

**California Radiological Society  
Annual Report to the Membership**

**Submitted by**

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Executive Director**

**Prepared for  
Members of the  
California Radiological Society**

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# **CALIFORNIA RADIOLOGICAL SOCIETY**

## **2014-2015 ANNUAL REPORT TO THE MEMBERSHIP**

Welcome to the 2015 CRS Annual Business Meeting. The Annual Report is presented to the membership as a highlight of the major issues CRS has addressed over the past year. Socioeconomic issues impacting diagnostic and interventional radiology and radiation oncology practice remains our focus. The Society continues to interact with California legislators, relevant regulatory agencies, payers, and colleagues in an effort to shape those issues.

### **I. LEGISLATIVE ISSUES**

#### **Out of Network/Balance Billing Prohibition**

On September 11, Assembly Bill 533 (Bonta) failed passage in the California State Assembly.

As AB 533 moved through the legislative process, multiple amendments were made, including amendments taken in Senate Health Committee at the request of Committee Chair Senator Ed Hernandez. CRS joined CMA and other specialty medical societies in opposing the bill.

The legislation was focused on removing the insured patient from the middle of the reimbursement dispute when the patient receives services from an in-network hospital or other facility and receives a "surprise" bill from a physician who also provides services and is not contracted to that plan, or is out-of-network.

AB 533 would have prohibited the out-of-network physician from charging or collecting from the patient any more than their policy's co-insurance and deductible. It would have also prohibited balance billing and require the plan to reimburse that physician/group at the plan's Medicare rate of payment.

Those plan rates would be confidential and not subject to disclosure or review. If the physician/group is unhappy with that reimbursement, they would exhaust the plan's appeal process and then appeal to an Independent Dispute Resolution Process (IDRP), established by DMHC and Department of Insurance, which would determine if additional payment is appropriate. The bill contained very few details on how that process would work.

AB 533 would have also exempted hospital emergency services that are used to stabilize the patient, including some radiology/imaging services. Providers remain unhappy with an interim payment rate that is determined by the plans, and not subject to disclosure or review—an IDRP process that is undefined, not loser-pays format, and lacks any provisions that would incentivize or require the plan to have an adequate network or contracts with hospital-based physician groups. The fact that all the plans supported the bill, and all the providers opposed the bill, was a good indication of a lack of balanced approach.

Though the legislation is dead for the year, it will likely re-emerge next year, and CRS will continue to push for a solution that does remove the patient from the dispute, but also provides fair reimbursement to providers.

#### **Bill to Expand Role of Naturopathic Doctors Fails in Assembly Committee**

On August 26, Senate Bill 538 (Block) failed passage in the Assembly Appropriations Committee. The most objectionable provision in the legislation would have allowed a naturopathic doctor to order, perform, review and interpret procedures commonly used by physicians, including diagnostic imaging techniques consistent with the practice of naturopathic medicine.

That would have been a major change from existing law, which allows a naturopathic doctor to only order some diagnostic imaging studies, including x-ray, ultrasound, mammograms and bone densitometry, but must refer the studies to an appropriately licensed health care professional to both perform and interpret the results. It also would limit the types of studies to those consistent with naturopathic training as determined by the Naturopathic Medicine Committee. SB 538 referred to studies commonly used by physician and surgeons.

Naturopathy uses a variety of approaches to care that may be used to complement traditional medicine. However, the theory and practice of naturopathy are not based upon the same scientific foundation that underlies conventional medicine and treatment.

The proposed changes could have included a variety of imaging modalities, such as CT scans and PET (Positron Emission Tomography) scans that include either ionizing radiation or nuclear pharmaceuticals. The use of such diagnostic studies to attempt to measure the impact of naturopathic therapy such as nutrition or herbs is medically suspect, and the removal of oversight by a medical physician on the appropriateness of ordering such studies and their evaluation is not in the best interests of patient care.

### **2015 Budget Deal Impact on Medi-Cal Provider Rates and Claw Back**

In June, the Governor held a news conference with Democratic leadership announcing the budget deal. There was nothing in the agreement regarding the Medi-Cal provider rate reductions or the claw back for radiology payments made between 2012-2014. The Legislature's version of the budget would have eliminated 5 percent of the 10 percent provider rate cut and 5 percent of the claw back in April of 2016. The only action regarding rates in the budget agreement was to eliminate the 10 percent cut for dental services. The radiology claw back is for payments that exceeded 80 percent of the Medicare allowable for the same service. That limit was supposed to have been implemented in 2011, but did not get completed until November 2014. DHCS decided to not apply the limit for 2010-2012 based upon the potential impact on access. This only applies to fee for service Medi-Cal.

