ARPE, CBRPA & RPAS NEWSLETTER

September 2014
Volume 7 Issue9

RPA REPORT

House of Representives passes bill to undo rural hospital supervision requirement

On Tuesday, September 9, 2014. the House passed legislation to delay enforcement of supervision requirements for outpatient therapeutic services in certain hospitals. Passed by voice vote, the bill would prevent the Centers for Medicare and Medicaid Services (CMS) from requiring Critical Access Hospitals and small rural hospitals from needing a physician to supervise therapeutic services like drawing blood.

CMS began enforcing the rule in January. Rep. Lynn Jenkins (R-Kansas), the measure's sponsor, said the requirement unnecessarily burdened small hospitals who may lack the resources. "This is a change in policy that will put a strain on providers while providing no quality improvements for the patients they serve," Jenkins said.

Rep. Michael Burgess (R-Texas) said the bill would prevent the possibility for people being unable to receive care at the hospitals. "This is a commonsense solution to a problem that has the potential to limit or delay access to health care for America's seniors in rural communities," Burgess said.

But Rep. Frank Pallone (D-N.J.) said that it was "reasonable" to require supervising physicians overseeing certain procedures. "It seems reasonable to me that out patient clinics that provide services to Medicare beneficiaries should meet some basic standards for having supervisory physicians available when an emergency rises," Pallone said. Pallone warned that changing the rule would not ultimately help patients. "Frankly, the likely result of the bill would be confusion for hospitals," Pallone said. Nonetheless, Pallone let the measure pass without demanding a roll call vote.

Source: Cristina Marcos, The Hill, Floor Action, September09, 2014

Quote of the Month:

Laws control the lesser man. Right conduct controls the greater one.

~Chinese Proverb

It is almost October and there is still time to make plans to be in Orlando, Florida on the 16-18th for an outstanding educational experience and to enjoy the variety of fun options!!

More evidence supports Medicare coverage of LDCT screening

A secondary analysis of the National Lung Screening Trial (NLST) has found that low-dose (LDCT) lung cancer screening is actually more effective for older high-risk patients than it is for younger ones, according to a study in the Annals of Internal Medicine. The findings should add more ammunition to CT lung cancer screening advocates in the debate on whether Medicare should cover screening for older, at-risk beneficiaries.

Researchers led by Paul Pinsky, Ph.D., found that the prevalence and positive predictive value (PPV) of LDCT screening was higher for patients ages 65 and older than for the under-65 group. The PPV was 4.9 percent for those 65 and over, compared to 3 percent for those younger than 65.

They also found, however, that the false-positive rate in the 65 and older group was higher than the under-65 group (27.7 percent vs. 22 percent), and that the number of invasive diagnostic procedures that were performed after a false-positive screening were also "modestly more frequent" in the older group (3.3 percent vs. 2.7 percent).

Last April, the Medicare Evidence Development and Coverage Advisory Committee voted against recommending Medicare coverage for LDCT screening. One of the concerns raised had to do with what critics said were evidence gaps regarding risk and benefits, since just 25 percent of the NLST screening subjects were age 64 and over.

But, in an editorial accompanying the study in Annals, Michael Gould, M.D., of Kaiser Permanente Southern California, wrote that it now appears that LDCT screening offers similar trade-offs in terms of risks and benefits for both older and younger age groups. "Until there is new and direct evidence to the contrary," he wrote. "It does not

Recertification Exam Cheat Sheet

Review the pre- and post-procedure requirements for minor invasive procedures, such as fluid drainage, lumbar punctures, biopsies, thoracentesis, paracentesis and PICC lines. Where are the puncture sites for each? What lab tests should be reviewed?

On neuroradiology, what are the reference sections of the brain? What brain tumors occur most often in adults, and in children? How do you tell the difference between an epidural and a subdural hematoma? What types of tumors occur in the juxtasellar region?

All of these topics will be covered in the Review Seminar in Orlando. Next month the GI and GU systems will be covered. To be definitive, consult the content specifica-

Interstate Medical Licensure Effort Advances

At least 15 states are considering a revised draft of the Interstate Medical Licensure Compact which has the support of the AMA. An effort to provide physicians a streamlined path to obtaining medical licensure in multiple states appears to be gaining traction.

