

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

Remember, the *Bulletin* is available on the Internet at the following home page: <http://www.paradsoc.org/>

PRESIDENT'S MESSAGE

Richard N. Taksin, MD, FACR

As I write this message fall is in full gear. The wind chills. The leaves are covering my lawn. Thanksgiving and Election Day 2007 are in the rear view mirror. With all the debates on the tube, the pundits spouting their wisdom, and the mainstream media and bloggers having a field day, the seemingly-forever-approaching Election 2008 feels as if it will never arrive. Some Republicans seem depressed. Some Democrats seem to be salivating. And radiologists seem to have a target on their backs, or at least a target on their wallets. We all know that if we radiologists are fired upon, it is the patients who are likely to get hit – in terms of decreased quality and decreased availability of imaging services. As Kurt Vonnegut wrote, "...so it goes."

Where is the Pennsylvania Radiological Society in this time of potential upheaval? We are financially sound. Unlike many other medical societies our membership appears to be stable. We have just completed perhaps our most successful meeting in my recent memory (which some wag might say doesn't mean much). The program prepared by Bob Pyatt and Dave Buck was excellent for both diagnostic radiologists and radiation oncologists. The dinner for President Buck and honoring Mike Federle was a treat. Bob Powell (assisted by Phyllis Smith) did his usually able job. "Hot issues" under discussion were quality of services, radiation dose reduction, and grassroots problems. In my inaugural address and at the board meetings I addressed

these issues and the PRS will be active in each of these areas. Bob Pyatt and I will be leading a push to have more practices utilize RADPEER throughout the state. [Ed. Note: For more information, please see www.acr.org, click on Quality and Patient Safety on the left, then on RADPEER.] Eric Faerber and a group of "helpers" will be available to advise radiology practices in making CT dose reduction a priority, especially for the pediatric population. We have increased our budget for assisting the radiology societies in Pittsburgh and Philadelphia, as well as socio-economic meetings for residents and fellows throughout the state. We have plans to make our website of greater value to Pennsylvania radiology practices.

Playing in the back of my brain is a recent Op-Ed piece by David Brooks in the New York Times under the possibly-appropriate-for-us headline, "The Segmented Society." It was an article (possibly metaphorical) on Stevie Van Zandt (of E Street Band and Sopranos fame), on rock music and its modern fragmentation. It started me thinking about radiology and radiologists as a once-organized society now threatened with fragmentation. I believe that if this happens each segment will inevitably be crushed by government, Wall Street corporate medicine, third-party payers, the hospital industry, etc. By banding together in the ACR and PRS we have been successful. However, to remain strong, these organizations must stay in touch with the membership (the organization is you) and continue to demonstrate value. Help us and help me in our endeavor. Let me hear from you.

Have a great holiday season and a very happy new year.

Rich

EDITOR'S COLUMN

Thomas S. Chang, MD, FACR

My RSNA Experience

Just like Dr. Pyatt (see his article in this issue), I attended this fall's RSNA meeting. I didn't get to see him, however, since we were there during different parts of the week, but I did run into a few other Society members.

At RSNA, it's fun to run into people I haven't seen in a while, which happens fairly frequently. In fact, it's hard not to see people I know in the heavily trafficked walkway connecting the two main buildings. If you've attended the meeting in the past, you know what I mean. You also know what I mean when I say that, as an Asian, I feel like I'm in the majority there.

A big draw to Chicago for me is the food, especially Thai. But one thing I found out the hard way is that there aren't many restaurants that stay open late in the Loop area (I like to view posters and the Cases of the Day in the evenings). In the past, I've stayed at hotels near the Magnificent Mile, where late dinners (and shopping galore) are easy to come by. But not so near the Palmer House. At least it's a shorter bus ride from there to McCormick Place.

What impresses me every year are the elaborateness and enormity of the vendors' exhibits, where I spent a fair amount of my time this year. I visited with lots and lots of RIS (Radiology Information System) companies. There must be a couple dozen manufacturers of RIS products out there.

If Radiology Were Like Cars ...

The problem with choosing a RIS for your practice is that it's virtually impossible to know how the RIS will fit in and perform in your own practice until you first purchase and implement it. As with buying cars, test drives may be fine for giving you a cursory sense of the look and feel of the system. But you can't know which features were done particularly well by one manufacturer or which quirks you originally thought were minor will turn out to be major annoyances until you've used it for a few weeks.

By the same token, it's no wonder that Dr. Aria reports elsewhere in this issue that 64% of radiologists are unhappy with their current PACS. Major radiology purchases are all like that.

