



Radical Views...

from the Department of Radiology

January



FROM THE CHIEF

Jonathan B. Kruskal, MD PhD

Dear All Members of the Radiology Department

This message comes with my very best wishes for a healthy and happy holiday season, and with a sincere thank you to each of you for all that you do for our department and our many patients. I appreciate the many unrecognized roles that many of you play, the additional unseen and unasked and even unexpected tasks that you perform each day, those many "little things" that you all do that contribute in such a positive manner to our Department. Thank you.

It would be remiss of me not to mention the holiday party, or the lack thereof! No, there was no smaller gathering this year, so we all missed out on the party. I know that many of you were disappointed not to be able to get together outside of our workplace but the current fiscal realities meant that the traditional downtown celebration was simply unaffordable this year. We are exploring other options and have every intention of reinstating this or a similar event in the future.

As 2011 draws to a rapid close, we should reflect on the many successes that occurred this year. These past 12 months can be characterized by the introduction of new clinical programs, many equipment upgrades, new community relations and partners, the arrival of superb new staff and surveys that again show overwhelmingly satisfied customers. Our educational and research missions continue to expand and innovate; more original scientific papers were published by our faculty than ever before. More national awards were received than ever before, and our expanded family of staff now exceeds 650 people, larger than ever before. Yes, over 650 people!

Within the framework of these many successes we must also reflect on the emerging realities of the healthcare industry. As mostly Massachusetts residents we all know that the political and insurance spotlights have sharply directed their focus onto the costs of imaging services. It is no surprise to any of us that the excellent services we provide have become very expensive and healthcare plans have responded in a variety of ways. Our world has become an alphabet soup of confusing terms such as AQC, ACOs, medical homes, tiered plans, medical exchanges and risk sharing. I want to assure each of you that we are responding to these changes as vigorously as we can as our providers seek ways to reduce their costs, to improve our efficiency, and to help us avoid unnecessary imaging studies. Our strategic planning process will continue to address ways in which we can remain nimble and anticipate and respond to each of these changes before they occur.

This time of joy and appreciation is also an opportunity to reflect on those many people living in Boston and beyond who struggle to exist, who see and experience little joy, who cannot afford their heating bills, bus fare, warm coats or gloves, or to put fresh food on the table each day. I am deeply grateful to the many of you who have made actual contributions in kind or in cash to local agencies, homes and community centers in our name. This is truly appreciated and remarkably generous of you. Thank you.

As we move into 2012, we will continue to seek ways to expand our services, to identify new community partners, to provide appropriate imaging at the right time and site, to continue to improve our customer service and more than this, to strive to improve your workplace and satisfaction.

With my very best wishes for a healthy and fulfilling 2012

- Jonny

Radiology Calendar January 2012

Mon	Tues	Wed	Thurs	Fri
2 New Year's Holiday	3 7:30 - 8:15 RUQ US -Kane 8:15-9:00 Itro - Shah 1:00-2:00 MRI meeting (Weekly) [TCC-484]	4 7:30 - 8:15 Emergent Pelvic US - Levine 8:15-9:00 Chest Trauma - Boisselle Weekly Wed Section Meetings: 11:00-12:00 MSK clinical conference 12:00-1:00 Thoracic Imaging, GI Oncology/GU Oncology 3:00-4:00 Mammo [TCC-484]	5 7:30 - 8:15 Scrotal US - Kane 8:15-9:00 Nontraumatic GU Emergencies - Shah Weekly Thurs Section Meetings: 12:00 - 1:30 Abd [WCC-354] 12:00-1:00 MSK	6 8:00 - 9:00 Chiefs Rounds
9 7:30 - 8:15 Upper Abdominal Pain - Lee 8:15-9:00 Lower Abdominal Pain - Lee	10 7:30 - 8:15 Face and Orbit Trauma - TBA 8:15-9:00 Spinal Infection - Keefield 10:30-11:30 Nuc Med meeting (GZ-103)	11 7:30 - 8:15 Bowel Obstruction/Ischemia - Siewert 8:15 - 9:00 Post-operative Abdomen Emergencies - Siewert	12 7:30 - 9:00 Pelvic Trauma - Camacho 2:00-3:00 West Med-Rads	13 8:00-9:00 Grand Rounds: Image processing for CT Dose Reduction (Dr. Oleg Pinykh)
16 7:30 - 9:00 No Conference - MLK	17 7:30 - 8:15 IR in ED - Ahmed 8:00 - 9:00 IR meeting [West Recovery Rm]	18 7:30 - 8:15 Chest Nontraumatic Emergencies - Spirn 8:15-9:00 Brain Emergencies - Reddy 7:15 - 8:00 US meeting (WCC-304A Gallery)	19 7:30 - 8:15 Nontraumatic MSK Emergencies - Wu 8:15-9:00 Stroke Imaging - TBA 5:00-6:00 pm "Anorectal MRI" Best in Practice MRI Lecture Series Riesman Lecture Hall, Rabb Bldg	20 7:30 - 9:00 No Grand Rounds/NERRS
23 7:30 - 8:15 Blunt Abdominal Trauma I - Shah 8:15-9:00 Blunt Abdominal Trauma II - Levenson	24 7:30 - 8:15 Spine Trauma - Teich 8:15-9:00 Neuro ED Case Conference - Moonis 10:30-11:30 Nuc Med meeting (GZ-103) 2:00-3:00 West Med-Rads	25 7:30 - 9:00 PE and DVT - Levenson	26 7:30 - 8:15 Lower Extremity Trauma - Didolkar 8:15-9:00 Upper Extremity Trauma - Hochman	27 8:00-9:00 Grand Rounds: Multiple trauma: use of extremity and pelvic CT angiography in the era of 64 MDCT (Dr. Jorge Soto, Vice Chair, Boston Medical Center)
30 7:30 - 9:00 Career Week	31 7:30 - 9:00 Career Week 10:30-11:30 Nuc Med meeting (GZ-103)			



January Grand Rounds speakers:

Jan 13 - *Image processing for CT Dose Reduction* by Oleg Pinykh (left), our Lead Imaging Scientist (CT Advanced Imaging Lab)

Jan 27 - *Multiple trauma: use of extremity and pelvic CT angiography in the era of 64 MDCT* by Dr. Jorge Soto (right), Vice Chairman of Radiology, BMC. Please see page 7 for information on Grand Rounds speaker Dr. Jorge Soto.

