June 2007
Volume 62, Issue 6

ACR BULLETIN

AMCLC 2007 Sparks Lively Debate

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For comments or suggestions on the *ACR Bulletin*, contact Managing Editor Betsy Colgan at bcolgan@acr.org.

ACR BULLETIN

ACR Bulletin is published 10 times a year to keep radiologists informed on current research, advocacy efforts, the latest technology, relevant education courses and programs, and ACR products and services. It provides a forum for members to share lessons learned, news and events, and achievements.

Refilling Our Cup With Knowledge

Arl Van Moore Jr., M.D.
BOC Chair

A learned man once sought advice from a revered teacher. As the teacher poured tea and attempted to answer his visitor's questions, the learned man kept interrupting with his own opinions. Soon the learned man's cup overflowed with tea, yet the teacher kept pouring. Finally, the learned man stopped talking and pointed out that the cup was full and would hold no more.

The teacher stopped and answered, "Like this cup, you are full of your own ideas and opinions. How can I show you anything unless you first empty your cup?"

Like the learned man, we proudly declare ourselves medicine's imaging specialists, diagnosing and treating diseases today with knowledge and technology that would've been called fanciful only a decade ago. However, we must recognize that, despite our capabilities and knowledge, we can still learn a lot.

The cornerstone of our remarkable achievements is research. It is through research that we have made, and will continue to make, great strides in technology, knowledge, and skills for our patients' benefit. As imaging specialists, it is also our principled responsibility to continually push the ever-expanding boundary between proposition and practice as we transition from theory to application.

As you would expect, the ACR has played a major role in many of the clinical advancements that radiology has achieved in recent years. The College's renowned research divisions, the American College of Radiology Imaging Network (ACRIN®) and the Radiation Therapy Oncology Group (RTOG®), have established themselves with groundbreaking studies that have received significant media attention and, more importantly, greatly influenced the way we practice radiology today.

Recent benchmark trials have helped validate such procedures as digital mammography, virtual colonoscopy, and breast MRI screening, each study generating increased interest among patients and referring physicians and reinforcing our role in the health care process. However, for every study featured on the national news, dozens of equally significant studies receive much less media attention. At this time, we have no fewer than 27 active ACRIN trials.

I encourage you to read the article on page 18 about a new joint ACRIN/RTOG trial that looks at two treatment options for patients with recurrent malignant glioma and the role that imaging can play in determining treatment effectiveness. In the article, ACRIN Principal Investigator Gregory Sorenson, M.D., sums up the goal of any new ACRIN or RTOG study by pointing out that we can't simply settle for successes and failures; we need to have *informed* successes and failures.

All medical advancements are the result of one physician or a team of physicians simply asking "What if?" Answers to that question typically include a fair share of disappointment. Yet, as Sorenson noted, we must remember that our failures can teach us almost as much as our successes, and we must be willing to learn from each one equally.

Even though we are the imaging specialists, we must be prepared to empty our cups often and open our minds to "What if?" The answers may well make a difference in the lives of our patients in the years to come. And as you ask "What if?" imagine where our profession would be if we were not actively pursuing research goals. I believe you will conclude that supporting research efforts with our time and resources is vital to our future.

Resident Blog: Conference Exceeds Expectations

Posted by **Trey Carr, M.D.** on May 23, 2007
Radiology Resident, University of Virginia Health System
Charlottesville, Va.

My initial motivation for attending the AMCLC centered on little more than an interest in learning more about the organization and function of the College and its impact on me as a resident in radiology. However, my experiences during the meeting revealed the profound impact that residents could have through involvement in the ACR and were of such a positive nature that, in years to come, I plan to return and attend the AMCLC whenever possible.

Having never attended the AMCLC before, I expected that most of the conference would revolve around radiologists, who were already well-established in either academic or private practice, debating policy and practice guidelines with little to no relevance to, or involvement from, residents or fellows. As soon as the conference kicked off with the meeting of the Resident and Fellow Section (RFS), these erroneous expectations were quickly refuted.

Seeing the active role that the RFS — through its executive committee and its individual members — played in so many aspects of the AMCLC greatly exceeded my expectations. Watching RFS members sit on committees discussing policies with far-reaching effects in our specialty; debating important issues facing residency programs and the field of radiology, such as the structure of the residency programs and the commoditization of radiology services; participating as the RFS successfully introduced and passed a resolution about the timing of the oral board examination before the Council of the ACR; and lobbying members of Congress demonstrated the impact that residents could have through active involvement with the ACR.

Perhaps the most beneficial part of these experiences has been realizing the ACR's commitment to actively engage residents and fellows in charting the current and future course of radiology. Knowing the ACR's commitment to its members-in-training, I strongly encourage other residents and fellows to become more involved with the ACR and hope to see as many of you as possible next year for the 2008 meeting.

Posted by **Grant R. Seeger, M.D., PGY3** on May 23, 2007
University of Texas Medical Branch, Radiation Oncology Department, Galveston, Texas

It's difficult keeping up-to-date with the politics of medicine during a busy radiation oncology resident service. We hear occasional political tidbits on the news or opinions from our attending physicians, but we don't have time to investigate further. Hence, we're often uninformed about changes such as decreasing reimbursement rates, medical-legal issues, and outsourcing that could negatively impact our careers.

I attended the 84th AMCLC to learn more about the current hot topics and politics in radiology and radiation oncology. After all, if you don't know the political issues in your profession, how are you going to protect its future?

I expected to participate in a few educational sessions and attend the Resident and Fellow Section (RFS) lectures. I also knew I would help develop and edit the ACR practice guidelines as a volunteer on Reference Committee II, which dealt with radiation oncology, nuclear medicine, and fluoroscopy.

The AMCLC greatly exceeded my expectations. One of the most informative meetings I have ever attended, it was a crash course in government relations, intersociety relationships, threats to the profession, residency structure and requirements, radiology technical standards and practice guidelines, research funding, and cutting-edge imaging and therapeutic technologies. The trip to Capitol Hill was exciting and instructive. I also learned how radiation oncology fits into the ACR and is represented in the Council's open sessions by ASTRO and CARROS members.

The RFS private lectures and fellowship were densely informative, inspiring, compassionate, and highly pertinent. The RFS executive committee did a spectacular job organizing its section of the conference.

My perspective on the current status of radiology as a specialty has changed. Now I not only know about such controversies as outsourcing, predatory academia, and the commoditization of radiology, but I care about them, too.

The meeting could be improved if more residents in both radiology and radiation oncology attended and also by ensuring that RFS meetings don't overlap with the educational lectures. Overall, though, I highly recommend this conference as a way for residents to stay informed.

ACCREDITATION DEADLINE APPROACHES

UnitedHealthcare has mandated that facilities officially apply for accreditation by March 1, 2008. Early submission of complete accreditation applications and materials is strongly recommended. Facilities seeking to meet the new UHc requirements should submit accreditation applications by January 15, 2008.

MEMBERS WIN VIDEO IPODS

Congratulations to Susan Danahy, M.D., Rochester, N.Y.; David Owens, M.D., Atlanta; and Sean Beaty, M.D., Las Vegas, each of whom has won a free iPod. The winning names were drawn from 5,000 entries among colleagues who completed and returned brief ACR demographic surveys in the 2007 ACR invoicing packet.

SURVEY REPORTS ON RADIATION ONCOLOGISTS

There are more radiation oncologists entering the work force and more of them are satisfied with their jobs than five years previously, according to an ACR research paper titled, "Radiation Oncologists in the United States," to be published in the *International Journal of Radiation Oncology*Biology*Physics (IJROBP)*.

Major findings of the paper include:

- The number of posttraining, professionally active radiation oncologists grew from nearly 2,900 in 1995 to nearly 3,500 in 2003, an increase of approximately 21 percent
- The proportion of radiation oncologists planning a career change decreased from 8 percent in 1995 to 4 percent in 2003

The abstract of the article is currently available at **www.redjournal.org**; the full version of the article will be available to subscribers only. The paper is currently in press at *IJROBP*, with the exact date of the print publication to be announced.

GEOFFREY SMORON RECEIVES AWARD

ACR Fellow Geoffrey L. Smoron, M.D., president of Midwest Radiation Oncology Consultants, was presented the Distinguished Service Award, or Gold Medal, the highest honor the Chicago Radiological Society can bestow upon a member, on April 18, 2007.

In addition to his teaching responsibilities at Northwestern University Medical School, Smoron has held leadership positions in the Illinois Radiological Society, the American College of Radiology, and the Radiological Society of North America, and is president of the Chicago Radiological Society.

Smoron has served as both alternate councilor and councilor on the ACR Council and in 1999, was presented with the Distinguished Committee Service Award for his work as liaison to the College of American Pathologists for the Commission on Radiation Oncology.

JULIE TIMINS RECEIVES AWARD

ACR Fellow Julie K. Timins, M.D., was presented with the Gold Medal Award of the Radiological Society of New Jersey (RSNJ) on March 10, 2007. Timins is a past president of the RSNJ and practices diagnostic radiology and nuclear medicine at Christ Hospital in Jersey City. She is a member of the American College of Radiology and is currently serving her fourth year as an elected member of the Council Steering Committee. Timins chairs the Committee on Guidelines and Standards of the Commission on General, Small, and Rural Practice and has recently published a paper in the *Journal of the American College of Radiology* on bone densitometry.

REMEMBERING ACR MEMBERS

The ACR was recently notified of the death of Fredric D. Lake, M.D., an eminent Chicago radiologist. Lake was a graduate of Harvard Medical School and was chief of radiology at Columbus Hospital for 30 years. During World War II he served with the 5th Battalion in Great Britain, North Africa, Italy, and Austria, earning the rank of Lt. Colonel and a Bronze Star. Lake served as president of the Illinois State Medical Society from 1974-1975 and as ACR President from 1977-1978.

ACR Fellow John H. Lohnes, M.D., emeritus, passed away April 5, 2007. A graduate of the University of Iowa College of Medicine, he served as a Navy flight surgeon before completing his radiology residency at the University of Iowa and joining Cedar Rapids Radiologists PC (now Radiology Consultants of Iowa PLC). A member of the Iowa Radiological Society, Lohnes also made substantial contributions to the American College of Radiology on the Commissions for Human Resources, Bylaws, Budget and Finance, and Radiography. He ultimately served as Council Vice Speaker (1979-1981), Council Speaker (1981-1983), and member of the Board of Chancellors from 1983-1988.

ACR Leaders Unite in Bold Vision for the College

Leaders of the American College of Radiology (ACR) gathered in Washington, D.C., to lay out a bold vision for the future of the College and the radiology profession. In a city known for its divisions, ACR leaders united to call for quality for patients, fair reimbursement for physicians, and the continuing success of the profession.

More than 850 members attended the 84th Annual Meeting and Chapter Leadership Conference (AMCLC), discussing and debating radiology's future in the democratic style that is the organization's hallmark.

The leadership did not shy away from the difficult challenges ahead. Chief among the concerns voiced at the conference was the need to restructure the government payment system to ensure access for patients and reasonable reimbursements for physicians. As Board of Chancellors Chair Arl Van Moore Jr., M.D., told the attendees, the effort to change laws in Congress will be difficult, but "Our patients deserve no less, and our country can afford no less."

FIRST, WE ARE PHYSICIANS

Council Speaker Albert L. Blumberg, M.D., using a crutch to support a knee he injured helping his son move after college graduation, recounted the advice and care he had received from fellow radiologists. "I'm going to remind us all: Though we may be radiologists of various stripes … we are first, above all, physicians," he said.

Blumberg was the first of several speakers to note the importance of young radiologists. "About 140 residents and fellows are attending the conference," he said, adding, "This is the future of our profession."

