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The Pennsylvania Radiological Society

A Chapter of the American College of Radiology

Executive Director

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PRESIDENT'S MESSAGE

Change

For my first president's message, I'd like to emphasize that "CHANGE is in the Air." After celebrating our centennial year in 2015, we are looking forward to what is in store for the Pennsylvania Radiological Society as we begin the next 100 years. We have a new Executive Director, John Klein who will be celebrating his first anniversary in this position in August. He is actively engaged in reorganization by cleaning our office, getting rid of outdated equipment and purging our records. We intend to be much more electronic in the future without forms, photos and documents which were kept in storage facilities for years at a significant cost.

CHANGE has always been a topic of conversation in our world! Here are a few quotes I'd like you to recall from my inaugural address. John F. Kennedy said "Change is the law of life. And those who look only to the past or present are certain to miss the future." Benjamin Franklin said "When you're finished changing, you're finished!" Maya Angelou said "If you don't like something, change it. If you can't change it, change your attitude." Winston Churchill said "To improve is to change; to be perfect is to change often." The goal of the leadership of the Pennsylvania Radiological Society is to change with the times as we begin the journey toward our bicentennial.

A great deal of effort was expended last fall and winter on defining our society anew with attention to our core purpose, service to our members, stating our organizational values and elucidating a vision for the next 100 years. I will have more to report in our next newsletter. The Executive Board and Council met in Washington DC in May at the annual American College of Radiology meeting to deliberate on a number of issues as usual. The ACR instituted a major change last year as we had the first "all member" meeting in the history of the College. This gathering is always just a phenomenal time for networking between our members and offices as well as those from all of the other state societies. Now that any member can attend both the governance and educational components of this meeting, there is so much activity that one must choose which lectures, presentations, receptions and other events to attend. CHANGE has also come to the College because for the first time in its history, a patient addressed the ACR Council from the Council floor and the speaker was Donna Adams, a patient advocate.

Another newsflash is that the state of Pennsylvania now has three members in major leadership roles in the College. Please congratulate Dr. Robert S. Pyatt, Jr, a past PRS president, who joins me on the Board of Chancellors after his election as the new chairman of the Commission on General, Small and Rural Practice. Similarly, Dr. Elaine Lewis, also a past PRS president, was 1 appointed to the Council Steering Committee. Elaine, in her capacity as chairman of our bylaws committee, has been working tirelessly with her members toward the first major revision of the laws governing the PRS in many years. More information will be forthcoming in the next few months so that we will be ready to handle any changes that may arise in the next century that could potentially relate to the governance of our society.

I am pleased to announce that we had 3 radiologists from our state who were inducted as new fellows of the College in 2016. They are Barton F. Branstetter IV, M.D., Michael Ian Rothman, M.D and Margarita Louise Zuley, M.D. As is our tradition, a dinner was held in their honor during the annual meeting. Kudos to Dr. Marcela Bohm-Velez and the fellowship committee who worked diligently with our society leadership to institute another major change which was to switch the deadlines in our fellowship application process. The PRS dates would correspond to the same dates employed by all of the other states.

The 101st annual meeting of the Pennsylvania Radiological Society is being held at the Hyatt at the Bellevue in Philadelphia,

September 16 – 18, 2016. The room block is available and open for reservations. I am also pleased to announce that Dr. Mary H. Scanlon is the PRS Honored Radiologist for 2016. Mary has served for approximately 10 years as the residency program director in the radiology department at the University of Pennsylvania Medical Center. In this capacity, she has had a tremendous impact on generations of radiologists and their patients. In addition, Dr. Scanlon has contributed significantly to organized radiology having served as president of both the Philadelphia Roentgen Ray Society and the Pennsylvania Radiological Society. Mary has continued to be an exemplary member of the PRS. She has tons of political energy and is very active in coordinating our Hill visits and urging us to contribute to RadPac, both tasks she performed this year with her usual zeal. She still serves on the PRS Board of Directors and chairs the PRS Nominating Committee, Resident Liaison Committee and the Committee for Leadership Development. Please join me in honoring Dr. Scanlon for her many years of dedicated service to radiologists in the state of Pennsylvania. We hope to have a record attendance in Philadelphia as we move forward into our next century!

Beverly G. Coleman, MD, FACR

Philadelphia

Editor's Note

Give patients their reports

There's a movement in healthcare which believes patients should have access to their medical notes. This movement is known as the Open Notes movement. The experience of patients having access to their notes has been studied. Patient satisfaction increased. Patients felt more involved in their healthcare. Some patients even edited their notes or annotated parts of it.