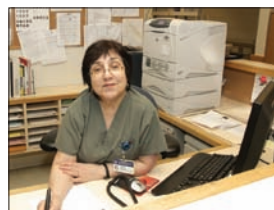
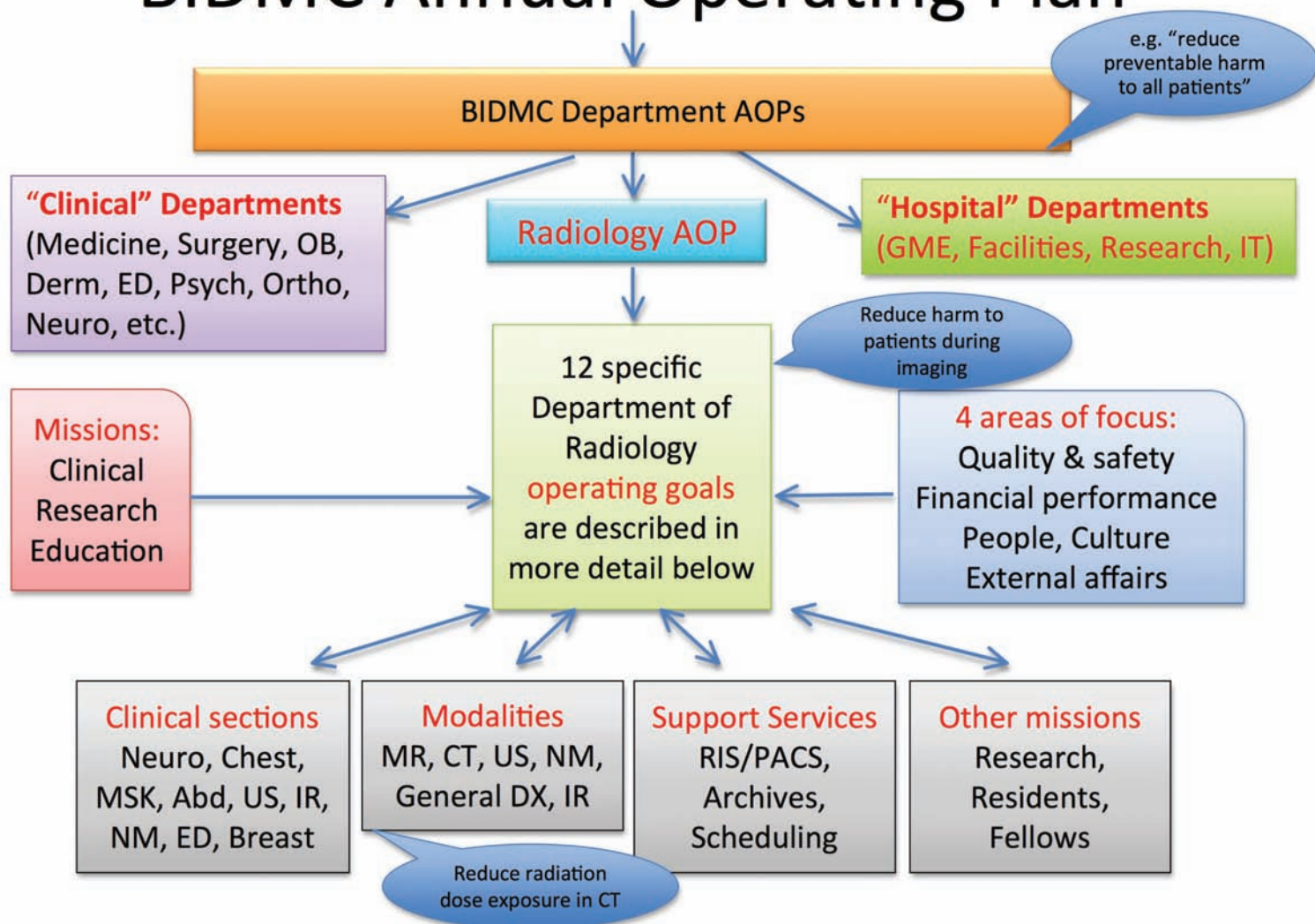


Introducing the Radiology FY2012 Annual Operating Plan (AOP). . . *But what is an Annual Operating Plan?*

Each year, hospital and physician leadership reconsiders our vision (a statement of where we ideally want to be in the future) and how we intend to achieve this (our strategy or roadmap). We are guided by a mission statement (why we exist and what we do to achieve our vision). Our strategic goals, each with specific measures and targets, timelines and responsible persons, are used to guide our progress each year and are presented as the Annual Operating Plan (AOP). We use the framework of our AOP to ensure that we have prioritized our goals in each of our three missions (clinical service, research and education) and the plan is then used to illustrate progress towards each stated goal.

Within our department, we have 12 high level goals that are described below. These goals are distributed to each division and clinical service that in turn select and prioritize their own goals. For example, if we take goal #2 (imaging appropriateness), our ED section may choose to focus on reducing unnecessary abdominal CT scans on ED patients. Similarly, for goal #5, our IR division may seek to minimize the ergonomic impact of wearing lead aprons for long hours each day.

