

**California Radiological Society
Annual Report to the Membership**

Submitted by

**Robert Achermann
Executive Director**

**Prepared for
Members of the
California Radiological Society**

September 2011

CALIFORNIA RADIOLOGICAL SOCIETY

2010-2011 ANNUAL REPORT TO THE MEMBERSHIP

Welcome to the 2011 CRS Annual Business Meeting. The Annual Report is presented to the membership as a highlight of the major issues CRS has addressed over the past year. Socioeconomic issues impacting diagnostic and interventional radiology and radiation oncology practice remains our focus. The Society continues to interact with California legislators, relevant regulatory agencies, payers, and colleagues in an effort to shape those issues.

I. LEGISLATIVE ISSUES

MAMMOGRAPHY-REPORTING OF BREAST DENSITY

SB 173 (Simitian) as introduced would have required that a patient undergoing screening mammography and is determined to have dense breast tissue would receive a specified notice. As introduced it would have also required that any additional screening procedures, such as breast ultrasound or MRI, would also be covered by a health plan or health insurer. The bill would require that any woman who obtains screening mammography and is determined to have dense breast tissue by the radiologist, a 3 or 4 density under the ACR BIRADS reporting system, would receive notification from the radiologist that she has dense breast tissue. The notice which would likely be included in the MQSA patient letter would indicate that breast density:

- 1) Could hide small abnormalities;
- 2) Patient might benefit from supplementary screening tests depending on individual risk factors, and;
- 3) A similar report has been sent to your physician and you should contact your physician with questions.

CRS initially opposed this bill along with OB-GYNs and the CMA with concerns over increased utilization of breast ultrasound and the inherent additional follow-up costs for biopsies. Though California law does require health insurers and plans to cover all medically indicated breast cancer screening tests, there is no clear consensus that breast ultrasound is appropriate where the only factor is dense breast tissue. SB 173 originally required that any subsequent procedures such as breast ultrasound or MRI would be required to be covered by the patient's insurance or HMO. That requirement however was deleted from bill language prior to the first hearing on the bill.

SB 173 is modeled after a law passed in Connecticut in 2009. Connecticut law however, includes both patient notification of dense breast tissue and mandatory health insurance coverage for any additional screening or diagnostic procedures.

Despite the opposition of the CRS and other medical organizations SB 173 passed the Senate. The bill was heard in two policy committees in the Assembly and did not receive a negative vote. It became clear that legislators of both parties would support this notice to impacted women irrespective of the potential increase in costs for breast screening though additional imaging procedures. Prior to its hearing in the Assembly Appropriations Committee the CRS moved to a neutral position after discussions with the author on suggested amendments. Though all our requested amendments were not

accepted the following changes were made prior to its hearing in the Assembly Appropriations Committee:

- Language was changed to place the requirement for the notice on the facility and not the individual practitioner.
- Provision to create an immunity from liability for failure to have sent the notice prior to the effective date of the new law, i.e. no penalty for not having provided the notice prior to the effective date.
- Sunset in 5 years for the notice requirement unless new legislation continues the requirement.
- Delayed operative date until April 1, 2012.

SB 173 then was heard and held by the Assembly Appropriations Committee in late August based upon an analysis by Committee staff that assumed increased costs to state programs, like Medi-Cal and EWC, of several million dollars based upon additional screening modalities being utilized for women with dense breast tissue.

SB 173 was effectively dead for the session with the Legislature set to adjourn on Sept. 9th for the remainder of the year. The author, Sen. Simitian, was however committed to seeing this issue succeed. On the last day of session he was able to “gut and amend” an unrelated bill and insert the provisions of his former bill into SB 791. The bill was passed and sent to the Governor in the final hours of September 9th.

The Governor ultimately vetoed the bill on Oct. 9 2011. His veto message indicated concern with the text of the notice and whether it over emphasized the need for additional screening rather than just informing women with dense breast tissue that it was a factor for consideration. We expect that Sen. Simitian may re-introduce a similar measure next year.