The Governor did announce at the time two special sessions of the Legislature—one on infrastructure and the other on the health care delivery system. The latter would focus on a bill to enact the Managed Care Organization (MCO) Tax to provide permanent funding for Medi-Cal, including provider rate increases "that will increase access to services." There has been an MCO tax on the premiums paid for Medi-Cal managed care plans, but recent federal regulations require that the tax be applied to all plan premiums.

The special session began on June 19th and ran concurrently with the regular session. The Governor wants to have this discussion outside of the budget process, which means that MCO dollars are available for any changes in provider rates. CRS will continue to advocate for relief from both the provider rate reductions and the claw back. This is not good news in terms of short-term relief, but the reality of the Legislature's solution was that it was insufficient since it only provided partial relief for a few months. Further action would have been required in the next budget cycle to provide greater relief.

### **Bill to Expand Nurse Practitioners' Scope of Practice Fails in Assembly Committee**

On June 30, SB 323 (Hernandez), which would have expanded the scope of practice for advanced level nurse practitioners failed passage in the Assembly Business and Professions Committee. It had passed the Senate as a previous iteration two years ago, but also languished in the Assembly. SB 323 was amended in Committee to apply the existing anti-kickback and self-referral laws to NPs, and there was an effort to also apply the corporate practice of medicine bar to NPs. That would have meant that most hospitals that currently employ NPs would not have been able to do so. That amendment was resisted by the author and supporters like the California Hospital Association. CMA, the major opponent to SB 323, advocated for its inclusion to ensure that both physicians and NPs operated under the same laws.

CRS previously sought and obtained an amendment to the bill that clarified that an NP would not interpret diagnostic studies, such as imaging, but could incorporate the results of studies in their treatment of a patient. It's likely that it will become a two-year bill and not heard again until 2016.

### **Bill to Register MRI Techs Failed to Move**

Assembly Bill 1092 (Mullin), as introduced, would have established a licensing mechanism within CDPH to require MRI technologists to be licensed and ARMRIT certified. CRS worked with the author to refine the provisions but remained neutral on the bill. As the legislation moved out of the Assembly Business and Professions Committee, it was amended to only require an MRI tech to register with CDPH, not meet any certification standard, and exempted any licensed RT who performed MRIs from the need to register or pay a fee. A licensed RT could indicate on their RT renewal with CDPH that they performed MRI procedures. In addition, the author added a provision requiring the MRI tech to report any incidents of MRI malfunction to CDPH. At our suggestion, that provision was altered to put the reporting onus on the facility.

As AB 1092 moved to the Assembly Appropriations Committee, the costs to implement the bill became the focus. The Committee analysis indicated a likely cost of one million dollars over a two-year period that would partially be offset by registration fees. Any bills with new state costs of over \$150,000 are automatically sent to the Suspense File and considered collectively with all other spending bills. The Assembly Appropriations Committee held, did not pass, a large number of bills including AB 1092. That means the bill is dead for the year.

### **Medi-Cal Change in Use of Billing Modifiers Takes Effect**

Last year we alerted you to a possible change by Medi-Cal to do away with the ZS modifier on radiology claims to indicate a global charge. Though eliminating the unique ZS modifier was a great idea, DHCS also would have required that that global charges then be broken into two claim lines, PC and TC. The CRS submitted numerous comments in opposition to the two-line process. The final policy went into effect August 1, 2015. It eliminates the ZS modifier and a global charge would contain no modifier. Below is a copy of the notice:

#### *Upcoming Changes: HIPAA Code Conversion for Local Modifier ZS*

*An article that published in the April 2015 Medi-Cal Update announced that the effective date for the discontinuation of local modifier ZS would be July 1, 2015. Local modifier ZS designates both the professional (26) and technical (TC) components of a split-billable procedure on a claim or Treatment Authorization Request (TAR). However, in order to allow sufficient time for providers to make the necessary changes, the effective date for this policy is now August 1, 2015.*

*Effective for dates of service on or after August 1, 2015, the Department of Health Care Services (DHCS) is discontinuing local modifier ZS. Modifier ZS designates both the professional (26) and technical (TC) components of a split-billable procedure on a claim or Treatment Authorization Request (TAR). When billing for both the professional and technical components, a modifier is neither required nor allowed. This change is to continue HIPAA compliance efforts and to align with the Centers for Medicare & Medicaid Services (CMS) guidelines.*

