ACR ADVOCACY UPDATE

March 9, 2011

ECONOMICS AND HEALTH POLICY

MedPAC Meeting
On February 23, 2011, the Medicare Payment Advisory Commission (MedPAC) held a session entitled, “Improving Payment Accuracy and Appropriate Use of Ancillary Services.” MedPAC staff presented background information on the topic and draft recommendations for the Commission’s consideration. The presentation was followed by questions and discussion by the Commission.

MedPAC Chairman Hackbarth stated that although he is convinced that self-referral is a problem he is “wary of a sweeping ban on the in office ancillary services exemption”. Instead, he believes that MedPAC needs to tackle the problem of the “toxic combination of self-referral, fee for service medicine and mispricing of services”. He also reported that several Commissioners had expressed concern that banning self-referral could be “disruptive to integrated practices”. Therefore, he believes that MedPAC should shift their focus to tackling the payment issues because that is in his opinion what drives self-referral.

The draft recommendations were as follows:

Draft Recommendation 1: The Secretary should request that the RUC and the CPT Editorial Board accelerate and expand efforts to combine discrete services into single comprehensive codes; and develop a bundled payment system that includes multiple ambulatory services furnished during an episode of care.
Draft Recommendation 2: Congress should direct the Secretary to apply Multiple Procedure Payment Reductions (MPPR) to the physician work component (of the Physician Fee Schedule) in addition to the technical component.

Draft Recommendation 3: Congress should direct the Secretary to reduce the work component payment for imaging services (and other diagnostic tests) that are ordered by the same physician.

Draft Recommendation 4: Congress should direct the Secretary to establish a prior authorization program for physicians who exhibit a significantly higher utilization rate of advanced imaging services as compared to their peers.

The majority of the Commissioners were comfortable with the first three recommendations but not the fourth one, which they felt would pose a large administrative burden on the Medicare system.

The ACR strongly disagrees with the MedPAC recommendations and will fervently oppose any legislative action reflecting these pronouncements.

Ambulatory Payment Classification (APC) Panel Meeting Update
The 2011 Hospital Outpatient Prospective Payment System (HOPPS) final rule placed three new combined CT abdomen and pelvis codes into ambulatory payment classifications (APCs) for single CT abdomen and single CT pelvis codes. The table below lists the three codes and their 2010 and 2011 APCs:

<table>
<thead>
<tr>
<th>Code</th>
<th>2010 (Composite) APC</th>
<th>2010 Payment Rate</th>
<th>2011 APC</th>
<th>2011 Payment Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>74176 : CT abd and pelvis without contrast</td>
<td>8005 – CT/CTA w/o contrast</td>
<td>$418.43</td>
<td>0332 – CT w/o contrast</td>
<td>$193.85</td>
</tr>
<tr>
<td>74177 : with contrast</td>
<td>8006 – CT/CTA with contrast</td>
<td>$626.96</td>
<td>0283 – CT with contrast</td>
<td>$299.81</td>
</tr>
<tr>
<td>74178 : without followed by with contrast</td>
<td>8006 - CT/CTA with contrast</td>
<td>$626.96</td>
<td>0333 – CT w/o followed by with contrast</td>
<td>$334.24</td>
</tr>
</tbody>
</table>
The ACR is very concerned with the reduction in payment rate from 2010 to 2011, over 50% for CPT codes 74176 and 74178, and close to 50% for CPT code 74178. We gave a testimony at the APC Panel Meeting on March 1st advocating for either

- the creation of new APCs with a median cost in line with the simulated calculation (as CMS has done for other new codes) or
- moving the three CT abdomen/pelvis codes to the CT/CTA composite APCs, but not requiring a second procedure be billed to receive the composite payment rate.

There was a lot of discussion among the panel, including some disagreements as to whether or not CT abdomen/pelvis should be considered one study or two separate studies. Ultimately, the panel decided not to recommend that CMS change the APCs for the CT abdomen and pelvis codes and, instead, to continue to monitor and collect claims data for future analysis.

After the panel meeting, we also met with CMS staff to discuss and reiterate our concerns and recommendations. CMS staff was very receptive to our comments and we are optimistic that CMS will come up with a systematic approach for placing future new bundled codes into the APC groups.

**February 2011 CPT Editorial Panel Meeting**

The ACR’s CPT Advisor, Dr. Daniel Picus, and ACR economics staff attended the February 10-12 CPT Editorial Panel Meeting held in Naples, FL.

During the meeting, the ACR, American College of Cardiology, American Roentgen Ray Society, Radiological Society of North America, Society of Interventional Radiology, and Society of Vascular Surgery CPT advisors and staff presented code proposals for renal angiography and IVC transcatheter code families as requested by the CPT/RUC Five-Year Identification Workgroup.

The above societies also met during the Panel meeting to discuss the outstanding bundling issues to be addressed in 2013 and if any of these could be delayed, i.e.,
how and when the specialty societies would submit code applications to address high frequency code pairs and procedures with substantially increased utilization.