"There's momentum," Humayun Chaudhry, DO, president and CEO of the Federation of State Medical Boards (FSMB), said this week. "We're seeing many stakeholders across the spectrum expressing support."

The FSMB finalized the draft version of its proposed Interstate Medical Licensure Compact earlier this month and Chaudhry says 15 state medical boards are already considering endorsements of the final version. Many boards "have been awaiting the final version," he said. "State legislators ultimately have to approve the language of the document."

"The American Medical Association has long supported reform of the state licensure process to reduce costs and expedite applications while protecting patient safety and promoting quality care," Robert Wah, MD, president of the AMA, said in a media statement. "We applaud the FSMB for developing the interstate compact and other reforms designed to simplify and improve the licensure process for physicians practicing across state lines, as well as providing telemedicine services in multiple states."

Chaudhry says the FSMB hopes that the Interstate Medical Licensure Compact will help address three acute challenges in U.S. medicine: the advancement of telemedicine, the growing physician shortage, and an increased demand for medical services that have resulted from implementation of the Patient Protection and Affordable Care Act. In August and early this month, the FSMB made a handful of revisions to the draft version of the proposed Interstate Medical Licensure Compact. The revisions include:

1. A requirement that physicians seeking licensure in multiple states through the Compact would have to pass licensing tests such as the U.S. Medical Licensing Examination within three attempts.
2. The adoption of a streamlined process for license renewal through the Compact.
3. A provision allowing members of the general public who serve on state medical boards to also serve on the commission that will govern the Compact.

With the revisions in place, about 80 percent of the country's physicians would be eligible to obtain medical licensure in multiple states through the Compact, Chaudhry estimates.

Source: Christopher Cheney, for HealthLeaders Media, September 17, 2014

2014 Educational Symposium

October 16-18, 2014

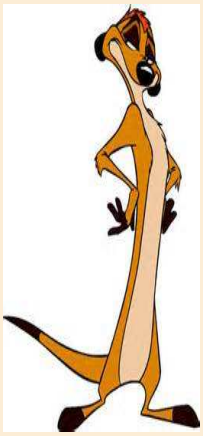
International Palms Resort
AND CONFERENCE CENTER

$70pn

407-351-3500

6515 International Drive

Orlando , Florida 32819



Presenting :
Advanced Radiology
Pattern Recognition

REGISTRATION: 16.5 A+ hours

Registration until 9/30/14: $250

Late/On site registration: $275

Students: $60

ACLS: $125

Register TODAY at http://www.Rpeacademy.org

New imaging system uses biomarker to guide brain cancer surgery

Brain surgeons have long relied on a pathology analysis to determine if they have completely removed a tumor. This can be a time-consuming and inaccurate process. Results from a study of a new imaging system that detects a molecular biomarker found in brain gliomas suggest it could improve upon that surgical practice.

The imaging system is known as desorption electrospray ionization mass spectrometry (DESI MS), developed by R. Graham Cooks at Purdue University. The study was performed in collaboration with Harvard Medical School and the Dana Farber Cancer Institute and was funded by the National Institute of Biomedical Imaging and Bioengineering (NIBIB), which is part of the U.S. National Institutes of Health (NIH).

Gliomas are tumors of the brain glial cells; they account for 80% of all malignant brain tumors. Gliomas produce large amounts of tumor metabolite 2-hydroxyglutarate (2-HG), a product of the mutant form of a gene known as IDH, which is associated with tumor formation.

The imaging system is designed to detect levels of 2-HG in samples via mass spectrometry during surgery to ensure that a tumor has been removed entirely. Researchers first tested the DESI MS system on glioma specimens from 35 patients; 21 of these samples contained high levels of 2-HG.

The researchers then equipped an operating room at Brigham and Women's Hospital with the DESI MS system. They reported that in two surgeries the DESI MS accurately detected the presence of 2-HG as confirmed by a postoperative analysis.

The DESI MS system was installed as part of the Advanced Multimodality Image Guided Operating suite; the suite has built-in imaging devices such as MRI so that the surgeon can map the tumor preoperatively.