Radiology Provider Rate Cuts in Medi-Cal

We had previously informed our members of the budget cut to radiology in the Medi-Cal program that was part of the state budget adopted for 2010-11. That change would have limited radiology reimbursement to no more than 80% of the average California Medicare reimbursement for the same service. This would result in significant reductions in Medi-Cal reimbursement for the more expensive procedures such as CT, MRI and PET scans. The change would not require that rates for procedures where Medi-Cal was currently below 80% of Medicare would be brought up to that level. As a result procedures like US and plain films would continue to be poorly reimbursed. The budget language called for implementation on 10/1/10.

In December 2010 the CRS Executive Committee decided to retain outside counsel to seek injunctive relief to block implementation of these egregious reductions which we would believe would limit access to diagnostic radiology and radiation oncology services. The CRS solicited contributions from members to help defray the legal costs. We have raised over \$50,000 for that effort and we appreciate the support of the membership.

To date the radiology reimbursement change has yet to be implemented now almost 1 year later. Our legal challenge would be predicated on the obligation under federal law for the Medi-Cal program to

assess the impact of rate changes on beneficiary access. See more below on this legal issue. We are prepared to take legal action when these cuts are implemented.

Now we fast forward to the next budget cycle this year for the budget year 2011-12. The budget deficit woes continued with a new Governor Jerry Brown. His January proposal called for a balance approach of program spending cuts and revenue increases. The first part was accomplished with spending reductions of approximately \$12 billion being adopted in April. Those reductions included additional Medi-Cal changes to elimination of the Healthy Families, Adult Day Health Care cuts, another 10% provider rate reduction, cap on physician office visits, and co-pays for many services.

These changes can only be implemented after CMS approves via a State Plan Amendment (SPA) to the Medi-cal Program. As of this writing CMS had not approved the change to allow the 10% reduction, which the budget had assumed would take effect on July 1, 2011. This comes as the US Supreme Court heard oral argument in October on the legality of the prior 2009-10 10 % provider rate reduction which was enjoined by a federal court in August 2009. A decision is not expected until spring of 2012 and the ruling will be limited to whether provider groups have standing in federal court to bring such a case. There will no doubt be additional litigation if the provider rate reductions do occur. We will keep you informed on further developments.

SB 1237 (Padilla) on Radiation Safety- Follow-up Bill

In 2010 the CRS was very active in shaping the provisions of SB 1237(Padilla) that created new requirements for tracking and recording dose for CT units, created new reporting requirements for radiation misadministration (wrong patient, anatomic area, exceed radiation therapy dose by 20%, etc), and accreditation requirement for all CT units by 1/1/12, hospital CT units by 1/1/13. The bill was driven by incidents of excess radiation exposure from CT scans at several California hospitals.

We had determined a drafting error in SB 1237 that we attempted to cure prior to passage by a Letter to the Journal from the Senator. It was noted that all provisions of the bill had delayed effective dates to at least 7/1/12, but there was no date on the section requiring new reporting. Hence it could be construed as taking effect on 1/1/11. We supported the introduction, passage and signature by the Governor of SB 38 (Padilla) this last August which inserted the 7/1/12 effective date for reporting.

Discussions continue on other possible changes to the statute. With additional time before the effective date we may seek legislation to modify the provisions as developments and recommendation develop at FDA and among professional associations involved in radiation safety.

Proposed Revisions to Workers Compensation Medical Fee Schedule

Last year the Division of Workers Compensation (DWC) published for initial comment some major revisions to the physician fee schedule that would greatly reduce radiology payments. The DWC was given authority several years ago to revise the current fee schedule that has its own RVS units distinct from the RBRVS. The proposal would have done the following:

1. Convert to the RBRVS for all unit values;

2. Adopt individual conversion factors for some services, including radiology, and over a 3 year period convert to one conversion factor for all medical services;
3. Adopt an equipment utilization factor of 90 % for radiology equipment which would result in a 34% reduction in reimbursement at the conclusion of the 3 year phase in; and
4. Adopt a contiguous body area reduction of 25% for the technical component, i.e. CT pelvis and abdomen; the second procedure would be reimbursed at only 75% of the TC with no change to the PC payment.

The CRS submitted extensive comments in opposition to these changes and specifically to the equipment utilization percentage. After a number of public meetings there was no action taken by DWC. With the change in Administration as of January 2011 there was no movement within DWC as leadership was also changing. The action shifted to the Legislature this year.