BIDMC Annual Operating Plan





Radiology FY2012 Annual Operating Plan (AOP)

Reflecting the BIDMC Multiyear Goals for Fiscal Year 2012 in Clinical Operations, Financial Performance, People Culture & Communications and External Affairs, Dr. Kruskal presents the following Radiology FY2012 AOP:

1. **Create a strategy for the future of clinical radiology:** Radiology is at the bleeding edge of health care reform. Our services are expensive, non-radiologists are expanding their services into imaging, and insurance payers are looking for ways to minimize reimbursement and reduce the extent of imaging. In order to stay competitive, we need to think strategically and explore options that will allow us to thrive in the future. This year we will launch at least two strategic initiatives: (1) to explore and implement cost-competitive, community-based joint ventures, and (2) to improve the alignment between staff and clinical volume in order to increase our productivity and provide better service.
2. **Improve appropriateness of inpatient imaging:** Many of us have questioned both the need for and utility of certain studies that we have performed. I am sure we can all think of unnecessary repeat studies, exams that imaged too many anatomical regions, and cases where a different modality may be been more useful. All of this contributes to the costs of caring for our patients. We need to focus on doing the right study at the right time to answer the clinical question, and this is what is meant by "appropriate" imaging. Our goal will be to identify the root causes of imaging studies that are potentially inappropriate, and determine their financial impact. Once these data are analyzed, we will introduce pilot interventions to minimize what may be considered "inappropriate" studies.
3. **Reduce preventable patient harm:** We will continue our work to eliminate causes of patient harm, in keeping with the stated BIDMC goal of reaching this goal by 2012. Through regular environment-of-care and safety walkabouts, we will monitor and seek to identify and eliminate all sources of harm. Specifically, we aim to reduce the number of patient falls and skin burns in MRI in each targeted area compared to results from FY2011. Also through our successful "Image lightly" campaign, we will continue to reduce patient exposure to ionizing radiation through protocol review and optimization in CT scan. We will deploy the widespread reporting of CT dose exposure in our scan reports. Also, as an extension of the National Patient Safety Goals, we will establish more effective ways for monitoring compliance with hand hygiene regulations.
4. **Create integrated service lines:** As we seek to improve our efficiency and the quality of our services, it makes a lot of sense to integrate some of our clinical services. We have already commenced integrating our breast imaging services with the Breast Care division in surgery, and many of our staff have been participating in an extensive Lean program seeking ways to best integrate the physical breast care areas currently located on Shapiro 4 and 5. We will also work toward the integration our interventional services this year. This initiative will include integrating the interventional scheduling process (to a single point of access for referring physicians) the pre- and post-procedure care plans, clinical databases, compliance monitoring, and monitoring of process and outcomes metrics.
5. **Reduce preventable employee injuries:** All of us are exposed to many risks in our imaging work environment. Think of the heavy equipment, lifting heavy patients, needle sticks, the patient with an infection, radiation, ergonomic and repetitive stress injuries, or even wearing heavy lead aprons. We have a very proud national reputation for improvements we have made and will continue to strive to eliminate all preventable sources of harm. Specifically we intend to closely monitor and to reduce number of employee injuries compared to those that occurred in FY2011.
6. **Improve service to patients and referring physicians:** With increasing competition, it is imperative that we provide the best service to our customers. We want our patients to be well satisfied with their experience in our department, and we want our referring physicians to be more than satisfied with the quality and timeliness of our services. We kicked off this program with a special Grand Rounds given earlier this year by Robin Brown on "Improving Customer Service". We will conduct service training for support staff and technologist staff through an Interactive Behavior Assessment Program. We will also conduct training for radiologists in improved patient communication. For referring physician satisfaction, we expect 100% compliance with our time standards for Report Turnaround Time as well as Critical Results Communication policies. We will also implement a new patient satisfaction measurement tool to replace the current Press Ganey system.

Radiology FY2012 Annual Operating Plan (AOP) *(cont'd)*


7. **Implement supply chain cost reductions:** We need to investigate ways of reducing the costs of services that we provide. Radiology imaging equipment is expensive to purchase and maintain, and the costs of supplies, catheters, stents and contrast materials (the chain of supplies that supports our services) have increased over the years. We will implement a lower cost equipment maintenance, and reduce our Interventional Radiology medical supply expenses through product review and standardization.
8. **Enhance Radiology Information System (RIS) functionality:** We've all become very skilled with electronic information systems, PACS and computers. Many outstanding people in our department have been diligently working behind the scenes to incrementally improve our radiology information system (RIS). Within the next six months, we will implement system components that will support a comprehensive RIS-driven radiologist workflow including front end Voice Recognition. Also, we will implement an Interventional Radiology module that will not only keep track of all studies and materials and equipment used, but will also serve as a database for monitoring and measuring patient outcomes.
9. **Increase staff and manager satisfaction:** We all spend many hours providing patient-related services in our department. It is very important that we also work to improve staff satisfaction and morale. With this in mind, we plan to implement "idea systems" in at least four divisions to collect and share staff suggestions for improving satisfaction. Satisfaction can also be improved by having a better understanding of what's happening in our department and we will display our department and division Annual Operating Plans along with regular progress updates in multiple relevant locations.
10. **Maintain outpatient volume:** With pressures to refer patients to lower cost providers in the community, with higher co-pays and deductibles, and with more careful thought put into ordering expensive imaging studies, we need to identify new sources of outpatient volume, and to maintain those patients who already come to our network for their imaging. We will undertake regular communication with our primary internal and external sources of referral. Many of our physicians are working to establish new relationships with referring physicians and even directly with patients. We need to establish new referral sources and are working diligently with our colleagues at Atrius, with our community affiliates (such as BID Needham), with APG and with others to seek new sources of patient referral. Also we will be actively working to reduce outpatient "leakage"
11. **Improve the educational experience of all staff:** We are a very large department (over 450 staff!) and as part of our educational mission, we strive to provide educational services to all of our staff. One area that has been identified as a challenge is the huge volume of rules and regulations that must be adhered to when working in a hospital. This year we will focus on newly hired physicians. If only everybody started on the same day each year! We will develop and implement a new "on-boarding" program so that all new physicians are familiarized with the array of policies, practice guidelines, passwords, dashboards and related processes that each is expected to become rapidly proficient in. We will also introduce a monthly educational event for MR techs which I hope will be extended to other modalities.
12. **Increase funded research:** Our faculty continue to publish outstanding impactful scientific manuscripts in top peer reviewed journals. Many of these studies have led to improvements in clinical performance and I hope that we can maintain this impressive trajectory. With intense competition for research space and resources, we must identify new ways of supporting our research mission. We have seen a reduction in the total amount of federal grants that support our research and this year we will refocus our efforts on submitting more competitive grants and seeking new means of research support. Specifically, we will implement selected recommendations of our Radiology Research Task Force (ably led by Vassili Raptopoulos, Dave Alsop and Alex Bankier), and we will plan to maintain or increase our publication productivity and quality. Other specific goals in this category include increasing the number of grants that are submitted and awarded. We will also actively seek new sources of revenue to support our research and through Koenraad Mortelet's expertise we are already exploring CME offerings and visiting fellowships.