**Private Payer Updates**

**Aetna**
In its March newsletter, Aetna announced that effective June 1, 2011, their policy for multiple imaging procedures will expand to include imaging procedures performed on non-contiguous body parts and across modalities. Aetna states that this change is based on the CMS policy change that took effect on Jan. 1, 2011. Their current multiple procedure reduction applies to CT scans, MRIs and ultrasounds performed on contiguous body areas based on 11 imaging families. The new policy will consolidate the 11 imaging families into one. On Feb. 1, 2011, Aetna implemented a claims payment policy whereby technical component and global claims for second and subsequent multiple CT scans, MRIs or ultrasounds on the same date of service are reduced by 50 percent. The ACR continues to fight the inclusion of the professional component in the 50 percent reduction of global claims and will now begin to address the application of this policy to non-contiguous body parts and across modalities.

**UnitedHealthcare**
Effective with claims submitted with a date of service on or after June 1, 2011, UnitedHealthcare will reduce by 50 percent the technical component payment of multiple imaging procedures reported in the same patient session that are considered second and/or subsequent. The new UnitedHealthcare policy would mirror changes in the CMS 2011 multiple imaging reduction payment policy. These changes will apply to all codes that have a CMS multiple procedure indicator of four on the NPFS.

The ACR will comment to UnitedHealthcare that these cuts are arbitrary and not supported by medical data. The College will continue to keep members informed of any developments regarding this very important issue.
National Correct Coding Initiative
The ACR and the SIR submitted a joint letter to NCCI on February 8, appealing active edit 76937 / 77001 (Ultrasound guidance for vascular access / fluoroscopic guidance for central venous access device...). We feel that the edit, even with modifier allowance, is not appropriate, and that both ultrasound guidance and fluoroscopic guidance serves its own purpose in allowing for safe placement of venous access in patients. Additionally, we stressed the fact that there is no duplication of practice expense when the codes are reported together, based on RUC valuations. Our societies first commented on these edits in November 2010 when they were initially proposed for implementation, but our recommendation was not accepted by CMS. The edits were implemented January 1, 2011 in Version 17.0. We are still awaiting a response from CMS regarding this issue.

Version 17.1 of the NCCI files, to be published April 1, 2011, will include corrections to forty active edits. The edits were implemented incorrectly on January 1, 2011. The correction is made to rectify an error by CMS in implementing the edits without allowing the use of a modifier to bypass the edit. A more detailed article is available in the January/February 2011 ACR Radiology Coding Source.

The ACR also submitted comment to NCCI regarding four different batches of NCCI edits proposed for implementation July 1, 2011. Due to confidentiality issues, and pending a response from CMS, no additional information may be provided.

To view the most current file of NCCI edits, please visit: http://www.cms.gov/NationalCorrectCodInitEd/01_overview.asp

Local Coverage Determination (LCD) Update
ACR staff reviewed five draft local coverage determinations (LCDs) in February.
The two draft policies released for comment by National Government Services (NGS), the Medicare contractor for Indiana, Kentucky, New York, and Connecticut, were:

- Cardiac Catheterization and Coronary Angiography (DL26880), and
- Percutaneous Coronary Intervention (DL28395).

The three draft policies released for comment by Pinnacle Business Solutions, Inc. (PBSI), the Medicare contractor for Arkansas and Louisiana, were:

- Diagnostic Abdominal Aortography and Renal Angiography (DL19658)
- Cardiac Computed Tomography (CCT) (DL22038)
- Non-Coronary Vascular Stents (DL16150)

There are currently a total of seven other draft policies from Trailblazer, Highmark, and First Coast, available for comment by April 2011.

**LEGISLATIVE**

**Federal Budget**
Congress and the Administration remain at odds on the federal budget, with roughly $50 billion dollars separating them. While both sides agree the federal budget should be reduced, there is a disagreement as to how deep these cuts should be. Congressional Republicans, many of whom are fulfilling campaign promises, are insisting on immediate and severe cuts, while Congressional Democrats and the Administration have argued that the economy has still not sufficiently recovered from the recession, and such severe cuts would only impede economic growth and deepen the economic crisis. The government is currently operating under a continuing resolution, a form of appropriations legislation designed to keep the government funded if a budget can not be enacted in a timely manner. The current continuing resolution will keep the government funded until March 18th. If a deal has not been reached by March 18th, Congress must either pass another continuing resolution of the federal government (essential services excepted) must shut down.
Medical Malpractice Reform

Congressman Phil Gingery, MD (R-GA), with the support of 97 of his colleagues, has recently introduced HR 5, the Help Efficient, Accessible, Low-cost, Timely Healthcare (HEALTH) Act of 2011. The legislation addresses Medical Malpractice Reform in a variety of manners, including:

- Sets conditions for lawsuits arising from health care liability claims regarding health care goods or services or any medical product affecting interstate commerce.
- Sets a statute of limitations of three years after the date of manifestation of injury or one year after the claimant discovers the injury, with certain exceptions.
- Limits noneconomic damages to $250,000. Makes each party liable only for the amount of damages directly proportional to such party’s percentage of responsibility.
- Allows the court to restrict the payment of attorney contingency fees. Limits the fees to a decreasing percentage based on the increasing value of the amount awarded.
- Allows the introduction of collateral source benefits and the amount paid to secure such benefits as evidence. Prohibits a provider of such benefits from recovering any amount from an award in a health care lawsuit involving injury or wrongful death.
- Authorizes the award of punitive damages only where: it is proven by clear and convincing evidence that a person acted with malicious intent to injure the claimant or deliberately failed to avoid unnecessary injury the claimant was substantially certain to suffer; and compensatory damages are awarded. Limits punitive damages to the greater of two times the amount of economic damages or $250,000.
- Denies punitive damages in the case of products approved, cleared, or licensed by the Food and Drug Administration (FDA), or otherwise considered in compliance with FDA standards.
- Provides for periodic payments of future damages.
HR 5 has recently been reported out of the House Judiciary Committee and must next be taken up by the House Energy and Commerce Committee.

RADPAC

**RADPAC Changes Format in 2011 for Reception & Dinner**

RADPAC will host its RADPAC Annual Reception on Tuesday, May 17 from 6:00pm to 7:00pm at the Washington Hilton. This reception is open to all AMCLC attendees and guests, and will include cocktails and light hors d’oeuvres. The RADPAC Gala will be replaced with a RADPAC Thank You Dinner available only for those ACRA members who have contributed (or pledged) $1,000 or more in the 2011 calendar year by no later than Friday, April 29.

Please note that contributions made at the AMCLC will not be counted for invitational purposes to this exclusive event. As an ACRA member, if you have a record of giving on a periodic basis to RADPAC and if you choose such a method again for 2011 you will qualify for the Thank You Dinner if your contribution totals $1,000 or more during this calendar year.

This year's entertainment at the RADPAC dinner will be a show featuring internationally acclaimed singer of opera, operetta, musicals and cabaret, Ute Gfrerer-Wald. **Those who contribute at the $1,000 level or above will receive two tickets for this event - one for themselves and one for a guest. These tickets are non-transferable.**

For information on this special event, please contact Heather Kaiser at the ACRA office at 1-800-227-5463, ext. 4543.

**RADPAC 2011 Statistics**

*Contributions raised in 2011 as of 2/28/2011:*
Hard money contributions: $190,579.86 ($197,124 in 2010)
Soft money contributions: $8,587.02 ($7,032 in 20110)
Total contributions: $199,166.88 ($204,156 in 2010)

Total number of contributors in 2011 as of 2/28/2011:
Hard money contributors: 550 (545 in ’10)
Soft money contributors: 85 (56 in ’10)

So far for 2011 and the start of the 112th Congress RADPAC has contributed $101,000 to federal candidates and has attended 48 fundraising events.

**RADPAC 2010 Annual Report**

RADPAC's website (www.radpac.org) now has the 2010 Annual Report which lists all RADPAC contributors in 2010 as well as a summary of RADPAC's numerous accomplishments last year. Click the link below to view this report: http://www.acr.org/SecondaryMainMenuCategories/GR_Econ/FeaturedCategories/RADPAC/2010-Report.aspx

**REGULATORY**

**NIH CT Radiation Dose Summit**

On February 24-25, the NIH National Institute of Biomedical Imaging and Bioengineering (NIBIB) held a summit titled “Management of Radiation Dose in Computerized Tomography: Toward the Sub-mSv Exam,” co-sponsored by the ACR, FDA, NCI, and others. ACR members speaking at the meeting included Drs. James Thrall, James Brink, Donald Frush, and Richard Morin.

**ACR Comments on Meaningful Use Workgroup’s Stage 2 RFC**

On February 22, ACR submitted a response to the request for comments from a workgroup of a federal advisory committee charged with drafting advice on potential objectives and measures for Stage 2 of the Medicare/Medicaid EHR Incentive Program or "meaningful use" (MU). The workgroup will use comments
from the public to finalize its draft recommendations to the full federal advisory committee, which will then combine the recommendations with advice from several other workgroups. Eventually, the combined advice will inform staff in the Office of the National Coordinator for Health Information Technology (ONC) and Centers for Medicare and Medicaid Services (CMS) as they begin the second stage of MU rulemakings later this year.

The ACR comments to the workgroup focused on the following concerns, among others:

- Diagnostic images and related information (radiology reports, imaging history, radiation dose data, etc.) should be accessible via certified EHR technology.
- Specialty-specific pathways to MU in the second stage would be better than the first stage’s one-size-fits-all paradigm.
- In lieu of specialty-specific pathways, exclusions from individual objectives/measures must be flexible and scope-based.
- The bar should be raised in terms of computerized physician order entry with integrated clinical decision support tied to appropriateness guidelines.
- Providers should only be required to implement those EHR modules that they actively use.

There will be several opportunities for input during future CMS and ONC rulemakings. Please regularly visit the ACR website for reliable MU information, analyses and updates.

