THE BULLETIN

Ohio Chapter, American College of Radiology, Inc.

Immediate Past-President's Message

Robert Paul, Jr., MD, FACR

There is one thing certain in life other than death and taxes - change. With a new presidential administration in power, and with control of both the House and Senate by the same party as the president, there could be significant changes coming to healthcare in this country, especially since "changing" healthcare was a primary policy issue the president and his party ran on during the past federal election. The growth of expensive diagnostic imaging procedures is directly in the crosshairs of the politicians in Washington looking to rein in healthcare costs. The primary drivers in the volume increase of expensive imaging services has been proven by recent statistical studies to be self-referral and the inappropriate use of diagnostic imaging procedures by non-radiologists. Even though Congress is fully aware that these are principle factors responsible for such growth in costs, they previously attacked the problem a few years ago by literally making a late night deal to cut technical reimbursement shortly after the ACR had lobbied vigorously against doing so. This late night deal is now known as the DRA (Deficit Reduction Act) cuts. Rather than take the difficult course and correct one of the fundamental reasons behind the problem of imaging procedure growth, known as the In Office Exception of the Stark II legislation banning self-referral, Congress took the easy way out and cut technical reimbursement for everyone. Congress did this even though they knew it would likely lead to a further increase in imaging procedures performed by the self-referrer's in order to make up the difference. But, alas, elections were coming up and they did not want to hurt their chances by going up against the lobbies of other medical specialty societies and the 800-pound gorilla known as the AMA.

So, what may be in store? While lobbying on Capital Hill in Washington this year, the members of the ACR council from Ohio were informed that the Senate had decided to take another look at the In Office Exception of the Stark II legislation. Most recently, Representatives Anthony Weiner (D-NY) and Representative Bruce Braley (D-IA) planned to offer an amendment to H.R. 3200, America's Affordable Health Choices Act of 2009, regarding physician self-referral that would address the in-office ancillary services exemption. However, this amendment still had not offered before congress adjourned for its summer recess. It is unclear whether or not the amendment will be offered when the committee reconvenes in September. Best case scenario is that the In Office Exception will be eliminated, but going upon past history, it likely will not happen soon if it happens at all.

Another place Congress is looking to curb costs is by reforming the Sustainable Growth Rate physician payment system. Congress has been considering separate expenditure targets for physician services as one option for moving away from the current flawed (SGR) payment system. Such an idea was recently

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Staff Contact
Anitra Metheny Ohio State Radiological Society
3401 Mill Run Drive, Hilliard, Ohio 43026
614/527-6808 614/527-6763 Fax
osrs@osma.org www.osrs.org

mentioned as a potential payment reform option in Senate Finance Committee Chairman Max Baucus' "Call to Action" for health reform in 2009.

What does this mean? It means that physician services would be separated into six categories with each category's reimbursements determined by its own growth in volume. Under the separate expenditure target scenario, medical imaging would be placed in its own category; therefore, if there is low volume growth in imaging, it will result in positive reimbursements while high volume growth in the imaging category would result in reimbursement cuts. A rationale for separate service categories is to have physicians be more responsible for volume growth within their service area. Unfortunately for radiologists, they are not really in control of imaging volume. All of medicine is responsible for the growth of imaging volume (primary care to surgeons) since medical imaging studies provide critical information over the course of patient care. The separate expenditure target policy would divorce the ordering physician from the impact of imaging growth entirely and subjects the reimbursements of those who perform the imaging exams to the whim of other physicians. Based on the current volume trends, if medical imaging remains in its own category, reimbursements would face annual cuts far into the foreseeable future.

What is being done? On Capital Hill, the ACR has been arguing that if Congress decides to pursue a multiple service category approach that all physicians should bear the responsibility for volume growth, since all physicians order imaging studies for their patients. The goal should be a system where physicians are held accountable for the amount of medical imaging they order. This could be accomplished by examining the ordering patterns of the various physician specialties and calculate a fair way to distribute the volume of the technical component of imaging services across the spectrum of providers accordingly. Another point of argument is that medical imaging has increasingly replaced older, more invasive and more expensive treatments such as exploratory surgery, and therefore saves money over the previous methods. The third point the ACR has been disseminating on Capital Hill is that the professional component (PC) of radiology services, the complex medical diagnosis rendered by radiologists, should be separated from the TC of imaging and placed with other cognitive services in the "other" evaluation and management (E&M) category.