DEPARTMENTAL NEWS, AWARDS & HONORS

Radical Views is pleased to introduce a new column to update the department on the many impressive initiatives aimed at reducing and reporting CT dose as part of our CT radiation dose reduction program, *Image Lightly*. We hope to publish updates as needed from our CT Advanced Imaging Lab members Vassilios Raptopoulos, Tim Parritt, Carol Wilcox, Rajeev Krishnapillai and others to keep us informed of where we are on our dose reduction journey!

Also new this year is the Best in Practice Lecture Series which carries CME accreditation for technologists.



Beth Israel Deaconess Medical Center
A teaching hospital of Harvard Medical School






BIDMC Radiology is proud to present

Best in Practice BIDMC MRI Lecture Series 2012

Anorectal MRI

Moderator: Koenraad J. Morteale, MD

Featuring

"What I need to know"
 Deborah Nagle, MD; Assistant Professor, Surgery, HMS; Chief, Colon and Rectal Surgery, BIDMC

"How I do it"
 Martin P. Smith, MD; Instructor, Radiology, HMS; Division of Abdominal Imaging and Body MRI, BIDMC

"What I look for"
 Koenraad J. Morteale, MD; Associate Professor of Radiology, HMS, Director of Clinical MRI, BIDMC

Thursday, January 19, 2012
5:00 pm – 6:00 pm
 Riesman Lecture Hall – BIDMC East Campus
 Rabb Building, 2nd Floor
 330 Brookline Avenue, Boston, MA

Local Organizing Committee: Jeremy Stormann B.S. RT (R), (MR); Steve Flaherty, MBA, RT (R), (MR); Ines Cabral-Goncalves, RT (R), MR; David Alsop, PhD and Koenraad J. Morteale, MD

Event Coordinator: Lois Gilden, Tel: 617-667-0299, Email: lgilden@bidmc.harvard.edu

This lecture is pending accreditation by the American Society of Radiologic Technologists (ASRT)
 Accreditation: 1 Category A Credit

The Gallery -

Announcing a new show of photographs by neuroradiologist, Dr. Jonathan Kleefeld, coming in January, 2012. Check it out at WCC-304A.

IMAGElightly



UPDATE

As we discussed in the last Abd Imaging meeting we are starting a pilot program in Reporting Radiation Dose from CTs read by the abdominal section. There are many good reasons to do this, most import of which is awareness. Presently the form has space for DLP but will be adding CTDIvol as well based on feedback from several sections. (As you know DLP is product of CTDIcol x length of scanning). Conversion on effective dose in mSv is made in the chart according to body region scanned. This Form will be linked with the reports as well as with webOMR.

Residents and Staff: when you report a case please add the following 2 numbers:

CTDIvol ____ mGy

DLP ____ mGy-cm

Technologists: Thank you for sending the dose report to PACS, this is an important process in our ability to capture and report on CT doses. Please continue to send dose reports to PACS

Rational on Reporting dose:

1. Increases our awareness toward dose and forces us to think twice before ordering high dose protocols. This is very important. It goes along with Image Lightly and the Hospital's policy of openness and transparency
2. It is the referring clinicians' and the patients' right to know.
3. It is simple and the best tool we have available to monitor what is going on while providing some broad guidance to clinicians.
4. By providing guidance with the report, we decrease clinician's apprehension and may actually optimize CT utilization that may be otherwise curtailed by unfounded anxiety and fear of the unknown.
5. We exhibit leadership in this important issue.

Thank you very much,
 - Vassili Raptopoulos

DEPARTMENTAL NEWS, AWARDS & HONORS

➤ Happy New Year!

You may have noticed by now that Radical Views has undergone a facelift. We are now 8.5 x 11 instead of the previous legal size of 8.4 x 14 for easier printing. Our top story is the Radiology Annual Operating Plan due to which we have moved the department monthly calendar - please note the schedule is a moving target and you should confirm events online as needed - and have now feature our visiting professors for Grand Rounds below. The January issue also introduce a new column on CT Dose Reduction. Thanks to everyone who has made comments and suggested new items, you have all helped **Radical Views** maintain its status as our number one instrument for sharing news among our ~650 department members!

- Donna Wolfe, Editor

➤ January Grand Rounds

Friday Jan 27 • 8:00-9:00 am, Sherman Auditorium

Multiple trauma: use of extremity and pelvic CT angiography in the era of 64 MDCT - Jorge A. Soto, MD



Dr. Soto is currently Vice Chairman of Radiology at Boston Medical Center and Professor of Radiology at Boston University School of Medicine. Dr. Soto earned his doctorate in medicine and surgery, as well as residency training, from the Instituto de Ciencias de la Salud (C.E.S.), Medellin, Columbia and in 1995 he completed a Body Imaging fellowship at Boston University Medical Center. He returned to Medellin as section head of Body Imaging at the Hospital Universitario San Vicente de Paúl, and ascended to Assistant Professor of Radiology at the Universidad de Antioquia. In 2002, he returned to Boston to head the Body Imaging Section at Boston Medical Center with the rank of Associate Professor. Among his many awards, he has won Gold and Bronze Medals from ARRS, Cum Laude Awards from the American Society of Emergency Radiology (ASER), and four *Radiology* Editor's Recognition Awards with Special Distinction. In September 2011, he published, Foster BR, Anderson SW, Uyeda JW, Brooks JG, **Soto JA**. *Integration of 64-Detector Lower Extremity CT*

Angiography into Whole-Body Trauma Imaging: Feasibility and Early Experience. Radiology. 2011 Sep 21. [Epub ahead of print]

➤ Congratulations Drs. Muneeb Ahmed (IR) and Tejas Mehta (Br Imaging/US)

for being selected as participants in the 2012 course, HMS Leadership Development for Physicians and Scientists in April, 2012. The goal of the Program is to build on participants' knowledge base and skills to enhance their professional development as administrative leaders in academic medicine. Participants will acquire skills in institutional organization, finance, legal and regulatory issues, and the full spectrum of communication skills.