**ONC HIT Policy Committee Meeting**

The ONC HIT Policy Committee held its monthly meeting on March 2 to discuss a variety of issues, including the Quality Measures Workgroup recommendations for clinical quality measures in Stages 2 and 3 of the CMS EHR Incentive Program. Those recommendations include eight different National Quality Forum-endorsed, or soon to be NQF-endorsed, clinical quality measures on
appropriate use of diagnostic imaging. Additionally, ACR staff delivered a prepared verbal statement during the public comment portion of the agenda summarizing some of the main points from the February 22 comments to the Meaningful Use Workgroup (see previous update).

3rd White House OSTP Meeting on Mo-99 Production and Supply
On March 1, the White House Office of Science and Technology Policy (OSTP) held its third stakeholder meeting on molybdenum-99 production and supply concerns. Representatives from the Nuclear Regulatory Commission, FDA, Department of Energy, Department of Health and Human Services, and State Department were in attendance, as well as representatives from various professional associations and industry.

The discussions covered the Canadian reactor’s current relicensing efforts with the Canadian Nuclear Safety Commission, a production problem on the horizon for the reactors in the Netherlands and Belgium because of a highly enriched uranium supply chain disruption, and the current state of the Mo-99 market in the United States following the 2009-2010 Mo-99/Tc-99m supply crisis.

Domestic Mo-99 Production/Supply Agreement Announced
NorthStar Medical Radioisotopes signed an agreement with the University of Missouri Research Reactor (MURR) to provide up to 3,000 six-day curies of molybdenum-99 per week. U.S. demand for Mo-99 was estimated by the National Academies to be between 5000 and 7000 6-day curies per week prior to the 2009-2010 isotope supply crisis.

2nd IOM Patient Safety and HIT Project Meeting
The Institute of Medicine (IOM) is currently in the midst of a project to review issues related to patient safety and HIT, with a final report planned for January 2012. The report will recommend options and opportunities for enhancements to the safety of HIT-assisted care. The second project meeting was held on
February 24. The discussed focused on a variety of subtopics such as software reliability and human error in the use of HIT and patient data.

NCI Public Meetings
Last week the National Cancer Advisory Board (NCAB) and the Clinical Trials and Translational Research Advisory Committee (CTAC) each met. Both groups discussed the proposed changes in the NCI’s Clinical Trials System, among other issues. In a somewhat surprising move, the NCAB voted that NCI should not move ahead with consolidation of the specimen banks that serve the Cooperative Groups until after decisions about restructuring the Cooperative Groups have been finalized. Although not coming to any agreement, there was significant discussion among CTAC members about how to preserve the unique capabilities of various cooperative groups (specifically referencing RTOG) under any consolidation plan.

STATE

State Government Relations Committee will meet via conference calls throughout the year. The next GR Committee call is scheduled for Wednesday, March 16th, 6-7pm Eastern. Participation as a guest caller allows state chapter leaders to present an issue or a legislative question from their state to the committee members and to get feedback from colleagues. If you have a legislative or regulatory issue and would like to get committee’s input, please contact Eugenia Brandt at ebrandt@acr-arrs.org or by calling 703-715-4398

2011 Session Information Snapshot
All 50 states will meet in the 2011 legislative session, 48 states are currently in session.

Convene Dates:
March
03/01/2011: Alabama
03/08/2011: Florida
April
04/25/2011: Louisiana

Adjourn Dates:

February: Virginia (02/27)

March: Wyoming* (03/03), Utah (03/10), West Virginia (03/12), New Mexico (03/19), Kentucky* (03/22), Idaho* (03/25), South Dakota* (03/28)

April: Georgia* (04/01), Mississippi (04/02), Arkansas* (04/08), Maryland (04/11), Alaska (04/17), Montana* (04/21), Arizona (04/23), Washington* (04/24), Kansas* (04/27), North Dakota* (04/28), Indiana* (04/29), Iowa* (04/30), Vermont* (04/30)

*Projected Adjourn Date

Schedule of State Legislatures 2011

Radiologist Assistant

With the addition of Vermont and Rhode Island, the list of states that recognize RAs has grown to 28! The current list of states with RA recognition is as follows (28): Arizona, Arkansas, Colorado, Connecticut, Florida, Georgia, Kentucky, Illinois, Iowa, Maryland, Massachusetts, Minnesota, Mississippi, Montana, New Jersey, New Mexico, New York, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, Tennessee, Vermont, Virginia, Washington, West Virginia, and Wyoming. We are anticipating RA bill activity in North Carolina, Texas, Utah, and California in 2011 legislative session. If your state chapter has included RA bills in their legislative agenda, please let Eugenia Brandt know by e-mailing ebrandt@acr.org

Alabama

Alabama State Board of Medical Examiners issued a proposed rule that would require interventional pain management services to be provided exclusively by physicians. In a comment to the Alabama State Board of Medical Examiners, Federal Trade Commission staff said that the Board’s proposed rule appears
overly restrictive and likely detrimental to Alabama patients. The proposed rule would prohibit certified registered nurse anesthetists (CRNAs) from performing, under physician supervision, many pain management procedures that CRNAs currently are allowed to provide under physician supervision, such as providing palliative care.


