ACR ADVOCACY UPDATE  
October 8, 2010

ECONOMICS AND HEALTH POLICY

Relative Value Update Committee (RUC) - October 2010 RUC
The ACR surveyed for 4908X2 Abdominal paracentesis (diagnostic or therapeutic); with imaging code over the summer. Physician work and practice expense recommendations were presented at the October RUC meeting. The RUC accepted our physician work recommendation for CPT code 4908X2. The Practice Expense Subcommittee revised the direct practice expense inputs recommended by the specialties for CPT codes 4908X1-4908X2. In summary, clinical labor was specifically refined after considerable discussion and revisions.

Migration of Radiologic Images from Film to Digital
The ACR, with another specialty society, has begun assessing the potential migration away from radiographic film based images to digital archiving systems (i.e. picture archiving and communication system [PACS]) in an effort to understand the dynamics and implications of this change within the practice expense methodology and presented the initial findings at the October RUC meeting.

Five-Year Review October 2010
The ACR surveyed for six codes that were part of the 5-year review. The Five-Year workgroup and RUC accepted the compelling evidence and the recommended values and times for all six codes.

The ACR, in collaboration with other specialties, submitted a letter to the AMA to recommend codes to be referred to CPT; they included two IVA filter and two Carotid Angiography codes. The RUC agreed that they would be referred to CPT.

In addition, the ACR in collaboration with other specialties submitted a letter for three Catheter Placement codes, for a global period change from an X-day to a 0-day global. The RUC acknowledged our concerns regarding the codes to be referred to CPT and surveying the Catheter Placement XXX codes and will ask CMS to change the global period to ‘000’.

Furthermore, the ACR, in collaboration with other specialties, submitted a letter to the AMA recommending that the current physician valuation for two Kyphoplasty and three Vertebroplasty codes are accurate, and therefore asked the AMA for their consideration of maintaining these current values.
Further, this letter also stated that the identified procedures (as well as the family of codes) were actually valued as outpatient procedures in the recent past by the RUC, both in terms of the physician work and practice expense. It was argued that this was a clerical error. The RUC accepted this explanation, and did not recommend surveying these codes again.

**New Technology**

The Relativity Assessment Workgroup reviewed 32 services identified on the New Technology/New Services list to discuss whether there has been a diffusion of technology for these services, which may warrant re-evaluation. After the Workgroup’s discussion it was determined that CPT codes 32998 *Ablation therapy for reduction or eradication of 1 or more pulmonary tumor(s) including pleura or chest wall when involved by tumor extension, percutaneous, radiofrequency, unilateral;* 70554 *Magnetic resonance imaging, brain, functional MRI; including test selection and administration of repetitive body part movement and/or visual stimulation, not requiring physician or psychologist administration; and* 70555 *Magnetic resonance imaging, brain, functional MRI; requiring physician or psychologist administration of entire neurofunctional testing,* would be removed from list.

**Medicare Administrative Contractors**

On September 9, 2010, Palmetto Government Benefit Administrators (Palmetto GBA) was given the green light by the GAO and CMS to continue their work in MAC jurisdiction 11. The jurisdiction is comprised of North Carolina, South Carolina, Virginia, and West Virginia. J11 had been under a work stop order since June 2010, when CIGNA Government Services protested the award to Palmetto GBA. Palmetto is expected to take over the J11 workload in the next couple of months.

**LEGISLATIVE**

**Congress Adjourns for Mid-Term Elections without Addressing Impending SGR Cuts**

Congress has adjourned for the November 2 elections and is not scheduled to return until the week of November 15. Prior to leaving, Congress was able to pass a short Continuing Resolution, or CR, which funds the federal government through December 2, 2010 and a small business assistance bill. However, Congress did not address legislation to further delay the impending 23% cut to the SGR, now scheduled to begin December 1, 2010.

Congress’s return to Washington to begin a lame duck session the week of November 15 would leave less than two weeks to debate and pass an SGR fix of any length. The American Medical Association (AMA) has called for a 13 month payment extension estimated to cost $16.5 billion. The AMA’s proposal is not paid for, which almost certainly means Republicans will oppose the legislation on the grounds that the extension would add to the national debt. Therefore, prospects for passing a 13 month extension during the lame duck session appear slim.
Further complicating prospects for a lengthy SGR extension is the short time period Congress will be in session prior to Thanksgiving. As a result of this condensed period, there is a real possibility that Congress fails to move anything beyond a 30 day Medicare physician payment fix before Thanksgiving. Even a 30 day extension may be difficult as it is likely Republicans will again put forward the politically charged proposal of using medical malpractice reforms to pay for a more permanent Medicare physician payment fix.

