ACR ADVOCACY UPDATE

May 11, 2011

ECONOMICS AND HEALTH POLICY

CMS Concludes MRI Improves Health Outcomes for Medicare Beneficiaries with Pacemakers

The Centers for Medicare & Medicaid Services (CMS) has decided that magnetic resonance imaging (MRI) improves health outcomes for Medicare beneficiaries with implanted permanent pacemakers (PMs) when the PMs are used according to the FDA-approved labeling for use in an MRI environment. Therefore CMS proposes that this use of MRI is reasonable and necessary under §1862(a)(1)(A) of the Social Security Act (the Act.) CMS proposes to change the language in section 220.2.C.1 of the NCD Manual to remove the contraindication for Medicare coverage of MRI in beneficiaries with implanted PMs when the PMs are used according to the FDA-approved labeling for use in an MRI environment. Other contraindications that may be present in any given beneficiary would continue to apply in patients with PMs.

CMS to Modify Active CT Abdomen and Pelvis NCCI Edits

In response to an ACR letter, CMS has agreed to modify active NCCI edits that bundle stand-alone CT abdomen (74150-74170) and pelvis (72192-72194) procedures with the combined CT abdomen and pelvis procedures (74176-74178). Currently, the edits do not allow for the use of an NCCI-associated modifier when reporting 74150-74170 or 72192-72194 in conjunction with 74176-74178 when the procedures are performed on the same date of service, even at separate patient encounters.
The NCCI edits will be revised to allow for the use of NCCI-associated modifiers to designate a separate patient encounter on the same date of service. The edits will be published July 1, 2011 in NCCI version 17.2, and will be retroactive to January 1, 2011, when the edits became active. It is recommended that providers not submit any claims that will be affected by the change until July 1, 2011. Claims that were previously submitted or denied may be appealed after July 1, 2011, if your claims processing contractor allows.

**AMIC Meeting with MedPAC Staff**
Members of the Access to Medical Imaging Coalition (AMIC), including the ACR, met with MedPAC staff to discuss the criticisms MedPAC raised with respect to the Moran data on imaging utilization during the recent public meetings. MedPAC staff revealed at the meeting that the imaging recommendations they adopted were not so much focused on controlling utilization as their bigger concern, which is efficiencies that can be gained by providing multiple imaging services during the same session. AMIC has offered to work with MedPAC staff to set up a site visit to a radiology practice in order to give them insight as to how radiology practices actually operate.

**April 2011 AMA/Relative Value Update Committee (RUC) Meeting**
ACR physicians, Dr. Bibb Allen, Dr. Geraldine McGinty, Dr. Zeke Silva, and ACR Economics staff attended the April 2011 RUC Meeting in Chicago, IL. During the meeting, the ACR along with other specialty societies presented data on renal angiography and IVC transcatheater families. In addition, data sets on CT of head, three plain films, and extremity study were presented. CT of head came out of the Harvard Valued-Utilization over 100,000 screen and plain film and extremity study codes came from the Low Value/ High Volume screen. The final physician work values for these codes will be available in the 2012 Medicare fee schedule final rule published in November 2011.

**Medicare Administrative Contractor (MAC) Update**
Implementation is in progress for Medicare Administrative Contractors (MAC) jurisdictions 11 and 15. The MAC awards for these jurisdictions were announced
in 2009 and 2010, respectively, but the implementations of these MACs were postponed by protests against the award.

**Jurisdiction 11** (North Carolina, South Carolina, Virginia, West Virginia)
Virginia is the first J11 state to transition its workload to its MAC, Palmetto GBA. Virginia’s transition from its Part B carrier, Trailblazer Health, to its MAC, Palmetto GBA, occurred on March 19, 2011. The other J11 states will transition in the coming weeks, with North Carolina transition on May 28, 2011, and West Virginia and South Carolina transitioning on June 18, 2011.

**Jurisdiction 15** (Kentucky, Ohio)
On April 30, 2011, Kentucky transitioned from its Part B carrier, National Government Services (NGS) to its Part B MAC, CIGNA Government Services (CIGNA). Ohio will be transitioning on June 17, 2011.