A movement in radiology calls for greater access of patients to their imaging reports. Whatever the merits and drawbacks of allowing patients access to their (yes, there are drawbacks, there always are), there is no doubt that this is the future. It is better to embrace the future, than be gripped by it.

Allowing patients access to their reports is an IT fix. Nobody needs to send reports by mail. Come to think of it, very few people send anything by US mail these days. When was the last time you wrote a letter (not email) and posted it?

What are the drawbacks allowing patients access to their reports? The chief drawback is that it will short circuit the path between the patient and the referring clinician. The patient will know the results before the clinician. Is this a problem? Mostly not, but sometimes, yes. The patient may have questions about treatment and prognosis which the clinician might not have had time to formulate. The ambiguous nature of some radiology reporting may confuse the patient. Patients may not be able to distinguish between clinical relevance and information overload.

Are there advantages to patients seeing their reports? Yes, potentially several. Perhaps we'll write less baroque, more committal and less evasive reports. We may avoid the term "clinically correlate." How will the patient clinically correlate?

Patients should be given access to their reports. Not because it'll revolutionize healthcare. Not because it'll empower patients (it might empower some). Not because it's the right thing to do. Because it's 2016. Patients get a copy of their films and reports in India. This is the US. The most consumerist of consumer societies.

Saurabh Jha MD,
Philadelphia

ACR Annual Meeting: 2016. Reports from the Conference

The ACR annual meeting opened with a very interesting and challenging presidential address by Dr. David Kushner. The title of the address was "Things Change." In radiology, Dr. Kushner pointed out that we are facing many changes including different payment models, practice models and outpatient expectations. There is a shift to patient and family centered care which is predicted to change the way radiologists function. Dr. Kushner pointed out that this change represents an opportunity for radiologists to reinforce their value as members of the patient care team with a personal investment in whether the patient's condition actually improves or not.

Dr. Kushner noticed several factors driving these changes in radiology including technical advances, generational thinking, adjusted patient expectations, increased patient expectations, medical literacy and a growing emphasis on diversity. He stressed that radiologists will be called upon to demonstrate their value both to the patients and to the health care system at large. He encouraged radiologists to keep the patients in the forefront of everything that we do and to also prioritize our interaction with the patients. We should function as the physicians who explain the procedures, the reports and the implications of the diagnosis to the patient as a part of the healthcare team.

On Sunday, the keynote address entitled "Predictions for the Future of Healthcare" was delivered by Ezekiel Emanuel, MD PhD, who started his address with the statistic that in 2015, US healthcare spending hit a grand

total of $3.24 trillion. Dr. Emanuel pointed to the 2010 Affordable Care Act which he stated has led to a significant drop in the number of uninsured patients.

He stressed that radiology has not been left out of the advances that have occurred as a result of this act. Our specialty has been instrumental in flattening the use of imaging and initiating efforts to decrease radiation risk to patients. He also noted that radiologists have been more visible and more engaged in directly advising patients regarding their overall care. D r. Emanuel identified five megatrends that he predicts will influence the future of healthcare and these included a decline in the use of hospitals, more outpatient care, more home care, fewer medical tests and machine learning. All five of these factors are predicted to shape the future landscape of medicine, however from a radiology perspective, he noted that machine learning will be the most challenging and he identified this technology as “The Real Threat to Radiology." Dr. Emanuel encouraged radiologists to recognize the benefits of machine learning which he predicts will only get better over time with larger data sets, greater computing power and more computing experience.

This year the Moreton lecture titled “Stepping Out of the Darkness Into the Light.” The lecturer was a patient advocate, Andy DeLaO who began his talk by reminding radiologists why they chose to enter the imaging profession. He emphasized that for radiologists, there is a purpose, cause and belief in their work which is making a profound difference in the lives and the health of their patients. He stressed that since medicine has become industrialized, it is more about efficiency, metric and compliance.

All physicians in their profession have become buried under the push to do things faster and faster. He queried the audience as to how could a radiologist understand the patient's perspective and articulate that to the various stakeholders who influence the patient experience. He advised radiologists to go beyond providing what they assume is the ideal experience which is a very well-equipped radiology program. He stated that we need to create a connection that allows the patients to recognize the impact that radiologists have
on their healthcare stories.