*Discontinuing local modifier ZS will affect claims and TARs for all split-billable procedures except for Magnetic Resonance Imaging (MRI), Magnetic Resonance Angiography (MRA) and Positron Emission Tomography (PET) procedures. See the relevant sections of the provider manual for details pertaining to the use of modifiers for MRI, MRA and PET procedures.*

**Note:**

*Effective for dates of service on or after August 1, 2015, providers who previously submitted claims or TARs for split-billable procedures using local modifier ZS are instructed to submit claims and TARs without a modifier.*

**Claim Completion**

*Except for MRI, MRA or PET procedures, providers will be instructed to use one of the following methods when submitting a claim for both the professional and technical components of split-billable procedures. See the relevant sections of the provider manual for details pertaining to the use of modifiers for MRI, MRA and PET procedures.*

*Physician Billing: The physician bills for both the professional and technical components and then reimburses the facility for the technical component, according to their mutual agreements. The physician submits a CMS-1500 claim form with the procedure code on one claim line without a modifier in the Procedures, Services or Supplies/Modifier field (Box 24D).*

*Facility Billing: The facility bills for both the technical and professional components and then reimburses the physician for the professional component, according to their mutual agreements.*

*The facility submits a UB-04 claim form with the procedure code on one claim line without a modifier in the HCPCS/Rate/HIPPS Code field (Box 44).*

## **SGR Fix**

The Congressional fix to the almost 15-year problem of the Medicare SGR adjustment was finally adopted on a permanent basis this year. The fix averted a 21 percent reduction in fees that would have been implemented as of April 2015. The fix now requires an annual increase of 0.5 percent each year through 2019. It would then remain fixed through 2025 but providers might be eligible for additional reimbursement through the alternative payment models that will be phased in.

## **Study on Physician Awareness of Breast Density Law**

A study published in the Journal of the ACR found that about 50 percent of primary care physicians were unaware of the California breast density notification law. The survey of internal medicine, family medicine, and OB-GYNs was conducted in February 2014 about 10 months after the breast density notification law took effect. The study suggests that for this process to be effective, other educational tools should be explored or other strategies should be utilized to assist patients with breast density issues.

The bill in California was adopted after an earlier version was vetoed by the Governor. Breast density notification laws have since been proposed and adopted in a growing number of states since then, and California was a target for advocacy groups who favored disclosure of breast density to patients undergoing screening mammography. CRS worked hard to develop a final bill that was workable for the radiology community.

## **II. REGULATORY**

### **Medicare Carrier Advisory Committee**

Our continued thanks for Drs. Mark Alson and Mark Yeh for their tireless efforts in participating in the important meetings of the CAC. They engage in the development and comment on the Local Coverage Determination policies that impact radiology. Existing policies were reviewed this year to assure that medical necessity criteria were consistent with ICD-10 terminology.

### **Radiologic Technology Certification Committee**

The CRS has four members that serve on the RTCC which serves as an advisory committee to the Radiologic Health Branch within the California Department of Public Health. The RTCC considers issue related to personnel licensing and training, facility quality assurance and the general regulation of users of ionizing radiation. Drs. Lightfoote, Go, Puckett and Neufeld-Rogers have represented radiology this past year.

Of interest this year was consideration of a policy to allow registered cardiovascular invasive specialist (RCIS) to be exempt from the requirement to obtain a fluoroscopy permit if they move equipment or position a patient when under the direct supervision of an individual with a Fluoroscopy Permit or a Radiology Operator/Supervisor. RHB announced a policy change that was extensively debated within the RTCC over several meetings. Ultimately the policy was withdrawn and no change or exemption was created.

### **Insurance Commissioner Regulations on Network Adequacy**

In January, California Insurance Commissioner Dave Jones issued an emergency regulation package to attempt to create higher standards for insurer physician networks for PPOs and indemnity insurance plans. Traditional HMOs and health plans are regulated by the DMHC.

The Commissioner issued them on an emergency basis, indicating that there were serious deficiencies with existing networks and the accuracy of network information being provided to insurers or patients.

The CRS submitted comments generally in support of many of the provisions, but with concerns over one specific provision. The regulations require insurers to provide greater detail about the availability of primary care and specialist physicians, submit more detailed provider participation information to the Commissioner, and assure prompt access to referral services.

One objection related to a new requirement that would require a health facility to disclose to an insured patient, prior to receiving non-emergency services in the hospital setting, any hospital-based physicians who were likely to provide services and were out-of-network along with an estimate of costs. That would apply to a radiologist who is out-of-network in the hospital setting, and is similar to bills that have been introduced in the Senate yet failed passage. CRS argued that this requirement would be difficult to meet due to the vagaries of what services might be required, and the risk of misinforming the patient. We suggested that a better mechanism to protect patients from out-of-network charges was to require insurers who contract with a hospital to also contract with hospital-based physicians.

