ACR 2020 FINAL COUNCIL ACTIONS REPORT

1 The ACR Council convened virtually on Sunday May 17, Monday, May 18, and Tuesday, May 19, 2020 via Zoom.
2 The sessions were attended by approximately 700 members.
3
4 The Council approved the following actions, which will be reflected in the Digest of Council Actions.

No.	RESOLUTION	TYPE	COUNCIL ACTION
1.	Ten-Year Extension of Policies (a) Commissions and Committees 1. Appointments to Commissions and Committees (b) Commissions and Committees 2. Representation of Related Organizations (c) Annual Council Meeting 5. Educational Topics for ACR Meetings (d) Education 2. Resident and Fellowship Training Programs a. Medical Physics Residency Training Program (e) Education 2. Resident and Fellowship Training Programs e. Residency Program in Socioeconomics (f) Education 4. Miscellaneous Education Policies	REVISED POLICY	ADOPTED
2.	ACR Practice Parameter for the Performance of Preoperative Image-Guided Localization in the Breast	NEW PP	REFERRED WITH INSTRUCTION
3.	ACR Practice Parameter for the Performance of Stereotactic/Tomosynthesis-Guided Breast Interventional Procedures	REVISED PP	ADOPTED AS AMENDED
4.	ACR–ACOG–AIUM–SRU Practice Parameter for the Performance of Sonohysterography **and Hysterosalpingo-Contrast-Sonography (HyCoSy)**	REVISED PP	ADOPTED
5.	ACR–AIUM–SPR–SRU Practice Parameter for the Performance of Scrotal Ultrasound Examinations	NEW PP	ADOPTED
6.	ACR–AIUM–SRU Practice Parameter for the Performance of Ultrasound Evaluation of the Prostate (and Surrounding Structures)	NEW PP	ADOPTED AS AMENDED
7.	ACR–AIUM–SRU Practice Parameter for the Performance of Diagnostic and Screening Ultrasound of the Abdominal Aorta in Adults	REVISED PP	ADOPTED
8.	Non-Physician Radiology Providers (NPRP) - Definitions	NEW POLICY	ADOPTED
9.	Roles of Non-Physician Radiology Providers (NPRP) – Policies, Parameters and Legislation/Regulations	NEW POLICY	ADOPTED AS AMENDED
10.	Interim Support Position for RRA Legislation and Regulation	NEW POLICY	Resolution 10 Split 10a. ADOPTED AS AMENDED WITH INSTRUCTION TO STAFF TO APPROPRIATELY RETITLE 10b. REFERRED TO BOC WITH INSTRUCTION TO REPORT BACK TO COUNCIL 2021