Muneeb Ahmed, MD



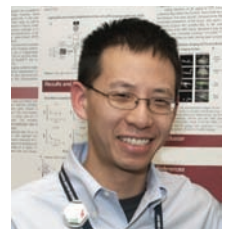
Tejas Mehta, MD, MPH

➤ Welcome new Chief Residents, James Knutson and Leo Tsai

Effective January 1st, we welcome current 3rd years residents, James Knutson and Leo Tsai as our new Chief Residents. Chief Residents are chosen by their peers (with input from the Residency Program Officials) and is a vote of confidence in their leadership abilities. Special thanks to outgoing Chief Residents, Adam Jeffers and Sachin Pandey!



James Knutson, MD



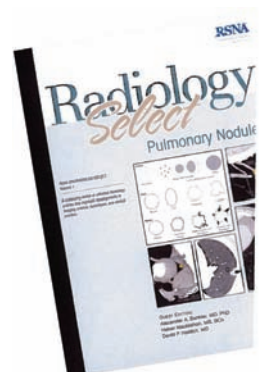
Leo Tsai, MD, PhD, MSc

➤ Introducing Radiology Select, a new *Radiology* publication

Series Editor: Deborah Levine (BIDMC Ultrasound)

Guest Editor: Alexander Bankier (BIDMC Thoracic Imaging)

The first issue of RADIOLOGY Select was edited by Alexander A. Bankier, Heber MacMahon, and David P. Naidich. The issue is entitled "Pulmonary Nodules" and includes 33 pertinent articles published on this topic in RADIOLOGY over the past seven years. The articles are grouped according to subtopics and preceeded by a general introduction on the topic. RADIOLOGY Select will be available in a print-on-demand-, a tablet, and an online version. The online version of RADIOLOGY Select includes self-assessment modules (SAMs), which, upon successful completion, will provide the readers with substantial CME credits. The online version is also accompanied by both audio and video podcasts on the various radiological aspects of pulmonary nodules, and on the impact of imaging on patient management. (See pg. 13 for more information)



DEPARTMENTAL NEWS, AWARDS & HONORS

➤ Farewell Musculoskeletal imager, Corrie Yablon

On December 15th, we said good-bye to Corrie Yablon who accepted an Assistant Professorship at the University of Michigan. She has been asked to build a foot and ankle interventional practice and will also serve as co-Director of the MSK Fellowship program. Corrie first came to BIDMC in 2007 after two years in private practice in Boston. Embracing the trifecta of academic medicine, she applied for and was awarded the Rabkin Fellowship in Medical Education at the BIDMC Shapiro Institute in 2010; and that same year, she was inducted into the BIDMC Academy of Medical Educators. She went on to develop the musculoskeletal section's fellowship curriculum and created the new MSK Ultrasound service. Most recently, she became co-editor with Ron Eisenberg of AJR's *Resident Section Career Path* series. She will be missed but we wish her the best in her new position!



Above: Dr. Yablon's co-workers, (L to R: Mary Hochman, Gunjan Senapati, Manjiri Didolkar, Jay Patel, Seth Berkowitz, Ammar Sarwar, Corrie Yablon, Jim Wu, Colin McArdle and Tejas Mehta) say goodbye to her in the Shapiro Ballroom. Dr. Yablon proudly poses with her farewell gift of a baseball bat made by Jim Wu.



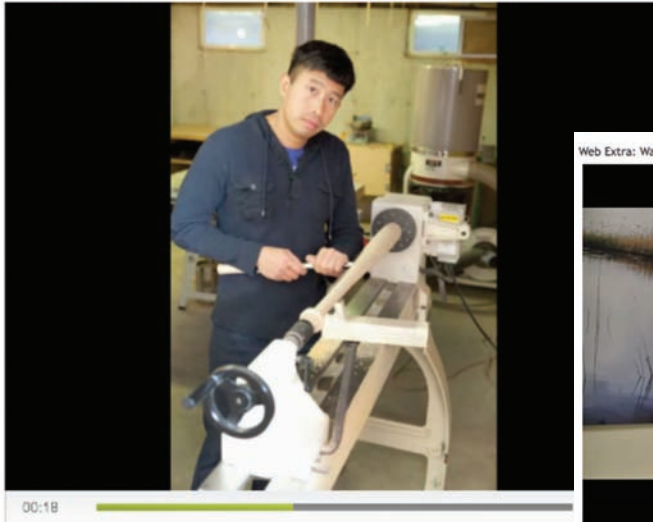
MSK section good bye dinner for Dr. Yablon featured here between her husband Patrick O'Brien and Ferris Hall as they toast her with gifts of a BIDMC ball cap and Harvard monkey.

DEPARTMENTAL NEWS, AWARDS & HONORS

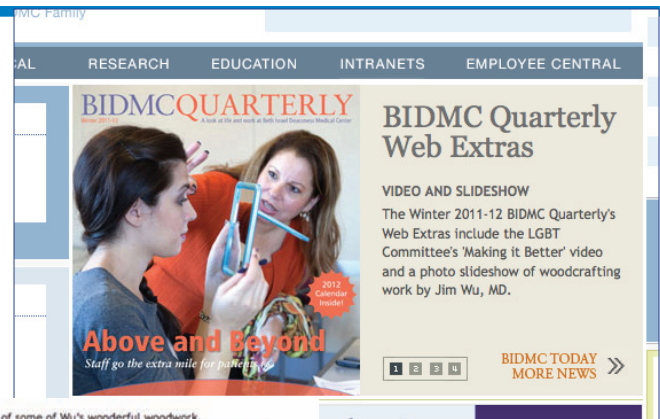
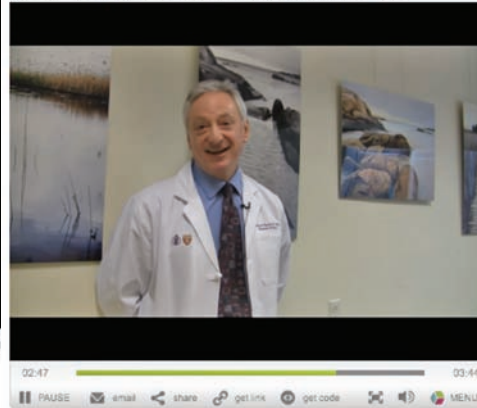
➤ *Did you know...*

That Musculoskeletal radiologist Jim Wu and Department Chief Jonny Kruskal are featured on our own BIDMC portal?