GIANT STIRS IN WASHINGTON, D.C.

Moore called the audience to action on some of the most important issues facing the profession. The ACR must take its message of access, quality, and fair reimbursement to federal and state legislators, he declared. Moore also highlighted the ACR's government relations activities, pointing out that *PRWeek* has recognized the ACR as one of the nation's most effective advocacy organizations.

The College continues to fight reimbursement cuts enacted in the Deficit Reduction Act (DRA) and remains concerned that this is only a first step by a Congress looking to dismantle "the long-standing, imperfect, but somewhat predictable, resource-based payment system without any clear visions of what system will replace it."

Last year, the ACR was instrumental in organizing and recruiting more than 40 organizations to the Access to Medical Imaging Coalition (AMIC), which seeks a congressional moratorium on DRA imaging cuts. The Access to Medicare Imaging Act, championed by the ACR and AMIC and aimed at reversing the impact of the DRA, has been submitted in both the House and Senate. The bill is gathering co-sponsors daily, Moore said.

In response to the challenges in Washington, D.C., the ACR has been educating radiologists across the country on what they can do to reach legislators. The ACR has also enhanced its Web-based communications to keep members up-to-date and created a more diverse Government Relations Commission to advocate for the profession.

Among other accomplishments Moore highlighted were:

- Recent acceptance of the *Journal of the American College of Radiology* for indexing on MEDLINE
- Investigation of a branding campaign to identify what radiologists do and who we are
- A white paper issued on radiation dose in medicine to counter concerns about patient exposure to medical radiation
- Meeting with international radiological organizations to look at cooperative efforts
- Expanded accreditation programs; the ACR now offers a cardiac MR program and is working on cardiac CT, modular MR, and breast MR programs

Moore also detailed the ACR's clinical research programs. "ACR is far and away the leading organization in radiology and radiation oncology research," he said, noting that the ACR's Philadelphia research office has 40 to 50 trials open at any given time.

"The coming year should be both interesting and challenging," Moore concluded. "I want you to know that, with your help, the ACR will be ready. It is up to you, and it is up to us."

STATE-OF-THE-ART EDUCATION CENTER

Detailing the ACR's continuous strides to serve its members, ACR Executive Director Harvey L. Neiman, M.D., took the podium. He added to the anticipation over the scheduled opening in January 2008 of the ACR Education Center, a state-of-the art training facility across the street from ACR headquarters in Reston, Va. The

center will offer hands-on learning and large data sets, as well as certificates of proficiency to help in hospital and insurance credentialing battles.

SOLIDLY IN THE BLACK

Secretary-Treasurer Paul H. Ellenbogen, M.D., reported that the ACR is solidly in the black with its revenue from operations. Investment income has also benefited this year from Wall Street's bull market.

PAY IT FORWARD

ACR President James P. Borgstede, M.D., brought a simple, powerful message to those gathered in the nation's capital: Embrace change with a bold vision of the future.

In an address capping years of service in the ACR's highest leadership roles, Borgstede asked members to do four things:

1. Adapt to change, even if it means merging with other specialties or subspecialties. He offered as an example radiology and medical oncology becoming one specialty some day.
2. Uphold imaging as part of a specialty, not as a commodity. Other doctors should not place orders for tests but rather requests for consultation. That may mean curtailing the use of after-hours services, Borgstede warned.
3. Pay it forward. Invest in the future of the profession as payment to the rich opportunities created by the pioneers of the past.
4. Embrace patient primacy. Radiologists should put a face on their profession by interacting directly with patients.

Borgstede ended the stirring speech with words about the future. "I've heard people say the golden age of radiology is over," he said. "I don't believe that. Our specialty is at its renaissance, and we must be part of that renaissance."

RADIOLOGY'S BEST ARE HONORED

Sixty-four radiologists were honored for their significant contributions to the profession during the ACR Convocation. Along with these new fellows, three members were awarded the gold medal and two honorary fellows were recognized.

Gold Medalists
E. Stephen Amis Jr., M.D., FACR, Bronx, N.Y.
Sarah S. Donaldson, M.D., FACR, Stanford, Calif.
Thomas S. Harle, M.D., FACR, Winston-Salem, N.C.

Honorary Fellows
Guy Frija, M.D., Paris
Michael R. Sage, M.D., Bedford Park, Australia

CALL FOR NOMINATIONS

There is still time to nominate someone for the ACR Gold Medal or for Honorary Fellowship in the College. The awards will be presented during the AMCLC 2008 next May in Washington, D.C. The deadline for submitting letters of nomination and support is July 1, 2007. For more information, please e-mail **mjdonahue@acr.org**.

Achievements of Volunteers and Members Recognized

On Day Two of the conference, research, education, and resident outreach took center stage.

EXPANSION AND EDUCATION

The Resident and Fellow Section (RFS), represented at the conference by 140 attendees, had a banner year, expanding its network and providing its members with greater service, noted Chair Gregory M. Galdino, M.D. RFS's most successful initiative was the development of a MRI teaching file of 100 member-submitted cases, expected to grow to 300.

RFS made significant outreach efforts, targeting six states for growth: Illinois, Virginia, Georgia, Tennessee, South Carolina, and Alabama. It also unveiled a sleek new Web site, which is receiving 700 to 1,000 daily visits. RFS sent each of its 5,000 members a CD-ROM toolkit with information on the issues facing radiology, such as the Deficit Reduction Act, and why it's important to be a member of the ACR. Galdino concluded by reminding the audience that young doctors are the future of the profession. His comment, "Encourage them to greatness," was followed by a standing ovation.

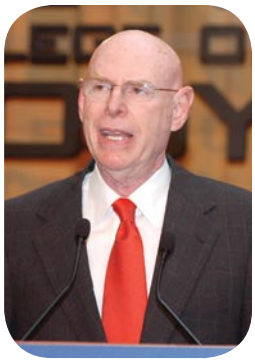
Gregory M. Galdino, M.D., demonstrates the MRI Database before Council members.

AN EDUCATIONAL PLAN

Like other specialty boards, the American Board of Radiology (ABR) has committed to a rigorous certification maintenance program. The last lifetime certifications were issued in 2001, noted President N. Reed Dunnick, M.D., adding that he hoped even the lifetime certification recipients will follow the 10-year maintenance program. That program requires radiologists to have an educational plan, take 500 hours of CME classes, complete 20 self-assessment exams, carry out a practice performance project, and take a cognitive exam.

This year, the ABR established a mechanism for international doctors to become certified in the United States — a crucial addition, Dunnick felt, because radiology suffers from a shortage of doctors.

THE GREATEST OPPORTUNITY OF MY LIFE



Bruce J. Hillman, M.D.

The American College of Radiology Imaging Network (ACRIN®) Chair Bruce J. Hillman, M.D., detailed ACRIN's rising profile. This spring, ACRIN published the findings of a study that revealed the value of MRI breast-cancer screening in high-risk patients.

ACRIN trials now include 118 participating institutions. To build more solid funding sources, ACRIN began a for-profit subsidiary, the ACR Image Metrix. It also established the ACRIN Fund for Imaging Innovation, which has so far received over $7 million in pledges.

Hillman went on to discuss the success of another of ACR's newer ventures: *JACR*, in its fourth year of publication. With 28,000 subscribers, *JACR* is now indexed by *MEDLINE* and recognized as one of the top radiology journals.

Hillman noted that this is the last of his 10 years of outstanding service to ACRIN. "This has been … perhaps the greatest opportunity of my life," he said, and received a standing ovation.

PROGRESS IN CANCER TREATMENT RESEARCH

The Radiation Therapy Oncology Group (RTOG®) continues to work in three major research areas: biophysical, pharmacological, and analytics. Chair Walter J. Curran, M.D., revealed that with 3,132 patients in 2006, RTOG is currently accruing patients to more than 40 trials. Last year's landmarks included partnering with European organizations in a trial examining brain tumors.

ETHICS RELIES ON THE INDIVIDUAL

ACR's Committee on Ethics received 32 ethics-related complaints last year, claimed Chair Leonard Berlin, M.D., mostly related to expert witness testimony. Berlin pointed out that ACR guidelines call for radiologists to be extremely cautious when giving testimony and to remember that expert testimony should stand up to peer review. He explained that though the ACR can and occasionally does suspend members for ethical breaches, ultimately, ethics relies on the individual conscience.

MORETON LECTURE: A POISONOUS PAYMENT SYSTEM

Elliot S. Fisher, M.D.

The system for paying hospitals and physicians in the United States is toxic and must be changed to solve the health care crisis confronting the nation, argued Elliott S. Fisher, M.D., M.P.H., a professor of medicine at Dartmouth Medical School, as he presented the annual Robert and Alma Moreton Lecture.

A leading researcher in health care quality and costs, Fisher endorsed the idea of pay for performance (P4P) as part of the solution but claimed it must also include more accountability at the local level and better performance measures. Pay for performance must be implemented cautiously, Fisher said, suggesting an incremental reform referred to as "shared savings." The idea is to establish a target rate of spending growth and reward physicians who meet that on a per-beneficiary basis with part of the savings.

Fisher quoted from the ACR statement on P4P: "Down the road, we hope that all providers involved in treating the same patient can share in a bonus for improved care efficiency and outcomes. The ultimate goal of P4P is to unify providers around what is best for the patient, eliminating the lack of coordination and segmentation so commonplace today and allowing quality to take center stage."

Fisher gave a compelling analysis of the factors behind rising health care costs and regional variations between costs. He showed that the fee-for-service payment system has given physicians and hospitals incentives to increase capacity, which, in turn, leads to higher utilization, higher costs, and ultimately, at the margins, lower quality of care.

After the lecture, Fisher was rushed at the podium by ACR members eager to discuss his findings. Though a few radiologists took issue with the specifics of his recommendations, no one disagreed with his call for change.

ACR 2007-2008 ELECTION RESULTS

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David C. Kushner, M.D.

Council Vice Speaker
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College Nominating Committee
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Isaac Raymond Kirk III, M.D.
W. Ross Stevens, M.D.

Members-in-Training
Henry Tsai Chen, M.D.
Colleen H. Neal, M.D.

2007–2008 ACR Officers

Front row, left to right, Barry D. Pressman, M.D., President; Arl Van Moore Jr, M.D., Chair. Back row, James H. Thrall, M.D., Vice Chair; Jeffrey C. Weinreb, M.D., Vice President; Alan D. Kaye, M.D., Vice Speaker; Paul H. Ellenbogen, M.D., Secretary-Treasurer; David C. Kushner, M.D., Speaker.

Economic Strategies Close Out Conference

Economic issues took center stage on the third day of the conference, as members focused on the complicated world of medical reimbursement.

BILLING CONCERNS

"Radiology and imaging reimbursements are still at great risk," John A. Patti, M.D., told the members as he launched a discussion of the ACR's major economic concerns.

Among them are growing questions around how to bill radiology assistants' (RA) time. The rules governing what procedures RAs can do, how they should be supervised, and how practices will be paid for their work is unclear. "If this continues the same way, billing for radiology assistants is going to become a complicated morass," said Patti, chair of the ACR Commission on Economics.

The ACR also supports Medicare rules requiring physicians to be financially independent of facilities to which they refer patients. Such rules might prevent kickback schemes as the one alleged to have occurred in Illinois early this year. In that case, the Illinois Attorney General claimed that doctors paid imaging centers one amount for procedures but billed insurers for a larger amount, pocketing the difference.

WAYS TO IMPROVE CODING

Richard L. Duszak, M.D., offered members a glimpse of the mechanism by which Medicare decides codes for different procedures. About 200 new codes are added each year. Last year, the ACR sponsored or co-sponsored 85 new codes, 22 deletions, and four editorial revisions.