**Local Coverage Determinations**
ACR staff reviewed six draft local coverage determinations (LCDs) in March and April:

- Four draft policies from Highmark Medicare Services, the Medicare contractor for Pennsylvania, District of Columbia, Delaware, New Jersey and Maryland:
  - Non-Covered Services (DL31686)
  - Non-Vascular Extremity Ultrasound (DL30271)
  - Non-Vascular Extremity Ultrasound for Guidance of Injection and Aspiration (DL31683)
  - Radiation Therapy (DL27515)

- One draft policy from Trailblazer Health Enterprises, the Medicare Contractor for Colorado, New Mexico, Oklahoma, and Texas:
  - Computed Tomographic Coronary Angiography (CTCA) (DL31692)

- One draft policy from First Coast Service Options (FCSO), the Medicare Contractor for Florida, Puerto Rico, and the Virgin Islands:
  - Non-Coronary Vascular Stents (DL31824)
There is currently one draft LCD available for comment from Wisconsin Physicians Services, Inc. (WPS), the Medicare Contractor for Iowa, Kansas, Missouri, Nebraska, Illinois, Michigan, Minnesota, and Wisconsin:

- Dialysis Shunt Maintenance (DL32009)

The comment period for this draft LCD ends August 1, 2011.

**LEGISLATIVE**

**House Energy and Commerce Health Subcommittee Holds Hearing on SGR**

On Thursday, May 5th, the House Energy and Commerce Health Subcommittee conducted a hearing entitled, “The Need to Move Beyond the Sustainable Growth Rate (SGR).” This hearing is the first step in a long legislative process designed to prevent a scheduled 29.5% cut in physician Medicare reimbursement rates from going into effect in January 2012. Lawmakers also utilized this Congressional hearing to express their continued support for repealing the flawed SGR formula before the conclusion of the 112th Congress. Hearing witnesses testifying before the Committee included Mark McClellan, MD, Ph.D., Director, Engelberg Center, the Brookings Institution, Harold Miller, Executive Director, Center for Healthcare Quality and Payment Reform, David B. Hoyt, MD, Executive Director American College of Surgeons (ACS), Michael Chernew, Ph.D., Professor of Health Policy, Harvard Medical School, M. Todd Williamson, MD, Coalition of State Medical and National Specialty Societies, Cecil B. Wilson, MD, President of the American Medical Association (AMA), and Roland Goertz, MD, President, American Academy of Family Physicians (AAFP).

In addition to highlighting problems with the current SGR system, witnesses discussed different ways to control Medicare spending through a variety of innovative payment models, including Accountable Care Organizations, Patient-Centered Medical Homes, and bundled Medicare payments. Representatives from the various medical specialty groups specifically urged Congress to repeal the SGR formula and provide five years of stable payment updates. The medical
groups also urged the Committee to utilize this five year period to test a wide variety of alternative payment models that could ultimately replace the current fee-for-service system. Finally, the physician specialty organizations urged Congress to avoid a one-size-fits all solution in favor of permitting doctors the freedom and flexibility to select from a variety of these newly tested payment options.

Select hearing participants also voiced support for new legislation, H.R. 1700, the Medicare Patient Empowerment Act, which seeks to permit physicians to “balance bill” Medicare patients. This bill, introduced by Representative Tom Price, MD (R-GA), creates a new Medicare payment option which allows patients and physicians to freely enter into contracts for Medicare services. Medicare beneficiaries would still be able to use their Medicare benefits and physicians, in turn, would be permitted to bill the patient for all amounts not covered under Medicare without being forced to opt-out of the government health care plan for two years, as is the case under current law. Both the AMA and the Coalition of State Medical and National Specialty Societies endorsed H.R. 1700.

Although elimination of the flawed SGR formula has garnered bipartisan support, Members of Congress are struggling to develop a policy that covers the approximately $300 billion cost of switching to an alternative payment system. ACR will continue to monitor all forthcoming bills to offset the potential 29.5% cut in physician reimbursement rates, as well as any legislative developments surrounding repeal of the current SGR formula.

**Anti-Self-Referral Bill Introduced in the House of Representatives**

On April 12th, Representative Jackie Speier (D-CA) introduced H.R. 1476, the Integrity in Medicare Advanced Diagnostic Imaging Act of 2011, in the United States House of Representatives. This important legislation seeks to protect patients and radiologists from inappropriate self-referral practices by removing advanced diagnostic imaging services, including MRI, CT, and PET, from the Stark in-office ancillary services exception. Representative Speier has been a consistent supporter of addressing inappropriate self-referral and introduced
similar legislation in the 111th Congress. Representative Anthony Weiner (D-NY) is an original cosponsor of this most recent bill introduced in the 112th Congress.