Web Extra: Watch a photo slideshow of some of Wu's wonderful woodwork.



Web Extra: Watch a photo slideshow of some of Wu's wonderful woodwork.



Click on or type into Search: "BIDMC Quarterly Web Extras" and then Click on menu of web extras videos of Jim Wu to see, among others, photos of him working on the iconic baseball bat he made for Corrie Yablon; and also click on the link for Dr. Kruskal's video which was filmed in our own West Campus Clinical Center Gallery, Rm. 304A.

➤ Administrative Staff Holiday Lunch & Outreach

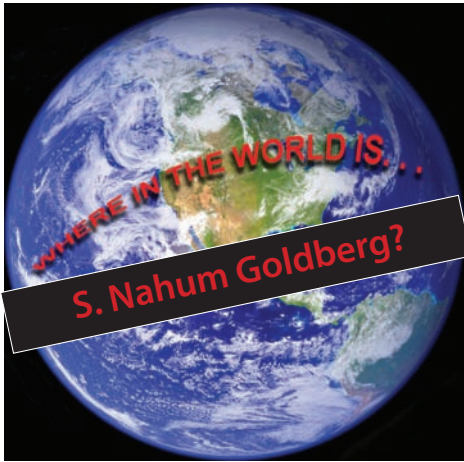
For the second year, the administrative assistants celebrated the holiday with a potluck luncheon that also included an outreach project to help those less fortunate. In addition to a luncheon item to celebrate the holidays, each invitee also brought a scarf that was wrapped and donated to the shelter residents of Rosie's Place in Boston. This year there was such generosity from the admin assistants that not only did Rosie residents received scarves but even the staff got surprise gift scarves!



Front row (L to R): Andrea Baxter, Diana Moran, Tara Bun, Nancy Williams, Lois Gilden, Linda Lintz.

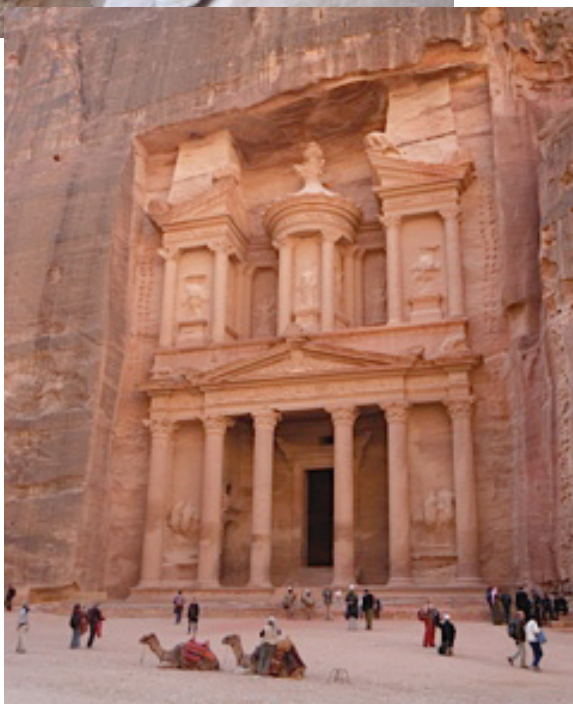
Back row (L to R): Catherine Walsh, Maxima Baudissin, Laura Major, Sheila Blalock, Richard Jennette, Claire Odom, and Jonny Kruskal (with red Boa).

DEPARTMENTAL NEWS, AWARDS & HONORS



Our own Dr. Nahum Goldberg send his greetings from BIDMC "Middle East Campus" and gives us an unprecedented view of a well-deserved trip to Petra, *the rose-red city half as old as time**, in Jordan with his wife Michelle. When not climbing around historical monuments, Dr. Goldberg is Unit Chief of Image Guided Therapies and Interventional Oncology at Hadassah University, Jerusalem.

**"Petra" by Dean Burgen*





Our Radiology professional practice group (HMFP) contracts with McKesson for diagnosis coding, allowables monitoring, revenue cycle management, accounts receivable, insurance denials, compliance and reporting for the Radiology practice. We offer this new column as an opportunity to keep you informed. During this time of revenue and utilization reductions, compliance scrutiny and increasing payer denials, our partnership with McKesson has been critical to our ability to maintain our financial stability. The content of this section is submitted by Kathleen West, McKesson's Director of Account Management for Radiology.

— Carl F. Nickerson, MBA, Business Manager, HMFP Radiology & BIH Radiologic Foundation

McKESSON

Empowering Healthcare

McKesson Corner

AMA Report Finds Inaccurate Claims Reach Crisis Level — Here's What You Can Do

An article in American Medical News confirms what physicians have known for years: claims processing errors and inaccuracies have reached near catastrophic proportions. The American Medical Association's Fourth Annual National Health Insurer Report Card reports such errors waste billions of dollars each year. Those dollars translate into lost income for the practice as well as lost opportunities for reinvestment, professional growth and a focus on better patient care. To minimize the impact of inaccurate claims, physicians need to understand the factors contributing to the situation, but more importantly, what they can do to combat the problem and ensure more accurate and timely reimbursement.

The Startling Statistics

- Commercial health insurers have an average claims-processing error rate of 19.3%, an increase of 2% compared to last year.
- The increase in overall inaccuracy represents an extra 3.6 million in erroneous claims payments compared to last year.
- Errors add an estimated \$1.5 billion in unnecessary administrative costs to the health system.
- The AMA estimates that eliminating health insurer claim payment errors would save the industry \$17 billion.

