Bulletin... Summer 2009

The Pennsylvania Radiological Society

A Chapter of the American College of Radiology

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PRESIDENT'S MESSAGE

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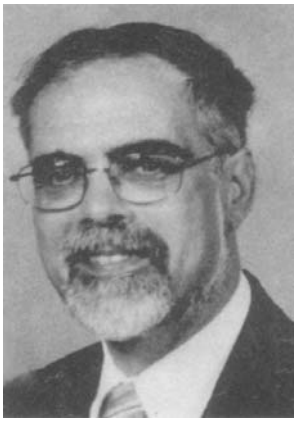

The spring board meeting, which was held in conjunction with the ACR Annual Meeting and Chapter Leadership Conference (AMCLC), was well-attended. The usual budgetary discussions were held without too much angst, in spite of the current economic climate.

An issue that had been raised at the annual meeting of the Pennsylvania Radiological Society (PRS) last fall was again discussed. That was the question of whether or not the current one-year term for president should be changed to two or more years. The logic behind this idea was that it takes time for the incoming president to become accustomed to the job and by that time, perhaps half of the one-year term has gone by, leaving only six more months for the president to accomplish his or her goals.

Having spoken with representatives from several state radiological societies in my capacity as CACC representative in the semi-annual meetings sponsored by the ACR at the RSNA and ACR annual meetings, I can say that I have heard the gamut of pros and cons of the issue. Pennsylvania is one of the largest ACR chapters and also one of the few that has a paid executive director and lobbyist. Other smaller chapters with significantly smaller membership rolls depend on volunteers to perform the day-to-day activities required to maintain their chapters.

While we certainly depend on our volunteer board members, committee people and officers, our pool of potential "involved people" is much bigger than the majority of ACR chapters. Our executive director and the paid staff perform the nitty-gritty work that keeps the PRS going. That leaves the volunteer radiologists, radiation therapists, physicists. and residents time to do the other, somewhat more important work of determining which way the society should move in our ever-changing world of imaging.

"We, as a group, need to make it easier for our colleagues in small- and medium-sized practices to participate in our society."

Of the societies that I have heard of that have longer than one-year terms for their presidents, the lack of availability of a cohesive group that can act like our executive committee

appears to be a common denominator. Our structure assures that there is a long-term societal memory and, more importantly, a long-term strategic development process.

The office of president may be held by a single individual for only one year. However, that individual would have been a part of the development process for at least three (and probably more that ten) years before ascending to the lofty heights of president. He or she would have served as a board member, councilor, and/or member of the executive committee for multiple terms. His/her ideas would have been shared with other members of the board and executive committee over that period of time. The group's purpose would have been distilled and its goals would have been refined so that, by the time the individual becomes president, the goals would have been shared (or should have been) for the good of all. It would then become the job of the president to act as the conductor of the symphony, rather than the 1st violinist (or in my case, 2nd trumpet). Our executive director does the dirty work.

The other reason that I would not be in favor of increasing the length of term of president is more practical and pragmatic for someone in a practice position similar to mine. We, as a group, need to make it easier for our colleagues in small- and medium-sized practices to participate in our society. Asking someone from such a group to guarantee their availability for a 2 or 3 year period as president may make it more difficult to have that person accept the honor and responsibility of the position.

As the changes in our working environment occur with increasing frequency, the challenges of maintaining the level of involvement necessary to guarantee the successful future of our society become more difficult. For all of these reasons, I believe that a one-year term as president in conjunction with our board and executive committee structure is appropriate.

EDITOR'S COLUMN

Thomas S. Chang, MD, FACR
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Imaging Self-Referral

A couple of months ago, I read an excellent AuntMinnie.com article about the role radiologists play in enabling much of imaging self-referral by non-radiologists. In identifying the culprits of self-referral, we in radiology often point our fingers at the cardiologists, orthopods, internists, and others. And yet, we forget to point those same incriminating fingers at ourselves. Not all of us, mind you. But many of us. Could it be you or someone you know?

I encourage all of you to read the entire article, "*Imaging self-referral: An inside manifesto*," written from the standpoint of a composite radiologist who benefits from imaging self-referral.

The article can be found online at:
http://www.auntminnie.com/index.asp?Sec=sup&Sub=imc&Pag=dis&ItemId=85062.