He stated that the words that we use in our interpretive reports represent the stories of our patients that are being told by others. He was emphatic that there is a real danger in radiologists writing the descriptive reports but allowing other specialists to take these stories to the patient and incorporate them as their own results. The patients will then not understand the value of the radiologist in their medical care. If the patients don’t understand our value, then it is likely that neither will others such as the hospital administration, insurance companies nor politicians who govern healthcare legislation. Andy stressed that we either choose to connect with our patients or we will be eliminated!!

His advice on to how to start creating a “connection economy” was to address four issues: #1 Permission: Do you have permission to talk to the patient and more importantly are the patients willing to listen? #2 Trust #3 Exchange of ideas and #4 Coordination: How can you bring multiple people together to create a valuable exchange? Andy suggested that radiologists consider what he calls the four T’s: Be willing to spend TIME with your patients. If you do this, it means you'll earn their TRUST. If you have trust, you must be willing to have a TRANSPARENT conversation. Finally, together you and the patient help manage TRANSITION. Andy ended the Morton lecture with rules for radiologists to follow as they begin to create patient connections.

These rules are as follows:

1. Healthcare begins and ends with the patient.
2. Healthcare cannot exist without the patient.
3. Healthcare includes a physician defined as someone who chooses the art of healing and creates a team devoted to that art.
4. Only focus on one patient at a time number.
5. Give the patient your full attention by being certain to turn off all rings, dings, pings and other things.
6. Radiologists have the ability to showcase their value but in order to do this, they must step out of the darkness.

As always, one of the more interesting aspects of the ACR annual meeting was the economic forum. This year, it was divided into two parts. Rosemarie Ryan, Co – CEO and founder of CO: Collective, a strategy and innovation company that works to revolutionize the customer experience, was the speaker for the first part of the forum.

Her message to radiologists was very simple. Basically, she related that as radiologists, we must figure out what our story is. A radiology department or group practice has to settle on a brand identity and once that is done, it is necessary to identify the pain points, areas in the workflow that cause patient discomfort or dissatisfaction, and then eliminate them. She drew analogies to a number of diverse companies including Uber, JetBlue and Zappos citing examples of where visionaries in those companies sought to eliminate the unease of their customers. She emphasized that radiologists must undergo organizational change in order to engender customer loyalty. She explained that "storytelling" is not about advertising and that the radiology story needs to be built into the patient experience. She stressed that if radiologists do not do this, someone else will come along and do it for us. If we start to organize and define ourselves, this will help us know where to focus in the future.

The second portion of the economic forum included a number of speakers including Dr. James V. Rosin, professor and chairman at the Medical College of Georgia. Dr. Rosin spoke about the state of radiology in transition from volume to value and emphasized that we have a patient centric healthcare system which requires that we work with patients. He is a new chairman of the ACR commission on Patient and Family Centered Care. He outlined that his commission is working on tools and resources to help radiologists take action to make patients and families feel more comfortable and empowered in the healthcare setting.

Dr. Raymond K. Tu, Chief of Staff at the Not-for-Profit Hospital Corporation and chair of the ACR Medicaid Network focused his presentation on the importance of Medicaid for patients. He noted that Medicaid and Medicare account for approximately 40% of healthcare spending currently in the United States. He offered statistics about who benefits from Medicaid including 31 million children, almost 4 million Americans with disabilities and 11 million non-elderly adults who now have health care coverage due to Medicaid expansion under the Affordable Care Act. There is so much more that happened but just not enough time and space to relate everything.

Beverly G. Coleman, MD, FACR, Philadelphia

Harrisburg Legislative Update

Budget

Pennsylvania's annual budget will expire on June 30th. Our commonwealth's constitution requires a balanced budget be in place, that is, passed by the legislature and signed by the governor, by July 1st to start the new fiscal year. Last year the process was drug out until well after the New Year. Each budget season brings new challenges but a similar number of the same arguments. Taxation and spending. Pennsylvania operates the state government on about 30+ billion dollars each year. Major components of the budget are corrections, human services (formerly welfare) and school district funding. The remaining amount, less than 10%, is like food in a piranha tank to legislators.

Liquor

Governor Wolf signed a measure recently that will allow beer and wine sales in some convenience stores and some grocery stores.
Distilled spirits will still be available only at state run stores. This is a large departure from the administration's position one year ago. Though they stated that they wanted modernization, there was no indication that the

loosening of these regulations was coming. House republicans have claimed victory pointing out the recent law is a move toward privatization. The debate continues but this latest move will quell this battle for quite some time.