A third area where change may be coming has to do with President Obama's budget initiative to finance health care reform by saving $260 million in Medicare over 10 years through utilization of radiology benefit managers (RBMs). This is allegedly being proposed so that Medicare is assured that it makes "appropriate" payments for imaging services. Subsequently, Congress is considering including RBMs in proposed health reform legislation. The ACR has voiced strong opposition to the use of RBMs, since RBMs are for-profit companies that insurers hire to regulate patients' access to imaging services. Patients are often denied the imaging studies their physicians believe are warranted or are forced to wait to receive needed imaging services, adding an additional unnecessary layer that takes money out of the Medicare system, while at the same time doing nothing to improve patient care. As an alternative to Radiology Benefit Managers, the ACR has been promoting the use of an E-Ordering with Decision Support to Congress. Such an electronic ordering system would be aided by the use of the ACR appropriateness criteria, helping to assure the clinically appropriate utilization of imaging services, as has already been done in Boston's Massachusetts General Hospital system since 2004. Since the ACR appropriateness criteria were developed through a consensus process with broad physician specialty representation, the criteria presently address over 160 clinical conditions with over 700 variants. The advantage of using such an E-Ordering system is that adherence to the criteria is likely to cause a decrease in inappropriate use of expensive imaging services with a subsequent cost savings. An added benefit is that an electronic order entry solution would not require a physician practice to hire additional FTEs as is certainly the case when dealing with RBMs.

A fourth area where medical imaging cost savings are being investigated by Washington has to do with a recommendation made by the Medicare Payment

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Advisory Commission's (MedPAC) in its most recent report to Congress on Medicare. MedPAC proposed that CMS change the percent utilization rate for imaging equipment (MR, CT and PET) from 50 percent to 95 percent, which is used in the formula that calculates practice expense. A 90 percent utilization rate assumption would add significant additional cuts on top of the $1.7 billion annual cuts that resulted from the Deficit Reduction Act (DRA) of 2005. The ACR has pointed out that the only public data that currently exists on imaging equipment utilization rates come from a flawed 2006 MedPAC survey that looked at utilization rates of MR and CT in only six urban areas. This survey was not intended to be nationally representative or designed to determine equipment use rates. Such a lack of sound data was cited by CMS when the agency decided not to increase the utilization rate assumption to 75 percent in 2007. The ACR has argued to Congress that CMS should make an effort to find the actual utilization rate for equipment and apply this real number to the practice expense formula that determines imaging reimbursement. At a June 24 Capitol Hill briefing ACR members including, James P. Borgstede, M.D., vice chair of radiology at the University of Colorado and former president of the ACR, urged members of the U.S. House of Representatives Rural Caucus against using both the proposed imaging equipment utilization rate change from 50 percent to 95 percent as well as to the use of radiology benefits managers (RBMs) in the Medicare system.

At the state level, it appears that the commoditization of radiology may have begun. A 19-member radiology group in Toledo was recently notified that they were being replaced by a teleradiology company at two of the three hospitals they cover. According to available information, radiology services are not being provided entirely by teleradiology as temporary locums radiologists are furnishing some onsite staffing at the hospitals. However, onsite department staffing levels are at a significantly lower level that provided by the previous radiology group. Unfortunately for the Radiology residents of the Medical College of Ohio program, this change in coverage has resulted in the loss of a major clinical training site. One of the most disturbing aspects regarding this situation is that the CEO of Imaging Advantage, the teleradiology company that replaced the existing radiology group, went out of his way to publicly disparage the Toledo radiologists in a letter to Carol Rumack, MD, the president of the ACR. This letter was filled with inaccuracies and bold, unsubstantiated accusations of malfeasance by the radiologists including sabotage, which border upon, if not constitute defamation. Whether this staffing model is sustainable over the long run remains to be seen. A more detailed article regarding this matter is included near the end of this newsletter.