What's worse is that demos at the RSNA meeting don't even amount to test drives. They're more like the glossy car brochures you get at dealerships. They're just glitzy presentations that show off only a few of their strengths and ignore any weaknesses. At least they try to ignore them. As Patrick, my practice's Information Technology guy, commented, the prettier the program, the more it tended to

crash during the demonstration. We want pretty. But more than that, we want usability, efficiency, dependability, and stability. And all at a reasonable cost. Is this asking too much?

For cars, there are reviews that compare one vehicle with others and describe their features in detail. There are *Consumer Reports*, *Motor Trend*, *Car and Driver*, and cars.com, to mention a few. Unfortunately, there's no such source for RIS (or for medical equipment in general, for that matter).

I recently saw in one of the throwaway magazines a large chart listing the different features of various RIS products. It looked promising, until I looked closer. Each entry was written by the manufacturer, not by an independent reviewer. This meant that it was just a superficial list of features, not an evaluation of how good the features are. On the bright side, I did find the chart to be a good place to start in our search for a new RIS.

Nuclear Situation in Canada

One story I read about recently on the excellent radiology new sources I subscribe to (ACR and RSNA) was interesting news to me. Did you know that more than 60% of the molybdenum-99 (which I'm sure you remember decays with a half-life of 66 hours to the really useful radioisotope technetium-99m) used in North America is produced in a single nuclear reactor in Ontario, the Chalk River Laboratories?

This came to the news forefront when that reactor was shut down by Canadian regulators from mid-November to mid-December for safety deficiencies, thereby leading to a decline in nuclear medicine tests that could be performed in this country. The effect of the shortage on different hospitals was variable, depending on the particular radioisotope supplier for each hospital, since some suppliers had other sources of Mo-99. Efforts are now in progress to increase production of Mo-99 in the U.S. so that we won't be so heavily dependent on a single source. I never knew this before and I thought you'd like to know.

IT AND RADIOLOGY TODAY IN THE PRIVATE PRACTICE

Robert Aria, MD, MBA

The business of radiology, both as a service provided in hospitals and as a standalone ambulatory enterprise, has consistently been an early advocate of information technology. RIS and PACS technologies have been around for well over a decade and these solutions quickly grew from "science experiments" in the early 1990s to more mature, common tools that are integral to the practice of radiology today.

During the past several years, the adoption of information technology has been rapidly spreading to other clinical specialties beyond radiology, such as cardiology or gastroenterology for both departmental and enterprise

solutions. As technology adoption becomes more widespread for other clinical specialties, it seems as if vendors' innovation for the radiologist and radiology departments has come to a screeching halt. One might even make the case that the radiologist and the radiology department have become an afterthought for most healthcare IT vendors and that much of the market is losing its focus on making radiology successful. In fact, according to a survey of radiologists at the 2006 Society of Computed Body Tomography and Magnetic Resonance (SCBT-MR) meeting, 64% of radiologists are dissatisfied with their current PACS.

The reality is that radiology represents 90% of the imaging volume in healthcare today, and the volume is growing faster in radiology than in any other specialty. In addition, each radiology case is getting more complex. What this means is, in addition to the increase in volume overall, radiologists need more time per case to process all data they receive. However, the majority of vendors are preoccupied by driving more and more features into their viewer, all in an effort to win the "viewer war." A vendor taking an all-encompassing approach from the perspective of radiology would look at the entire workflow and identify the bottlenecks and design solutions to improve productivity.

"You can find pockets of excellence in the radiology IT market today. Find a partner that focuses on radiology, a partner that can devote all of their resources toward fixing your real-world problems."

Consider some provocative conclusions drawn by University of Cincinnati College of Business researchers studying radiology productivity at Cincinnati Children's Hospital. Some of their most interesting findings revealed that very simple tasks, such as having to find a referring physician's phone number or getting interrupted by referring physicians while reading a case were cutting deeply into the radiologist's productivity.

The major inhibitor to productivity was not whether or not the radiologist had access to an EKG or the ability to do a MIP reconstruction. Their productivity was hurt because of ongoing interruptions while they were doing their job. So then, why aren't vendors focusing on ways to improve this? The Deficit Reduction Act (DRA) of 2005 is another example of a fundamental problem facing the radiology industry. Many ambulatory imaging businesses will see a revenue decrease on the order of 20-30% in 2007, depending on their modality mix. What are IT vendors doing to help address this issue? The reality is that most ambulatory imaging businesses have a fixed-cost basis and will not get any relief on their monthly bills. So they need to offset that with improved productivity and higher study volume.

Subsequently, the best way to grow a private radiology practice is to grow your referral base. However, most vendors today consider the referral base an afterthought. A better answer to the DRA challenge is to make your referring doctors so happy with the service you provide them that they will want to send you more referrals. You can do this by making their jobs easier. Here is how ambulatory imaging centers can provide excellent service to their referring doctors:

- Proactively send them information
- Personalize that information
- Do not burden them with ugly IT requirements

Each of these steps will make doing business with you easier and your volume will grow as a result. Again, most vendors today consider the referring physician as an afterthought, which makes growing your practice a very difficult task.