**California**

New law (CA SB 1237) requires facilities performing CTs to record radiation dose for patients if technologically feasible. (Signed by the Governor, September 2010). There are plans to rework the language of the new law in two separate efforts when the legislature convenes in January 2011. One will be an “urgency bill” to postpone the effective date of the adverse event reporting to 7/1/12. Second effort will be a bill to rework the details of the new law.

**SB 173** Requires that all mammography reports include information & notice about breast density --DENSE legislation (Referred to Com. on HEALTH. - 02/03/2011).

**AB 352** Radiologist assistants. An act to add Chapter 7.75 (commencing with Section 3550) to Division 2 of the Business and Professions Code, relating to radiologist assistants. (Referred to Com. on B., P. & C.P. - 02/24/2011)

**Colorado**

State Medical Society representatives have reported possible changes to the state Medicaid program that may adversely effect physician reimbursement in the state. A conference call has been scheduled for January 21st by Medicaid Program Division as part of an effort to define Colorado Medicaid’s coverage policies for CT Scans, MRIs, and PET Scans. This activity is part of the Benefits Collaborative, a process used to define benefits – what is covered and who can provide it. Stakeholders are invited to participate in the Benefits Collaborative process by reviewing the draft policies.
Connecticut

SB848 To prohibit insurers from imposing a coinsurance, copayment, deductible or other out-of-pocket expense on an insured for breast ultrasound screening.

HB 5448 To provide insurance coverage for breast thermography when an annual mammogram demonstrates heterogeneous or dense breast tissue or if a woman is believed to be at increased risk for breast cancer due to family history or prior personal history of breast cancer, positive genetic testing or other indications as determined by a woman's physician or advanced practice registered nurse.  
(Referred to Joint Committee on Insurance and Real Estate - 02/16/2011)

SB 10 Insurance and Real Estate Committee. An act concerning insurance coverage for breast MRI.

To provide insurance coverage for breast magnetic resonance imaging when an annual mammogram demonstrates heterogeneous or dense breast tissue.

SB 848 Insurance and Real Estate Committee. An act concerning breast ultrasound screening. To prohibit insurers from imposing a coinsurance, copayment, deductible or other out-of-pocket expense on an insured for breast ultrasound screening.

SB 923 Insurance and Real Estate Committee. An act concerning health insurance coverage and certain cancer screenings. To require (1) health insurance coverage for lung cancer screening tests, and (2) the American College of Gastroenterology to additionally consult with the American College of Radiology for colorectal cancer screening recommendations.

SB51 That chapter 368v of the general statutes be amended to require that any health care institution that performs a computerized axial tomography diagnostic imaging service for the benefit of a patient shall record the radiation dose associated with such service and, in the event there is a radiation overdose attributable to such service, shall inform the patient and patient's physician of such overdose.

HB 5637 An act requiring lifetime retention of electronic medical records. To ensure the preservation of a patient's medical history when recorded electronically.
**HB 5639** An act concerning the licensing of nuclear medicine technologists. To require those who prepare and administer radiopharmaceuticals to be licensed.

**Florida**

**S96 (H25)** Requires that all mammography reports include information & notice about breast density. ACR’s Breast Imaging Commission has finalized talking points on the subject.

**Corporate Practice of Medicine**

Florida does not have a corporate practice of medicine law and we have received reports on hospitals pursuing physicians to join the employment model operations and negotiating new contracts under the ACO model. Orlando hospital has already gone in that direction (Geisinger/Mayo model). Whereby some practices were successful with recruiting in the past and have built younger groups of physicians, some have expressed concerns that recruiting may be inhibited by the employment model.

**Hawaii**

**SB 956** Health Care; Patient Brokering Prohibited. Creates the class C felony of patient brokering to prohibit payments for patient referrals and for the acknowledgement of treatment by health care providers, health care facilities, and health insurers.

**Illinois**

Illinois is reviewing a bill regarding contractingbalanced billing for out-of-network providers who practice in in-network hospitals. The current version of the bill provides for arbitration similar to the Texas law and with a $1500 limit (arbitration only for amounts above $1500). In addition, there is language mandating that the insurer offers a contract and enters into negotiations with the out-of-network providers. This has been a joint effort between radiology, emergency medicine, pathology, and pathology societies with the help of the State Medical Society. Currently, a draft bill has been circulated for review of the Societies and, if approved, will then be presented to the legislators and insurers.
**SB 140** Creates the Interventional Pain Medicine Act. Defines "interventional pain medicine", "interventional techniques", and other related terms. Provides that a person shall not practice or offer to practice interventional techniques for pain medicine in this State unless such person is a physician licensed to practice medicine in all its branches.

**Indiana**

**SB 174** Exempts accountable care organizations from the corporate practice of medicine limitation.

**HB 1582** A health care service provider shall, not later than the first day of each month, send to each physician who refers patients to the health care service provider notice of the actual current price, including technical and professional costs, which will be charged by the practitioner to a health plan or patient for the health care service.