So as one can see, there may be many changes on the horizon. Radiology continues to be assailed from both reimbursement and business model standpoints. What happens in the future, one can only surmise. Only through the efforts of the entire membership and their leaders in the state and national radiology organizations does radiology stand a chance to survive. This is why it is important to voice your concerns and be active in the state (Ohio Radiological Society) and national (ACR) radiology organizations in any way possible, be it through monetary support or sacrifice of one's valuable time. Otherwise, the future will not be very bright for the specialty.

Silver Medal Presented to OSRS President

Michael J. Seider, MD, PhD, from Akron was awarded the Silver Medal which is the highest honor given by the society.

The Ohio State Radiological Society in appreciation for Dr. Seider's invaluable leadership and service to the Society and for furthering the image of the specialty of Radiology, for teaching and the practice of the principles of Medicine, and for his dedicated service as a physician. Dr. Seider is also serving a second term 2009-2010 as our President of the Ohio State Radiological Society.

Fellowship in the ACR

Yogesh Patel, MD, FACR, is Clinical Professor at the University of Toledo, College of Medicine, Toledo. Dr. Patel is with the Consulting Radiologists, Inc., of Toledo and received his Fellowship from the ACR. Dr. Patel is now the President-elect of the Ohio State Radiological Society and is serving as Treasurer. Dr. Patel received his Bachelor of Science and M.B.B.S. in Ahmedabad, India. has served on council for many years as a Delegate and Alternate to the American College of Radiology. Dr. Patel also served as Secretary to the OSRS Executive committees along with numerous professional organizations and has written many publications.

Fellowship Committee Report

Stanley B. Ignatow, MD, FACR

- Ohio radiologist Yogesh Patel, MD, FACR has received his fellowship for 2009.
- Three fellowship applications to consider for 2010.
- May 1, 2009 was the deadline for submission to the ACR for fellowship consideration for 2010
- Councilors and alternate councilors need to edentify candidates for ACR fellowship in their regions, and encourage them to apply.

Legislative Report

Victor Goodman and Billie Fiore,
Benesch Friedlander Coplan & Aronoff LLP

Ohio's Budget Bill As Related To The Practice Of Radiology July 23, 2009

The Ohio Senate and House wrapped up the first half of the 128th General Assembly's 2009 session. As the State Budget bill's July 1st deadline came and went without an agreed upon budget bill from the Senate and House Joint Conference Committee, the Legislature passed, and the Governor signed, two interim State Budget bills permitting state operations and programs to continue through the first few weeks of July. On July 13th, the Ohio Legislature sent Amended Substitute House Bill 1 ("HB1") to the Governor. The Governor signed the bill on July 17th but not before vetoing 61 provisions contained in the bill.

The OSRS, ACR, interested parties and Victor Goodman participated in the hearings on HB1 to ensure the practice of radiology had a voice in legislative process. There were three main issues impacting the radiology profession: 1) Radiology Practitioner Assistants ("RPA") exemption from Medical Board Licensure and RA Standards/Education/Licensure; 2) Prior Authorization for High-Tech Radiological Services; 3) Ohio Department of Health's Radiation Fee increase on Inspections and Registrations.

We were successful in removing a provision that was placed into the Senate version of the budget bill that would have exempted RPAs from licensure by the Ohio Medical Board. The original amendment would have exempted from licensure certain RPAs who had been certified by the Certifying Board for RPAs. Last year, the OSRS successfully worked to enact Senate Bill 229 of the 127th General Assembly to provide authority to the Medical Board to regulate the practice of Radiology Assistants, set forth eligibility requirements for licensure as a Radiology Assistant, and define the scope of practice for a Radiology Assistant. During the deliberations on Senate Bill 229, the legislature determined that the minimum education level for a Radiology Assistant should be a baccalaureate or post-baccalaureate certificate degree. As RPAs did not meet the minimum educational and certification requirements needed to practice, they were not recognized in statute. The amendment to the Budget Bill would have created two separate tiers of practitioners: (1) Licensed Radiology Assistants who have met the minimum education and training requirements as set forth in the Ohio Revised Code; and (2) unlicensed RPAs who were unable to attain these minimum requirements and were

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not subject to administrative discipline or prosecution for unlicensed practice. The language would have also permitted RPAs to use any title they deemed appropriate other than RA; practice as unlicensed individuals who are not accountable for their actions within the course of practice defined in SB 229; practice without supervision by a physician; be exempt from continuing education; and likely be able to perform tasks that are prohibited by a licensed RA. If these provisions had remained in the bill, radiologists and other medical facilities and professionals would have been open to increased medial liability issues which could have dramatically impacted health care and patient safety.