Duszak also offered suggestions for improving coding, including careful documentation. "It's not mistakes, but what you do when you find them," he said.

BE AT THE TABLE

Christopher G. Ullrich, M.D., chair of the ACR's Managed Care Committee, suggested that radiologists who build relationships with managed care companies and intervene early will have the most success staving off problems and working out fair payments for new procedures. "If you're not at the table, then you're on the menu," he said.

At the local level, Ullrich advises radiologists to approach major payers and ask for input. "Ask to be on an interdisciplinary panel," he suggested. "Ask for a dedicated radiology panel."

CHANGING VALUE

Reimbursements may change drastically if a movement to redefine how services are valued in the Resource-Based Relative Value Scale (RBRVS) goes ahead, reported Bibb Allen Jr., M.D. The RBRVS is one way that Medicare determines reimbursements, and it has generally been good to radiologists, he said. However, it's an easy target for cost-cutters because slight changes in the formula can have a big impact.

Changes to the RBRVS might range from tweaking the formula to an overhaul of the committee that oversees the system. "Challenges always present opportunities," Allen said. "This is an opportunity to define ourselves."

MEDICARE'S HUMAN FACE

James V. Rawson, M.D., advised radiologists who want to influence reimbursements to add input to the charge data at the hospitals where they work. Such data is used to set the hospital outpatient prospective payment system, another system that Medicare uses to decide physician reimbursements.

Rawson also recounted a story that put a human face on Medicare, rare during a session focused more on bureaucracy. He said that in a meeting, he and another doctor complained about a recent reimbursement decision on Medicare's part that they believed might hurt access to care.

"Then we went and had lunch," he said. "(Meanwhile) they sat through lunch and reanalyzed all the data … they were worried they had done something to harm Medicare beneficiaries."

"And we were wrong. The procedure in question had gone up in use."

WHERE ARE THE STUDIES?

Frank J. Lexa, M.D., M.B.A., detailed the fast-rising movement toward pay for performance and shed some doubt that it will work to lower costs or raise quality. As of 2007, 110 pay-for-performance programs are in place nationwide, he said.

"But how many peer-reviewed studies show improved patient outcomes for radiology?" he asked. His answer: "None." However, doctors who participate in a pay-for-performance program by providing data on quality of care can receive a 1.5 percent rebate on their total Medicare reimbursement.

BORGSTEDE RECEIVES THORWARTH AWARD

James P. Borgstede, M.D., FACR, is the 2007 recipient of the William T. Thorwarth Jr., M.D., Award for Excellence in Economics and Health Policy.

Borgstede began his tenure with the Commission on Economics in 1999 as the ACR's advisor to the AMA Relative Value Scale Update Committee (known as the RUC), where he was well-liked and respected by other specialty advisors and staff for his diplomacy and fairness. Universally known as a strong ACR advocate for membership participation in the RUC surveys that help value new CPT® codes, he wrote the famous presentation, "Just Seven Easy Questions."

While serving on the RUC, Borgstede also became advisor to the AMA's Practice Expense Advisory Committee, attending meetings and presenting radiology code-specific practice expense data. In 2001, Borgstede followed James Moorefield, M.D., FACR, as the ACR representative on the RUC. He carried on a tradition of dedication and diplomacy established by his predecessor, garnering respect and stability for radiology among committee members.

Borgstede continued in this role throughout much of his term as chairman of the ACR Board of Chancellors (BOC). In fact, as chair of the BOC, Borgstede would often refer to himself as "just an economics guy." Bordstede's extensive knowledge and understanding of the ACR's socioeconomic and health policy issues were a great asset when he took the leadership role in advocating for the ACR's Designated Physician Medical Imager legislation on Capitol Hill, with the membership, to other specialties, and to the media.

James P. Borgstede, M.D., accepts the William T. Thorwarth Jr., M.D., Award. Shown with him are Pam Kassing, ACR senior director, Economics and Health Policy, John A. Patti, M.D., and William T. Thorwarth Jr., M.D.

The Thorwarth award was created in 2004 by the ACR's Commission on Economics to honor members or staff who show extraordinary leadership, diplomacy, and integrity in the field of economics and health policy. The award is not given annually, but rather, whenever a deserving individual is recognized.

Edmund F. Haislmaier, M.D.

HAISLMAIER SPEAKS ON STATE HEALTH REFORM EFFORTS

State health reform efforts offer the promise of successful, transformative change for the U.S. health care system, said Edmund F. Haislmaier, senior research fellow in health policy at the Heritage Foundation in Washington, D.C.

State reforms, such as those enacted in Massachusetts, that realign incentives so that the system is answerable to the consumer, could save money in the long term or improve quality, or both, said Haislmaier.

Many states are planning to follow the Massachusetts lead, but near-term action at the federal level is unlikely, Haislmaier said. First, with control of Congress and the presidency up for grabs, it's unlikely that either party will emerge from the next election with a clear mandate for change. Second, he said, the federal government doesn't have the money for new initiatives and will have even less as the Baby Boom generation starts retiring.

However, state reforms may eventually prompt federal action, he said, noting that welfare reform worked in that fashion. Three states have reform plans waiting in the wings: South Dakota, Kansas, and Montana. Others, including Washington, Missouri, New Mexico, and Maryland, are at various stages along the reform path.

Massachusetts established a health exchange, through which consumers, not employers, choose their health care plans. Because people tend to stick with plans that they chose, Haislmaier said, such an arrangement may end up giving insurers a strong incentive to keep their customers healthy.

Massachusetts also required everyone in the state to buy health care coverage, subsidizing those who could not afford it.

NCRP Annual Meeting

Updates Presented on Radiation Protection

Editor's note: *The 43rd annual meeting of the National Council on Radiation Protection & Measurements was held April 16-17 in Arlington, Va. Highlights from the keynote address by James A. Brink, M.D., and from papers presented by Fred Mettler Jr., M.D., titled, "Magnitude of Radiation Uses and Doses in the United States: NCRP Scientific Committee 6-2 Analysis of Medical Exposures," and Richard L. Morin, Ph.D., "Research Involving Human Subjects," are presented here.*

Medical imaging has transformed the practice of medicine as imaging studies increasingly replace more invasive, and often more costly, techniques for any number of indications. However, the amount of radiation the U.S. population receives from medical imaging has risen 750 percent in the last 25 years, according to the preliminary results of a report of the medical subgroup of the National Council on Radiation Protection & Measurements (NCRP).

HOW MUCH HAS IMAGING GROWN?

Medical imaging may now be the largest source of radiation exposure in the United States, topping natural sources, said ACR Fellow Fred A. Mettler Jr., M.D., of the New Mexico Federal Regional Medical Center. The collective annual dose of radiation from radiology and nuclear medicine is 930,000 person-Sv, he estimated, while the dose from natural background sources may be less than 900,000 person-Sv.

Mettler presented the results April 16, at this year's National Council on Radiation Protection & Measurements conference in Arlington, Va. The full report is likely to be published in 2008. "I don't think most radiologists have a clue about how much this has grown," he said in an interview after the presentation.

The American College of Radiology (ACR) also released on April 16 the "ACR White Paper on Radiation Dose in Medicine," a far-reaching and extensive set of recommendations designed to counteract medical and societal trends that have contributed to any increased radiation dosage that Americans may experience as this beneficial technology advances.

The paper advocates 33 separate measures, including a plan to educate patients, doctors, and others in the principles of radiation safety and appropriate use of imaging, as well as a dose index registry, which is now in progress. The ACR has long been involved in other efforts to make medical imaging safe, such as publishing guidelines and technical standards and offering accreditation programs and a patient education Web site, **www.radiologyinfo.org**, a cooperative effort with the Radiological Society of North America (**www.rsna.org**).

The size of the increase in the collective annual dose was a surprise to many who attended the conference. The increase stems from the growth in the number of scans being done, and from larger doses delivered by new kinds of scans. CT scans deliver the largest portion of the annual collective dose, 440,000 person-Sv, with chest and abdominal/pelvic scans delivering the largest shares, 17 percent and 58 percent respectively, of that number. Nuclear medicine procedures account for 220,000 person-Sv of the collective dose, with cardiac studies accounting for more than 85 percent of that total.

Between 1993 and 2006, the number of CT scans grew by more than 10 percent a year, to 62 million scans annually. Multislice CT scanners deliver higher doses of radiation than single-slice scanners, though it's hard to estimate the doses that patients receive because different machines in the hands of different practitioners deliver doses that vary by as much as a factor of 10.

THE NEED FOR STANDARDIZATION

The widely varying dose demonstrates the need for standardization, said Richard L. Morin, Ph.D., of the Mayo Clinic in Jacksonville, Fla., ACR fellow and chairperson of the ACR's Dose Index Registry Committee. Morin gave an afternoon presentation on regulations and ethics governing research using human subjects. He noted that with the exception of mammograms, the size of the doses delivered during scans is largely unregulated.

"If you're concerned about the dose of the scans, the safest place to be is in a study, where doses are regulated," Morin said. "If you want your kid to get low-dose scans, get him into a research study," he said.

In one case, that of CT colonography, the requirements for a low-dose scan for a research study led to the wider adoption of the low-dose scan in other situations. The strict regulation of studies means that human subjects are now well-protected, Morin said.

WHEN TO ORDER IMAGING

Mettler and ACR Fellow James A. Brink, M.D., of Yale University, who was the conference keynote speaker, both advocated more quality standards in medical scanning as one antidote to the increasing dose of radiation, though it's unclear what form those requirements should take. Regulation of mammography has been cumbersome, according to Mettler. "But it's upped the quality for women," Mettler said.

Brink suggested that what's needed now are diagnostic algorithms that indicate when a test ought to be used. Some facilities have begun incorporating such guidelines into the computer systems used to order tests. Also, many facilities and many private payers have already incorporated ACR Appropriateness Criteria® into their imaging decision-making process as well.

A large part of the problem may be the lack of knowledge on the part of patients and doctors, especially nonradiologists, about the potential dangers of radiation. Mettler noted that many emergency room physicians routinely order multiple scans on trauma patients without stopping to consider the amount of radiation that a patient may be exposed to.

In order to alleviate this lack of knowledge regarding radiation safety, the ACR white paper advocates that nonradiologist providers receive more radiation physics training as part of their medical education.

RECOMMENDATIONS FOR RADIOLOGISTS*

- The ACR should support the current multiorganizational effort to improve radiology resident training in medical physics.
- The ACR should include additional questions on radiation safety and patient dose in its Annual In-Training Examination.
- The ACR should request that the American Board of Radiology consider requiring at least one self-assessment module on patient safety, to include radiation dose, every 10 years as an integral part of the maintenance of certification.
- The ACR should develop and implement maximum radiation dose estimate pass/fail criteria for the ACR CT Accreditation Program.
- The ACR should review and update the CT Accreditation Program's recommended scanning protocols on a routine basis and make them available on its Web site.
- The ACR should request that the editor of the *Journal of the American College of Radiology* (*JACR*) add a monthly column on patient safety (to include radiation exposure issues).
- The ACR should create a prominent safety link on its Web site's home page to facilitate access to this information and to demonstrate the priority given to patient safety.
- The ACR should include in its *Practice Guidelines and Technical Standards* additional considerations for special radiosensitive populations, such as children and pregnant and potentially pregnant women.
- The ACR should encourage radiology practices to record all fluoroscopy times, compare them with benchmarks, and evaluate outliers as part of ongoing quality assurance programs.
- The ACR should encourage radiology practices to define a surveillance mechanism to identify patients with high cumulative radiation doses due to repeated imaging.