**Iowa**

As you may recall, the Iowa Board of Nursing (BON) promulgated rules stating that it was within the scope of practice of Advanced Registered Nurse Practitioners (ARNPs) to supervise RTs and students performing fluoroscopic procedures. This raised serious safety concerns for the Iowa Radiological Society, the ACR, and the Iowa Medical Society. Because the Board of Nursing issued the rule fairly late in the legislative session 2009, adoption of the rule could not be blocked through legislative means in 2009. In the meantime, adoption of the rule moved through the regulatory process.

The Board of Nursing rule changes could not become effective without concurrence by Iowa’ Bureau of Radiological Health and the Iowa Board of Health. In its final decision, the Board of Health approved the adoption of the rule. Adoption of the rule took place too late in the legislative session to seek resolution through legislative means. The state medical society is pursuing legal action against Iowa Board of Nursing and Iowa Department of Health. To read the press release, please go [here](#).
On August 4th, Iowa Board of Medicine sent a notice “New rule assists physicians who treat chronic pain patients.”

Kansas

HB 2123 (SB142) Enacting the Kansas adverse medical outcome transparency act. In any claim or civil action brought by or on behalf of a patient allegedly experiencing an adverse outcome of medical care, any and all statements, activities, waivers of charges for medical care provided or other conduct expressing regret, sympathy, commiseration, condolence, compassion or a general sense of benevolence which are made by a health care provider, an employee or agent of a health care provider, shall be inadmissible as evidence and shall not constitute an admission of liability or an admission against interest.

Maryland

As a background, the Maryland Self-Referral Law (Md. HEALTH OCCUPATIONS Code Ann. § 1-301 et seq.), enacted in 1993, prohibited non-radiologists from referring patients for MRI, CT, and radiation therapy on machines within their practices or practice groups. The law remained largely unenforced until 2006 when the Maryland Board of Physicians issued an interpretation of the 1993 statute against the practice of self-referral. Thirteen physician groups filed a lawsuit (Potomac Valley Orthopedic Associates, et al. v. Maryland State Board of Physicians) with the Circuit Court in opposition to the Board’s ruling, claiming that the Board misinterpreted the General Assembly’s intent.

In early 2007, the MRS intervened as party-defendant, urging the court to uphold the Board’s ruling as a valid interpretation of state law. At that time, the ACR provided policy arguments and utilization data that the MRS included in its brief. Joining the opposition in amicus were the American Association of Neurological Surgeons, Society of Cardiovascular Computed Tomography, Mid-Maryland Musculoskeletal Institute, American Urological Association, Inc., and the American College of Surgeons.
After the Circuit Court ruled in favor of the Maryland Board of Physicians, self-referring physicians immediately filed an appeal. The Court of Appeals, Maryland’s highest court, heard oral arguments on the case in October of 2008. On January 21, 2011, the Court of Appeals upheld the lowest court’s decision in favor of Maryland Board of Physicians hence ruling against the appellant orthopedic practices. Court’s opinion.

Coverage in the media:
Medical Imaging War Pits Doctor vs. Doctor
Orthopedist-owned MRIs a recipe for soaring costs

As anticipated, the law is being challenged legislatively.
SB 808 (HB782) Health Occupations - Imaging and Radiation Therapy Services - Accreditation
Altering the definition of "in-office ancillary services" as it relates to specified referrals by health care practitioners so as to exclude magnetic resonance imaging services, computed tomography scan services, and radiation therapy services unless specified conditions are met; altering specified exceptions to patient referral prohibitions; requiring specified health care entities that provide specified services on or after January 1, 2012, to be accredited by specified organizations; etc. (Senate Bill Hearing scheduled for 3/9 at 1:00 p.m. --House Bill Hearing scheduled for 3/10 at 1:00 p.m.)

Massachusetts
MA HB 2178 – An Act relative to ionizing radiation. Physicians may delegate radiological procedures, including procedures using fluoroscopy, to a physician assistant who has completed a radiation safety course as prescribed by 105 CMR-120.405. (Study order 4/27).

Mississippi
SB 2625. Physicians who self-refer diagnostic imaging tests; limit billing options.
The bill will limit the ability of third parties to bill for technical component of imaging services: “if you did not perform the service--you cannot bill for it”. (Died in committee 2/1/2011)

**Missouri**

**SB 76. (HB280)** Prohibits insurers from denying reimbursement for providing diagnostic imaging services based solely on the specialty or professional board certification of a licensed physician. (hearing on HB 280 completed 2/8/11—Senate bill Second Read and Referred S Health, Mental Health, Seniors and Families Committee 01/20/2011)

**SB 136** Prohibits hospitals from requiring physicians to agree to make patient referrals as a condition of receiving medical staff privileges. (Hearing Conducted S Health, Mental Health, Seniors and Families Committee - 03/01/2011)

**HB 110** This bill requires every noninvasive vascular laboratory to be certified by the Intersocietal Commission for the Accreditation of Vascular Laboratories or the American College of Radiology. A vascular laboratory must complete the process for accreditation to one of the certifying entities by July 1, 2012. Documentation confirming the accreditation must be provided to the Department of Health and Senior Services by October 1, 2012. (Public Hearing Completed (H) - 02/16/2011)

**Nebraska**

**LB 481** Provide exemption from medical radiography licensure for auxiliary personnel and cardiovascular technologists.