The article is so insightful and entertaining that I just had to share some tasty morsels from the article with you.

"My name is Bill W. Like the fellow in the AA meetings. I'm a radiologist, and I'm addicted to imaging self-referral."

"I didn't have much of an opinion about self-referral early on. It didn't matter to me who owned the scanner. If we, the radiologists, couldn't or didn't, what difference did it make if it belonged to the hospital or to some internists across the road?"

"If we even heard so much as a rumor about an internist or orthopod installing an MRI or a CT system (or even a digital x-ray machine!), we were on the phone offering our services. After all, we reasoned, someone had to read the exams. The patient might as well get the benefit of our expertise, and we might as well make the money. Everyone wins."

"Today, we are the kings of outside reading in our region. We interpret hundreds and hundreds of exams every day from clinician-owned equipment… We make thousands of dollars a day in this manner, while our colleagues make tens and hundreds of thousands. But it's all good, isn't it? Everybody wins."

"Radiologists contribute to the self-referral and over-utilization problem by reading studies for the self-referrers."

"The breach in trust lies in the ability of our friends to generate money by ordering a test that they don't actually perform… [W]hen the internist orders a CT scan on the machine in his office, he profits instantly without any further effort on his own. He deludes himself, and his patient, about the motivation behind the scan and even the presence of the scanner in his office altogether. It's here for your convenience, he tells his grateful, trusting patient, and so it would seem."

"If the clinicians were so interested in patient convenience, they could offer lots of other things. How about extended office hours, valet parking, meals, or at least drinks and snacks? Nah. Convenience is a smokescreen, nothing more."

"And I'm bothered by something else. If the rate of scanning requested by those who profit thereof is normal, then those without scanners are underserving their patients. Since no one has come forth with the latter accusation, I have to think that the truth is rather the other way around -- that our friends and partners are overutilizing their equipment."

"Radiologists who enable this, and I'm one of them, need to stop and look at what they are doing. This is dirty money we are generating, and we need to walk away. But I can't. The draw is too great."

So you see: Radiologists contribute to the self-referral and over-utilization problem by reading studies for the self-referrers. Some of us get involved in such ventures with the clinicians. I'm sure most clinicians who own their own equipment want to do what's best for their patients. But sometimes the allure of extra income becomes too irresistible. Once they've been bitten by the money bug, it's hard to go back. But the fact of the matter remains: While they are the self-referrers, we are their accomplices.

In This Issue

This issue is filled with a host of timely articles. Matt Pollack writes about the highlights of the recent ACR Annual Meeting from the Senior Councilor's point-of-view, while Jason Itri describes what he gained from the meeting as a resident representative. Elaine Lewis updates us on the pertinent matters being considered at our state legislature in Harrisburg. Laura Coombs, from the ACR, discusses the registries that have been developed for radiologists to use.

Mike Love congratulates the three Pennsylvania radiologists who were honored as Fellows of the ACR in Washington and lists those who will be honored next year. Finally, our President, Irv Ehrlich lays on the table the issue of whether our presidents should serve one-year or two-year terms. Which is better for the Society? Read his column and find out which he favors and why.

Ideas for Future Issues

Bob Pyatt passed along to me a great idea for future articles in our newsletter. We would love to have a Personal Profiles section in each issue in which one board member or officer is profiled, along with his/her photo. Interesting information could include why that person chose medicine and/or radiology, why s/he became involved in our Society and organized medicine, how the Society and the ACR benefit his/her practice, why s/he stayed in Pennsylvania when so many of our colleagues were leaving the state, what s/he likes best and least about radiology in general or radiology in Pennsylvania, etc. The potential topics are endless.

If you would like to write a profile about any board member or officer (past or present), even yourself, please email your submission to me at tscjiv@verizon.net.

MCARE: HISTORY AND UPDATE

Elaine Lewis, MD
West Reading Radiology Associates
Reading, PA

There are many issues at stake in the 2009 legislative year for Pennsylvania radiologists.

The first issue, as a follow-up to my Spring 2009 article, is the Mcare phase-out. As you know, there was no abatement for the Mcare portion of liability insurance in 2008. Unfortunately, according to many of our legislators, there were few complaints from physicians about the lack of an abatement. Due to the significant state budget deficit for the upcoming year, the Pennsylvania Medical Society (PMS) will concentrate on the Mcare phase-out and unfunded liability, as opposed to a 2009 abatement.