*Thirty-three recommendations addressing radiation dose were developed by members of the ACR Blue Ribbon Panel on Radiation Dose in Medicine, a panel convened by the chairman of the ACR Board of Chancellors. These recommendations cover the following areas: measurements, referring physicians, radiologists, technologists, patients, medical physicists, vendors and regulatory agencies, accrediting bodies, and third-party payers. Only the recommendations for radiologists are printed here. To read the remaining recommendations and the white paper that was printed in the May 2007 issue of *JACR* titled, "American College of Radiology White Paper on Radiation Dose in Medicine," visit **www.acr.org/SecondaryMainMenuCategories/quality_safety/white_paper_dose.aspx**.

ADVOCATE

DEFINING THE VOICE OF RADIOLOGY

Economic Chairman's Report

John A. Patti, M.D.

CMS and Radiologist Assistants

Although fewer than 400 radiologist assistants (RAs) currently provide services in the United States, their numbers are expected to increase substantially as more programs are created and more practices consider the benefit that these advanced-level technologists can provide to patient care. Therefore, it is important that radiologists understand the current Medicare rules governing claims submission and payment for services performed by RAs, and stay informed on the ACR's efforts to create rational changes in those regulations.

An RA can provide services in a hospital, in a radiologist's office, or in an independent imaging center. RAs can be employed by a hospital, a radiology group, or an independent imaging center. An RA can perform services that are identified by CPT® codes comprising both the technical and professional components (70000 series), as well as services identified by so-called surgical or nonimaging CPT codes (non-70000 series). The combination of these numerous scenarios can be represented by a grid or spreadsheet that contains 16 cells (see table). The Centers for Medicare and Medicaid Services (CMS) rules governing these cells are sufficiently diverse that they require careful study and understanding. In addition, the term "supervision" has different meanings depending on the context in which it is used.

The Medicare rules governing supervision apply only to performance of the technical component of diagnostic tests (70000 series CPT codes) in a nonhospital setting.[1]

The supervision levels recommended by the American Registry of Radiologic Technologists (ARRT) in its role-delineation document[2] refer to standards of education and certification that have been jointly developed by ARRT, ACR, and the American Society of Radiologic Technologists (ASRT). The supervision that may be required in hospitals is usually governed by state licensing regulations, JCAHO regulations, and hospital medical staff policy. The supervision described by *Current Procedural Terminology*® in the title of certain imaging codes refers to a requirement that the interpreting radiologist provide both the "supervision and interpretation" of the professional component (PC) of those procedures regardless of where they are performed.[3]

When a nonimaging procedure (non-70000 CPT code) is performed by a physician in a hospital, CMS requires the physician performing that procedure to submit the claim for payment under the Medicare Physician Fee Schedule (MPFS). For the

same procedure, CMS requires the hospital to submit the claim for its services to outpatients for payment under the Outpatient Prospective Payment System (OPPS), and for inpatients, under the Diagnostic Related Group (DRG). When an RA performs such a procedure in a hospital, CMS considers the services of the RA to represent hospital services, even if the RA is employed by the radiology group, and will pay for those services only under OPPS or DRG. If a radiologist submits a claim to the MPFS for a hospital procedure performed by an RA, it could be considered a fraudulent claim.

When an RA performs an imaging procedure (70000 CPT code) in a hospital, the hospital submits the technical component (TC) claim for that procedure to the Medicare contractor in the usual manner. CMS supervision rules do not apply to the TC in this situation. If the RA provides supervision for a specifically designated "supervision and interpretation" code or provides a portion of the professional component such as GI fluoroscopy, the radiologist performing the interpretation must use the –52 (reduced services) modifier when submitting the PC claim.

When an RA performs a nonimaging procedure in a nonhospital setting, strict rules[4] govern whether the radiologist can bill Medicare for the procedure. If the RA's services are "incident to" billable services rendered by the radiologist and *all* the criteria[4] of such "incident to" services are met, it *may* be possible, in selected cases, for the radiologist to submit a valid claim. CMS officials have stated clearly that performance of a procedure by an RA, requested by a referring physician, does not meet the "incident to" requirements.

When an RA performs an imaging procedure in a nonhospital setting, the same rules apply to the PC as in the hospital. For the TC, or the TC portion of the global claim, the CMS supervision rules must be obeyed. Currently, there are several imaging procedures, represented by approximately 40 CPT codes, for which ACR, ASRT, and ARRT have deemed direct supervision (physician in the office suite) appropriate but for which CMS still requires personal supervision (physician in the room).

For some time, the ACR has been engaged in discussions with CMS and has made a specific proposal for changes that we were led to believe would occur in late 2006. The bureaucracy is such that we were required to meet again in April with the Acting Director, Center for Medicare Management; Acting Director, Hospital and Ambulatory Policy Group; and other CMS staff to restate the proposal. Until CMS responds to our request, the TC for nonhospital imaging services that require personal supervision of the RA cannot be billed to Medicare unless the radiologist is in the room during the procedure.

At our April meeting with CMS, we discussed the confusion that will prevail due to the complexity and diversity of rules that govern, but were not specifically intended to apply to, RAs. At that time, we also proposed possible solutions that could simplify claim submission, eliminate the risk of unintended fraudulent claims, and provide CMS a mechanism to track the volume of services provided by RAs for future policy development. In the near future, the ACR will pursue these proposals within the appropriate regulatory and legislative processes.

For a comprehensive discussion of all other aspects related to RAs, I strongly urge you to read the upcoming article by Paul Ellenbogen, M.D., et al., in the July 2007 issue of the *Journal of the American College of Radiology*. ◆

References

1. Centers for Medicare & Medicaid Services. Medicare Carriers Manual, Part 3 – Claims Process, Transmittal 1725. Available at www.cms.hhs.gov/transmittals/downloads/R1725B3.pdf. Accessed May 15, 2007.
2. American Registry of Radiologic Technologists. Registered Radiologist Assistant Role Delineation, January 2005. Available at www.arrt.org/index.html?content=radasst/raintro.htm. Accessed May 11, 2007.
3. *Current Procedural Terminology* (*CPT*®), American Medical Association, Chicago, 2006:286.
4. Centers for Medicare & Medicaid Services. Medicare Carriers Manual, Part 3 – Claims Process, Transmittal 1764, Sec 2050. Available at www.cms.hhs.gov/transmittals/downloads/R1764B3.pdf. Accessed May 11, 2007.

	Hospital		Nonhospital	
	Hospital Employee	**Radiology Group Employee**	**IDTF* Employee**	**Radiology Group**
70000 Global	N/A	N/A	Supervision rules apply. IDTF bills MPFS with –52 modifier.	Supervision rules apply. Group bills MPFS with –52 modifier.
70000 TC Only	Hospital bills OPPS/DRG. Supervision rules do not apply.	Hospital bills OPPS/DRG. Supervision rules do not apply.	Supervision rules apply. IDTF bills MPFS.	Supervision rules apply. Group bills MPFS.
70000 PC Only	Radiologist bills MPFS with –52 modifier.	Radiologist bills MPFS with –52 modifier.	Radiologist bills MPFS with –52 modifier.	Radiologist bills MPFS with –52 modifier.
Non-70000	Hospital bills OPPS/DRG.	Hospital bills OPPS/DRG.	IDTF bills MPFS only if all conditions for "incident to" service are met.	Group bills MPFS only if all conditions for "incident to" service are met.

*Independent Diagnostic Testing Facilities

Spotlight on Rep. Carolyn McCarthy

Advocating for Medical Imaging

On March 1, 2007, Congresswoman Carolyn McCarthy (D-N.Y.) introduced H.R. 1293, the Access to Medicare Imaging Act of 2007, which would put a two-year moratorium on the reductions to Medicare physician payments for advanced diagnostic imaging services. Congresswoman McCarthy represents the 4th District of New York, which has one of the highest percentages of women diagnosed with breast cancer. She understands the value of diagnostic imaging and is hoping to repeal the harmful cuts made to imaging services so that all patients have access to quality health care in the future.

Before getting elected to Congress in 1996, Congresswoman McCarthy had a long, successful career as a nurse. Her firsthand experience in health care has made her a tireless advocate for both providers and patients.

ACRA™ staff recently interviewed Rep. McCarthy regarding her role on health care policy in the House and what changes she expects with the new Democratic majority in terms of health care legislation. Following are excerpts from this interview.

Q: As a member of the new Democratic majority, what do you think will be the top legislative priorities in health care in the 110th Congress?

Ensuring that all Americans have access to health care will certainly be a priority. Reducing dramatically the number of uninsured or underinsured in the United States is of critical importance to the well-being of our nation as a whole.

Q: Last year you introduced legislation to repeal the imaging cuts included in the 2005 Deficit Reduction Act (DRA). What inspired you to champion this fight on behalf of the imaging community, and what type of role do you envision playing on this specific issue in this Congress?

I was approached by a group of radiologists from my congressional district about the problem in February 2006. The fallout from the DRA cuts are far-reaching — the fact that many imaging services performed in outpatient imaging centers were being reimbursed below cost before the cuts went into effect puts even more strain on providers' ability to perform Medicare and Medicaid services. Unfortunately, these cuts were enacted on January 1 of this year, but even more unfortunately, they were enacted without ever investigating the impact of these cuts on seniors' access to needed health care.

H.R. 1293, the Access to Medicare Imaging Act of 2007, places a two-year moratorium on those cuts and requires that the Comptroller General of the United States perform a study on the impact of these cuts.

Representative McCarthy discusses issues with Harvey Neiman, M.D., Arl Van Moore Jr., M.D., and James H. Thrall, M.D., during the Fourth Annual RADPAC® Gala.

Q: How important is it to you to hear from the constituents in your district about legislative issues? What type of role does their input have on how you prioritize legislative issues that are important to you?

I get the sense that constituents often underestimate their power over us as legislators, and I frequently remind them how important it is to let us know if they feel an issue is important. Contact from a constituent is often what makes the difference between my simple support of an issue and my co-sponsorship of legislation to support that issue. My priorities are my constituents' priorities, as is evidenced by my introduction of H.R. 1293. My constituent radiologists contacted me about one of their priorities, and it became one of my legislative priorities. ◆

Representative McCarthy gathers the New York delegation at the RADPAC® Gala.

RADPAC
Chairman's Report

James H. Thrall, M.D.
RADPAC Chair

RADPAC® enjoyed a record-breaking first quarter in 2007 by raising more hard money ($290,000) and hard and soft money combined ($340,000) than in any other year. Much of RADPAC's growth can be attributed to entire group practices signing on to contribute to RADPAC. This is often done by electronic wire transfer of funds and has proven to be an effortless way to get whole practices to contribute to RADPAC.

In addition, the RADPAC board has started a pilot program to target the biggest practices within select states. The states involved in this pilot program are Arkansas, Florida, Idaho, Illinois, Maryland, Michigan, Minnesota, Mississippi, Oklahoma, Oregon, Tennessee, Washington, and West Virginia. To date, more than 30 practices have 100 percent of their radiologists contributing to RADPAC.

The money that RADPAC has raised has helped it become more visible on Capitol Hill. Already this year, RADPAC has attended more than 100 fundraisers for members of Congress and has hosted fundraisers for Rep. Ron Lewis (R-Ky.), Rep. George Radanovich (R-Calif.), Rep. Charles Boustany, M.D. (R-La.), Rep. Adam Putnam (R-Fla.), Sen. Blanche Lincoln (D-Ark.), Sen. Jay Rockefeller (D-W.Va.), and Rep. Xavier Becerra (D-Calif.). One of the ways to keep key radiology issues such as imaging reimbursement on the legislative forefront is to educate congressional members and their staff at fundraising events.