The comment period on the regulations closed on January 26, and we continue to expect that there may be some revisions prior to implementation.

### **Medi-Cal Denials of Services if Ordering/Referring Physician is not Enrolled**

Medi-Cal is required to only reimburse for services that are ordered by a physician or other provider that is enrolled in Medi-Cal or Medicare. It is expected that in the very near future, any claim that contains a physician who is either not enrolled in the Medi-Cal program or does not have a Type 1 (Individual) NPI will be denied. DHCS indicates that they have been indicating on provider RADs any claim referred by a physician or provider that does not meet that requirement. Those claims are not yet being denied, but it is being used as an educational tool for billing providers. Here is the recent notice posted on the DHCS website. We expect that the edit will be activated in the near future.

*ACA Billing and Enrollment Requirements for ORP Providers  
June 25, 2015*

*Based on the Affordable Care Act (ACA) of 2010, providers are now required to list the National Provider Identifier (NPI) and name of the provider who ordered, referred or prescribed the goods or services being billed. In addition, all ordering, referring or prescribing (ORP) providers must be enrolled as participating providers in Medicare or Medi-Cal, with a Type 1 (individual) NPI, even if these providers do not send claims to Medi-Cal for the services they provide.*

*If the ORP provider identified on the claim is not enrolled in Medi-Cal or Medicare, claims for reimbursement of the goods or services provided in filling the order, prescription or referral from the ORP provider will not be paid.*

### **United Healthcare Announcement Regarding Implementation of the PC MPPR**

In August 2015, UnitedHealthcare announced a November 15, 2015, implementation date for expansion of the multi-procedure payment reduction to the professional component of advanced imaging services. Previously, UnitedHealthcare announced the policy change in the spring of 2014, "to align with Medicare policy." At that time, the ACR held a conference call with UHc leadership to inform them that the Protecting Access to Medicare Act of 2014, passed by Congress in April 2014, included a provision requiring CMS to produce data used to justify their professional component MPPR policy. CMS acknowledged the mandate in the proposed and final rules for the 2015 Medicare Physician Fee Schedule (MPFS), and said they would be publishing the data "soon." CMS has yet to publish the data, and they did not mention the mandate in the 2016 MPFS proposed rule released last month.

ACR staff has been reaching out to national contacts at UHc to request a conference call to discuss their announced implementation. The 21st Century Cures Act (H.R. 6), passed by the House on July 10, includes provisions to permanently repeal the 25 percent professional component multi-procedure payment reduction (PC MPPR). We expect the Senate to act on this legislation by the end of 2015. Our hope is that they will once again delay implementation pending Senate action.

### **Low-Dose CT for Lung Cancer Screening**

Earlier this year, CMS announced that Medicare would begin to cover low-dose CT for lung cancer screening. CMS will now cover the exam for individuals between 55-77 years of age with a 30 pack-year smoking history, and who currently smoke or have quit within the past 15 years. One pack-year is the equivalent of smoking one 20-cigarette pack per day for one year. Patients will also have to receive a written order from a physician or qualified non-

physician practitioner that meets certain requirements. No decision has been announced by CMS on the amount of reimbursement for the procedure.

Medi-Cal released a notice to also cover and posted the following notice for clarification, which adopted similar criteria. Note that Medi-Cal will process claims on a "By Report" basis. We are in contact with DHCS to get information on how they will price payment. Now that Medicare will reimburse, they will be bound to not pay more than 80 percent of the Medicare allowable.

***Updated Requirements for Lung Cancer Screening With Low-Dose CT***  
*February 02, 2015*

*Contrary to what an article stated in the December 2014 Medi-Cal Update, claims for HCPCS code S8032 (low-dose CT lung screening) will be reimbursed "By Report" only, and do not require an invoice.*

*In addition, the required report must document one or more of the following criteria to justify the need for the use of low-dose computed tomography (CT):*

- *Current or former smokers, 55 to 74 years of age*
- *A smoking history of at least 30 pack-years (a pack-year is the calculated equivalent of smoking 20 cigarettes every day for one year)*
- *No history of lung cancer*

## **Workers' Compensation Fee Schedule for Radiology**

The Workers' Compensation Program converted to a Medicare RVS-based reimbursement system using multiple conversion factors, including a unique one for radiology. As we have described before, the radiology conversion factor began in 2014 and is reduced over a three-year period. If you have tried to find a list of the actual fee schedule for radiology services on the Division of Workers Compensation website, you know that there is no actual fee schedule posted for any medical services.