Act 13, which was passed in 2002, begins a phase-out of the Mcare portion of liability coverage beginning in 2010. At this time, Pennsylvania physicians will begin purchasing $750,000 in liability coverage (previously $500,000) from their primary carrier. The Mcare assessment will be for the remaining $250,000 of required coverage.

However, due to the "tail" of the Mcare coverage, physicians will also be assessed for claims made for prior years and therefore will actually be paying more for their total coverage than if they purchased the entire 1 million in coverage from their primary carrier. This is termed the unfunded liability. Governor Rendell has agreed that the unfunded liability should be paid from the Health Care Provider Retention Account, which is projected to have 700 million dollars by the end of June.

"House Bill 1358 … would require that a written summary of any test be sent to the patient within 10 days."

The difference in opinion is how much will be needed and when the unfunded liability begins. The PMS estimates that 450 million dollars will be needed to begin covering the unfunded liability in 2010. Governor Rendell's estimate is 280 million dollars to begin covering the unfunded liability in 2013. Without the support of physicians in Pennsylvania, the difference will be paid by all physicians with a current license

to practice in PA, whether practicing for 20 years or beginning their first year of practice. Please go to the PMS website (www.pamedsoc.org). There is a link in the bottom box titled, "Ask Your Legislators to Support Our Mcare Phase-Out Plan." The box on the following page has a link to Capwiz, which makes it easy to contact your legislators and will only take a few minutes of your time.

A second issue is House Bill 1358, which would require that a written summary of any test be sent to the patient within 10 days. Our society strongly supports giving the patient a copy of the report after the referring physician has had the opportunity to meet with the patient and review the results. The PRS has many concerns with the present bill. As an example, the report may be misunderstood by the patient, thereby generating unnecessary anxiety on the part of the patient. Under present law, a patient may request a copy of their report, and the patient could be given information as to how to request a copy, if desired. The PMS has agreed with the concerns of the PRS and also opposes the bill in its present form.

Finally, you should all be aware that both certificate-of-need and self-referral legislation has been introduced. House Bill 247 covers both CON and self-referral. House Bill 1405 addresses the self-referral issue alone. The Pennsylvania Radiological Society is supporting the concept of both of these bills.

As you can see, there is much at stake in Pennsylvania alone. There are also many issues on the national level; these will be discussed in the next Bulletin.

ACR DATA REGISTRIES

Laura P. Coombs, Ph.D.
Director of Data Registries
American College of Radiology

There is a growing demand across the healthcare enterprise to develop and report measures to monitor quality. In such an environment, radiologists can either take the lead to develop, collect, and report on the measures that they feel are important, or they can let others make the decisions for them.

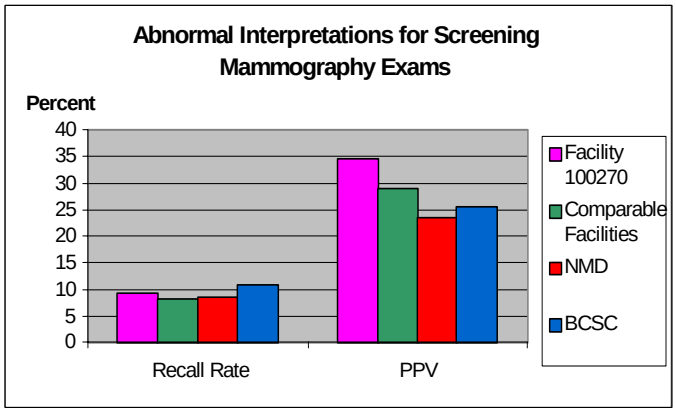
To take a proactive lead in addressing the growing demand for quality improvement programs and performance measurement and feedback, the American College of Radiology has established the National Radiology Data Registry known as NRDR (pronounced "Near Dear"). This data warehouse is a compilation of data registries designed to enhance individual practices, the specialty of radiology, and the care patients receive by providing accurate and objective measures of practice processes and outcomes.

The infrastructure for NRDR was set in place in 2006 with the creation of the National Oncology PET Registry (NOPR). Medicare reimbursement for certain cancers was obtained through NOPR if the patient's referring physician and the provider submitted data to a clinical registry to assess the impact of PET on cancer patient management. NOPR now includes records for over 100,000 patient scans.