The Senate version of the Budget Bill included a provision that would have required prior authorization for High-Tech Radiological Services for Medicaid recipients. This new section of law would have prohibited the Ohio Department of Job and Family Services' Office of Medicaid from reimbursing a provider for providing high-technology radiological service to a Medicaid recipient unless the service is prior authorized. The proposed amendment defined high-tech radiological services as "magnetic resonance imaging services, computed tomography services, positron emission tomography services, cardiac nuclear medicine services, and similar imaging services." Senator Neihaus, sponsor of the amendment, provided the OSRS a supporting analysis for his proposal which claimed that "Radiology is the fastest growing health care cost." The Senator cited information provided by Med Solutions asserting that "Radiology is an extremely effective diagnostic tool when used correctly. However, experts estimate that at least 30% of tests currently preformed are unnecessary. The rapid growth of inappropriate imaging is due to many factors, including technological advancements, increasing availability of testing facilities and financial incentives for physicians."

We arranged for meetings and telephonic conferences with representatives from the ACR and OSRS to discuss these issues with Senator Neihaus. As a result of our discussions, Senator Neihaus agreed to rethink his position and to consider legislation which had been enacted in the State of Washington and supported by the ACR. In the course of our discussions and negotiations with Senator Neihaus, we learned from Director John Corlett, Office of Medicaid, that an ODJFS "recently completed study determined that only 2% of the radiology procedures could be determined medically unnecessary." Ultimately, Senator Neihaus was persuaded by the facts and arguments offered by OSRS and the ACR with the result that his original amendment was withdrawn and language inserted into the Budget Bill which "removes the bills provisions that prohibits ODJFS and Medicaid from reimbursing a provider for providing a high-technology radiological service to a Medicaid recipient unless service is prior authorized." The new language inserted into the bill requires the ODJFS to implement evidence-based, best practice guidelines or protocols and decision support tools for advanced diagnostic imaging services available under the fee-for-service component of the Medicaid program not later than January 1, 2010.

While we were able to remove all of the Ohio Department of Health's Radiation Fee increases on Inspections and Registrations in the Senate version of the bill, because of a substantial deficit in state revenues, radiology like every other industry and profession regulated by the state had their fees increased. These fees were initially inserted in the Governor's version and House passed version of the bill. We were successful in holding these fee increases to the minimum as first recommended in the original version of the bill.

The legislature is on break and will return in the fall to continue reviewing the implementation of the budget bill's provisions and impact of the current financial condition of the state.

ORSPAC

If you would like to help support Ohio Radiology as a player in the Ohio political arena, mail you check today to:

ORSPAC
c/o Ms. Billie Fiore
41 S. High St., 26th Floor
Columbus OH 43215

The ORSPAC over the last ten plus years has been critical to the success of advocating and educating members of the legislature on the issues that impact the practice of radiology. Without continual support from the radiology community, being able to deliver that message will become more difficult. Please remember to support the ORSPAC by contributing today at the Chairman's level of just $200 for a yearly membership. (Corporate checks are prohibited, please personal checks only).

Health care is at the forefront of the state and national levels and many PACs and organizations advocate for health care and medical professional, but ORSPAC is there to specifically advocate for the Practice of Radiology. Your support is crucial. As we move into the fall legislative cycle, the time is now to step up the efforts to educate the legislative and executive branches of government on the impact of legislative and regulatory changes to radiology, health care, patient access and patient safet

Special thanks due to Drs. Kathryn Gardner and Robert Paul, Jr.