Medical Cannabis
Pennsylvania has joined the growing ranks of states that will permit the growing, distribution and use of cannabis oil for treatment of certain epilepsies and other neurological diseases. A limited number of licenses to grow the plant will be issued by the commonwealth. Distribution and use regulations are still being drafted by the Department of Health. What remains to be seen is how physicians and hospital systems grapple with this subject while considering administering a Schedule I controlled substance as defined by the federal government.

Patient Test Results Legislation

A subject that has been in the news for Pennsylvania-based radiologists for years, legislation requiring patient test results be sent directly to the patient, is still with us. Electronic medical records and a focus on this subject have improved communications with patients dramatically. However, specific requirements to send these results or a summary of these results, is part of the bill. PRS remains active and a key player as this subject persists.

Representing the Pennsylvania Radiological Society in Harrisburg is a great honor and a well-established respect has been built over the years for the organization. Routine interaction with the executive branch, legislators, senior staff and regulators is a big part of our function. We work constantly with the PA Medical Society and other specialties' government affairs staff. The support we receive from the PRS Executive Committee and Board is second to none. As we continue our work, watch for reimbursements as the number one issue for our physicians.

We thank you all for your efforts in the legislative arena.

John Kline,
Executive Director,
Pennsylvania Radiological Society

ACR Senior and/or Retired Section (SRS)

On Monday, May 16, 2017 the first official meeting of the SRS, a newly created section of the ACR, was held at the Marriott Wardman Park Hotel. Approximately 80 radiologists were in attendance. Following wine, beer and cheese, initial remarks were given by David Kushner and Catherine Everett and a panel of speakers was introduced by Richard Taxin.

Don Bachman, M.D. on "Preparing for Retirement - A Radiologist's Perspective"

Dennis Gogarty and Chase Deters from Raffa Wealth Management on "The Do's and Don'ts of Financial Management in Retirement

James Borgstede, M.D. on "International Outreach - A Volunteer's Perspective
Following the panel a question and answer session was held. It was an auspicious beginning to this new section.

Richard Taxin, MD, Southeast Radiology

Stepping Out of Our Comfortable Shadows

As radiologists, we have always been both the doctor's doctor and the patient's doctor, but for some reason have always advertised ourselves more as the former than the latter. In some ways, it made us special: we not only took care of the patients, but we took care of our colleagues.

In the days before PACS, when images were created, interpreted and stored on film, it was essential for our referring physician colleagues to come to the reading room to see the images and pick our brains. Additional clinical history and physical exam findings were traded with imaging findings and differential diagnoses. There were "trusted" radiologists, whose opinions surgeons would seek out before taking a patient to the operating room; even in the era of PACS, their legends live on.

But today, when you call an ordering physician to report a diagnosis of acute appendicitis or a misplaced central line, so often the response is, "Oh, I know" or "Oh, I saw that already". By embracing technology that has assuredly improved patient care in many ways, we have sacrificed the intimacy of the reading room and the valued conversations that were once a de facto aspect of daily patient care. Perhaps our fellow procedural/interventional radiologists and mammographers don't face this challenge; they see and interact with patients daily. But for the rest of us, Andrew DeLaO, this year's Moreton Lecturer at the ACR Annual Meeting, issued a challenge: "step out of the dark and into the light".

Mr. DeLaO pointed out the irony of being the doctor's doctor as he compared radiologists to artists: we invest time and energy to create an interpretation of an imaging examination--the report--and proceed to let someone else tell our story by forgoing direct communication with the patient, and instead having the referring physician convey and interpret our results. Again, this is not true of all radiologists; however, the majority of us do not have scheduled encounters with the patients whose diagnostic imaging we interpret.

Mr. DeLao described radiology as operating in the "experience economy". Pine and Gilmore introduced this concept in an article published in 1998, to describe the environment that followed the agrarian, industrial and service economies. In the experience economy, the economy, the intangible experience now becomes the intangible experience now becomes the product. The scanners are the commodity; the images they produce are the goods; the generated report is the service. But the sum total of the experience becomes a part of the transaction and the assessment of its value also. No wonder our Press-Ganey surveys seem to gather more about the convenience of parking and the comfort and temperature of the gowned waiting area than the quality of the radiology interpretation or the interaction with the radiologist. It's no surprise, then, that some patients think that the technologist performing the study or the physician who referred them for imaging is the one who ultimately performs the interpretation.