**New Jersey**

**A 365** Concerning practitioner referrals to out-of-State health care services and supplementing Title 45 of the Revised Statutes. Requires practitioners to disclose business relationship with out-of-State facilities when making patient referrals to those facilities.
New Mexico

SB 336. Amending sections of the medical imaging and radiation therapy health and safety act to exempt certified registered nurse anesthetists from environmental improvement board licensure requirements and to exempt from environmental improvement board licensure requirements those certified nurse practitioners, clinical nurse specialists and certified nurse midwives who meet certain imaging education prerequisites. (DO PASS, as amended, committee report adopted-Senate Judiciary Committee - 02/18/2011)

New York

The state is addressing the issue of RA/RPA. The original NY law was written in the seventies and, at that time, no restrictions were placed on what type of procedures the specialist assistants were able to do (i.e. there are no restrictions on reading images, etc.) Currently, the state is working to enact a law clarifying the scope of practice for specialist assistants.

AB 1431 (SB1883) Requires individual and group health insurance policies, and health maintenance organizations to provide coverage for comprehensive ultrasound screening and/or magnetic resonance imaging for breast cancer in certain cases; requires mammography reports to include information about breast density. (DENSE legislation)

SB 2058. AN ACT to amend the public health law, in relation to site selection and a statewide registry for magnetic resonance imaging facilities. Add Art 35-B SS3560 & 3561, Pub Health L Creates a structure for the planning and placing of magnetic resonance imaging (MRI) facilities to ensure that as many regions of the state are serviced as is possible; sets out a process whereby a municipality shall approve, as well as comment or make suggestions, regarding the site selection of an MRI facility; provides for establishment of a statewide registry, operated by the department of health, listing all MRI facilities located in the state.

SB 2059. An act to amend the public health law, in relation to prohibiting the denial of employment of an MRI technologist solely based on their lack of licensure and/or Amd S3501, add S3501-a, Pub Health L Prohibits the denial of
employment of an MRI technologist, as an MRI technologist, solely based on their lack of licensure and/or certification in x-ray or radiography.

**Medicaid**
On January 5, 2011, New York Governor Andrew Cuomo issued Executive Order #5 establishing a Medicaid Redesign Team to find ways to cut costs within the New York Medicaid program for the 2011-2012 fiscal year. The Governor would like to restructure New York State Medicaid program to achieve measurable improvement in health outcomes, sustainable cost control, and a more efficient administrative structure.

**Oklahoma**
[American Board of Physician Specialties](http://www.abps.org) (ABPS vs. ABR) offers certification in diagnostic radiology.

**SB 318** An Act relating to radiology practitioner assistants; creating the Radiology Practitioner Assistant (RPA) Licensure Act. The state medical board shall be the final authority in all matters pertaining to licensure, continuing education requirements and scope of practice of radiology practitioner assistants. Creating the Radiology Practitioner Assistant Advisory Committee. The Committee shall have no members serving concurrently on the Radiologist Assistant Advisory Committee created under Section 541.2 of Title 59 of the Oklahoma Statutes. (Second Reading referred to Health and Human Services - 02/08/2011)

**Oregon**
[HB 2368](http://www.leg.state.or.us) Relating to medical imaging. Requires Oregon Health Policy Board to convene work group to address unnecessary medical imaging. Sunsets January 2, 2013. (Public Hearing held. - 02/28/2011)

[HB 3522](http://www.leg.state.or.us) Relating to health care practitioner referrals to health care entities; creating new provisions; and repealing ORS 441.098. Prohibits health care practitioners from referring patients to health care entities in which practitioner has beneficial interest or with which practitioner has compensation arrangement, subject to specified exceptions. Requires full disclosure of beneficial interests or
compensation arrangements of practitioner. Prohibits billing for services improperly referred. Authorizes health professional regulatory board to investigate and discipline violations of Act.
(Referred to Health Care. - 02/28/2011)

**Pennsylvania**

**HB 319**  Self referral. This act is intended to prohibit patient referrals between health care providers and entities providing health care services in which health care providers have a financial interest and to protect the residents of this Commonwealth from unnecessary and costly health care expenditures.
(Referred to HEALTH - 01/31/2011)

**HB 383**  An act to prohibit all forms of discrimination, disqualification, coercion, disability or liability upon such health care providers and institutions that declines to perform any health care service that violates their conscience.
(Referred to HEALTH - 02/01/2011)

**Rhode Island**

**H 5285 (S203)**  Certificate of Need, raising the limit from $1M to $3M. This act would increase the dollar value in definitions used in determining the need for new health care equipment and new institutional health services. This act would take effect upon passage.

Rhode Island chapter is engaged in efforts to repeal the 2% imaging cuts for imaging services.