The Ohio Radiological Society owes a special debt of gratitude to our two most recent past-presidents, Kathryn Gardner and Bob Paul, who aside from their presidential duties helped pass the Radiologist Assistant Law which was signed by Governor Strickland last year. Kathy and Bob worked tirelessly and extremely effectively on our behalf along with our lobbyist Victor Goodman to pass a bill along the lines of the American College of Radiology model legislation.

About five years ago a bill was introduced into the Ohio House of Representatives that would have enabled some x-ray technologists to practice independently and bill independently for providing x-ray technology service. This bill might have passed on a fast track were it not for the vigilance of Mr. Goodman who monitors all government initiatives in Ohio that affect our interests.

The first task was stopping this independent practice of Radiologic Technology. Then, with ACR support, they crafted a suitable bill allowing for a high level of technologist to work as an assistant to the radiologist but always under supervision. This bill was introduced by Representative Randy Gardner of Bowling Green (no relation to Dr. Gardner) Drs. Paul and Gardner with Mr. Goodman sheparded the bill through the legislative process reasoning some opponents into neutrality and defeating others with the soundness of their witness and testimony. Some medical specialties even tried to highjack this bill so that they could employ “super technologists” to help them interpret imaging .

This all involved many hours of preparation, presentation and negotiations, often on short notice and took away from practice and personal time. Dr. Paul, in particular, was involved with the intricacy of negotiating the language of the bill to meet concerns of potential opponents without sacrificing the bills intent. Dr. Gardner had to leave the ACR Annual Meeting in Washington, DC last year and drive back to Columbus to represent us at a hearing called suddenly and possibly with intent to catch us off guard.

Our bill did pass and was signed into law by the Governor. Thank you Drs. Gardner, Paul and Mr. Goodman. You transformed a threat to radiologists into an opportunity.

Radiologists Assistant Law
John O. Olsen, MD, Columbus

BYLAWS CHANGE

The OSRS Executive Committee voted to support a by-laws change. As Chairman, George Belhobek, MD, is responsible for periodic reviews of the Bylaws. Dr. Belhobek was ask to make additions and changes that would follow with the American College of Radiology Bylaws. If you have any questions or concerns with regard to this addition to the by-laws change please feel free to contact the Ohio State Radiological Society

Section 7 Article IV

Conflict Of Interest

The Ohio Chapter of the American College of Radiology depends to a great extent on the knowledge, expertise and efforts of members who volunteer their services and it is desirable that as many members as possible participate in its activities. The confidence that members of the profession and public have in radiology and radiologists, radiation oncologists and medical physicists depends on the integrity of those who represent the chapter.

Officers, Executive Committee members, Committee members, Staff, Volunteers and all others representing or acting on behalf of the Ohio Chapter of the American College of Radiology should avoid conflicts of interest or the appearance of conflicts of interest. All decisions and actions considered or made by such individuals should be based solely on the best interests of the Chapter and in accordance with applicable federal, state and local laws and regulations. Personal considerations should not be a factor in any action or decision made on behalf of the Ohio Chapter of the American College of Radiology.

What is a Conflict of Interest?

A conflict of interest occurs whenever an individual or a member of his/her immediate family has a direct or indirect interest or relationship, financial or otherwise, that may conflict or be inconsistent with the individuals duties, responsibilities or exercise of independent judgment in any transaction or matter involving the Chapter.

A conflict of interest does not necessarily imply that an individual is ineligible to serve on a Chapter Committee, task force or cannot represent the Chapter in a specific situation, but it may indicate that participation in some matters should be avoided or limited. Questions relating to whether a conflict might arise should be referred to the President of the Chapter.

Reporting Conflicts of Interest

If an individual has an actual or potential conflict of interest relating to business or transactions before the Chapter, he/she should immediately notify the Chair of his/her Committee or task force, or the president of the Chapter. Members of the Chapter's staff should disclose potential or actual conflicts of interest to the Chapter President. The president of the Chapter should disclose his own conflicts of interest to the Executive Committee as a whole. In making the disclosure, the individual should reveal all material facts about the conflict of interest and explain his/her relationship to the transaction or matter at issue. In some circumstances, full disclosure of the conflict may in itself be sufficient to ensure the integrity of the Chapter operations.