He suggests that we need to consider our patients' priorities and instead transition to the "connection economy". The value is now placed on coordination of meaningful connections, trust between a patient and his or her radiologist, and the exchange of ideas. This demands face time between patients and radiologists, whether in-person or virtually. But it requires us to leave the reading room and the worklist for an indeterminate period of time, which remains a challenge in our RVU-driven practices. What's the CPT code for a consultation with diagnostic radiology? How is it scheduled in the radiology information system? Which radiologists are staffing the patient consultation service today? How does this non-interpretive work factor into their non-RVU-based productivity? One day, we will have answers to all these questions.

In the meantime, it is no secret that our patients want to talk to us. Many practices now include the interpreting radiologist's name and phone number on all reports. This makes it easier for patients to directly contact a radiologist and ask a question without getting lost in a phone tree or being directed to a voice mailbox that may not be checked. Patient members of the ACR's Patient- and Family-

Centered Care Commission lauded this suggestion, and have shared their own personal experiences (as both patients and caregivers) of how impactful conversations with radiologists have been for them. Dr. Mangano and colleagues at Massachusetts General Hospital collaborated with a primary care physician to offer radiology appointments in conjunction with primary care follow-up appointments. They found that participating patients better understood the role of the radiologist in their care, and expressed a greater desire to review results and discuss the need for follow-up with a radiologist in future.

We also live in the modern era of radiology, where patients can access their test results online via electronic health records and patient portals. Dr. Lee and colleagues at the University of Washington reviewed the behavior of nearly 130,000 patients with access to a portal, and found that at least half of patients with a radiology report available viewed them, and that women, English speakers, and patients 25-39 years old were the most likely to view their reports online. My colleagues Dr. Oh, Dr. Kahn Jr. and I at the
University of Pennsylvania developed PORTER, a radiology report annotator that allows patients to view their reports with definitions of medical and technical terms, hyperlinks to Wikipedia, and public-domain illustrations of anatomy and pathology. Patients reported improved report comprehension, but notably not an improved understanding of their disease and treatment.

Not surprisingly, Dr. Lee's study found that underserved patient populations were less likely to access and review their radiology reports online. So while patient portals can be helpful and can serve as the first step towards communicating directly with a radiologist, they are not going to be universally accessible. At the end of the day, as we found with the PORTER experience, nothing replaces an actual conversation with a real, live radiologist.

Mr. DeLaO encouraged all of us to become the trusted node in our practices, citing Metcalfe's Law, that the power of any network is proportional to the square of the number of trusted nodes on that network. By becoming a radiologist that patients can contact and trust, we not only directly impact their care with our image interpretation, but we step out of the darkness of the reading room and into the brightly lit but sometimes daunting world in which our patients experience their medical care. Are there challenges to doing so? Sure. But is it worth the effort? Let's decide before someone decides on our behalf.

Tessa Cook MD PhD,
Philadelphia

RESIDENTS SPEAK

PRS Resident to Resident Bulletin – ACR 2016

- Based on the annual ACR survey, projected number of radiologist to be hired in 2016 represents a 16.2% increase from hiring in 2015.

- Predicted hiring has nearly doubled from 2013, estimated at 1,713-2,223 openings in 2016.

- Resident representatives met with members of congress to discuss:

o Mammography Screening Recommendations
o Medicare reimbursement for CT Colonography Screening for Colorectal Cancer, USPSTF Transparency and Accountability.

Recent legislative victories thanks to RADPAC include:

o The Consolidated Appropriations Act of 2016, which lowers the 25% reduction in professional compensation for multiple procedures to 5%, effective January 1st 2017.
o Also, a provision to this act places a two-year moratorium on the flawed mammography screening recommendations issued by the United States Preventative Services Task Force (USPSTF).

- Members-in-training should consider donating even as little as $5 to support our profession. Having a political voice will prevent non-physicians dictating how our profession practices medicine. The fact that you give matters more than the amount you give. Donations can be made at www.RADPAC.org.

- Beyond the annual meeting: Educational Resources for residents, opportunities to become involved, and information on applying to fellowships can be found at http://www.acr.org/Membership/Residents-and-Fellows/About-RFS.

- Reminder for the Pennsylvania Radiological Society Annual Meeting on September 16, 2016 in Philadelphia PA. Resident participation is strongly encouraged. For more information please refer to http://paradsoc.org/ event-2060664.