While popular with physicians, the trial bar’s opposition to such a proposal makes it unlikely that it could garner the 60 votes needed in the Senate for passage. The political debate surrounding a proposal linked to medical malpractice reforms will inevitably use what little time is available to deal with this issue in the less than two-week November portion of the lame duck session.

This sets up the possibility that Congress could fail to act before the payment cuts go into effect on December 1, 2010. In such a scenario physicians could see once again the Centers for Medicare and Medicaid Services directing Medicare carriers to hold physician claims and payments with the hope that legislation is passed during the December part of the lame duck session.

RADPAC

RADPAC 2010 Statistics

Contributions raised in 2010 as of 9/30/2010:
Hard money contributions: $884,555.94 ($919,229 in 2009)
Soft money contributions: $86,594.21 ($81,656 in 2009)
Total contributions: $971,150.15 ($1,000,885 in 2009)

Total number of contributors in 2010 as of 9/30/2010:
Hard money contributors: 2010 (2,157 in 2009)
Soft money contributors: 289 (250 in 2009)

So far for 2010 RADPAC has contributed $858,500 to federal candidates and has attended 350 fundraising events. In September alone RADPAC contributed $210,000 and attended over 70 fundraising events. This 2009-2010 election cycle RADPAC has contributed over $1,790,000.

Voter Guide

The 11th Voter Guide allows ACRA members to view the House and Senate Races in 2010, the dates for each state’s primary and the listing of candidates that have received RADPAC contributions. RADPAC continues to update this information periodically so that it remains current through the general elections in November, 2010.
Website Statistical Resources
If you want to see where your state ranks and compare your state with other states click here.

If you want to see if your state has any outstanding group practices click here.

If you do not see your practice listed and want more information on our wire transfer option for contributing to get your group or practice listed you can click here.

RADPAC/Doctor Hosted Fundraisers

Dr. Girish Patel (right) and his wife recently hosted a fundraiser in their home for Rep. Kevin McCarthy, Deputy Whip of the House Republicans (center).

Drs. Ken Robbins (left) and Steven Dunnagan (right) recently attended a fundraiser for Tim Griffin (center) who is running for Congress in Arkansas.

Click here to see a listing of the 2010 RADPAC Outreach activities that have already occurred at other facilities across the nation.
REGULATORY

NCI Cooperative Groups
ACR is working with fellow NIH National Cancer Institute (NCI) stakeholders to advocate for constructive enhancement of the NCI’s Clinical Trials Cooperative Group Program in the wake of the Institute of Medicine’s Spring 2010 report. Efforts include collaborating with the U.S. Congressional delegation from Pennsylvania, as well as with pertinent medical specialties and science organizations, to stress the invaluable contributions of the program.

On September 21, the Clinical Trials Advisory Committee (CTAC) met to discuss a variety of issues related to NCI clinical trials. During a presentation on updating the program, NCI staff noted that analysis shows that the Institute covers only 50 percent of the total costs of the cooperative groups, with the rest of the funding being raised by the groups.

FDA Review of Medical Devices that May Be Used With Contrast
ACR has partnered with the Medical Imaging Technology Alliance in requesting a meeting with FDA Center Directors to discuss FDA’s regulatory pathway for the clearance of imaging equipment that may be used with contrast agents. FDA’s recent guidance on combination products has virtually halted the clearance process for imaging products that may be used with contrast agents.

Second White House OSTP Meeting on Mo-99/Tc-99m Production and Supply
On October 5, the White House Office of Science and Technology Policy (OSTP) hosted its second meeting on production and supply of Molybdenum-99 used in generators to produce Technetium-99m. The meeting—a follow-up to the OSTP discussions on March 10—featured presentations by representatives of the Department of Energy/National Nuclear Security Administration, Covidien, and Lantheus Medical Imaging. Discussion topics included the continued prevalence of Thallium-201 in the practice of nuclear cardiology due to widespread reluctance to return to Tc-99m even though it is (temporarily) commercially abundant for the first time since May 2009; the imminent decommissioning in 2016 of the National Research Universal reactor in Canada; the status of the Pallas reactor project to replace the High Flux Reactor in The Netherlands; the Senate hold on the American Medical Isotopes Production Act of 2009; NNSA’s cooperative agreements for production of Mo-99 using alternatives to Highly Enriched Uranium targets; a potential upcoming production gap in March-April 2011; and other related issues.