In addition to advocating for enactment of the Integrity in Medicare Advanced Diagnostic Imaging Act, the American College of Radiology is simultaneously working with a broader coalition of medical specialty and health care practitioner groups to address inappropriate self-referral stemming from the in-office ancillary services exception. This coalition, entitled the Alliance for Integrity in Medicare (AIM), includes representatives from the College of American Pathologists (CAP), American Clinical Laboratory Association (ACLA), American Physical Therapy Association (APTA), American Society for Clinical Pathology (ASCP), American Society for Radiation Oncology (ASTRO), and the Radiology Business Management Association (RBMA). In fact, the coalition recently submitted a letter to Democratic and Republican leaders on the House Energy and Commerce Committee urging them to close the in-office ancillary services loophole as one of several potential initiatives designed to cover the cost of a permanent repeal of the SGR. The AIM coalition continues to diligently educate members of the House and Senate about how addressing loopholes within the Stark self-referral law will positively impact patient care and control excessive Medicare spending.

**RADPAC**

**RADPAC 2011 Statistics**

Contributions raised in 2011 as of 5/05/2011:

Hard money contributions: $523,820.00 ($394,274 in 2010)
Soft money contributions: $24,453.17 ($42,911 in 20110)
Total contributions: $548,273.17 ($437,185 in 2010)

Total number of contributors in 2011 as of 5/05/2011:

Hard money contributors: 1312 (1069 in ’10)
Soft money contributors: 139 (181 in ’10)

So far for the 112th Congress RADPAC has contributed $394,000 to federal candidates and has attended 155 fundraising events.
**Website Updates**

Last year, RADPAC had 12 states at the 20% contributor participation goal. This year RADPAC already has four states at the 20% contribution participation level: South Dakota (41%), Puerto Rico (31%), Wyoming (27%) and North Carolina (20%). Click the link below to see where your state ranks and compare your state with other states, as well as see how your state’s contribution levels compare this year to last year:


In 2010, RADPAC had 73 practices with 100% contribution participation. Currently RADPAC has 45 practices at 100% contribution participation for 2011. RADPAC would like to reach a total of 100 practices in 2011. There are several states that do not currently have any practices at 100% contributor participation including: Alaska, Colorado, Connecticut, Delaware, Hawaii, Idaho, Illinois, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Michigan, Mississippi, Montana, Nebraska, Nevada, New Hampshire, New Mexico, North Dakota, Ohio, Oklahoma, Oregon, Puerto Rico, Rhode Island, South Carolina, Utah, Vermont, West Virginia and Wisconsin. To view the listing of the 2011 outstanding group practices click the link below:


**REGULATORY**

**ACR to Present at HIT Policy Committee-Meaningful Use Workgroup Meeting**

The ACR was invited by the Office of the National Coordinator for HIT (ONC) to participate in a May 13 public hearing of the HIT Policy Committee-Meaningful Use (MU) Workgroup on “Specialists and Meaningful Use.” Keith J. Dreyer, DO, PhD, chair of ACR’s IT and Informatics Committee-Government Relations Subcommittee, will be a panelist for the topics of EHR support of specialists in patient care and clinical decision support (CDS). Additional panels will address the topics of care coordination between primary care, patients, allied health
professionals and specialists, population health and data registries and experiences from the field.

The invitation follows numerous efforts to increase awareness of the concerns of many specialists related to MU, including a December 2010 letter from the ACR, American Society of Anesthesiologists and College of American Pathologists to HHS. Dreyer’s invitation also comes in the wake of verbal comments he delivered to the MU Workgroup members on March 22.

**NRC ACMUI Meeting**
On April 11-12, the U.S. Nuclear Regulatory Commission (NRC) Advisory Committee on the Medical Uses of Isotopes (ACMUI) held its spring business meeting. Topics discussed included plans for the upcoming Part 35 expanded rulemaking, the medical events in permanent brachytherapy rulemaking, and the I-131 patient release issue. NRC is planning to host two public workshops in summer 2011 to collect stakeholder feedback on these and other issues.