If a conflict of interest arises in connection with the activities of a deliberative body, such as the Executive Committee, or a committee, the conflict should be disclosed to the other members of the body and the individual should not participate in the consideration of the matter at issue. Any withdrawal by a member of the committee or task force and the reason for it, should be recorded in the minutes of the meeting. Members of the Executive Committee with a conflict of interest relating to a policy matter before the Committee may participate in debate on that issue after disclosing the conflict to the Committee, but should refrain from voting.

When a conflict arises from an individual's presentation or participation in a seminar, workshop or other such event, or in connection with an

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individual contribution to a chapter publication, the facts giving rise to the conflict should be disclosed to the other participants, attendees or readers and the individual should clearly identify his/her statements or contributions as personal opinions.

Letters to the Editor

Screening Mammograms/
Representative Jean Schmidt

Many of you have noticed that Ohio radiologists are getting a fairer payment for screening mammograms including recognition of Digital and CAD. Until a few years ago many screening payments were fixed at an $85.00 global ceiling and in some practices the hospital collected and kept the entire global payment with nothing to the radiologist. Several years ago U.S. Representative Jean Schmidt of Cincinnati, then serving in the Ohio Senate, introduced a bill that revised and increased screening mammography payments, recognized new technology and specified the division of global payments between radiologist and institution. This was initiated by our lobbyist Mr. Victor Goodman who enlisted Representative Schmidt's support to help radiologists with our screening mammograms thereby making screening more available to Ohio women. Frank McWilliams, MD, also of Cincinnati and former OSRS president, assisted in preparing and getting the legislation passed attending many meetings and hearings.

Senator Schmidt has since gone to Washington to serve in the U.S. House of Representatives. She barely won re-election in the last general election and is under considerable pressure – being targeted for defeat. She helped Ohio radiologists greatly when in the Ohio Senate and I would appreciate any help we can provide to keep her in the U.S. House of Representatives.

Contributions supporting Representative Schmidt can be made to: Jean Schmidt for Congress Committee, P.O. Box 867, Milford, OH 45150.

Please also remember to support ORSPAC with your contributions. This is your primary but not your only responsibility. ORSPAC contributions are made to:

ORSPAC
c/o Ms. Billie Fiore
41 S. High St., 26th Floor
Columbus OH 43215

Remember all contributions must be a personal check. No corporate or business contributions are allowed.

Sincerely,

John O. Olsen, MD, Columbus

Letters to the editor are the personal opinion of our members and not the official policy of the OSRS.

Toledo: A Test Case for the Radiology Community

Yogesh P. Patel, M.D., F.A.C.R.
President-elect, OSRS, and CRC radiologist

Recently, a radiology group in Toledo, Ohio, was displaced by non-radiologist-led company. What occurred has significant implications, not just for the Toledo, Ohio, community, but also radiology in general. Its outcome will likely shape how, where, and for whom radiologists work in the future.

The Consulting Radiologists Corporation (CRC), a group of 19 radiologists, had provided radiology services to three hospitals of Mercy Health Partners (MHP) in the Toledo area for over 60 years. MHP, a part of Cincinnati-based Catholic Health Partners, covers seven hospitals in Northwest Ohio. MHP decided to terminate radiology services from CRC with 19 days notice on May 19, 2009. MHP entered into an exclusive contract with non-radiologist-led, California-based Imaging Advantage (IA) to provide radiology management and interpretation services to all three hospitals. This

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decision to change providers completely bypassed medical staff and the medical executive committees at all three hospitals. IA pushed their product to MHP using the names of Massachusetts General Hospital (MGH) radiologists and MGH resources like their 3D lab, implying that MGH would be acutely involved in the activities at the MHP facilities. High-ranking MGH faculty members were initially listed on the IA website as "company leadership," but their listing was suddenly removed following publicity of the connection.

About nine months prior to the radiologists' removal, MHP administrators told CRC that an outside, "independent" consultant would evaluate the radiology departments to improve services at the their facilities, and report back to CRC and the administration with their findings. CRC believed that hospital administration was acting in good faith to address some issues within the departments, and was candid with their assessment. CRC never received any report from the consultants' findings.