ONC HIT Policy Committee Meaningful Use Workgroup – Stage 2 Discussions
On September 30, the Meaningful Use Workgroup of the Office of the National Coordinator for HIT’s (ONC) HIT Policy Committee held its initial meeting to discuss Stage 2 “meaningful use of certified electronic health record (EHR) technology” draft recommendations. The Meaningful Use Workgroup plans to submit its preliminary draft recommendations on Stage 2 to the full HIT Policy Committee on October 20, 2010, which will then be followed by a call for public comments on the preliminary draft. The
HIT Policy Committee hopes to complete its Stage 2 recommendations by mid 2011, when the Stage 2 rulemakings at ONC and CMS will get underway.

**Clinical Decision Support - Radiology Order Entry**

On September 30, representatives of the Imaging e-Ordering Coalition, including ACR, met with ONC staff to advocate for radiology order entry technology (ROE/CPOE) with integrated clinical decision support (CDS) tied to appropriateness criteria guidelines for Stage 2 or 3 of the meaningful use/EHR incentive programs. The meeting was the third time the Coalition formally met with ONC, including participating in an October 2009 meeting between ACR IT & Informatics Committee leaders and ONC staff.

**FDA Radiological Devices Panel Meeting**

On September 24, the U.S. Food and Drug Administration (FDA) held a meeting of its Radiological Devices Panel to discuss Hologic’s Pre-Market Approval (PMA) application for its Selenia Dimensions 3D digital mammography tomosynthesis system. The Panel voted that Hologic’s PMA application adequately demonstrated the effectiveness and safety of the system. Moving forward, FDA will consider the vote of the panel as it makes its final determination.

**NIH-NACBIB Meeting**

On September 13, the National Advisory Council on Biomedical Imaging and Bioengineering (NACBIB) held its regularly scheduled meeting to discuss the business of the NIH National Institute of Biomedical Imaging and Bioengineering (NIBIB). Discussion topics included the Institute’s strategic plan workgroup, strategies for CT dose reduction, and more. NIBIB Director, Dr. Roderick Pettigrew, also mentioned that NIBIB was in communication with ONC on issues pertaining to image exchange and radiation dose management via HIT.

**NRC Part 37 Rulemaking**

On September 20, the U.S. Nuclear Regulatory Commission held a public workshop to discuss the 10 CFR Part 37 [proposed rule](#) and [draft implementation guidance](#) regarding physical protection of IAEA Category 1 and 2 quantities of radioactive materials. The proposed Part 37 would essentially enhance and codify the various NRC Increased Controls Orders from the past decade.

The meeting provided NRC materials licensees the opportunity to listen to NRC staff’s perspectives on the proposed rule and share ideas and concerns in an open microphone forum. Following the meeting, ACR joined the American Association of Physicists in Medicine, American Society for Radiation Oncology, Nuclear Energy Institute, and other stakeholders in requesting comment period extensions for both the proposed rule and the corresponding draft implementation guidance. NRC granted the extension, and the deadline for submitting public comments will be moved to January 15, 2011.
If you have specific concerns you would like to be addressed in the future ACR comments to NRC rulemaking and adjudications staff on this issue, please contact Mike Peters, Assistant Director of Regulatory and Legislative Portfolio, at mpeters@acr.org / 202-223-1670.

**ACR Nominates Dr. Frank J. Lexa for the USPSTF**

ACR submitted the nomination of Dr. Frank James Lexa (University of Pennsylvania School of Medicine) to the Agency for Healthcare Research and Quality (AHRQ) for membership on the U.S. Preventive Services Task Force (USPSTF).

**USPSTF Transparency Initiative**

The Access to Medical Imaging Coalition had a meeting on September 21 with Senator Harkin’s office to discuss transparency in the USPSTF recommendations development process. The meeting was a follow-up to AMIC’s discussion in August with AHRQ staff, including liaisons to the USPSTF.

**AHRQ 2010 Annual Conference**

AHRQ held its 2010 Annual Conference on September 26-29. Discussion topics included health information technology, USPSTF transparency, Patient Safety Organization regulations and operations, comparative effectiveness/patient-centered outcomes research, and other projects and initiatives housed within or supported by the agency.