Akash Patel MD,
Philadelphia

The RLI Experience

The only certainty in life is change. So while in the past it may have been enough to master diagnostic skills in order to have a great radiology practice, radiology and healthcare have changed. Nowadays, in order to have a successful radiology practice, it is essential to understand healthcare policy and the business of radiology. The Harvard Emerging Leaders Seminar by the Radiology Leadership Institute (RLI) was an excellent course that filled a major gap in my training: business knowledge.

The course consisted of lectures from radiologists who are leaders in the field, simulations, and case studies. Although the simulations and case studies were not specific to radiology, they all applied very well to the current state of radiology. The course consisted of three modules: Personal Leadership, Business & Financial Acumen, and Managing Change. The 'Personal Leadership' module helped me define my personal leadership style and gave me concrete ways to improve that style. The 'Business & Financial Acumen' module was the most challenging one for me because I do not have any business background. It helped me understand the importance of, and how to develop and execute a successful business model. The 'Managing Change' module was very relevant to the current state of radiology and healthcare. It allowed for developing tools and techniques for successfully managing change in practice. Most of all, the course was an excellent foundation to build on business knowledge. I highly recommend the course for anybody who is considering enrolling and thank the Pennsylvania Radiological Society for proving the funding for my course tuition.

Sarah Abdulla, MD
Pittsburgh

My RLI Experience

Participating in the RLI-Harvard Emerging Leaders Seminar as a resident was an invaluable opportunity. The course consists of weekly 90-minute interactive online sessions with renowned leaders in business and Radiology from the comfort of your home. The time commitment can easily be worked into anyone's schedule and the value of the experience in exchange is priceless.

The mediators provided each of us with tools to explore our personal leadership development through literature from Harvard Business Publishing, case studies and interactive group exercises. The curriculum is geared toward early leadership development with additional material for those who wish to advance. The most important lesson I learned is that successful leadership is a dynamic recipe made of the leader's action logic, leadership style and their fit with the situation at hand. This helped me understand that leaders are not born, but rather developed through their own experience and development of emotional intelligence.

I was inspired by the teachings of the seminar and had the opportunity to share some of these lessons with my colleagues at Penn State Hershey Medical Center. My senior lecture to the Department was focused on personal leadership development, emphasizing the importance of the development and practice of leadership skills at all levels.

Overall, the seminar was well worth the time and I'm grateful for the opportunity provided by the Pennsylvania Radiological Society. I will continue to participate in RLI curriculum as I now, more than ever, value the importance of leadership and business education in the advancement of Radiology.

Hazem Matta MD,
Hershey

3D Mammography is now a covered service in Pennsylvania, Right? Maybe

On October 5, 2015 Pennsylvania Governor Tom Wolf announced that 3-Dimensional (3D) mammography is included under the state law defining mammography examinations. This was a reinterpretation of existing state law covering existing mammography services such that 3D mammography must be covered by insurers in the same manner as traditional 2D mammography. This was to take effect on December 1, 2015. This announcement was not an Executive Order from the Governor and there was no new legislation that defined this coverage.

This announcement was exciting news to those organizations who closely followed medical services that are available for women's' health. Existing literature suggests that 3D mammography increases the sensitivity for detection of small breast masses and, therefore, may lead to earlier diagnosis of breast carcinoma and, subsequently, earlier treatment. In addition, 3D mammography, also according to existing literature, decreases callback rate therefore potentially reduces the anxiety associated with awaiting mammographic report results. This announcement was expected to expand the availability and use of this potentially promising imaging technology.

And indeed it has resulted in the availability of this service at no additional cost to certain patients. Our patients who currently receive their health insurance through Pennsylvania Medical Assistance Programs (ie Medicaid) can now receive 3D screening mammograms without additional costs such as co-pays or deductibles. This coverage is identical to the pre-existing coverage that they received for 2D screening mammography in accordance with the reinterpretation of existing statute by Governor Wolf. In addition, according to the Medical Assistance Bulletin issued by the Pennsylvania Department of Human Resources on December 9, 2015, 3D Diagnostic mammography (Billing Code G0279) was also added to the Medical Assistance Program Fee Schedule.

Simple, right? Well, not exactly. Private insurance is far more complicated and I will do my best to provide as much detail as possible.