There is still considerable controversy about whether the patient release criteria in 10 CFR 35.75 should be interpreted as per annum or per release. At the meeting, the ACMUI passed a motion stating that the interpretation of the regulation should be per release. NRC continues to view the limit as per annum; however, they do not advise a strict enforcement of this interpretation by the regional investigators for reasons of practicality.

**AHRQ NAC Meeting**
The National Advisory Council (NAC) for the Agency for Healthcare Research and Quality (AHRQ) held its spring business meeting on April 8. Topics discussed included the latest National Healthcare Quality and Disparities Reports, the March publication of the National Quality Strategy, and healthcare-associated infections research.

**IOM Review of Use of AFIP’s Tissue Repository**
An Institute of Medicine (IOM) Committee tasked with review of the appropriate use of Armed Forces Institute of Pathology’s (AFIP) tissue repository met on April 21st and 22nd. During the open public session of the meeting, the
committee members were introduced to their charge. They also received a status update of the transition from the AFIP to the new Joint Pathology Center. In closed session, the committee deliberated and planned their research strategy, how to approach their charge, and parameters of the study. They also began preliminary planning of a July workshop and meeting.

**Molybdenum-99 Availability**

The ACR joined other medical stakeholders in signing a letter of support for the American Medical Isotopes Production Act of 2011 (S. 99). The legislation is designed to support the development of domestic production of Mo-99 using alternatives to highly enriched uranium (HEU) targets. The ACR supported the bill in the 111th Congress when it made it through the House with bipartisan support, but was held up in the Senate.

**ACR Supports National Cancer Research Month**

The ACR joined the American Association for Cancer Research (AACR) and Senators Dianne Feinstein and Kay Bailey Hutchison in an effort to introduce a resolution reinforcing the fact that May is “National Cancer Research Month.”

**STATE**

State Government Relations Committee holds conference calls throughout the year. GR Committee will meet in person during the AMCLC on Sunday, May 15th, 4:00-5:30pm. Participation in the role of a guest 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.org or by calling 703-715-4398

**2011 Session Information Snapshot**

All 50 states will meet in 2011 legislative session, 31 states are currently in session.
Adjournment Dates:
April: Mississippi (04/07), Idaho (04/07), Maryland (04/11), Georgia (04/14),
Alaska (04/17), Arizona (04/20), Washington (04/22), Arkansas (04/27),
Montana (04/28), North Dakota* (04/28), Indiana (04/29)
May: Hawaii (05/05), Florida (05/06), Iowa* (05/10), Kansas* (05/10), Colorado
(05/11), Vermont* (05/15), Minnesota* (05/23), Missouri (05/23), Oklahoma
(05/27), Texas (05/30), Tennessee* (05/31)
*Projected Adjourn Date

Schedule of State Legislatures 2011

Radiologist Assistant
With the addition of Utah in March of 2011, the list of states that recognize RAs
has grown to 29! The current list of states with RA recognition is as follows (29):
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,
We are anticipating RA bill activity in North Carolina, Texas, and California in
2011 legislative session. If your state chapter has included RA bills in their
legislative agenda, please let Eugenia know by e-mailing ebrandt@acr.org

Medical Liability Reform in the States
Iowa H.F. 490 – Certificate of Merit legislation
Montana H.B. 405 – Physician judgment/defensive medicine legislation
New Meixco--S.B. 333 (vetoed by Gov’r)
New York – Governor’s Budget Proposal - $250,000 cap on non-economic
damages
North Carolina S.B. 33 - $500,000 cap on non-economic damages
Oklahoma H.B. 2128 - $350,000 cap on non-economic damages (enacted)
Oregon H.B. 3519 – Medical review panels
Tennessee H.B. 2008/S.B. 1522 - $750,000 cap on non-economic damages
Virginia – H.B.1459/S.B. 771 - Cap modification bill, incrementally increasing the Commonwealth’s cap on total damages from $2 million to $3 million over the course of 20 years (enacted)

**NCOIL Model Legislation**

In March, the National Conference of Insurance Legislators (NCOIL) passed the “Healthcare Balance Billing Disclosure Model Act.” Originally envisioned as a model bill against balance billing for hospital-based services, the new model legislation instead promotes transparency of out-of-network health care costs.