The consulting firm in question, RCG HealthCare Consulting, is neither "independent" nor unbiased. Many of the board members of RCG were also listed as "company leadership" on the IA website. Several have co-appointments at MGH. There is a clear RCG-IA-MGH axis, whereby presumably RCG would evaluate the radiology department seemingly acting as an "independent" agent, while covertly pushing IA's services, and using the MGH name to exert influence on hospital administrators. Also, there are people within the ACR leadership who serve on RCG and IA boards. ACR leaders are in their bounds to work with IA and RCG. Ethically and morally speaking, however, ACR leadership should not be in the business of displacing local radiology groups or decreasing the independence of radiology practices.

CRC has been providing radiology services in the three hospitals for many decades with a gentleman's agreement. In spite of that, CRC had been providing services through many challenges, such as hospital administration turnover, ups and downs of the hospital business, local hospital competition, and changes due to the overall economic climate in the region. The group had always provided services to MHP through good and bad times.

During the short transition, CRC members were offered 3 to 4 weeks of locum work with the verbal understanding to work "longer term" (though not necessarily permanently) as an employee of IA. All CRC members independently decided against this offer due to its ambiguity (no written, official contract was ever offered by IA) and to maintain independence to practice medicine through a radiologist-led group. The group decided to go forward and maintained the existence of the CRC by providing services to another non-MHP hospital, group-owned imaging center, and the Northwest Ohio community at large.

Immediately after the announcement of the termination of services on May 19, 2009, the hospital administration and IA began a smear campaign against CRC and its reputation of high-quality services by various means to justify their action. This included an open letter to Dr. Carol Rumack, President of the ACR, by the CEO of IA, Mr. M. Naseer-Uddin Hashim, as well as verbal communication, meetings, and emails with hospital clinicians, staff, and employees. CRC submitted to the ACR a response to Mr. Hashim's open letter, refuting the allegations contained therein. In writing, CRC asked the MHP administration and Mr. Hashim to provide evidence for the allegations made in the open letter and an MHP bulletin. To this date, there has been no response to the letter from either IA or the MHP administration.

The post-CRC situation at the MHP facilities are dismal. I have heard from many sources indicating markedly decreased quality of patient care, a very unfortunate event. IA is still relying on temporary, locum radiologists and utilizing help from Idaho-based NightHawk Radiology Services for both day and night work. To my knowledge, IA does not have a permanent radiologist on the ground in Toledo at this time. Many procedures, including IR, are delayed or cancelled, due to the lack of available, qualified radiologists. I am deeply concerned about the decreased quality of and delayed patient care in the community.

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Another entity affected by the change in radiology providers has been a radiology residency program. MHP hospitals served as clinical training sites for a residency program under the auspices of the University of Toledo College of Medicine. CRC physicians were accredited clinical faculty at the MHP hospitals. With the abrupt departure of CRC from these hospitals, the future of the residency program was called into question. Mr. Hashim maintained that the residents could still train at the facilities after IA began their radiology services. The Program Director, who is not a CRC member, stated that the replacement of local clinical faculty members with rotating locum radiologists as clinical instructors would violate radiology residency committee (RRC) and Accreditation Council on Graduate Medical Education (ACGME) guidelines. It should be noted that the Program Director was never contacted regarding the eminent removal of CRC from the MHP hospitals prior to their removal. IA maintained in their open letter that CRC was responsible for the removal of the residents, which is clearly not the case. Despite this recent turmoil, the residency program is stronger, with the support and cooperation of non-MHP hospitals in the Toledo area. CRC is still aligned with the University of Toledo radiology residency program, serving as clinical faculty members and committed to the education of future radiologists. The future of medicine in Northwest Ohio is at stake, given that many program graduates stay to practice in the region. Cessation of the program would have made it more difficult to recruit physicians to the Toledo area.