American Medical News – 4th Annual Health Insurer Report Card, June 2011

You Don't Know What You Don't Know

One of the more startling statistics reported in the AMA survey was that, "physicians received no payment at all from commercial health insurers on nearly 23% of claims they submitted." The reasons for lack of payment of claims stem from a wide range of factors including:

- Patient has not met deductible. This is often cited as one of the most common reasons for claims denials. It's a simple matter, and happens almost daily, yet costs practice additional dollars to fix.
- Patient not covered by insurer. Another common error is when a patient presents the wrong insurance card. Often, it's for a common oversight, perhaps the patient's employer may have simply switched insurers or the patient is using an older card. Occasionally, fraud is involved.
- Lack of pre-authorization. More insurers are requiring pre-auth for certain services. The AMA survey notes that requests for first-time pre-auth have increased by 20% over the past few years. Again, it's a simple fix, but adds to administrative costs and delays in reimbursement.
- Claims associated with bundled services denied. When a patient presents for one illness such as cold or flu, but during the course of the examination that patient or physician identifies another need resulting in a separate service at the same visit insurers will often automatically deny the claim.
 - o Physicians note that often they are not at fault for the kickback on claims. Even when a coder uses the applicable modifier on the primary procedure to ensure the secondary procedure is paid; insurers are still denying the claim.
- Denials of claims within global service period. Most insurers have a 90-day global period for high-dollar claims, such as those associated with surgeries. As an example, if a patient has rotator cuff surgery, but then comes to visit the physician for a knee injury, often the insurers will deny the claim. And again, practices report that denials frequently occur even when the proper codes and modifiers are used.

Since the onset of initiatives to ensure more prompt payment of claims, it appears that some insurers are finding other ways to delay reimbursements, adding further to administrative costs for providers and creating additional challenges for

revenue cycle management. As another example of delays and administrative hurdles physicians must overcome, over the past few years, physicians are reporting a marked increase in insurers' requests for medical records. As a result, often claims that should have been paid in 30 days takes 60 to 90 with manual intervention.

The ripple effects of inaccuracies, coupled with inconsistent adjudication rules often forces medical providers to write off unnecessary lost revenue. One key area to consider is the inability to develop predictive forecasting. Without this data, a practice has no way of accurately predicting claims payment and no way to develop accurate financial plans. In short, if you don't know what claims are owed the practice, how do you know how to budget? How can you plan for new staff, investments, expansion, etc.?

The Game of Cat and Mouse

At times physician efforts to ensure prompt and accurate claims payment may seem like a game of cat and mouse. However, physicians can take several steps to minimize the problem. They should:

1. **Get it right the first time.** Minimize material risk and develop a sound set of policies and procedures to ensure staff meticulously codes, checks insurer guidelines for pre-authorization and takes other steps to ensure a clean claim submission. Know each insurer's policies backward and forward. Practice management technology combined with consulting can help develop effective procedures and ensure accurate submissions.
2. **Conduct pre-appointment or pre-service analysis.** Determining a patient's insurance eligibility and copays prior to the appointment allows for fees to be collected at the point of service, provides time to check on required pre-auth and allows the practice to alert patients of their liability (so no surprises for them).
3. **Train staff, including physicians, and give them the tools, technology and education to code properly.** Noting the complicated processes for submitting claims, many practices are simply opting to hire trained coders or outsource coding entirely. If that's not an option, learn what programs and seminars are available for your staff. That, combined with top practice management systems, can further ensure accurate claims submissions.
4. **Conduct a claims audit to ensure contract compliance.** Most practices assume that insurers are reimbursing within contract guidelines. A claims audit could indicate problems and can better ensure contract compliance. In addition, practice management software provides the ability to delineate reimbursement detail from the system and compare the flat billed allowable rate against contract and actual payment to identify and correct any discrepancies.
5. **Create and implement sound tracking procedures for payment integrity.** Remember that you can't manage what you don't measure. Develop plans to track and trend revenue to gauge your performance based on measurable financial targets. The Medical Group Management Association and American Medical Association provide research to help establish target baselines. This data can help identify inaccuracies as compared to similar practices.
6. **Chase down those dollars.** The AMA notes that it costs \$25 to resubmit a single claim, multiplied by the hundreds of claims that require resubmission and that adds more to the revenue practices loss each year. That may lead some practices to simply not resubmit on smaller balances. However, practice management consultants recommend practices chase down every dollar they are entitled to receive. It's the fair thing to do and could also become a deterrent for some insurers. Staffing and time can be an issue for such tracking, so look for practice management systems that provide the features and functions to support your efforts or enlist the help of a business partner.

Ever Vigilant - The take away advice for any practice today is simple: be proactive, not reactive when it comes to your practice's financial health.

The challenge to ensure accurate reimbursement will continue. Some insurers are making inroads to reducing claims inaccuracies and should be recognized for their efforts, but physicians will need to remain vigilant.

For more information about the the 2011 National Health Insurer Report Card visit the AMA website at: www.ama-assn.org/go/psa-webinars or check out their white paper for administrative simplification at: <http://www.ama-assn.org/go/simplify>.

The findings from the 2011 National Health Insurer Report Card are based on a random sampling of approximately 2.4 million electronic claims, representing about 4 million medical services submitted in February and March of 2011 to leading health insurers. Copyright © 2011 McKesson Corporation and/or one of its subsidiaries. All rights reserved.