RADPAC continues to work with the new congressional leadership and will continue to fight for legislative fixes for appropriate reimbursement for imaging services. On March 1, Congresswoman Carolyn McCarthy (D-N.Y.) introduced H.R. 1293, the Access to Medicare Imaging Act of 2007. This bill is a continuation of the ACR's fight against the imaging cuts that were included as part of the Deficit Reduction Act of 2005.

Another RADPAC focus this quarter was to make RADPAC more attuned to contributors' needs and interests. Several new resources were instituted to do just that. For example, each month, a survey question will be posted on the RADPAC Web site, **www.radpac.org**, which will be used to gather information ranging from contributors' needs to identifying RADPAC's strengths and areas for improvement. RADPAC has also created an "Ask RADPAC" feature that will allow you to ask specific questions or request RADPAC information for presentations at chapter and practice meetings.

Throughout the rest of the year, RADPAC will list the top three performing states based on both total contributors and percent of contributors in an effort to recognize states for their outstanding support.

If you have any questions, please contact Ted Burnes, director of RADPAC and political education at (888) 295-8843 or **tburnes@acr.org**, or e-mail Heather Kaiser at **hkaiser@acr.org**. ◆

RADPAC®— Another Successful Evening

ACRA™ and RADPAC hosted the Fourth Annual RADPAC Gala to recognize contributors to what has become one of the most well-respected and influential medical specialty political action committees in the United States.

During the gala, Rep. Carolyn McCarthy (D-N.Y.) was presented with the Congressional Award for Radiological Excellence for her tireless efforts to improve the health care system and especially radiology.

Entertainment was provided by Jim Morris, political humorist.

RADPAC Chair and ACR Vice Chair James H. Thrall, M.D., presents the Congressional Award for Radiological Excellence to Rep. Carolyn McCarthy.

Capitol Hill Visits

More than 300 ACR members took three issues to U.S. senators and representatives on the final day of the conference:

1. **The DRA's draconian reimbursement cuts**, which were enacted in a conference committee session without public hearings — the ACR is pressing for a two-year moratorium on the cuts while their impact is investigated.
2. **The danger of a decline in access to mammograms** — a critical issue, as the Mammogram Quality Standards Act is expected to come up for reauthorization this year.
3. **The necessity of more funding for NIH's National Institute of Biomedical Imaging and Bioengineering** — funded at $298 million, the ACR is calling for a 2008 level of $350 million.

"This is a marathon, not a sprint," said Joshua J. Cooper, ACR senior director, Government Relations, reminding members that legislative change takes persistence — and years.

ACR members Jonathan Breslau, M.D., and Roger Thomas, M.D., talk with Rep. Xavier Becerra (D-Calif.) about issues affecting radiology.

Sen. Blanche Lincoln (D-Ark.), middle, meets with a group from the Arkansas Radiological Society in her Senate office.

Decoding How Antiangiogenic Drugs Work

Patients with recurrent malignant glioma face a poor outlook; even with the use of various chemotherapy regimens, they have a median survival of only four months. A new collaborative effort between the American College of Radiology Imaging Network (ACRIN®) and the Radiation Therapy Oncology Group (RTOG®) will investigate two treatment options for these patients and examine the role that imaging can play in evaluating the effectiveness of treatment.

The study, ACRIN 6677/RTOG-0625, A Randomized Phase II Trial of Bevacizumab With Irinotecan or Bevacizumab With Temozolomide in Recurrent Glioblastoma, will determine whether the drug bevacizumab, in combination with one of two other drugs, is effective in treating glioblastoma. A key part of this study will be exploring whether three different advanced MRI techniques can act as biomarkers by providing valuable information about patients' responses to treatment.

Researchers hope that targeting angiogenesis (the growth of new blood vessels) will make treatment of gliomas more effective. In these cancers, vascular endothelial growth factor promotes both angiogenesis and invasion of tumor cells. In an important component of the angiogenic process, endothelial cells invade the tumor. Bevacizumab is an antiangiogenic agent designed to interrupt the body's ability to grow new blood vessels and thus cause tumors to shrink. Preliminary information suggests that bevacizumab may eliminate poorly formed blood vessels in tumors, resulting in improved blood flow — which facilitates the delivery of chemotherapy agents.

ACRIN Principal Investigator Gregory Sorensen, M.D., from the A.A. Martinos Center for Biomedical Imaging at Massachusetts General Hospital, says, "This study marries advanced imaging techniques with one of the most important topics in oncology today: antiangiogenic drugs. We hope that by doing this study we'll understand better how antiangiogenic drugs work, how imaging can shed light on making decisions about therapeutic choices, and how to better develop improved treatments for cancer."

RESEARCH GOALS

The study, which will enroll 121 participants with recurrent glioblastoma, has two primary aims: to determine the efficacy of the combination of bevacizumab and irinotecan, as measured by the six-month progression-free survival rate in patients with recurrent glioblastoma; and to determine the adverse event profile and tolerability of the combination of bevacizumab and temozolomide in patients with recurrent glioblastoma. The advanced MRI substudy, which will be performed at a subset of participating sites, has two main objectives: to assess the potential role of perfusion MRI and MR spectroscopic imaging as early indicators of response to therapy after two weeks of treatment with bevacizumab; and to assess the potential role of perfusion MRI and MR spectroscopy as prognostic indicators based on images taken before treatment, two weeks after treatment, and after two cycles of treatment.

According to Sorensen, "We now have a new class of agents that seem to work in some people and not at all in others. There's quite a bit of interest in what mechanism these drugs might exert their beneficial effects through, and we'd like to answer that in a way that's robust and noninvasive. This study provides the tools to do so. It also meets ACRIN's goals because it's developing technically advanced imaging biomarkers to help identify mechanisms of therapeutic intervention."

Sorensen explains that the study grew out of the desire of the ACRIN Head and Neck/Central Nervous System Committee to identify advanced imaging biomarker tools that could be developed and perfected in a multicenter setting: "We had already identified three techniques we wanted to explore, and when we found out about this RTOG study, it just seemed like a perfect match. We had the tools, but we didn't want to develop them in a vacuum. Meanwhile, the neuro-oncologists had been concerned that if this drug succeeded, they wouldn't know why."

Structural MRI remains the standard for assessing both recurrence of glioblastoma and its response to treatment. Structural MRI, however, provides very little mechanistic information. A subgroup of participating sites will perform advanced MR imaging to gain insights into possible mechanisms of the action of bevacizumab combined with chemotherapy. This question is important because, when used alone in recurrent glioblastoma, each of the agents in this study has not shown substantial efficacy — but, in combination therapy, they appear to have significant effect.

Understanding how combination therapy might be effective will enable further advances in designing accurate treatment.

Because patients are already undergoing MRI as part of their regular cancer care, researchers will simply use advanced MRI techniques that can be easily added to the existing schedule of imaging. MR spectroscopic imaging can provide chemical information about the microenvironment in and around a tumor, and could identify regression of cancer markers that might suggest functional changes to the tumor.

Perfusion MRI can be used to quantify the passage of contrast agent into the tissue using a method called dynamic contrast-enhanced MRI. This method can provide estimates of the transfer constant of the agent across the vessel wall. Dynamic susceptibility contrast MRI can provide estimates of blood volume, blood flow, and, with certain methods, an estimate of average blood vessel size. Diffusion MRI can, in certain settings, identify early changes that suggest cytotoxicity.

Researchers hope these techniques will help them unlock the mechanisms of antiangiogenic drugs. Sorensen says, "In this study, ACRIN and RTOG are trying to change the paradigm of how drugs are developed. In the past, there were successes and failures. Now we're aiming to have *informed* successes and failures."

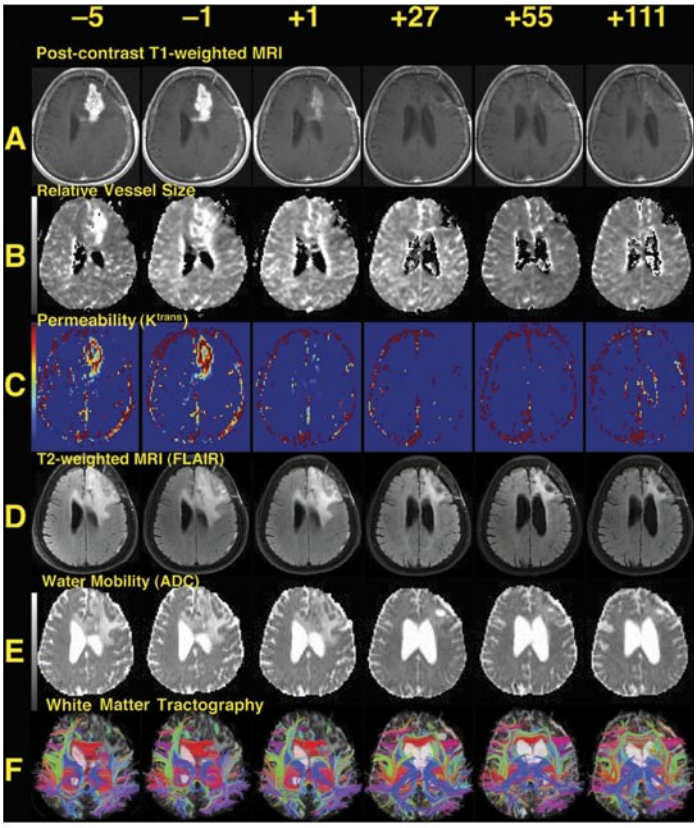

Figure 1. Representative Images From the Best-Responding Patient Receiving Antiangiogenic Therapy. (A) T1-weighted anatomic images after intravenous administration of a contrast agent (gadolinium-DTPA), demonstrating a region of bright signal corresponding to the recurrent brain tumor in the left frontal lobe shrinking over time. Note also the decreased mass effect on the left lateral ventricle. (B) Map of relative microvessel size, also showing decrease over time. (C) Maps of K^{trans}, a measure of blood-brain barrier permeability. Note the substantial change after the first dose. (D) T2-weighted images acquired with a fluid-attenuated inversion recovery sequence (FLAIR), where edema is seen surrounding the tumor enhancement evident in (A), also decreasing over time. (E) Images of apparent diffusion coefficient (ADC) demonstrating water mobility, which identifies areas of vasogenic edema as high (bright) signal surrounding the region of enhancing tumor; these also reduce over time. The displacement of the ventricle is also reduced over time. (F) Tractography. These images demonstrate directional water mobility suggesting the presence of white matter tracts. As the vasogenic edema decreases and the mass effect subsides, these white matter tracts become more evident. *All images are displayed per standard radiographic convention.*

SITES NEEDED TO PERFORM ADVANCED IMAGING

ACRIN 6677/RTOG-0625 is now accruing participants, and additional sites are welcome to participate. Sites where patients are enrolled and receive protocol treatment must be current RTOG members or affiliates. However, sites performing MRI do not have to be RTOG members. All sites enrolling participants in the ACRIN 6677/RTOG-0625 trial will coordinate the trial's baseline imaging component. In addition, sites have the opportunity to participate in the optional advanced imaging component that includes performing dynamic contrast-enhanced and/or dynamic susceptibility contrast MRI sequences along with MR spectroscopy. ACRIN staff is willing to help sites implement the specific imaging protocols needed for this study.

The full protocol and application information can be found at **www.acrin.org/6677_protocol.html**. Details on the advanced imaging requirements are described in the protocol's Appendix V. An RTOG site may collaborate with an independent imaging facility that meets all requirements for the protocol's imaging component. For more information, contact ACRIN 6677 Project Manager Bernadine Dunning at **bdunning@phila.acr.org**.

ACR Initiates National CAS Registry

Most facilities that perform carotid artery stenting (CAS) procedures are interested in quality improvement through peer comparisons, benchmarking, and reimbursement. Soon they'll have help with all three. This month, the ACR launches the ACR National Carotid Artery Stent registry (ACR-NCR™).