Today, several registries have been added to NRDR, allowing facilities to benchmark their results against aggregate data of similar facilities and the nation as a whole. Facilities are provided with semi-annual reports including tables and graphs of relevant process and outcomes measures.

One such registry that began piloting in the Fall of 2008 is the General Radiology Improvement Database (GRID). GRID allows facilities and physicians to compare turnaround times, patient wait times, reacquisition rates, and many other process and outcome measures with other facilities and practices of similar size and type. Data for GRID is submitted monthly through the NRDR website (NRDR.acr.org) and is now open for enrollment to all imaging facilities.

Another registry that will begin enrolling sites in July 2009 is the National Mammography Database or NMD. The NMD leverages data that radiology practices are already collecting under federal mandate by providing them with comparative information for national and regional benchmarking. Measures included in the semi-annual feedback reports include important measures such cancer detection rates, positive predictive value rates, and recall rates (see below).



Submitting data to the NMD requires no extra data entry beyond what is already being collected at the site. Using an NMD-certified BIRADS® software vendor, data is extracted from the site's database and is uploaded to the NMD website in a simple one-click process. The NMD has been submitted as a Practice Quality Improvement (PQI) project as part of the Maintenance of Certification requirement by the American Board of Radiology. In addition, four of the measures included in the NMD have been submitted to CMS to be included as registry-reported Physician Quality Reporting

Initiative (PQRI) measures. The NMD is also being considered as a requirement for Breast Imaging Centers of Excellence. Finally, facilities that participate in the NMD (or any of the NRDR registries) can access the aggregate data for research purposes through the NRDR Steering Committee.

"The National Radiology Data Registry … is a compilation of data registries designed to enhance individual practices, the specialty of radiology, and the care patients receive."

Leading breast imaging experts strongly support participation in the NMD. "The NMD represents a valuable tool that will allow breast imagers to track their results in a meaningful, comprehensive way," said Carol Lee, M.D., FACR, chair of ACR Commission on Breast Imaging. "It also affords the opportunity for us to set benchmarks and improve our performance where needed. NMD will allow us in the breast imaging community to demonstrate our ongoing commitment to quality care."

Other registries included in NRDR are the CT Colonography Registry (CTC) which collects data critical to evaluating performance of CT colonography and is an approved PQI project; the IV Contrast Extravasation Registry (ICE), an approved PQI project sponsored jointly by the ACR and the Society of Uroradiology focused on CT IV contrast extravasation rates; and the Dose Index Registry (DIR), currently in its pilot phase. The DIR focuses on CT and allows participants to compare average dose estimates across facilities using the image exchange software developed by ACRIN.

For more information about any of the NRDR registries, please contact Laura Coombs or Lu Meyer at nrdr.acr.org or 1-800-227-5463.

THE 2009 ACR ANNUAL MEETING: A NEW PERSPECTIVE

Jason N. Itri, MD, PhD
Radiology Resident
University of Pennsylvania

If someone had asked me a few months ago about the American College of Radiology (ACR) and what it does, I would have replied, "Case in Point" and stopped there. Almost two years into residency and that was the extent of my familiarity with the College. I don't think it would be an exaggeration to say that many residents share this pinhole view of the ACR. Residency programs are charged with the vital task of teaching us how to be good clinicians.

Yet an essential component of our education is nowhere to be found in our collective curricula. Many of the decisions that determine how radiology is practiced in the real world are made outside the safe confines of residency, and it is becoming increasingly important that we not only understand how these decisions are made, but that we take an active role in the decision-making process. With this in mind, I will highlight some of the key concepts discussed and debated at the recent ACR conference from the perspective of someone who truly had an eye-opening experience.

My favorite quote:

"If you're not at the table, you're on the menu."

These ominous words were uttered on the first day of the ACR meeting, as well as at every radiologic meeting I've attended over the last two years. When Congress, governmental groups such as CMS (Centers for Medicare and Medicaid Services), and managed health-care organizations meet to discuss important issues such as access to imaging services, self-referral, and over-utilization, physician reimbursement and fee schedules, and health care policy, it is critical to have representation at those meetings. If your group or organization is not represented, your concerns might as well not exist. One of the vital functions of the ACR is to represent radiology and radiation oncology at all levels – local, state, and national. The ACR is the ONLY organization that lobbies solely on the behalf of radiologists[1]. Remember, though, that the effectiveness of the ACR in performing this function greatly depends on how many members it represents – thus the importance of becoming a member.