**Tennessee**

**HB 496**  Professions and Occupations - As introduced, provides for licensure or certification of radiology practitioner assistants as radiologist assistants.
- Amends TCA Title 63. (Assigned to s/c General Sub of HHR - 02/16/2011)

**HB 343**  Professions and Occupations - As introduced, requires a radiologist assistant to work in the employ or at the direction of a radiologist.
- Amends TCA Title 63. (Assigned to s/c General Sub of HHR - 02/16/2011)
HB 569  Physicians and Surgeons - As introduced, regulates the activities of radiology benefit managers with respect to orders or recommendations of treating physicians. - Amends TCA Title 56 and Title 63.

Texas
We are anticipating a bill relating to the registration of diagnostic imaging equipment, accreditation of diagnostic imaging facilities, and the regulation of diagnostic imaging providers. The language is being drafted.

HB1108  Radiologist Assistant (RA) legislation. (H Referred to Public Health - 02/28/2011)

SB 401  Relating to the licensing and regulation of diagnostic imaging facilities and fluoroscopy-guided pain management procedure centers; providing penalties.

HB 834  Relating to supplemental breast cancer screening. (DENSE legislation) Mammography reports provided to patients must include information about breast density. (H Referred to Public Health - 02/23/2011)

Utah


SB 91  Medical Practice Self Referral. This bill amends the Health Code and the Division of Occupational and Professional Licensing code to require disclosure and reporting by a health care provider when the health care provider refers a patient for imaging services and the provider has a financial interest in the imaging services. (Senate committee report sent to Rules/ substituted/amend - 03/02/2011)

Vermont
The Department of Vermont Health Access (DVHA) has announced a proposed amendment (Vermont Medicaid State Plan Amendment (SPA #11-001)) to implement the Medicare RBRVS system to change its Medicaid fee schedule. The
specifics can be found at http://dvha.vermont.gov/news-info/public-announcement. The proposal purports to follow Medicare methodology in fee calculation, and does in utilizing RVUs and geographic indices; however, where Medicare RBRVS uses one “conversion factor” (currently $36.87), multiplying Total RVUs to determine fees, the DVHA proposes eight (8) different conversion factors/categories ranging from a high of $32.37 to a low of $24.34. As a percent of Medicare, these convert to 87.8% to 66%.

DVHA’s proposal to create an RVRBS-based system with a budget neutral overall result benefits virtually every provider except Radiologists. Other providers within the physician fee schedule would get a boost in payments, but the result is achieved through decreasing radiology fees 37.2%, or $1.8 million annually.

The Vermont Medical Society strongly opposed the amendment as and offering an alternative proposal of a single Conversion Factor, with a lower limit to fees not to drop below Medicare rates. This would result in a 6% decrease for Radiologists rather than the proposed 37% cut. DVHA has responded favorably towards the alternative proposal.

__Single Payer proposals in Vermont__

The health care bill has been introduced in the House as H.202 and in the Senate as S.57. Proponents of the single payer system have put together a web site.

**Virginia**

Medical Society of Virginia (MSV) and the Virginia Trial Lawyers Association (VTLA) have reached an agreement which serves to maintain an aggregate medical malpractice cap for the next 20 years. The agreement between MSV and VTLA provides for a modest $50,000 annual increase to Virginia’s current $2 million cap – representing an average annual increase of roughly two percent – beginning July 1, 2012 through June 30, 2032. (As of Nov. 2, 2010, VHHA had not signed on to the agreement.)

**HB 306** Adverse medical outcomes; pilot program created. Creates a pilot program to assess the creation of disclosure programs in health care facilities designed to facilitate disclosures of adverse medical outcomes between health
care providers and patients. The Department of Health shall adopt guidelines concerning the standards for such disclosure programs. Participating health care facilities are required to assess any such program and make reports to the Department of Health. The pilot program sunsets on December 31, 2015.

**HB 143** (2010) Practitioner self-referral; clarifies those that may make a referral. Clarifies when a health care practitioner may make a referral to an entity in which he or an immediate family member is an investor. (Governor: Acts of Assembly Chapter text (CHAP0743) - 04/13/2010)

**SB 263** Nurse practitioners; moves responsibility for licensure and regulation to Board of Nursing.
Moves responsibility for licensure and regulation of nurse practitioners from the Boards of Medicine and Nursing jointly to the Board of Nursing. Also, creates the Advisory Board on Nurse Practitioners and removes certain physician supervision requirements.

**Washington**

**HB 1311** Improving health care in the state using evidence-based care.
Requires the state health care authority to convene a collaborative, to be known as the Robert Bree collaborative, to identify health care services for which there are substantial variations in practice patterns or high utilization trends in the state that are indicators of poor quality and potential waste in the health care system. Requires all state-purchased health care programs to implement certain evidence-based practice guidelines or protocols and strategies. (Placed on second reading by Rules Committee - 03/03/2011)

**West Virginia**

**HB 2014** Relating to the practice of medical imaging and radiation therapy. The purpose of this bill is to make the practice of radiologic assistants and radiologic practitioner assistants (RPA) who are regulated by the Board of Medicine. Make CBRPA certification acceptable for licensure as an RA. (To House Health and Human Resources - 01/12/2011)