SB 923 (De Leon) was sponsored by one of the major providers of occupational medicine providers, US Health Works to require DWC to convert to an RBRVS. Initially the bill established specific conversion factors for medicine, including a separate conversion for radiology of \$60. Physicians also raised concerns that any RBRVS conversion would not implicitly include any Medicare Ground Rules, which could impact the actual procedure reimbursement, i.e. PQRA, contiguous body areas for imaging. As the bill moved through the Senate concerns about possible costs caused labor groups to push for removal of the specific conversion factors for fear that increased medical costs would lead to a diminution in disability payments. Primary care physicians are poorly reimbursed under Work Comp and their push for greater reimbursement will come at the expense of specialists like radiology.

As SB 923 emerged from the Assembly Appropriations Committee there were further amendments that sought to reduce any increase in Work Comp costs. The bill set an implementation date of 1/1/13 and included a provision that would require cost neutrality when the RBRVS conversion. That would ensure that specialty compensation would decrease as primary care was increasing. SB 923 with the opposition of organized medicine failed passage on the Assembly floor at the end of session. We can assume that this issue will return and could now move back to action or proposals from DWC which already has the authority to proceed under existing law.

Bills to Allow District Hospitals to Employ Physicians

Current California law prohibits hospitals from employing physicians with exceptions for some county hospitals and purely charitable institutions. This is the bar on the corporate practice of medicine intended to allow physicians to practice without interference from business interests though an employment situation. It allows the medical staff to function independently in the best interests of the patient.

Several years ago, legislation was adopted to create a program for up to 20 physicians to be employed by district hospitals that met certain criteria, i.e. rural, financial operating losses, and have at least 50% Medi-Cal patient base. That pilot program also required the Medical Board of California to issue a report on the pilot. The report issued in 2009 was inconclusive since the number of actual physicians employed by district hospitals under the pilot was only five.

Last year there were three bills introduced to modify the current prohibitions for either district hospitals only, or all acute care hospitals. None of those bills were successful and no change was adopted in 2010.

This year there are two new bills, AB 1360 (Swanson), AB 684 (Chesbro) introduced to allow district hospitals to employ a limited number of physicians. District hospitals cite the difficulty in recruiting physicians to rural and poor performing hospitals and that being able to employ physicians will make that easier. We oppose any change to the current prohibition except one that focuses on certain types of troubled hospitals and only expands the number of employed physicians to five. We believe so for the following reasons:

- The existing prohibition is important for patients and quality of care to maintain physician independence.
- The real problem for some of these district hospitals is inadequate reimbursement from Medical and others that does not provide sufficient practice revenue to allow a physician to practice.
- Some hospital based specialties like radiology and pathology need a group practice in order to provide adequate hospital coverage. Hiring individual physicians will not solve that issue.

Neither of these bills moved out of the Assembly or house of origin this year. There was an actual compromise reached with Assemblyman Swanson on a limited ability for district hospitals to employ a small number of physicians with advice and consent of the medical staff. The unions that are sponsoring his bill however did not support the changes and the bill stalled in the Assembly Health Committee. Both bills are now two year bills, meaning they can be taken up next year and are alive.

Bill to License Radiology Assistants

This year the ASRT sponsored the introduction of AB 352 (Eng) which would create a licensing program for radiology assistants. Previous legislation sponsored by the CRS had stalled in the Legislature due to fiscal concerns with the creation of a new license category in a difficult state budget situation.

AB 352 is similar to prior bill proposals and would rely on certification standards established by the ASRT in cooperation with the ACR. To limit expense the radiology assistant license committee would be housed within the Medical Board of California, which provides a similar function for physician assistants and others. Supervision of a RA could be provided by a radiologist or other qualified physician.

The CRS supported AB 352 but unfortunately was not heard in its first Committee. There was late opposition from the nurses association over any bills to expand the scope of other allied health practitioners that might impact nurses. AB 352 is a two year bill and could be heard next year.

Every Woman Counts Program

In 2010 the Every Woman Counts (EWC) program for breast cancer screening made changes effective 1/1/10 that they would no longer cover screening mammography for women ages 40-49 and would suspend enrollment of new patients into the program until July 1, 2010. The EWC program had a deficit in expected revenue over costs of approximately \$16M in the fiscal year ending June 30, 2010. The EWC program is funded primarily through a portion of tobacco tax revenue and a small percentage for CDC. The portion of revenue available from the tobacco tax has continued to decline.

