power of imaging?

As I continued researching the notion of non-radiologists doing ultrasound, I found an organization (http://www.emergencyultrasound.com) that provides ultrasound courses taught by emergency physicians for emergency physicians.

In the "Introductory Ultrasound Course," with 22 hours of instruction and hands-on training, the course purports to "empower" emergency physicians to perform and interpret their own ultrasound studies. That's correct: 22 hours. With regard to obstetrical and gynecological ultrasound, for example, there is a total 1.5 hours of lecture followed by 4 hours of "training lab." The presence of this kind of course should be an insult to all radiologists who have trained in a radiology residency. It should also concern patients requiring care in the emergency departments, patient advocacy groups, and legislatures. I personally have done over 300 ultrasound exams during my 3 years of training and each of these exams was personally reviewed by a radiologist with years of experience and specialty training in ultrasound. My fellow residents have had similar experience. Similarly, we have all attended hundreds of hours of lecture and will have to pass exams in physics and clinical radiology before our accrediting body approves us to practice.

As an added insult, the website's home page states: "…You could do this [perform your own ultrasound] without the reliance on other (often reluctant) consultants who may not have the best interest of the patient or you in mind at the time." For this organization to question radiologists' motivation and integrity on a public website is unprofessional, at best, and slanderous, at worst.

The bad news is that this will be just one of many challenges that face radiology. The question is: who will represent radiology? Who will be our advocates? Who will educate the public, other physicians, and legislatures about the issues facing radiology? The answer to all of these questions is the American College of Radiology and its state chapters, including the Pennsylvania Radiological Society.

With regard to resident-specific issues, the ACR's Resident and Fellow Section is charged with advocating on our behalves. The hot topic at this year's meeting in May was the proposed change to the timing of the oral boards. The RFS will be advocating to maintain the current timing of the boards (at the conclusion of residency). In the past, the RFS has weighed in on proposed changes to AFIP, the length of radiology training, and increasing exposure of residents to cardiac imaging.

Whether the issue is turf wars, reimbursement, appropriateness criteria, or training, this year's annual meeting once again demonstrated that the ACR and its state chapters are critical to the future health of radiology. As residents, we have the most to gain (and lose) in how the issues our resolved. I encourage all residents to be knowledgeable about the issues facing radiology and to advocate on behalf of our profession.

THE PRS ON CAPITOL HILL

Richard N. Taxin, MD, FACR

Elaine Lewis, Marcela Böhm-Vélez, Irv Ehrlich, Tim Farrell, and I spent the day after the ACR meeting in May traversing the halls of Congress to meet with our Congressional representatives and their staffs to work on behalf of the radiologists throughout our commonwealth. The primary issue on which we lobbied was to place a moratorium on the cuts to imaging reimbursement enacted in the Deficit Reduction Act of 2005 so that the issue may be further studied with the hope of permanently rescinding the cuts and seeing that comprehensive imaging reform legislation is passed. The legislation we are urging to be passed is H.R. 1293, The Access to Medicare Imaging Act of 2007 and a companion Senate Bill. Congressman Joe Pitts from Pennsylvania has been a prime supporter of this legislation.

We met with Representatives Jim Gerlach, Joe Sestak, Mike Doyle, and Todd Platts, along with their staffs. We also met with the staffs of Senators Bob Casey and Arlen Specter (I had met personally with Senator Specter the previous day). The discussions were free-wheeling and useful. We are happy to report that while Rep. Gerlach and Sen. Casey had already signed on as sponsors, after our visits Rep. Doyle and Sen. Specter also agreed to be sponsors of the legislation. We expect to hear positive news as well from the offices of Rep. Platts and Sestak. Should you have the opportunity, thank your elected representatives for their support. This is only the beginning, but indeed an auspicious one.

SENIOR COUNCILOR'S REPORT

Irving Ehrlich, MD, FACR

The ACR Annual Meeting and Chapter Leaders Conference was again held at the Hilton Hotel in Washington, DC, last month. This year's resolutions were predominantly cooperative in origin (with other societies), meaning that they could not be changed substantively from the floor of the meeting. Thus, while there was some discussion on some of those resolutions, they were passed without much debate. Notably, however, there was significant discussion concerning several of the non-cooperative resolutions. This included the rejection of one resolution relating to MR spectroscopy that was felt to be lean on details. Our own Matt Pollack was one of the leaders in its downfall. The other resolution of note addressed the issue of encouraging younger members to participate in the ACR by allocating a councilor/alternate councilor seat to the under-40-year-old group. This resolution engendered a lively discussion. Everyone who spoke agreed this is an important issue to the future of the society and possible solutions were discussed. Another issue that did not require much discussion was a suggestion that the annual meeting be held at different sites around the country rather than continue to have it in Washington, DC. This idea was rejected based on the belief that a strong showing on Capitol Hill was necessary to have our voices heard clearly.

I would like to thank the fifteen councilors and alternate councilors who participated in this year's meeting, including those chairpersons (Elaine Lewis, Melvin Deutsch and Beverly Coleman) who were unlucky enough to have been given that assignment.

REFERENCE COMMITTEE I - Elaine Lewis, M.D.

Resolutions 1 through 4 and 6 through 9 were adopted with no significant changes.

Resolution 5 (Practice Guideline for the Performance of Magnetic Resonance Spectroscopy of the Brain), which was a collaborative resolution with ASNR, was defeated.

Resolution 10 (ACR Policy on Applying Uniform Credentialing Criteria to Grant Privileges for Image-Guided Interventional Procedures Performed by Multiple Specialties) was referred due to concerns about unintended consequences. This will be evaluated by the Board of Chancellors and may be resubmitted at a future meeting depending on the Board's decision.

Resolution 50 (Timing of the Oral Boards in Diagnostic Radiology) was an add-on resolution and was defeated.

ANNOUNCEMENTS

**** August 2-5, 2007**: 25th 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 Gilda Cardenosa, MD, Christopher Comstock, MD, Farhad Contractor, MD, FACR, Laurie L. Fajardo, MD, MBA, FACR, Terri-Ann Gizienski, MD, MPH, Steven E. Harms, MD, FACR, Thomas B. Julian, MD, FACS, Stuart S. Kaplan, MD, Louise Miller, RTRM, Dorothy McGrath, BHE, Ellen B. Mendelson, MD, FACR, Ingrid E. Naugle, MD, FACR, Judi Painter, RT, MBA/HMSA, William Poller, MD, FACR, Shelia Solomon, MS, Jules H. Sumkin, DO, 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.**

Breast Imager wanted to staff a new, 10,000 square foot, state-of-the-art breast center in Sharon, PA. The center is part of the Sharon Regional Health System, which is located 70 miles north of Pittsburgh, PA. Flexible schedule includes opportunity to work at Allegheny General Hospital Breast Care Center in Pittsburgh. Extremely competitive compensation and vacation package. Please contact William Poller, MD, FACR, at 412-359-8366.