Designed to promote quality of care for patients undergoing a CAS procedure, the ACR-NCR will provide data on evidence-based health outcomes for decision-making processes. Its major goal is to provide the ability to define characteristics of ideal performance based on the national experience. These data will help model performance-based measures that contribute to optimal patient outcomes and help provide facility-specific feedback on performance. The registry will collect data elements needed for reporting to Centers for Medicare and Medicaid Services (CMS) to meet recertification requirements for CAS facilities.

To respond to CMS requirements (see sidebar), the ACR-NCR will begin collecting data from registered facilities this month. The registry will provide facilities with both confidential quarterly benchmarking reports that will allow them to compare their results with regional and national results and data quality reports to ensure that the data being collected are consistent and complete.

DEVELOPING THE REGISTRY

The ACR joined forces in a March 2005 meeting in Baltimore with other leading organizations to develop a data registry before the CMS issued its coverage decision on CAS procedures. The group discussed common data elements that CMS might endorse as a single mandatory national registry to capture all pertinent data related to CAS procedures. The group also discussed CAS registry "host engine" goals and objectives.

Other participating organizations included the American Academy of Neurology (AAN), American Association of Neurological Surgeons (AANS), American Society of Neuroradiology (ASNR), American Society of Interventional & Therapeutic Neuroradiology (ASITN), American College of Cardiology (ACC), Society of Interventional Radiology (SIR), Society for Vascular Surgery (SVS), and the Society for Cardiovascular Angiography and Interventions (SCAI).

The workgroup discussed at some length how the registry should be governed. At the time, all groups agreed that the registry should be independent of any single specialty society, and its control and governance should include representatives from all partner stakeholder organizations. All participants agreed that the multidisciplinary nature of this new procedure, its complexity, and its tremendous potential to benefit patients mandate that the registry must operate independently from the outset.

However, when CMS announced the CAS coverage decision the next day, it opted not to mandate a single "national CAS registry." Although all of the groups continued to work together to develop common data elements, it became clear that more than one CAS registry would be developed. Even before the initial multispecialty workgroup meeting, the SVS was only months away from launching its CAS data registry. And the ACC made a strong case to the workgroup that, given its long history of registry development, its "hosting" of the CAS registry would streamline implementation.

The registry will provide facilities with both confidential quarterly benchmarking reports that will allow them to compare their results with regional and national results and data quality reports to ensure that the data being collected are consistent and complete.

Due to concern that radiologists would not have a strong voice in governing a registry hosted by a nonradiology specialty group, the ACR, SIR, ASITN, and ASNR established a working group of interventional radiologists and neuroradiologists to develop data elements for an ACR-hosted registry. As with the SVS and ACC CAS registries, the initial framework of the ACR-NCR registry was based on a set of common data elements plus the goals and operating principles that were discussed during the workgroup meeting. In addition to these common data elements, the ACR-NCR

added a comprehensive set of data elements related to preprocedural imaging especially relevant to radiologists. Once the elements were finalized, beta testing for the registry began last month.

The availability of carotid artery stenting (CAS) techniques as an effective means of preventing strokes in high-risk patients represents a major advance for patients with carotid artery disease.

Additionally, the ACR-NCR formed a governance committee in March 2007 with members of SIR, ASITN, ASNR, and the ACR. One priority of this committee is to establish an intracranial stenting component to the CAS registry. ACR-NCR will be the *only* registry with this capability. The committee will also oversee the development of outcome reports that will allow facilities to compare their results with national benchmarks. And, the committee will continue to coordinate with CMS and other CAS registries in ongoing standardization efforts.

Facilities can begin to register for ACR-NCR on June 18 by visiting **www.ncr.acr.org**. For more information, e-mail Laura Coombs at **lcoombs@acr.org**.

CAS TECHNIQUES: HIGH-LEVEL SKILLS FOR HIGH-RISK PATIENTS

The availability of carotid artery stenting (CAS) techniques as an effective means of preventing strokes in high-risk patients represents a major advance for patients with carotid artery disease. Carotid stenting, a nonsurgical alternative to carotid endarterectomy, provides revascularization with a comparable or lower incidence of adverse events in high-risk patients when compared with surgery.

This technique involves practitioners from multiple specialties, including interventional radiology, neuroradiology, vascular surgery, and cardiology, and requires skills that few physicians currently possess. Because the target organ affected by this procedure is the brain, small errors or complications may lead to devastating consequences. Therefore, as this procedure becomes more widespread, it is essential to monitor procedures and clinical outcomes closely to ensure operator and institutional competence, as well as patient safety.

CMS CERTIFICATION IMPACTS REIMBURSEMENT

On March 17, 2005, the Centers for Medicare and Medicaid Services (CMS) issued a national coverage determination statement (NCD) that provides reimbursement of carotid artery stenting (CAS) procedures for a narrowly defined patient set (Pub. 100-3, 20.7). Visit **www.cms.hhs.gov/mcd/viewdecisionmemo.asp?id=157** for the full text of the decision. This determination also outlines several criteria, including mandatory data collection, upon which, coverage would be contingent. Specifically, the NCD for carotid artery stenting requires, *as a condition of coverage, that all facilities must be certified by CMS to perform CAS procedures.*

To become certified initially, facilities submit a written affidavit stating that they meet the minimum standards outlined in the NCD: physician training standards, standards for facility device inventory and support, and data collection to evaluate outcomes during a required re-evaluation period. The NCD also states that facilities will be expected to submit data to CMS upon request, and internal analysis of these data should occur at least every six months.

After reviewing submitted data elements, each facility will either maintain certification or no longer be certified by CMS to perform CAS procedures. Facilities that do not maintain certification will no longer be eligible for Medicare reimbursement for these services.

e-RADPEER™ Popularity Doubles

Evaluating the accuracy of interpretations should be part of any imaging department's quality-improvement program. The electronic version of the ACR's peer review program, e-RADPEER™, is becoming increasingly popular as a user-friendly way to help facilities with this process.

Developed to accommodate radiologists' busy schedules, e-RADPEER provides a simple and quick method of peer review. Within seconds, a colleague's interpretation of a study can be reviewed, scored, and submitted to the ACR via the Internet.

Today 3,340 radiologists at 180 facilities submit data electronically to the ACR. By comparison, 1,500 radiologists at 133 facilities use the program's paper version of RADPEER, which the ACR made available in 2002.

Since going live in August 2005, e-RADPEER has allowed radiologists to participate in an online peer review program while conducting routine interpretations of current images. If there are prior images of the same area when a new study is being interpreted, the current reviewer will review and score the previous study report and its related image, using a standardized four-point rating scale, with "1" indicating agreement with the previous interpretation and "4" indicating misinterpretation of the previous findings.

To submit scores electronically, the reviewing radiologist logs onto the e-RADPEER Web site, selects the "reviewed" physician from a drop-down list, scores the image by selecting the appropriate modality and number, and clicks the "send" button. To maintain confidentiality, facilities assign each radiologist a numeric identifier, such as physician #222. This number — not the physician's name — is used for scoring and for the individual radiologist reports. Only the radiologist's facility knows the actual names of the participating radiologists.

The e-RADPEER program provides the facility's medical director online access to reports for the individual radiologist and summary data for the facility, as well as comparison data from all participating facilities. The individual report also provides information on each radiologist's case submissions to e-RADPEER to ensure that all members of the practice are involved in the peer review process.

As of April 2007, facilities applying for ACR accreditation in CT, MR, nuclear medicine, PET, ultrasound, and breast ultrasound (excluding ultrasound-guided breast biopsy) are *required* to have a physician peer review program in place. Facilities may use their own peer review program instead of RADPEER, if they follow the criteria for an alternative program (a program equivalent to RADPEER) as outlined on **www.acr.org**.

All RADPEER data collected by the ACR — in print or electronic formats — are considered privileged and confidential peer review records of the ACR and subject to the legal protection of the Medical Malpractice Act of Virginia under Section 8.01-581 of the Code of Virginia. Facilities and practices, however, should be familiar with their own institutional policy and state law regarding the protection and confidentiality of peer review information. The ACR will work with facilities to ensure that RADPEER data remain confidential.

To learn more about this quality improvement tool, call (800) 770-0145, ext. 4490, or visit the Quality and Safety section of the ACR Web site (**www.acr.org**), where you can try out e-RADPEER and apply for the program.

"The backbone of our QA program is e-RADPEER. It compiles information in easy-to-understand reports and allows us to track by modality and reader. The process takes advantage of the fact that the radiologists view comparison films with current reads, and it is easy to use. The reports and program are monitored by the compliance officer, and the process involves no extra work for the radiologist. Hospitals are now requiring QA for their radiologists. Once e-RADPEER kick-started our program, we could meet the increasing demand for quality without extra time input."

—Linda Mercer, R.N., B.S.N., R.C.C.
Compliance Officer
Great Plains Radiology
Kearney, Neb.

Residents Take 2007 In-Training Exams

In its ongoing commitment to radiology education, the College administered its 30th ACR In-Training Examination for Diagnostic Radiology to 3,554 residents in February and its 24th In-Training Examination for Radiation Oncology to 572 residents in March. These exams, designed to measure general achievement for residents and program directors, are offered to all approved residency programs throughout the United States and Canada.

Institutions apply to participate in the exam, and the ACR recognizes the institution or site (hospital or university program) — not the individual resident — as the registrant for the exam. The In-Training exams are not intended as the only measure of an examinee's performance for qualification to any postgraduate program or certification. All scores are strictly confidential and are reported only to program directors, who may use the data to help analyze and evaluate residency programs.

Although exams are open to all residents at all training levels, senior residents and those who have already taken their boards are particularly encouraged to participate for an overview of the entire program.

IN-TRAINING FOR DIAGNOSTIC RADIOLOGY

Under the direction of Debra L. Monticciolo, M.D., chair of the ACR Committee on Residency In-Training for Diagnostic Radiology, the diagnostic exam covers the following areas: breast imaging, cardiac, chest radiology, gastrointestinal, general competency, genitourinary, interventional, musculoskeletal, neuroradiology, nuclear, physics, and ultrasound.

IN-TRAINING FOR RADIATION ONCOLOGY

Arnold C. Paulino, M.D., chairs the ACR Committee on Residency In-Training for Radiation Oncology. The following clinical subjects are included in the radiation oncology exam: gynecological tumors, lymphomas, pediatric tumors, and GI tumors. Brachytherapy, treatment planning, medical physics, and radiobiology are also covered.

Residents, mark your calendars for the 2008 exam dates: Diagnostic Radiology on Thursday, February 7, and Radiation Oncology on Thursday, March 6.

For more information, please call the ACR's education department at (703) 648-8900, ext. 4040, or visit the residents Web site at **http://rfs.acr.org**.

ACR Campus Courier Highlights Educational Opportunities

ACR Campus Courier, a monthly electronic newsletter featuring the latest educational opportunities, meetings, and events, premiered in April 2007. Designed to accommodate the busy schedules of ACR members, the e-newsletter provides a brief summary of ACR's newest online educational tools, upcoming conferences, timely lectures and seminars, new books and self-assessment tools, accreditation requirements, CME opportunities, and other information to keep ACR members up-to-date on the ever-changing radiology field.

Created jointly by the ACR's Education and Marketing, Communications & Public Relations departments, the *ACR Campus Courier* newsletter banner is designed with easily recognizable ACR Campus™ branding; text is abbreviated for quick and easy reminders.

Look for the *ACR Campus Courier* in your e-mail in-box every month.

For questions, please e-mail the education department at **acrcampus@acr.org**.