First, even though the Medical Assistance Programs added 3D Diagnostic Mammography to its fee schedule, the existing statute covering 2D mammography did not require coverage of diagnostic mammography. Furthermore, some private insurers still consider 3D mammography to be “experimental”. This means that 3D mammography will remain a non-covered service for those patients insured by those payers who continue to view 3D mammography as experimental.

Next, some insurance plans are not regulated by Pennsylvania state law. For example, ‘self-insured’ plans are not regulated under state law but, rather, are covered under Federal Law (ERISA) unless those self-insured plans choose to have the service covered. Since the Affordable Care Act (Obamacare) does not include 3D Mammography as a preventative service, private insurers are not required to cover the service (i.e. neither screening NOR diagnostic mammography). Since some payers continue to view 3D mammography as experimental, they do not cover the service for these patients.

Nevertheless, there is some good news. Pennsylvania-based fully insured groups are regulated by state law. Those plans are now required to cover 3D screening mammography without cost sharing (no co-pay or deductible). But

back to the bad news. These same patients may be subject to a co-pay or deductible if 3D mammography is performed in a diagnostic setting.

Now I hope that you may have found this discussion confusing. Do you know who is even more confused? Our patients. The media coverage of this announcement has, not surprisingly, failed to examine the nuances of this announcement. This has led many patients to believe that, under all circumstances, 3D mammography is now a covered service and that they would not incur ANY out of pocket expense. This disconnect has led to discontent and many patients are unhappy. And even though the patients should be focusing their energy on their insurance companies, they direct their anger at their doctors and hospitals. If this has not happened to you yet, don't worry. It will, unless you carefully review these issues with your hospital finance and compliance departments. You need to develop methods to communicate these details to your patients in a manner that they can understand. The patients need to be informed that they need to discuss these issues with their insurance companies and that, despite what they may have seen in the media, there may still be costs to them that associated with the performance of 3D mammography. It is time for the advocates for healthy women to step up to the plate.

Eric Rubin MD
Southeast Radiology

Skill Mix

In March of 2016 the Pennsylvania State Board of Medicine decided to examine where on the spectrum of simple to complex fluoroscopy procedures should a radiology technologist (RA or RPA) or PA be allowed to perform procedures?

On the one hand the argument can be made that procedural examinations in radiology provide radiologists with the opportunity to have face time with patients increasing the visibility of radiologists in the public eye. However, on the other hand these procedures are often time consuming and decrease overall radiologist productivity. Depending on the physician extender employed to perform these procedures different levels of supervision are required, and therefore some options are more beneficial from a productivity stand point. Additionally, as autonomy increases for these physician extenders, increasing amounts of time must be devoted to training them to perform procedures of increasing complexity.

Alternatively, in the era of cost containment in healthcare, the idea of the use of physician extenders throughout most aspects of medical practice has been widely adopted. Fluoroscopy is certainly no different, even some of the most straightforward fluoroscopic examinations can be time consuming and the use of PAs, RAs, and RPAs to aid in workflow is a boon.

I think the selection of which of these practitioners one is going to employ in their practice is an individual decision and may relate to very practice specific needs. In our practice we employ a physician assistant (although we were looking to employ an RPA; however the hospital did not recognize RPAs scope of practice for what we were interested in at the time) for performing fluoroscopic examinations, thyroid biopsies, lumbar punctures, and PICC line placement.

The PA was trained by myself and two of the other radiologists who routinely perform fluoroscopy. Additionally, she has been educated in multiple facets of radiation safety. Additionally, she has received some education from one of our urology colleagues.

We provide supervision for our PA for all examinations and procedures. To me the advantage of the PA over the RA and RPA is the ability of the PA to make diagnoses. In an effort to contain costs we rely heavily on the PA to handle the fluoroscopy schedule and minor procedures to free up radiologists to be more involved or complicated examinations and procedures.

At the Pennsylvania State Board of Medicine meeting no physician extender privileges were rescinded; however, the Bureau of Radiation Protection will likely update their guidelines for allied health professionals, likely making it more restrictive.

Sandeep P. Deshmukh MD
Philadelphia

Educational Exhibits

Applications should be submitted along with the electronic exhibit. All electronic exhibits must be submitted by Wednesday, August 31, 2016. Submissions received after this date will not be accepted for the annual meeting.

All exhibits will be considered regardless of whether they have been previously shown at other meetings. A maximum of up to 12 slides is recommended.

Electronically Submit Application To:

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