"Many of the decisions that determine how radiology is practiced in the real world are made outside the safe confines of residency."

My favorite presentation:

"More than meets the eye" by Richard Gunderman, MD, PhD

Dr. Gunderman's message was clear: there is a lack of leadership in radiology. That is not to say that leaders in radiology are not doing a good job. To the contrary, current leadership in radiology is working tirelessly to ensure the future of our specialty. The problem is that there aren't enough leaders. Dr. Gunderman presented some startling facts about leadership in both radiology and medicine to the Resident and Fellow Section, followed with complementary presentation about the different components of leadership. Why did he give these presentations to the residents and fellows? It is because we represent the future of our specialty.

If we are to develop and cultivate future leaders to ensure the growth and prosperity of our specialty, then residents and fellows are where we should start. So not only is it important to become a member of the ACR, it's equally important to get involved.

My favorite experience:

Meeting all the other residents and fellows who are members of the ACR

The first person I sat next to when I arrived at the breakfast bright and early Saturday morning was a first-year resident from a program in Washington, DC. At first it was surprising that a first-year resident would be attending the ACR conference, mostly because I assumed the conference was for senior residents who had more experience and a better understanding of the many difficult issues facing radiology. Then I realized my mistake – we all have a shared responsibility in ensuring the future of our specialty. It doesn't matter if you are a first-year resident or a fellow, we all have something to offer. There are countless opportunities within the ACR to get involved and participate in ongoing projects. If you did attend the ACR leadership conference, download the ACR presentation and tell other residents at your program about it. Getting others involved is an incredibly valuable and rewarding experience, and it is vital to the success of the ACR.

Final thoughts

The reality is that there are difficult times ahead for radiologists. There will also be great opportunities, particularly for those who choose to get involved. The ACR offers fellowships in education, economics and health policy, quality and safety, and health services research. You can volunteer to be on the executive committee and serve as a liaison to other professional societies. Go to the ACR website and learn about the "Face of Radiology" and "Heart of Radiology" campaigns. Click on the Residents tab and read about ongoing projects such as the Dollars and Sense on-line resource, "Getting Started" handbook, AFIP Housing Zone, Resident Grassroots committee, and RFS toolkit. Or simply mark May 15-19, 2010, down on your calendar to attend the next ACR Annual Meeting and learn about the important issues facing radiology, what the ACR is doing about them, and the many opportunities for residents and fellows to get involved. We look forward to meeting you.

Become a member, get involved, get others involved. Go to http://rfs.acr.org to learn more.

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[1] Excerpt from the ACR RFS PowerPoint 2009 presentation provided by the ACR RFS.

FELLOWSHIP COMMITTEE REPORT

Michael B. Love, MD, FACR
Pennsylvania Hospital
Philadelphia, PA

Newest Fellows

The degree of Fellowship in the American College of Radiology was conferred upon the following Pennsylvanians at the 2009 meeting of the ACR, held recently in Washington, DC:

- Vikram Dravid, MD
- Eric N. Faerber, MD
- Rosaleen B. Parsons, MD

The Committee joins the rest of the membership in sincerely congratulating these individuals for their remarkable achievements.

Pending Nominees

The candidacy of each of the following Pennsylvanians has been endorsed by our Board of Directors, and their nomination materials have been sent to the ACR for review. If approved by the ACR, all five will become Fellows in spring 2010. They are:

- David S. Buck, MD
- Richard P. Kennedy, MD
- Elaine R. Lewis, MD
- Mitchell D. Schnall, MD, PhD
- Mark Trombetta, MD

New Cycle for Submission of Fellowship Nomination Forms

The next cycle for consideration of new nominations is almost over. Members are urged to review the qualifications for Fellowship approval; these vary with length of membership and are readily accessed from the ACR web site (www.acr.org). Anyone wishing to discuss his/her Fellowship potential should feel free to call me at any time at 215-829-6657.