**STATE**

**California - CA Senate Bill 1237**

The chaptered version of the bill can be found [online](http://www.akos.net).

1. Commencing July 1, 2012, persons (facilities) utilizing CT X-ray systems for human use will be required to record the dose of radiation on every CT study by either recording the dose within the patient’s radiology report or attaching the protocol page (that includes the dose of radiation) to the radiology report. Provisions of this bill are limited to CT systems capable of calculating and displaying dose.

2. Facilities conducting the CT studies will be required to send each CT study and protocol page that lists the technical factors and dose of radiation to the electronic picture archiving and communications system (PACS).

3. The bill requires the displayed dose to be verified annually by a medical physicist to ensure the displayed doses are within 20 percent of the true measured dose measured in accordance with No. 6 below, unless the facility is accredited.

**Dose Reporting**
4. As referenced in No. 1, the bill requires that the dose of radiation be included in the radiology report of a CT study by either recording the dose within the patient’s radiology report or attaching the protocol page that includes the dose of radiation to the radiology report.

5. The provisions in this bill are limited to CT systems capable of calculating and displaying the dose.

6. For the purposes of this bill, dose radiation will be defined as one of the following:

   - The computed tomography index volume (CTDI vol) and dose length product (DLP), as defined by the International Electrotechnical Commission (IEC) and recognized by the federal FDA.
   - The dose unit as recommended by the American Association of Physicists in Medicine.

Facility Accreditation

7. Commencing July 1, 2013, facilities that furnish CT have to become accredited by an organization that is approved by the federal CMS, an accrediting agency approved by the Medical Board of California, or DPH.

Medical Event Reporting

8. Health facilities, except for an event that results from patient movement or interference, will be required to report to DPH an event in which the administration of radiation results in and of the following:

   - Repeating of a CT examination, unless otherwise ordered by a physician or radiologist, if the following dose values are exceeded:
     a. 0.05 Sv (5 rem) effective dose equivalent;
     b. 0.5 Sv (50 rem) to an organ or tissue; or
     c. 0.5 Sv (50 rem) shallow dose equivalent to the skin.

   - CT X-ray irradiation of a body part other than that intended by the ordering physician or a radiologist if one of the following dose values are exceeded:
     a. 0.05 Sv (5 rem) effective dose equivalent;
     b. 0.5 Sv (50 rem) to an organ or tissue; or
     c. 0.05 Sv (50 rem) shallow dose equivalent to the skin.
- CT or therapeutic exposure that results in unanticipated permanent functional damage to an organ or a physiological system, hair loss, or erythema, as determined by a qualified physician;

- A CT or therapeutic dose to an embryo or fetus that is greater than 50 mSv (5 rem) dose equivalent, that is a result of radiation to a known pregnant individual unless the dose to the embryo or fetus was specifically approved, in advance, by a qualified physician;

- Therapeutic ionizing irradiation of the wrong individual, or wrong treatment site; and, the total dose from therapeutic ionizing radiation delivered differs from the prescribed dose by 20 percent or more.

- Require a report in any instance where the dose administered exceeds 20 percent of the amount prescribed in a situation where the radiation was utilized for palliative care for the specific patient.

- Require the radiation oncologist to notify the referring physician that the dose was exceeded.

9. The bill requires facilities, no later than five business days after discovery of an event described in No. 1 above, to provide notification of the event to DPH and the referring physician of the person subject to the event. The bill also requires the facility, no later than 15 business days after discovery of an event described in No. 1 above, to provide written notification to the person who is subject to the event.

10. Requires the information required in the provisions of this bill to include, but not be limited to, information regarding each substantiated adverse event, as defined in existing law, reported to DPH, and may include compliance information history.

**Iowa - NP Supervision of Fluoroscopic Studies**

ACR provided an affidavit supporting the Iowa medical Society’s motion to stop implementation of a state health regulation that would allow Nurse Practitioners to supervise fluoroscopic studies in Iowa. Referencing ACR’s Technical Standard for Management and Use of Radiation in Fluoroscopic procedures, the affidavit raised concerns related to patient safety and quality of care. It also pointed out that adoption of the rule allowing ARNPs to supervise fluoroscopy an outlier in relegating supervision for this medical procedure to ancillary personnel, as the trend in other states is toward more rigorous oversight of radiation safety practices.