The purpose of the Model Act has shifted from prohibition on balance billing to providing patients with transparency, accountability and disclosure. Provisions of the model bill require health care facilities, facility-based physicians, other health care providers, and health insurers to provide information regarding billing practices, notice of out-of-network benefits and financial responsibilities in the delivery of non-emergency medical care.

**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
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 appropriations. 5/4/2011).

**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. (In committee; hearing cancelled by author’s request-5/3/2011)

**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. (Referred by Senate to Committee on Appropriations - 04/27/2011)

**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.

SB 923 An act concerning the American College of Radiology and colorectal cancer screening recommendations. 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.

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.
**FL H 935** - Health Care Price Transparency. Authorizes primary care provider to publish & post schedule of certain charges for medical services offered to patients; requires schedule to include certain information regarding medical services offered; provides that schedule may group provider's services by price levels & list services in each price level; provides exemption from license fee & continuing education requirements for provider who posts schedule of charges; requires primary care provider's estimates of charges for medical services to be consistent with posted schedule, etc.

(Ordered engrossed, then enrolled -HJ 1142 - 05/04/2011)

**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 contracting/balanced 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](http://www.acr.org).
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 was 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. Both bills died in committee. Maryland legislature adjourned on April 14th

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).
HB 1542 (SB 1067) Qualifies a physician's assistant to perform some radiological procedures, including fluoroscopy, if said assistant has completed a radiation safety course, and also under the delegation of a physician. (Hearing Scheduled JPH - 04/12/2011 10:00 AM A-1 - 03/30/2011)
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)

**SB 344**  Requires health insurance policies to cover ultrasound screenings where mammograms demonstrate dense breast tissue. Under this act, certain health insurance policies must provide coverage for comprehensive ultrasound screening of an entire breast or breasts if a mammogram demonstrates heterogeneous or dense breast tissue based on the Breast Imaging Reporting and Data System established by the American College of Radiology 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. (Hearing Conducted S Small Business, Insurance and Industry Committee - 04/21/2011)
**HB 982** Restricts the authority of radiology benefit managers to deny diagnostic testing ordered and recommended by a licensed physician. This bill specifies that if a health carrier or health benefit plan provides coverage for diagnostic radiology testing and if a treating physician presents an order for a test to a radiology benefits manager for authorization, a decision to deny the authorization must only be made by a licensed physician. (Referred: Health Care Policy (H) - 04/12/2011)

**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 years. 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.

North Carolina
HB 753 An act to establish Radiologic Technicians Licensure, providing for the regulation and licensing of persons who perform and administer medical imaging and radiation therapy procedures. (House Filed - 04/06/2011)

HB 878 (SB 672) Study RA licensure (House ref. to Committee on Rules 5/4/11)
Oklahoma
American Board of Physician Specialties (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 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 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 (SB1338) 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. (Rec. for Pass. if Am. ref. to: Finance, Ways & Means Committee - 04/27/2011)

SB 790 As introduced, requires a radiologist assistant to work in the employ or at the direction of a radiologist. - Amends TCA Title 63. (ref. to S. GW,H&HR Comm. - 02/17/2011)

SB 792 As introduced, provides for licensure or certification of radiology practitioner assistants as radiologist assistants. - Amends TCA Title 63. (ref. to S. GW,H&HR Comm. - 02/17/2011)
Texas

**HB 1809** Relating to the registration of diagnostic imaging equipment, the accreditation of diagnostic imaging facilities, and the regulation of diagnostic imaging providers; providing penalties. (Reported favorably as substituted - 05/02/2011)

**HB1108** Radiologist Assistant (RA) legislation. (Pending on committee 5/4/11)

**SB 401 (HB 1621)** Relating to the licensing and regulation of diagnostic imaging facilities and fluoroscopy-guided pain management procedure centers; providing penalties.

**HB 834 (SB1381)** Relating to supplemental breast cancer screening. (DENSE legislation) Mammography reports provided to patients must include information about breast density. (Pending in committee 4/13/2011)

Utah

**HB 238** Radiologic Technologist and Radiology Practical Technician Licensing Act. Radiologist Assistant (RA) legislation. (Senate/ strike enacting clause - 03/10/2011)

**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. (Delivered to Governor. - 04/22/2011)

**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)