All nomination materials must be prepared in complete compliance with the procedures defined by the Committee on Fellowship. These can be accessed on the PRS website. Send all materials directly to me, NOT TO THE ACR OR THE PENNSYLVANIA RADIOLOGICAL SOCIETY.

Failure to fully comply with our procedures will likely result in delay in Fellowship consideration. The strict deadline for receipt of completed Fellowship nomination dossiers is **July 1, 2009**.

SENIOR COUNCILOR'S REPORT

Matthew S. Pollack, MD, FACR
Warren Radiology Associates
Phillipsburg, NJ

At this year's Annual Meeting and Chapter Leadership Conference, the ACR Council deliberated and voted on 37 Resolutions. The PRS was represented by 15 Councilors, but many additional Councilors and Alternate Councilors contributed by spending many weeks reviewing the draft resolutions on-line.

Most of the resolutions were new or revised ACR Practice Guidelines and Technical Standards. Most were voted on and passed by the Council with little fanfare. Of note, the ACR Guideline for the Performance of Scrotal Scintigraphy was allowed to sundown as the technique has been supplanted by color Doppler sonography for the evaluation of suspected testicular torsion.

Two proposed revisions to the ACR bylaws garnered the most interest and debate. One dealt with ACR Fellowship nomination review. Some members thought the proposed new language allowed the ACR to bypass State Chapters in the fellowship nomination process, undermining the chapters' role in the process, serving to marginalize them. Others argued that some State Chapters were less than objective in the fellowship nomination process and rejected candidates had no recourse at the College level. Ultimately the Resolution was adopted after language was added requiring a Chapter that vetoes a member's fellowship application to submit a written explanation to the ACR Committee on Fellowship Credentials.

The other controversial proposed bylaws change would have allowed radiation oncologists to become ACR members through CARROS membership without being members of their State Chapters. There was concern among many that this would be an undesirable precedent. Others noted that the proposal was a manifestation of a feeling of disenfranchisement by members of some subspecialty societies. Ultimately the Council voted to refer the matter back to the Board of Chancellors.

I want to thank all of my fellow Councilors and Alternate Councilors for their time and effort and valuable input.

ANNOUNCEMENTS

Alfred B. Kurtz Receives Educator Award

This year, the Philadelphia Roentgen Ray Society presented the Mary Fisher Outstanding Educator Award to Dr. Alfred B. Kurtz, Professor of Radiology, Obstetrics and Gynecology at Jefferson Medical College. The award acknowledges Dr. Kurtz's career in academic Radiology, which has been devoted to his passion in teaching ultrasound to generations of students, residents, and fellows, not only in the Philadelphia area, but also nationally and around the world, through his many lectures, well-known books, and other teaching materials. The award was presented at the PRRS Annual College Bowl on May 7, 2009.

Harvey L. Nisenbaum Becomes AIUM President

Harvey L. Nisenbaum, M.D., FACR, FAIUM, FSRU, Associate Professor of Radiology at the University of Pennsylvania School of Medicine and Chairman of the Department of Medical Imaging at Penn Presbyterian Medical Center in Philadelphia, PA, became the 28th President of the American Institute of Ultrasound in Medicine (AIUM) at its Annual Meeting in New York City, NY, April 3-5, 2009.

The AIUM is a multidisciplinary association consisting of approximately 8,000 members including physicians, sonographers, scientists, engineers, other healthcare providers, and manufacturers of ultrasound equipment. The AIUM is dedicated to advancing the safe and effective use of ultrasound in medicine through professional and public education, research, development of guidelines, and accreditation.

August 6-9: Breast Imaging Seminar

27th Annual Pittsburgh Breast Imaging Seminar to be held at the David L. Lawrence Convention Center, with all events on one floor, Pittsburgh, PA. The seminar includes a special day-long Stereotactic Biopsy session for physicians and technologists.

Featured speakers to include Gilda Cardenosa, MD, Christopher Comstock MD, Farhad Contractor, MD, FACR, Terri-Ann Gizienski, MD, Steven Harms, MD, FACR, Mark Helvie, MD, FACR, Thomas Julian, MD, FACS, William Poller, MD, FACR., Jane Raymond, MD, Maria Velasquez, MD, Lawrence Wickerham, MD. Course Director: William R. Poller, MD, FACR. For further information please call 412-359-4952 or e-mail Cheri Jackel at cjackel@wpahs.org.