Practicing radiology has never been more challenging than it is today. Volumes are increasing and reimbursement is dropping, all while case complexity is increasing. When you combine all of these challenges with what appears to be healthcare IT's lack of focus on radiology, the situation could seem overwhelming.

The good news is that you can find pockets of excellence in the radiology IT market today. Find a partner that focuses on radiology, a partner that can devote all of their resources toward fixing your real-world problems. Make sure you focus on the right things when you are evaluating a solution. It is not the widget that matters. At the end of the day, it is all about increasing your productivity and fueling your growth.

SOME PERSONAL OBSERVATIONS OF

RSNA 2007

Robert S. Pyatt, Jr., MD, FACR

This year's RSNA was exciting once again. I was fortunate and able to attend the meeting from Sunday to Tuesday. Here are some observations from my perspective that were major events:

Nick Bryan, MD, PhD received the Gold Medal from RSNA. Dr. Bryan, a neuroradiologist, is Chairman at Penn, and is on the PRS Board. He is a past President of the RSNA and has made many contributions to our field. *Kudos to Dr. Bryan from all of us in the PRS!*

The Commoditization of Imaging

This was a very big theme at the beginning sessions. With 50% of US hospitals now using some form of Nighthawk, and more Dayhawk also occurring, will radiology become a commodity? This year there are 30 more companies doing Nighthawk than there were a year ago. At what point will insurers strike deals

for a very large teleradiology vendor to read all their MRIs in Central PA at ___ price (less than your fee)? When will your hospital request that all neuro MRIs be read by a specialty telerad site with radiologists CAQed in neuro? When will insurers require that all neuro cases be read by a CAQed neuroradiologist, either on site or by a teleradiology vendor? Get the emerging picture? Various ways to make radiology not a commodity were discussed, such as increasing personal contact with patients and better customer service. This commoditization issue will play out with greater force in rural areas and in small groups, due to the subspecialty readings offered and 24/7 service. Becoming a larger group with sub-specialization may become very important. Nighthawks are buying out group practices, too. Stay tuned for future trends...

“Becoming a larger group with sub-specialization may become very important. Nighthawks are buying out group practices.”

Communication of Radiology Reports

There are several components to this topic. National templates for reporting procedures are in development, some of which may be required by insurers in order to be paid. RADLEX, the national lexicon for imaging was released at this RSNA. This will tie together reporting of studies, templates, speech recognition systems, and report data mining for quality reports. Future imaging reports will routinely have annotated reports and hot links to reference sites, including the new radiology search engine, Yottalook.com (put this on your workstation). Some sites are using a “patient-centered care” concept and set up meeting times with patients to review their reports, charging patients fees for this, and being very successful. Will patients get emailed reports in the future? Stay tuned on this whole topic... much is happening in “communications.”

Radiologist Training Will Be Changing Significantly

Future radiologists will be very involved with molecular imaging and will sub-specialize earlier in their residency. Boards will be after at least a year of private practice, like many other specialties. There is a need to recruit more women in imaging. Mammography is seeing declining interest from most new radiologists.

Molecular Imaging

What a huge topic. This was the New Horizons lecture, by Dr. Zerhouni, NIH Director, and former Chair at Johns Hopkins. He demonstrated to a packed auditorium the rapid growth of molecular biology information and the coming huge growth in molecular imaging, bigger than CT, MRI, etc. We will be the disease detectives at the cellular and molecular level in the future.

Quality Initiatives Advance

There were numerous programs on P4P (Pay for Performance) and ACR programs with national data registries, such as NRDR and GRID. More education changes will occur with MOC (Maintenance of Certification) and increasing roles of peer review and RADPEER. Insurers, employers, and public groups want better performance and accountability, including web-based methods to evaluate performance of radiologists and radiology groups. The PRS anticipates a greater role in assisting with quality issues/performance in the future.

Radiology is Popular

Many residencies report 90-100 applications for each residency slot. We are very popular. It was announced that there are efforts to add 30 more residency slots in the future, due to the ever-increasing need for radiologists, especially with the aging population.

New Technologies

Toshiba unveiled the 320-detector Titan. Tomosynthesis continues to make progress in breast imaging, along with BSGI (breast-specific gamma imaging). 10 Tesla MRI units are now doing research. Nanotechnology advances with new delivery systems of therapeutic agents. There are many new advances across the imaging spectrum.