Several audits of the program resulted from several legislators expressing concerns over program costs and the reductions in service. Funding was stabilized in the 2010-11 fiscal year budget. Enrollment

began again and the screening program was changed back to include women aged 40-49. EWC also eliminated the \$100 fee paid to clinicians to track and provide follow-up on patients after screening. Clinicians now only receive \$50 if the patient had a positive mammogram and no payment if the mammogram is negative.

We continue to decry the low payment for screening mammography under EWC that limits payment to the Medi-Cal rate for analog even when the radiologist uses digital mammography.

II. REGULATORY

Medicare CAC Committee

The CRS is very fortunate to have the dedication and participation of Drs. Mark Alson and Mark Yeh in the Medicare Carrier Advisory Committee process conducted by our California Part B carrier Palmetto. They attend the quarterly advisory committee meetings and provide input on issues affecting the radiology community. We also maintain active liaison with Palmetto staff to assist members with provider enrollment and reimbursement issues.

RAC Audits of Medicare MRI Payments

We have heard from multiple groups complaining about a high volume of audit letters from Health Data Insights, a RAC Auditor, seeking repayment of prior MRI procedures alleging that the patient had a pacemaker at the time of the procedure, a contraindication for an MRI. The Medicare Coverage Determination until March of this year was to not allow payment for an MRI if the patient had a pacemaker. .

Starting in August radiology groups have received hundreds of letters demanding repayment of MRI reimbursement even though the group has patient intake forms and other documentation indicating that the patient did not in fact have a pacemaker.

The CRS contacted the CMS Region IX Office and has been trying to determine the medical information being utilized by the RAC auditor to claim evidence of a pacemaker. At the time of this writing those discussions were continuing.

Radiologic Technology Certification Committee

The RTCC is an advisory committee to the Bureau of Radiologic Health that provides guidance on issues related to licensing, certification, and education of users of ionizing radiology. The CRS has been ably represented by Drs. Roger Eng, Johnson Lightfoote and John Go who have served on the RTCC and attend meetings twice per year.

III. CRS NOMINATING COMMITTEE REPORT

The Nominating Committee of the California Radiological Society has recommended the following individuals for 2011 - 2012 Officers:

President	Michael Puckett, MD, FACR
President - Elect	Vivian W. Wing, MD, FACR
Secretary	Roger S. Eng, MD, MPH
Treasurer	Janak Raval, MD, FACR
Past President	Nancy Ellerbroek, MD, FACR

These nominations will be considered during our Annual Meeting on Friday, September 16, 2011, during the Business Meeting at the Grand Hyatt in San Francisco, CA.

IV. MEMBERSHIP SERVICES

CRS maintains the tradition of providing valuable services to its members with e-mail broadcasts and website to communicate with members. Our thanks to Dr. Roger Eng for his work as program chair for this year's Annual Meeting.

CRS membership currently consists of 1,374 radiologist members, 528 retired members, 39 physicists, 65 residents, for a total membership count of 2,006. CRS currently has 23 Councilors and Alternates to the American College of Radiology.

V. FINANCIAL REPORT

The accountant's review and year-end financial statement for the fiscal year ending December 31, 2010 showed cash of \$61,457 and prepaid expenses of \$24,572 for total assets of \$86,029. In 2010 CRS had income of \$282,237 and operating expenses of \$253,949 for a surplus of \$28,228. The unrestricted General Fund is \$39,764 for the beginning of 2011.

VI. CONCLUSION

I am grateful to CRS Officers and the Executive Committee for their dedication and support this past year. Your support and participation now and in the future will continue our efforts to strengthen the voice of Radiology and foster greater knowledge and understanding in your field.

Respectfully submitted,



Robert Achermann
Executive Director

Officers

Nancy A. Ellerbroek, MD, FACR, President
Michael Puckett, MD, FACR, President Elect
Vivian W. Wing, MD, FACR Secretary

Roger S. Eng, MD, MPH, Treasurer
Mark Alson, MD, FACR Immediate Past President