Why Patients Sue Their Radiologists

Bill Shields, ACR general counsel, and Tom Hoffman, ACR associate general counsel

Members often ask us why patients choose to sue their radiologists. The easy answer is that, with very few exceptions, patients do not think of any radiologist as "theirs." In fact, most patients don't even know the names of the radiologists who read their studies. Going even further down this path, many patients and other members of the public don't recognize that radiologists are physicians but instead think of them as highly specialized technologists.

Once again, we confront the fact that most diagnostic radiologists rarely "see" their patients. In fact, many patients think that radiologists are technologists because the tech is often the only medical professional with whom the patient comes into contact in a radiology facility. Over the years, this reality of radiology practice has generated concern over its potentially negative impact on the doctor-patient relationship and, ultimately, on the course of treatment.[1] However, the same lack of direct patient contact also can determine who is sued when there is a real or imagined injury to a patient.

Many doctors believe that because lawyers, rather than patients, choose which physicians to sue in a medical malpractice case, the doctor-patient relationship has no effect on the decision. While this is largely true, the first instinct of many lawyers is to take a "shotgun" approach and file against all physicians whose names appear in the chart or other record in relation to the treatment (or lack of treatment) of the claimed injury. Ignoring the psychological impact on the physicians involved, these lawyers rationalize that they can always drop an individual defendant if and when the facts become clearer. Meanwhile, there is always the possibility that a physician will simply make a settlement payment in order to get out of the case.

What's often not recognized is that while lawyers may decide who to sue, it is patients who most often decide who *not* to sue. Just as being sued is an emotional experience for physicians, deciding to sue is an emotional process for patients. When patients believe they have been harmed by substandard medical treatment, they usually seek a specific target for their ire. How do they choose the target? Anecdotal reports tell us that many patients are reluctant to bring claims against their obstetricians and gynecologists. This is thought to be because the patients have developed strong emotional ties with those physicians. When liability issues arise, if other specialists have been involved in her treatment, a patient may choose to target those other physicians, rather than the ob-gyn with whom she has developed a bond. The same may be true in any long-established physician-patient relationship.

Many doctors believe that because lawyers, rather than patients, choose which physicians to sue in a medical malpractice case, the doctor-patient relationship has no effect on the decision.

Unfortunately, radiologists almost always fall into this "other specialist" category. A patient who has never met or even heard of the radiologist does not have to overcome any guilt about suing a "friend" or trusted caregiver. It is just easier for patients to sue someone they don't know. It is also easier for patients to believe the physician they do know and trust when that physician says that the radiologist is the one who missed something or made a mistake and is therefore the one responsible for the misdiagnosis, the improper treatment, and ultimately, the claimed injury.

WHY IS THE PROBLEM SO HARD TO SOLVE?

So what is the solution to this problem? It's the same as it's always been — radiologists should meet, talk to, and get to know radiology patients. It seems almost too simple, yet it still proves difficult to implement in practice.

First, there is the issue of time. Meeting and talking to each patient, even briefly — before the study, after the study, or both — is quite time-consuming and certainly reduces the hours available for formal, uninterrupted diagnostic work.

Next is the issue of who actually interprets the study. Many current group practice arrangements may collect studies for later interpretation by a radiologist who is not present contemporaneously with the patient, thus making it difficult, if not impossible, to meet in person to discuss the study or results.

Then there is the issue of where the interpreting radiologist is physically located. In some practice settings, the interpreting radiologist isn't located on-site, so even if the radiologist is interpreting during or immediately after the study is completed, it is very difficult to make a face-to-face connection with the patient. Although the radiologist might be able to discuss the findings with the patient by telephone or computer, this is still not the same as meeting and establishing a formal relationship.

All of these factors are magnified in situations where group teleradiology is in routine use. In addition, nighthawk or dayhawk use can make it even more difficult for the patient to feel connected to either the radiologist or the radiology group. Even if the practice setup favors patient-radiologist interaction, some referring physicians strongly object to radiologists speaking directly to patients and specifically request that radiologists neither deliver reports to patients nor discuss the implications of the reports with patients.

Finally, there is the question of whether physicians choose diagnostic radiology as a specialty because they prefer not to deal directly with patients. While it is never wise to attribute a characteristic to all members of a large group, if this one is true for any significant percentage of diagnostic radiologists, it obviously affects the likelihood that they will voluntarily increase face-to-face contact to facilitate the doctor-patient bond.

A patient who has never met or even heard of the radiologist does not have to overcome any guilt about suing a "friend" or trusted caregiver. It is just easier for patients to sue someone they don't know.

THE SOLUTIONS

So what's the answer? As some commentators have suggested, the first step might be to include patient contact skills as part of all residency and fellowship training.[2] This would involve providing classroom training in the psychological aspects of interacting with patients and providing more opportunities for mentored patient contact. Additionally, as has been the case with integrating interventional radiologists into radiology groups, group leaders must be willing to restructure practice processes to provide patient contact time. This would involve allowing, and perhaps requiring, interpreting physicians to be on-site with patients for whom they are interpreting as well as insisting that those physicians meet with "their" patients.

None of this will be easy, and it will require leadership and resources to achieve such a significant change in radiology practice. However, such changes have the potential to improve the radiologist-patient relationship and thus reduce legal risk, while at the same time helping ensure the long-term survival of the profession.

REFERENCES

1. Gunderman R.B., Davilla J., Shetty S., Galdino G. Visibility Matters. *Journal of the American College of Radiology* 2005:971-4.

2. Halsted M.J., Perry L., Racadio J.M., Medina L.S., LeMaster T. Changing Radiology Resident Education to Meet Today's and Tomorrow's Needs. *Journal of the American College of Radiology* 2004:671-8.

The ACR Legal Department welcomes questions from members on general legal topics. We cannot provide specific legal advice but will answer questions that apply broadly to radiologists and their practices.
Please submit questions in writing to:

ACR Legal Office
1891 Preston White Drive, Reston, VA 20191
legal@acr.org

Coding Source Q&As

If a radiologist reviews previous images obtained from another (outside) facility in order to provide an interpretation for a current imaging study, can a separate charge be billed? The radiologist reviews the previous studies for comparative purposes to evaluate any change in the patient's condition.

When a radiologist reviews previous images performed either at the same institution or from an "outside" facility at the time that he or she interprets an "inside" study, it is not appropriate to code separately for the review of the previous examination. The review of an outside institutional examination is no different from reviewing old inside studies at the time the new inside service is interpreted. A comparison with old studies, when available, is an integral part of the interpretation of any study, regardless of where they were performed.

Is it appropriate to report a diagnostic breast MRI twice when a diagnostic breast MRI is performed on one day, followed by an MRI-guided breast biopsy procedure on the following day?

No, it is not appropriate to report a diagnostic MRI study code twice when a diagnostic MRI study is performed on one day, followed by an MRI-guided biopsy study on another day. CPT® codes 77058 and 77059 (formerly 76093 and 76094) are diagnostic MRI breast study codes. The diagnostic MRI code should be reported only once on the day it was performed. Code 77021 (formerly 76393) should be used to report the MRI guidance used for placement of a needle during a breast biopsy procedure. If a diagnostic MRI breast study is performed on the same day as the MRI-guided breast biopsy, it is appropriate to report the diagnostic MRI code and the MRI guidance code, as well as the appropriate surgical code for the breast biopsy.

The November/December 2006 *ACR Radiology Coding Source* and the March 2007 *ACR Bulletin* state that it is appropriate to report 3-D rendered angiography images using codes 76376 and 76377 when performed in addition to the base angiography procedure code. Please clarify this statement as this appears to be contradictory to what has been published previously by the ACR and AMA.

The statement that it is appropriate to report the 3-D angiography reconstruction images using codes 76376 or 76377 in addition to the base angiography procedure code does not contradict prior coding guidance published by the ACR and AMA. This statement refers to the reporting of 3-D imaging when performed in conjunction with *catheter* angiography. It does not refer to the reporting of 3-D with *computed tomography* or *magnetic resonance* angiography, where the 3-D rendering is incorporated into the base CTA and MRA codes.

What is the correct way to bill for a diagnostic mammography examination on a mastectomy patient when one or two additional films are taken of the axillary region on the mastectomy side when there is no obvious breast tissue?

A bilateral study should be reported when additional films are taken of the axillary region on the mastectomy side, even though there is no obvious breast tissue. This is analogous to a male mammogram, where there is little breast tissue. If there is enough clinical concern to warrant imaging of both the remaining breast side and the mastectomy side, there is probably clinical concern that a tiny amount of breast tissue remains at the mastectomy site.

Job Listings

The following job listings are paid advertisements. The ACR Professional Bureau cannot ensure complete accuracy of all information, and publication of a job listing does not constitute a recommendation by the ACR. The ACR and the ACR Professional Bureau assume no responsibility or liability for any personnel decisions and selections made by the employer.

These job listings have previously appeared on the ACR Professional Bureau Web site. Only jobs posted on the Web site are eligible to appear in the *ACR Bulletin*, on a space-available basis.

Rates: ACR members: $50 per ad, maximum 50 words. Nonmembers: $125 per ad, maximum 50 words.

Complete advertising policies, rate information, and other instructions are available on **www.acr.org** under the "Jobs/Career Development" tab.

Job listings are in order of state.

ARKANSAS - **Rogers** - General Diagnostic Radiologist - Radiology Associates P.A. - Seeking diagnostic radiologist for full-time position in northwest Arkansas. Sites include two hospitals and two clinics, which are equipped with CT (includes 64-slice scanner), MRI, US, mammo, and fluoro. Hospitals have PACS. **Contact:** Beverly Teasley by phone at (501) 686-2614 or e-mail C.V. to Shannon Turner at shannon.turner@comcast.net.

ARKANSAS - **Rogers** - Interventional Radiologist - Radiology Associates P.A. - Seeking interventional radiologist for full-time position in northwest Arkansas. Sites include two hospitals and two clinics, which are equipped with CT (includes 64-sl. scanner), MRI, US, mammo, and fluoro. Hospitals have PACS. **Contact:** Beverly Teasley by phone at (501) 686-2614 or e-mail C.V. to Shannon Turner at shannon.turner@comcast.net.

CALIFORNIA - **Huntington Beach** - Outpatient MR/CT Center Opening in S. California - MIMG Inc. - MIMG Inc. is a 23-year-old, outpatient imaging practice in Los Angeles and Orange Counties, concentrating on noninvasive MR/CT services with immediate opening in the Huntington Beach office. No night or weekend call. Fellowship training preferred. **Contact:** Keith Burnett by phone at (562) 498-6322.

COLORADO - **Colorado Springs** - Radiologist - Radiology and Imaging Consultants - Colorado Springs partnership-track position available. Join democratic subspecialty group performing over 250,000 exams/year at several outpatient centers and both adult and children's hospitals. Angiography and mammography not required. Excellent equipment, including 64-slice CTs. **Contact:** Karl Wolff, M.D., by phone at (719) 365-1178 or via e-mail at karl.jen@adelphia.net.

FLORIDA - **Crestview** - Diagnostic Radiologist - West Florida Radiology Associates P.A. - Excellent opportunity in northwest Florida. Hospital-based private practice. The first two years with a competitive base salary and a generous benefits package. Board certification/eligibility required. State license required. **Contact:** Patricia Hambley by phone at (850) 626-9942, by fax at (850) 626-5808, or via e-mail at westfl@mchsi.com.

FLORIDA - **Hollywood** - Chief Pediatric Radiologist - Radiology Associates of Hollywood – Excellent opportunity with large group. Three-year partnership or per diem. All pediatric subspecialties represented at children's hospital with new hospital planned. Competitive salary without buy-in, excellent benefits. **Contact:** Jill Avendano by phone at (954) 437-4800, ext. 2148, by fax at (954) 437-6628, or via e-mail at Jill.avendano@rahmail.net.