Radiation Concerns

Increasing reports, such as the *New England Journal of Medicine* report, indicate that 2% of cancers are from CT scans. This will be an even greater issue next year. The ACR has a white paper on this issue and a task force working on solutions.

Radiology Assistants

There were many programs covering this topic. More groups are using RAs. Most are already hired long before they graduate. They can be valuable to a group practice, such as seen here in Pennsylvania with Quantum Imaging in Harrisburg/York and elsewhere.

Political Action

This coming year will be potentially huge for medicine, especially if Hillary Clinton is elected. Large further cuts in Imaging are anticipated. PARADPAC and RADPAC funding is expected to increase significantly. More groups are taking \$20/paycheck out for funding RADPACS. This is easily done, with more information at the ACR web site and via the PRS office.

So Many Other Impressions

There were so many other impressions that I was not able to make, due to the size of the meeting and my partial time there. Nonetheless, talk with your colleagues about their impressions. Or attend the summary meeting in sunny warm Florida in February!

CODING Q & A

Eric Rubin, MD

Fetal Ultrasound

How should I properly code a “Level II” fetal ultrasound?

The CPT coding manual describes two codes for a fetal ultrasound that is performed at or after 14 weeks’ gestational age. The codes are as follows:

CPT 76805 *Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, after first trimester (> or = 14 weeks 0 days), transabdominal approach; single or first gestation.*

CPT 76811 *Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation plus detailed fetal anatomic examination, transabdominal approach; single or first gestation.*

These codes indicate that for a pregnancy that is not considered high risk, the proper coding should be CPT 76805. A “high risk” pregnancy is one in which there is a risk of fetal anomaly in the current fetus based on a previously abnormal pregnancy for the mother, maternal risk factors that increase the risk of fetal anomaly, or fetal risk factors that increase the risk of fetal anomaly (such as an abnormality suggested on an earlier fetal ultrasound during the current pregnancy). If there is a high risk of fetal anomaly in the current fetus, then CPT 76811 should be reported.

In addition to the detailed fetal anatomy that must be documented under CPT code 76805 (*survey of intracranial/spinal/abdominal anatomy, 4 chambered heart, umbilical cord insertion site, placenta location, and amniotic fluid assessment*), CPT 76811 also requires documentation of *the fetal brain/ventricles, face, heart/outflow tracts and chest anatomy, abdominal organ-specific anatomy, number/length/architecture of limbs, and detailed evaluation of the umbilical cord and placenta and other fetal anatomy, as clinically indicated*. Furthermore, CPT 76811 may only be billed once per pregnancy.

Some of you might believe that you should bill CPT 76811 for all of your “Level II” cases since many of us obtain the detailed fetal anatomic survey that is required of this code. You have obviously never been on the wrong side of an audit.

“Some of you might believe that you should bill CPT 76811 for all of your ‘Level II’ cases... You have obviously never been on the wrong side of an audit.”

Renal Ultrasound

How should I properly code a “Renal Ultrasound”?

A specific code for “Renal Ultrasound” does not exist. It has been previously suggested to me that, since this is not actually a “complete” retroperitoneal ultrasound, that a -52 modifier (*Reduced Services*) should be added to the coding in order to designate the study as a limited examination of the retroperitoneum. This is incorrect. The CPT coding manual specifically states, “*Alternatively, if clinical history suggests urinary tract pathology, complete evaluation of the kidneys and urinary bladder also comprises a complete retroperitoneal ultrasound.*” The proper coding for this study is:

CPT 76770 *Ultrasound, retroperitoneal (eg, renal, aorta, nodes), real time with image documentation, complete.*

ANNOUNCEMENTS

Breast Imaging Seminar

**** August 7-10, 2008:** 26th 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 Stamatia V. Destounis, M.D., Beth DuPree, M.D., FACS, Michael N. Linver, M.D., FACR, Jay R. Parikh, M.D., FRCP, Margarita Zuley, M.D, William Poller, M.D., FACR. Course Director: William R. Poller, M.D., FACR. For further information please call 412-359-4952 or e-mail Cheri Jackel at cjackel@wpahs.org.

Breast Imaging Fellowship (Funded)

The Department of Human Oncology at Allegheny General Hospital has a Breast Imaging Fellowship position available January 1, 2009, to June 30, 2009. Enjoy the comforts of a 10,000-square foot breast center that is fully digital. In addition, there are two stereotactic units, state-of-the-art ultrasound units, the hand-held Mammotome, the Intact biopsy device, MRI, and CAD. Twenty-four thousand (24,000) total breast imaging studies are performed yearly. Research opportunities are also available, either with the NSABP (National Surgical Adjuvant Breast Project) or the ACRIN (American College of Radiology Imaging Network) trials associated with breast imaging. There is direct interaction with dedicated breast surgeons who are associated with the NSABP.

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