We have been in contact with other medical specialty organizations that had an outside consultant do the math and create a list of all the CPT codes and the applicable allowable under the Work Comp unit's values and conversion factors. A link was provided to a PDF that contained the fee schedule for radiology procedure codes earlier this year.

## **DMHC Finds Plans in Violation for Provider Directories**

The Department of Managed Health Care issued a report finding both Anthem and Blue Shield in violation for maintaining inaccurate directories of participating providers. The report found that 25 percent of the providers listed in their directories were not accepting patients with Covered California, or no longer practicing at the location listed. It follows a lawsuit filed by Consumer Watchdog against Anthem in Los Angeles over alleged errors in their listing of network providers. In the DMHC matter, both plans indicated that they have taken corrective actions to verify their provider listings.

The issue of both the adequacy and accuracy of provider directories and participation in plan offerings in Covered California will continue to garner regulatory and legislative scrutiny. Similarly, as the Medi-Cal rolls expand dramatically due to the ACA, we expect that the shortage of specialists and primary care physicians accepting new Medi-Cal patients will be a major concern. Some plans have had contracts in place with physicians for many years and simply added new products or patients to the underlying agreement. A bill to mandate that plans be responsible for their provider directory accuracy is on the Governor's desk for signature.

## **Medi-Cal and the Duals Initiative**

In 2014, DHCS announced some changes in the implementation of the Duals Initiative, or MediConnect program, to transition dual eligible beneficiaries to a Medi-Cal managed care plan. The initial pilot program involving eight large counties has been slowed multiple times, staggering implementation dates or delays and the use of passive enrollment.

DHCS announced in November 2014 that Alameda County and the use of the Alameda Alliance will not go forward. The Alliance has had serious financial issues, and the Department of Managed Health Care took action to restore their financial solvency.

The Medi-Cal program has also been criticized about problems in enrolling new eligible beneficiaries due to the ACA rollout. Similarly, even those who were successfully enrolled in Medi-Cal were required to re-enroll in the last quarter of 2014 during the open enrollment period for 2015. A lawsuit was filed against DHCS by a patient advocacy group over the time constraints and requests for additional information on renewal that was not required in initial enrollment.

## **III. CRS NOMINATING COMMITTEE REPORT**

The Nominating Committee of the California Radiological Society has recommended the following individuals for 2015 - 2016 Officers:

President	Jinha Park, MD, PhD, FACR
President - Elect	Stephen Holtzman, MD
Secretary	Harvey Wolkov, MD, FACR, FACRO
Treasurer	Mark Yeh, MD, FACR
Past President	Janak Raval, MD, FACR

These nominations will be considered during our Annual Meeting on Saturday, October 3, 2015, during the Business Meeting at the Hyatt Regency Hotel in Newport Beach.

## **IV. MEMBERSHIP SERVICES**

CRS maintains the tradition of providing valuable services to its members with e-mail broadcasts and a website to communicate with members. Our thanks to Dr. Harvey Wolkov for his work as program chair for this year's Annual Meeting. He was joined by Drs. Eng, Park, Holtzman and Raval who were program chairs in previous years.

CRS membership currently consists of 1,057 radiologist members, 586 retired members, 28 physicists, and 136 residents, for a total membership count of 1,807. CRS currently has 25 Councilors and Alternates to the American College of Radiology.

**V. FINANCIAL REPORT**

The accountant’s review and year-end financial statement for the fiscal year ending December 31, 2014 showed cash of \$125,858, prepaid expenses of \$16,702 and accounts receivable of \$10,739 for total assets of \$153,299. In 2014 CRS had income of \$297,540 and operating expenses of \$ 348,543 for a deficit of \$51,003. The unrestricted General Fund is \$21,693 for the beginning of 2015.

**VI. CONCLUSION**

I am grateful to CRS Officers and the Executive Committee for their dedication and support this past year. Your support and participation now and in the future will continue our efforts to strengthen the voice of Radiology and foster greater knowledge and understanding in your field.

Respectfully submitted,



Robert Achermann  
Executive Director

<b>OFFICERS</b>  Janak Raval, MD, FACR <i>President</i>  Jinha Park, MD, PhD, FACR <i>President-Elect</i>  Stephen Holtzman, MD <i>Secretary</i>	Harvey Wolkov, MD, FACR, FACRO <i>Treasurer</i>  Roger S. Eng, MD, FACR, MPH <i>Immediate Past President</i>  Bob Achermann <i>Executive Director</i>  Laurence Kessenick, Esq. <i>Legal Counsel</i>
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