11.	Update to Existing ACR Policies on Radiologist Assistants	NEW POLICY	ADOPTED AS AMENDED
12.	Ten-Year Extension of Policies (a) Drugs and Equipment 5. Portable Image Media (CDS and DVDS) (b) Drugs and Equipment 7. Radiographically Identifiable Markers on Medical Devices (c) Professional Liability 3. ~~Tort~~ **Medical Liability** Reform (d) Workforce 1. Federal/State Restrictions (e) Radiological Practice and Ethics 1. Accreditation	REVISED POLICY	ADOPTED
13.	ACR–AAPM–**ACNM–SNMMI** Practice Parameter for Reference Levels and Achievable Administered Activity for Nuclear Medicine and Molecular Imaging	REVISED PP	ADOPTED
14.	ACR–**ACNM–SNMMI**–SPR Practice Parameter for the Performance of **Neuroendocrine** Tumor Scintigraphy ~~(with Gamma Cameras)~~	REVISED PP	ADOPTED AS AMENDED
15.	ACR–**ACNM–SNMMI**–SPR Practice Parameter for the Performance of Radionuclide Cystography	REVISED PP	ADOPTED
16.	ACR–**ACNM–SNMMI**–SPR Practice Parameter for the Performance of Gastrointestinal **Tract, Hepatic, and Splenic**, Scintigraphy	REVISED PP	ADOPTED
17.	ACR–ACNM–ASTRO–SNMMI Practice Parameter for Lutetium-177 (Lu-177) DOTATATE Therapy	NEW PP	ADOPTED AS AMENDED
18.	Sunset the ACR–SPR Practice Parameter for the Performance of Liver and Spleen	NEW POLICY	ADOPTED
19.	Supervising Radiologist Understanding for Imaging Indication	NEW POLICY	ADOPTED
20.	Extension of Review Cycle for One Practice Parameter	NEW POLICY	ADOPTED
21.	ACR Conflict of Interest Policy	NEW POLICY	ADOPTED
22.	Paid Family/Medical Leave in Radiology and Radiation Oncology Practices	NEW POLICY	WITHDRAWN
23.	Ten-Year Extension of Policies (a) Radiological Practice and Ethics 2. ACR Radiation Oncology Practice Parameters and Technical Standards (b) ACR Radiation Oncology Practice Parameters and Technical Standards 2. ACR Radiation Oncology Practice Parameters and Technical Standards y. Revision of Practice Parameters and Technical Standards Review Cycle (d) Radiological Practice and Ethics 5. Miscellaneous Radiologic Practice and Ethics Policies n. Conflict of Interest Disclosure (e) Radiological Practice and Ethics 5. Miscellaneous Radiologic Practice and Ethics Policies n. Efficacy (f) Technologists and Allied Health Professions 7. Other Non-Physician Radiology Providers (NPRP) Performing Fluoroscopic Procedures	REVISED POLICY REVISED POLICY	ADOPTED ADOPTED AS AMENDED

24.	ACR–SAR–SPR Practice Parameter for the Performance of Computed Tomography (CT) Enterography	REVISED PP	ADOPTED
25.	ACR–SAR–SPR Practice Parameter for the Performance of Magnetic Resonance Imaging (MRI) of the Abdomen (Excluding the Liver)	REVISED PP	ADOPTED AS AMENDED
26.	ACR–SAR–SPR Practice Parameter for the Performance of Magnetic Resonance (MR) Enterography	REVISED PP	ADOPTED AS AMENDED
27.	ACR–SAR–SPR Practice Parameter for the Performance of Magnetic Resonance Imaging (MRI) of the Liver	REVISED PP	ADOPTED AS AMENDED
28.	ACR–SAR–SPR Practice Parameter for the Performance of Magnetic Resonance Imaging (MRI) of the Soft-Tissue Components of the Pelvis	REVISED PP	ADOPTED AS AMENDED
29.	ACR–NASCI–SPR Practice Parameter for the Performance of Body Magnetic Resonance Angiography (MRA)	REVISED PP	ADOPTED AS AMENDED
30.	ACR–SPR–SSR Practice Parameter for the Performance and Interpretation of Magnetic Resonance Imaging (MRI) of Bone and Soft-Tissue Tumors	REVISED PP	ADOPTED AS AMENDED
31.	ACR–SPR–SSR Practice Parameter for the Performance and Interpretation of Magnetic Resonance Imaging (MRI) of the Knee	REVISED PP	ADOPTED AS AMENDED
32.	ACR–SPR–SSR Practice Parameter for the Performance and Interpretation of Magnetic Resonance Imaging (MRI) of the Shoulder	REVISED PP	ADOPTED AS AMENDED
33.	ACR–STR Practice Parameter for the Performance of High-Resolution Computed Tomography (HRCT) of the Lungs in Adults	REVISED POLICY	ADOPTED
34.	Mandatory Early Radiology Education for Medical Students by Radiologists	NEW POLICY	ADOPTED AS AMENDED
35.	RFS & YPS Standing to Submit ACR Resolution	NEW POLICY	ADOPTED
36.	Ten-Year Extension of Policies (a) Technologists and Allied Health Professions 14. Radiologic Technologists and Radiation Therapists	REVISED POLICY	ADOPTED AS AMENDED
	(b) Third Party Carriers and Compensation 13. Applicable CPT Codes for Patient Evaluation and Clinical Management (c) Third Party Carriers and Compensation 4. Balancing Billing (d) Third Party Carriers and Compensation 16. Mammography Screening Insurance Coverage (e) Third Party Carriers and Compensation 28. Reimbursement for Radiology and Radiation Oncology Services	REVISED POLICY	ADOPTED
37.	ACR Practice Parameter for Communication of Diagnostic Imaging Findings	REVISED PP	ADOPTED AS AMENDED
38.	ACR–SAR Practice Parameter for the Performance of Adult Cystography and Urethrography	REVISED PP	ADOPTED AS AMENDED
39.	ACR–SIR Practice Parameter for **Minimal and/or Moderate** Sedation/Analgesia	REVISED PP	ADOPTED AS AMENDED
40.	ACR–SIR Practice Parameter for the Performance of Angiography, Angioplasty, and Stenting for the Diagnosis and Treatment of Renal Artery Stenosis in Adults	REVISED PP	REFERRED
41.	ACR–**ACNM**–ASNR–**SNMMI** Practice Parameter for Brain PET-CT Imaging in Dementia	REVISED PP	ADOPTED AS AMENDED
42.	ACR–ASNR–SPR Practice Parameter for the Performance and Interpretation of Cervicocerebral Computed Tomography Angiography (CTA)	REVISED POLICY	ADOPTED