The researchers concluded that the DESI MS identified the tumors with "high sensitivity and specificity within minutes." They added that metabolite-imaging mass spectrometry "could transform many aspects of surgical care."

Source: Stacy Lawrence. FierceMedicalImaging.com August 28, 2014

Editor's Note: A job advertisement for RPAs is listed on Aunt Minnie.com.

A listing on Aunt Minnie is an indication of progress! The site is:

http://www.auntminnie.com/index.asp?sec=mkt&sub=emp&pag=adv&item_id=141669

Roadblocks for implementing value-based healthcare

While there may be a stake in the heart of the fee-for-service payment model, replacing it with value-based healthcare won't be easy since stakeholders face obstacles in the way of this change, *BenefitsPro* reported.

Instead of paying providers for every service they render, the value-based model would pay them based on patient outcomes. Sixty-four percent of payers recently surveyed reported being on track to make the leap to value-based reimbursement. Insurers are starting to view value-based care as "a way of getting a handle on the totality of [healthcare] costs," Kaiser Permanente's Jack Cochran told FierceHealthPayer in an exclusive interview.

According to *BenefitsPro*, one problem in transitioning to this model is defining what value is, how to measure it and how to reimburse for it. Not every program that calls itself value-based improves health; some of these programs are just cost-shifting by another name.

Care coordination isn't easy to achieve in the healthcare system as a whole due to a lack of collaboration, *BenefitsPro* reported. While insurers are developing incentives for doctors to coordinate care, "the necessary infrastructure to facilitate collaboration and alignment is woefully inadequate," the article noted. Care coordination requires addressing socio-economic determinants of health including housing, jobs, diet and transportation. That's new territory for doctors and hospitals.

Another complicating issue is that to structure value-based payments, payers must collect data on high-quality, low-cost network providers; but metrics that measure these factors can differ by product and insurer, *BenefitsPro* reported.

Getting doctors to agree on best-practices can also be challenging. Even when there are evidence-based, peer-reviewed protocols for procedures, standardization of care isn't always possible given the unique health issues some patients present, the article added.

Finally, "one of the worst-kept secrets in the industry is that many payers are running on old technology- systems that are 20-, 25- 30 years old," Ray Desrochers, executive vice president of the software company HealthEdge, told .

Source: Jane Antonio, FierceHealthPayer.com September 9, 2014

Premium educational program, good friends, cuisine variety, exceptional entertainment at the ARPE meeting in Orlando. See ya' there!

RPA REPORT

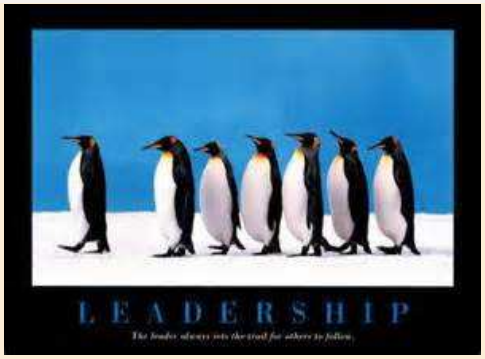
225 Dupont Drive
PO Box 1626
Lander, WY 82520
Phone: 307-335-5201
Fax: 307-335-522
EMail: Jvan225@cbrpa.org

Web Sites

ARPE — rpeacademy.org

CBRPA — CBRPA.org

RPAS — RPASociety.org



Example is not the main thing in influencing others. It is the only thing. ~Albert Schweitzer *A RPA in an imaging department is viewed as a leader and as such, assumes responsibilities. to co-workers, the department and health care facility. Above all , a good example is of utmost importance in actions and demeanor because you not only represent the department and facility , but most important you represent all RPAs. If you have integrity, nothing else matters. If you don't have integrity, nothing else matters.* ~Alan Simpson *Your actions must always reflect integrity.*

Save some money and go online to purchase discount tickets to the theme parks in Orlando. Visit the Orlando web site to get a notion of all of the entertainment available. A little planning makes your trip more enjoyable.

SeaWorld
ADVENTURE PARK
Orlando