FLORIDA - **Hollywood** - Interventional Radiologist - Radiology Associates of Hollywood - Board-certified, fellowship-trained interventional radiologist with experience in all forms of intervention including biopsies, vascular, and endovascular intervention. Join our 10 interventional associates in a rapidly growing practice. **Contact:** Jill Avendano by phone at (954) 437-4800, ext. 2148, by fax at (954) 437-6628, or via e-mail at Jill.avendano@rahmail.net.

FLORIDA - **Jacksonville** - Cardiovascular Imager - University of Florida College of Medicine - Seeking fellowship-trained cardiovascular imaging (CT/MR) faculty, at the level of assistant/associate/full professor M.D. (or equivalent); BC/BE; and meet ACR, ACCF/AHA Level-3 standards. **Contact:** Paula Everett via e-mail at paula.everett@jax.ufl.edu or mail to Search Chair, Department of Radiology, 655 W. 8th St., Jacksonville, FL 32209. Reference #00023693. An E.O. institution.

FLORIDA - **Pensacola** - Diagnostic Imager - Radiology Associates of Pensacola - An eight-member group with strong hospital/outpatient practice seeks board-certified radiologists for a dynamic fellowship-trained group. Busy, expanding practice including five magnets, MDCT/CTA and PET/CT, and IDX-PACS. Practice includes the Andrews Institute. Night call taken by a teleradiology service. **Contact:** Karen Schell by phone at (850) 432-6851.

FLORIDA - **Pensacola** - Interventional Radiologist - Radiology Associates of Pensacola - Eight-member radiology group seeking an interventional radiologist to join a well-developed, expanding hospital practice. We have an established outpatient interventional radiology practice and vein clinic and provide AAA endovascular repair, chemoembolization, RFA, and UFE. Excellent benefits with short partnership. **Contact:** Karen Schell by phone at (850) 432-6851.

FLORIDA - **Titusville** - BC Radiologist - Space Coast Radiology Associates - Five-member group seeking personable BC radiologist for practice near Orlando. Fellowship preferred and skilled in all aspects of radiology, including interventional. Excellent equipment in new hospital with PACs. Call 1:5 with nighthawk. Early partnership/excellent vacation time. 50K signing bonus. **Contact:** Send C.V. to Richard Mayer via e-mail at rmayer5@gmail.com.

IDAHO - **Moscow** - BC/BE General Radiologist - Radiology Consultants - Well-established group of three seeking fourth (2007) and fifth (2008) for rapidly growing practice. New hospital, 16-slice CT, 1.5T MR, PACS, digital mammo, stereo. **Contact:** Joyce Romey by phone at (208) 882-8369; by fax at (208) 882-1887; via e-mail at jradcon@moscow.com; or mail to Radiology Consultants, P.O. Box 9105, Moscow, ID 83843.

MICHIGAN - **St. Joseph** - General Radiologist/Subspecialist - Radiology Associates Berrien Co. - Eleven general/subspecialty radiologists seeking one-two general radiologists with additional expertise in MSK, cardiothoracic, and/or angio/IR. PACS, Powerscribe, Vocada, nighthawk. One-year partnership track. 325K + benefits to start. **Contact:** Nathan Jordan by phone at (269) 982-4104 or via e-mail at njordan@lakelandregional.org.

MINNESOTA - **Bemidji** - Radiologist - MeritCare Health System - Seeking BC/BE radiologists to join expanding practice. All modalities performed. State-of-the-art equipment, including PACS, teleradiology, and nighthawk at 7 p.m. Practice in both clinic and hospital settings. Join 57-physician multispecialty group practice. **Contact:** Dick Reis via e-mail at Dick.Reis@meritcare.com or call our Physician Recruiting Office at (701) 280-4887.

NEW JERSEY - **Camden** - Body Imager/Angiographer - Lourdes Radiology Associates P.C. - Dynamic imaging practice seeks body imager/angiographer for immediate career growth opportunity. BC/board-eligible, fellowship-trained preferred with strong track record in either musculoskeletal, neuro imaging, and/or angiography. Competitive compensation and benefits package. **Contact:** Lourdes Radiology Associates P.C., Kathleen Greatrex, M.D., President, 1600 Haddon Ave., Camden, NJ 08103.

NEW YORK - **New York City** - Radiation Oncologist - Columbia University - The Department of Radiation Oncology at Columbia University Medical Center is searching for a radiation oncologist. Salary and academic rank commensurate with qualifications and experience. **Contact:** Philip Alderson, M.D., by fax at (212) 305-4835 or mail to Radiation Oncology, Columbia University, 622 W. 168th St., New York, NY 10032. Columbia University is an E.E.O/A.A. employer.

NEW YORK - **Orange, Sullivan, Suffolk Counties** - Radiologist - S & D Medical - 50-person hospital-based radiology group seeking radiologists for locations in Orange and Sullivan Counties, Nassau, N.Y.; and Suffolk Counties, Long Island, N.Y. All modalities. **Contact:** Kenneth Schwartz by phone at (914) 666-2220, fax at (914) 666-2987, or via e-mail at js@arksradiology.com.

NORTH CAROLINA - **Roanoke Rapids** - General Radiologist - Halifax X-Ray Associates - Board-certified radiologist needed for a hospital-based group private practice. Read all modalities including mammography and MRI. Located in the beautiful Roanoke Valley with Lake Gaston and the river at your back door. Competitive salary and full partnership in one year. **Contact:** Send C.V. by fax to (252) 535-1011 or e-mail C.V. to Bert Piggot at halifaxxray@telpage.net.

OREGON - **Portland** - Musculoskeletal Radiologist - EPIC Imaging P.C. - EPIC Imaging P.C. is the largest outpatient, multimodality imaging center located in Portland, Ore. We are seeking a full-time, fellowship-trained musculoskeletal radiologist to join our dynamic, progressive group of 16 radiologists performing 85,000+ exams yearly. Board certification/state license required to practice. **Contact:** Geral Warnock by fax at (503) 535-7001 or e-mail C.V. to hschopp@epicimaging.com.

PENNSYLVANIA - **Johnstown** - Body Imager - Cambria-Somerset Radiology and Nuclear Medicine Group Inc. - Fifteen-member group seeks strong body imager with either MR or multislice experience. We cover three hospitals and an imaging center. The center is a 50/50 joint venture performing approx. 15K MRs/year. Salary in top 2 percent nationwide. One year to partnership. **Contact:** Gary Kramer by phone at (814) 534-9591.

TEXAS - **Houston** - General Radiologist/Body Imager - Michael E. DeBakey VA Medical Center - **Contact:** Please send current C.V., a statement of interest, and names of three references to: Meena S. Vij, M.D., phone (713) 794-7725; fax (713) 794-7761; or mail to Diagnostic & Therapeutic Care Line Executive, Michael E. DeBakey VAMC, 2002 Holcombe Blvd., Mail code (114), Houston, TX 77030. E.O.E.

TEXAS - **Houston** - Interventional Radiologist - Michael E. DeBakey VA Medical Center - Seeking interventional radiologist. **Contact:** Send C.V., statement of interest, and names of three references to: Meena S. Vij, M.D., phone (713) 794-7725; fax (713) 794-7761; or mail to Diagnostic & Therapeutic Care Line Executive, Michael E. DeBakey VAMC, 2002 Holcombe Blvd., Mail code (114), Houston, TX 77030. E.O.E.

TEXAS - **San Antonio** - Neuro or MSK Radiologist - Sendero Imaging - Outpatient imaging center seeking a fellowship-trained neuro or MSK radiologist. General radiologists with Neuro/MSK experience. MRI, CT, plain film, U/S, bone density, NM, fluoro procedures, arthrograms, and myelograms. Current Texas license a plus. **Contact:** Olivia by phone at (877) 614-8899 or via e-mail at oullman@senderoimaging.com.

VIRGINIA - **Fairfax** - MSK, Neuro, Body, or Women's Imager - Reston Radiology - Partnership position available for fellowship-trained, ABR-certified musculoskeletal/body/neuroradiology or women's imager. **Contact:** Please forward C.V. to Stuart Fruman via e-mail at restonrad@gmail.com.

VIRGINIA - **Roanoke** - Radiologists - Carilion Clinic - Carilion Clinic is accepting C.V.s for ABMS/AOA-BC radiologists in all subspecialty areas for its 835-bed teaching/tertiary referral hospital with Level I trauma center, serving 1 million people. **Contact:** Rhonda Creger via e-mail at rhondac@carilion.com or mail to Rhonda Creger, Senior Physician Recruiter, Carilion Clinic, P.O. Box 40032, Roanoke, VA 24022-0032. A.A./E.O.E.

WEST VIRGINIA - **Charleston** - General Diagnostic Radiologist - Kanawha Valley Radiologists - Partnership income above 95th percentile with 15 weeks' vacation. Nighthawk coverage. Very generous starting package. Charleston is a beautiful, safe community with good schools; abundant cultural, outdoor, and sport activities; ample restaurants and shopping; and a mild four-season climate. **Contact:** James Baek by phone at (304) 342-3838 or via e-mail at jbaek@suddenlink.net.

WYOMING - **Casper** - General/IR radiologist - Casper Medical Imaging P.C. - Immediate opening in central Wyoming. Join an active interventional and general practice within Wyoming's largest diagnostic radiology practice. Outstanding professional satisfaction, first-class equipment, income potential at or above the 90th percentile, more than 15 weeks off each year, and partnership after 12 months. **Contact:** Geoffrey Smith by phone at (307) 234-6963.

WYOMING - **Lander** - General Radiologist - Wind River Radiology - Two-person practice with one radiologist retiring. 26 weeks of vacation. Work with very supportive clinicians and excellent equipment and techs. Remaining partner Stanford and Duke trained. Small town at base of Wind River Mountains with great hiking, climbing, riding, fishing, hunting, 26 weeks vacation, etc. No state income tax. **Contact:** Perry Cook by phone at (307) 332-5337.

ACR CAMPUS

http://campus.acr.org

ACR Calendar of Events

Pay for Performance: Road Map to Quality in Radiology Practice

July 16–17, 2007

Sun Valley Resort, Sun Valley, Idaho

With this two-day course, you'll become motivated to adhere to quality and efficiency standards, use information technology, and see higher patient satisfaction.

Second Annual Body MRI Update Course

October 13–14, 2007

The Wigwam Golf Resort & Spa, Phoenix, Ariz.

In this two-day course, you'll learn to create a more efficient body MRI practice, find out about the latest on contrast agents, and attend demonstrations by industry vendors on MRI hardware and software.

Cardiac CT: Supervised Review With California Radiological Society

October 20, 2007

Hyatt Newporter, Newport Beach, Calif.

Document 50 supervised case reviews, learn from a world-class faculty, earn CME credits, and satisfy the new ACR guidelines and accreditation requirements. New accreditation programs in cardiac CT and MR, to be released shortly, require participation in supervised cases and CME credits in cardiac imaging.

For more information on ACR's courses, visit **www.acr.org** and click on "Meetings and Events."
Or, call (800) ACR-LINE for additional information.

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See What's New at

www.acr.org

The ACR Web site has been redesigned to better meet *your* needs. The revised site is the direct outcome of member-driven research and suggestions. Premiering on June 1, the improved, streamlined format demonstrates less is more:

- More Streamlined Pages — Less Scrolling
- More Graphically Appealing — Less Cluttered
- More User-friendly — Less Confusing
- More Organized Navigation — Fewer Click-throughs
- More Personalized — Easier Customization

We listened to your issues and suggestions — and we want to hear more as we continue to work to make your Web site your preferred online destination. Visit **www.acr.org** and let us know what you think about *your* new Web site.

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