43.	ACR–ASNR–SNIS–SPR Practice Parameter for the Performance of Cervicocerebral Magnetic Resonance Angiography (MRA)	REVISED PP	ADOPTED AS AMENDED
44.	ACR–ASNR–SPR Practice Parameter for the Performance of Computed Tomography (CT) of the Head ~~Brain~~	REVISED PP	ADOPTED
45.	ACR–SPR Practice Parameter for the Safe and Optimal Performance of Fetal Magnetic Resonance Imaging (MRI)	REVISED PP	ADOPTED
46.	ACR–SPR Practice Parameter for the Performance of Contrast Esophagrams and Upper Gastrointestinal Examinations in Infants and Children	REVISED PP	ADOPTED
47.	Multispecialty/General Radiologist	NEW POLICY	REFERRED
48.	Article IX, Sections 1, 3, 5, 6, and 8	BYLAWS	ADOPTED AS AMENDED
49.	Article VIII, Section 4	BYLAWS	ADOPTED
50.	ACR Position on Certifying Bodies in Radiology	NEW POLICY	ADOPTED AS AMENDED

ADOPTED AS AMENDED

The following Resolution(s) presented to the 2020 Council of the American College of Radiology have been adopted as amended by the Council:

*(The amended language is specified by line numbers which correspond to the resolution as noted in the Reference Committee Reports. Language amended by the respective Reference Committee on Sunday, May 17, 2020 and Monday, May 18, 2020 is **bolded** reflecting **~~strikethrough~~** for deletions and **underline** for insertions in Blue. Language amended by the Council during deliberation on Tuesday, May 19, 2020 is reflected in RED.)*

Resolution No. 3 **ACR Practice Parameter for the Performance of Stereotactic/Tomosynthesis-Guided Breast Interventional Procedures**

(Lines 162)

3. Continuing ~~**medical**~~ education (C~~**M**~~E)

Resolution No. 6 **ACR–AIUM–SRU Practice Parameter for the Performance of Ultrasound Evaluation of the Prostate (and Surrounding Structures)**

(Line 25)

Although newer techniques using elastography and contrast-enhanced ultrasound may provide superior detection of prostate cancer, these techniques are not sufficiently established to be included as ~~standard of care~~ routine imaging at this time.