On June 8, 2009, when IA took over radiology services at the MHP hospitals, Dr. Paul Berger, the founder and, until November 2008, CEO of NightHawk Radiology Services, abruptly resigned from the board of directors at the company. Whether NightHawk's involvement with IA is related to his resignation is a matter of debate, however, in his resignation letter, Dr. Berger stated that "the Company has embarked on business and strategic initiatives which in good conscience I cannot support and do not wish to be a part of going forward." Since November 2008, the CEO of publicly traded NightHawk has been a non-radiologist. NightHawk's involvement with IA has caused a backlash against the company from the radiology community. Radiology groups have either cancelled contracts or are strongly debating doing so.

In addition, a recent analyst stated NightHawk's future strategy should include disintermediation, that is, negotiate with the hospitals directly, thereby bypassing the intermediary, the radiology group. This statement, and the recent events with IA, forced the non-radiologist CEO of NightHawk to issue a letter to its customers, stating unequivocally that the company will not pursue that strategy. I can only presume that the backlash was strong enough to force a CEO to make such a statement.

Even though the current CEO denies pursuing such a strategy, it is only a matter of time before NightHawk deals directly with hospitals, bypassing radiologists altogether. As with any other publicly traded company, the growth of the bottom line is fundamental to growth of the stock, and therefore the profits of large Wall Street investment firms and individuals. Once the company believes they have saturated the market through working with radiologists, the only way to increase profits is to displace groups that did not sign with them. Clearly, one way of pursuing such ends is by offering hospitals an alternative to their current situation. This should be worrisome to private radiology groups.

With the abrupt termination of CRC's services at the hospitals, many radiologists might be wondering how to prevent such a takeover by outside entities. The ACR code of ethics requires radiologists to notify the local radiology group prior to entering into talks with the hospital administration. IA did not do that, but then again, IA is not a radiology group; it is an MBA- and JD-led enterprise that employs radiologists.

The long-term health of radiologists and their autonomy regarding their practices are at stake here. This is only a trial run, and could be a harbinger of realignment in radiology. Given this and the recent debate over healthcare expenditure nationally, it is important for radiologists to realize that without proactive steps, it is almost inevitable that the field will be commoditized.

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First and foremost, the ACR and its affiliated state societies need to be stronger in the protection of radiologists right to self-autonomy. As we know, the ACR is actively involved fighting self-referral, imaging overutilization, in-office imaging services, and protecting reimbursement and patient safety and quality. In addition, the ACR should be active in informing members regarding the perils of non-radiologist-led companies such as IA and NightHawk. The more members are aware of such companies, the more likely members would refrain from using or providing their services to these enterprises. It is in the best interest for radiology as a specialty, and therefore, each individual radiologist.

Second, and I cannot state this enough, radiologists need to provide 24/7 service to their hospitals through different means, such as internal call coverage or developing shared night coverage between local groups. Over the past several years, there has been an increasing reliance on services such as NightHawk to provide weekend and overnight coverage for radiologists. I hope radiology groups realize that by providing their own services, hospital administrators and patients will realize the importance of radiologists as valuable consulting physicians in their hospital.

Third, radiologists need to be more involved in the medical community in their own setting. Radiologists should be more active in the medical staff activities, involve themselves in hospital committees, and have more communication with other clinicians for patient care. All radiologists must also be active in the political process to protect the specialty from outside forces.

Time will tell regarding the long-term result of the IA situation in Toledo, and its business model at large. The situation was chronicled in a recent Radiology Business Journal issue as well as in local media outlets. In addition, the situation has been hotly debated online, in the general radiology forums at Aunt Minnie and Dr. Dalai's PACS blog.

ORSPAC

The Ohio Radiological Society Political Action Committee has been fairly successful in supporting the interests of Ohio Radiologists at the state level. Your financial support is essential and many of you have given generously but most Ohio Radiologists give no financial support.

Regionally our largest source of contributions has been from the Toledo area. It is not fair to expect them to continue to carry the rest of Ohio and with the developments at St. Elizabeth many are less able to provide support.

This is serious business. Government has a tendency to act and although it may act with the best intention whenever it acts someone wins and someone else loses. We must always be in a position to know of their intentions and to be able to influence those actions of state government that concern us. Your support is an essential component of this process.

Please make your contributions to ORSPAC today. Personal checks only

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In Memoriam

Edmund L. Saunders, MD, Piqua