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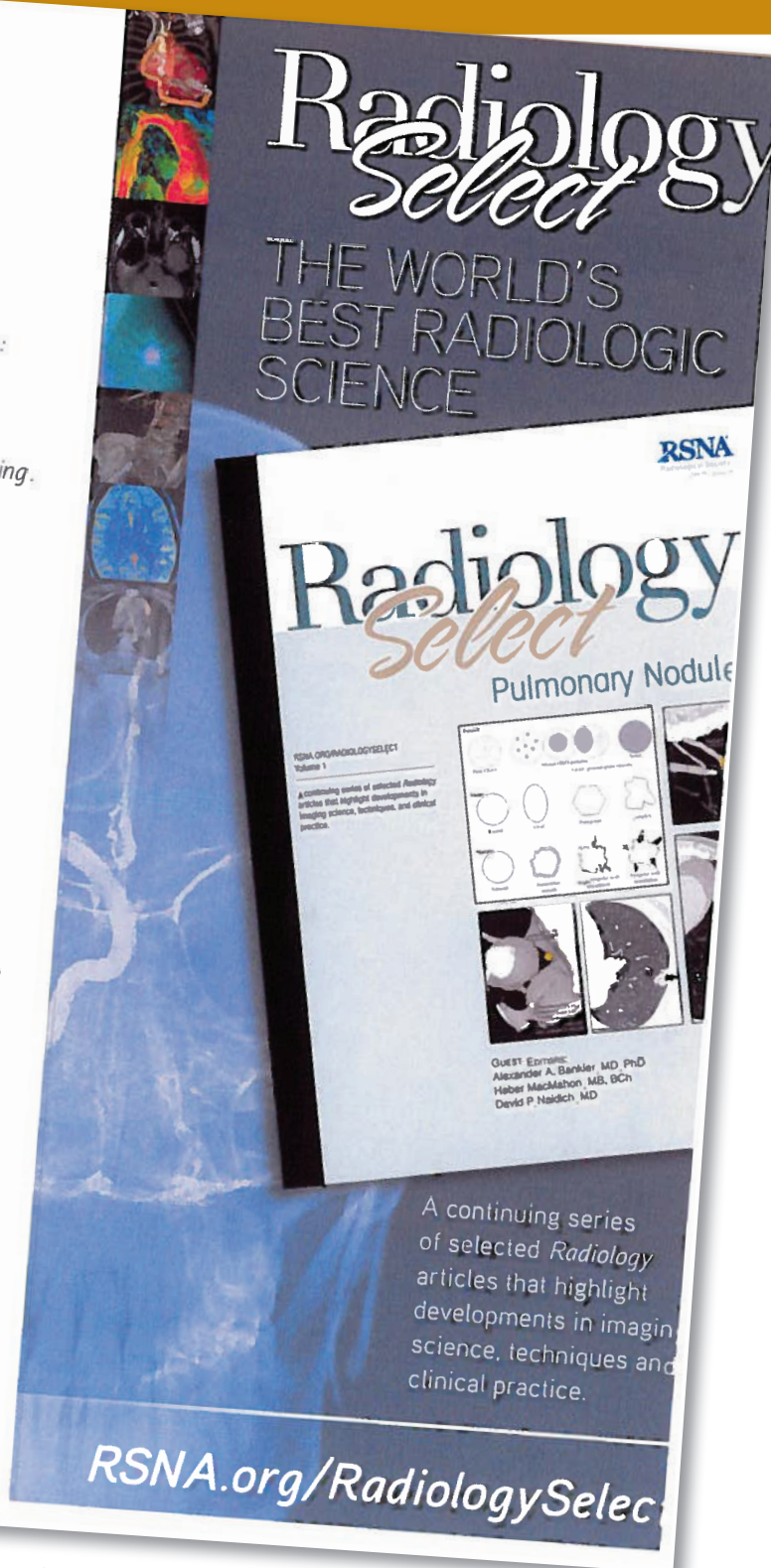
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Note that publications do not always appear in Pubmed in the same month they are actually published and publications listing an Epub date may be updated into the new year, thus their paper publication will appear in 2012.

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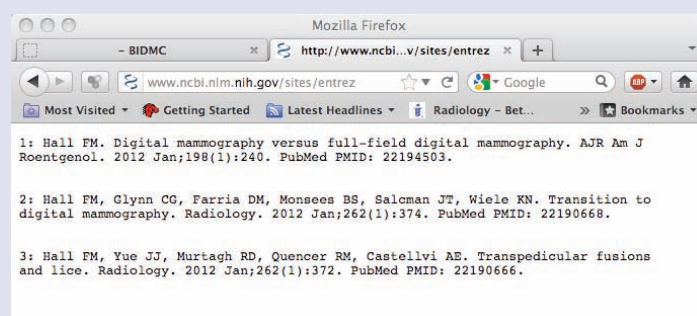
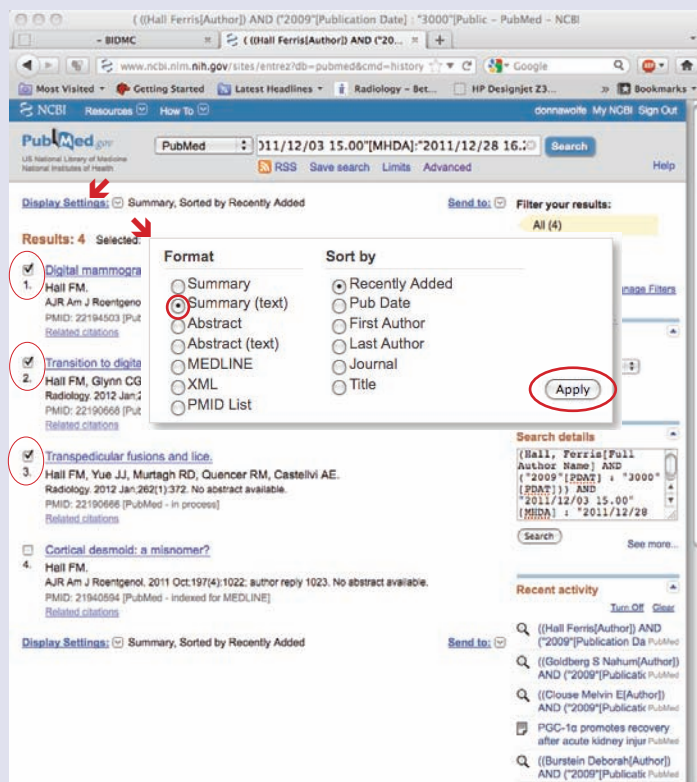
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2011 BIDMC Radiology Publications Cumulative Stats:

197 original article and editorials
8 with residents
33 with fellows

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Thanks to Meredith Cunningham for suggesting this tip be included in Radical Views. Please contact Donna Wolfe (dwolfe@bidmc.harvard.edu) if there are other tips you would like to share with the Radiology community.

2011 BIDMC Radiology Publications - [New citations in Blue].

Below is the cumulative listing of all publications for the year 2011, including, in blue, citations which appeared after our last search in November, 2011 for the December issue of *Radical Views*. We do a monthly PubMed search for new BIDMC publications and may miss those in which your affiliation is not noted. If we miss your paper, please send the reference to dwolfe@bidmc.harvard.edu. Note that publications do not always appear in Pubmed in the same month they are actually published and publications listing an Epub date may be updated into the new year, thus their paper publication will appear in 2012.

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