(Line 43)

1. Real-time guidance for the placement of peri-prostatic spacer material

The AIUM, and SRU representatives affirm that in their best judgement the proposed changes would be acceptable to AIUM, and SRU; subject to ratification by AIUM and SRU.

Resolution No. 9 **Roles of Non-Physician Radiology Providers (NPRP) – Policies, Parameters and Legislation/Regulations**

BE IT FURTHER RESOLVED,

that existing and future ACR policies and practice parameters concerning NPRPs will be reviewed, modified, and written such that the intention of the policy and practice parameter reflects that NPRPs (including but not limited to NPs, PAs, and RRAs) will not perform interpretations (preliminary, final, or otherwise) of any radiological examination. Imaging findings and observations identified by NPRPs may be communicated only to the supervising radiologist. ~~NPRPs may identify imaging findings or observations and communicate those only to the supervising radiologist.~~ Rendering interpretations of medical imaging studies (preliminary, final, or otherwise) is beyond the scope of practice and is not the intended role of an NPRP. Interpretations are distinguished from observations in that interpretations involve synthesizing imaging findings in the context of clinical histories, physical examination findings, laboratory testing, and/or comparison with prior or other imaging studies in a manner that leads to clinical impressions or conclusions, specific diagnoses and/or differential diagnoses; and

BE IT FURTHER RESOLVED,

that existing and future ACR policies and practice parameters concerning NPRPs will be reviewed, modified, and written such that the intention of the policy and practice parameter reflects that NPRPs working in a radiology setting (e.g. diagnostic, interventional, or neurointerventional radiology; nuclear medicine; or radiation oncology setting) assisting with or participating in minimally-invasive procedures must operate under the supervision of a Radiologist and as part of a Radiologist-led team; and

BE IT FURTHER RESOLVED,

that the ACR continue to oppose any legislation or regulation permitting the independent practice of NPRPs (e.g. NPs, PAs, RRAs, ...) in radiology; and

BE IT FURTHER RESOLVED,

that the ACR will:

1. assist medical and radiology societies and specialty organizations that seek to enact legislation that would define the valued role of mid-level and other health care professionals within a physician- and radiologist-led team-based model structured to efficiently deliver optimal quality patient care and to assure patient safety; and

2. actively support the concept of radiologist-led radiology teams and oppose radiology teams that are not radiologist-led;

BE IT FURTHER RESOLVED,

that these ACR policy and practice parameter reviews and language modifications would ideally be accomplished prior to the 2021 ACR annual meeting and will be completed no later than the 2022 ACR annual meeting.

Resolution No. 10a. **Interim Support Position for RRA Legislation and Regulation**
(Council instructed staff to make editorial policy title change prior to publishing Res. 10a. in the Digest of Council Actions.)

BE IT RESOLVED,

that the ACR supports its RRA policies as approved by Council in 2003 (and renewed in 2013), 2006, and 2008; and

BE IT FURTHER RESOLVED,

that ACR will study updating the 2003 RRA policy to contemporary practice (2020) at or before its scheduled 10-year renewal in 2023; and

BE IT FURTHER RESOLVED,

that any current, past, or future RRA ELCA document that has not followed the approval process outlined in 2003, 2008, and other ACR RRA policies is not ACR policy; and

BE IT FURTHER RESOLVED,

that the ACR will continue to work with the ARRT, ASRT, and other RRA stakeholders to align both the ELCA document and the processes for modification and approval of future RRA scope of practice changes with ACR policy; and

~~**BE IT FURTHER RESOLVED,**~~

~~**that until the BOC and CSC review and approve ELCA and RRA scope of practice documents consistent with existing ACR policy, the ACR shall suspend all activities to promote, sponsor, or otherwise support MARCA and other legislation and regulations on the national, state, and local levels that would in any way expand or modify RRA clinical activities beyond those explicitly cited in ACR policy**~~

Resolution No. 11 Update to Existing ACR Policies on Radiologist Assistants

BE IT RESOLVED,

that the Council of the American College of Radiology adopt the revised *ACR Statement on Radiologist Assistant Roles and Responsibilities* in lieu of the ACR ASRT Joint Statement on Radiologist Assistant Roles and Responsibilities, currently Appendix H, adopted in 2003 as Resolution 2; and

BE IT FURTHER RESOLVED,

that the ACR will work with ASRT to get approval for ~~the~~ a **revised statement ~~so that it may be accepted as~~** using this blueprint to develop **a new ACR ASRT Joint Statement on Radiologist Assistant Roles and Responsibilities; and**

BE IT FURTHER RESOLVED,

that the Council of the American College of Radiology adopt the revised policy *Registered Radiologist Assistant Inclusion in Practice Parameters* in lieu of the policy originally adopted in 2006 and renewed in 2016 as Resolution 1-c; and

BE IT FURTHER RESOLVED,

that the Council of the American College of Radiology adopt the revised policy *Developing a Process for Updating the Roles and Responsibilities of the Radiologist Assistant* in lieu of the policy originally adopted in 2008 as Resolution 39.

APPENDIX H

ACR ~~ASRT Joint~~ Statement on Radiologist Assistant Roles and Responsibilities

The American College of Radiology adopted a statement on Radiologist Assistant – Roles and Responsibilities; **2003 (Res. 2).**

A Registered Radiologist Assistant (RRA) is an advanced-level radiologic technologist who works under the supervision of a radiologist to enhance patient care by assisting the radiologist ~~in the diagnostic imaging environment~~. The RRA is an ARRT-certified radiographer who has successfully completed an advanced academic program encompassing a nationally recognized RRA curriculum and a radiologist-directed clinical preceptorship. Under radiologist supervision, the radiologist assistant **may** perform patient assessment, patient management and **assist the radiologist with** selected exams, as described below and subject to state law:

- Obtaining consent for ~~and injecting agents that facilitate and/or enable~~ **contrast agents administered as part of radiology procedures** ~~diagnostic imaging~~
- Obtaining clinical history from patients or the medical record
- Performing pre-procedure and post-procedure evaluation of patients undergoing ~~invasive~~ procedures
- Assisting radiologists with invasive procedures
- Performing fluoroscopy for non-invasive procedures ~~with the~~ **under** radiologist ~~providing direct~~ supervision~~ of the service~~
- Monitoring and tailoring selected exams under **radiologist** ~~direct2~~ supervision **[**e.g. ~~IVU,~~ **CT Urogram**, ~~GI studies,~~ VCUG, ~~and~~ retrograde urethrograms**, and preparation and colonic insufflation for CT Colonography.]**
- ~~Communicating the reports of radiologist's findings to the referring physician or an appropriate representative with appropriate documentation~~
- ~~Providing naso-enteric and oro-enteric feeding tube placement in uncomplicated patients~~. **Attempt placement of fluoro-guided naso- or oro-enteric feeding tubes in patients whom the supervising radiologist has determined are appropriate for RRA involvement and under radiologist supervision as part of a radiologist-led team.**
- ~~Performing selected peripheral venous diagnostic procedures~~

~~The RRA will should not perform interpretations (preliminary, final or otherwise) of any radiological examination, nor will he or she transmit his or her observations other than to the supervising radiologist~~.
~~The RRA may make initial observations of diagnostic images and forward communicate them to the supervising radiologist.~~ **The RRA may identify imaging findings or observations and communicate those only to the supervising radiologist (i.e. make 'observations'). Rendering interpretations of medical imaging studies (preliminary, final, or otherwise) is beyond scope of practice and is not the intended role of an RRA. Interpretations are distinguished from observations in that interpretations involve synthesizing imaging findings in the context of clinical histories, physical examination findings, laboratory testing, and/or**

comparison with prior or other imaging studies in a manner that leads to clinical impressions or conclusions, specific diagnoses, differential diagnoses, and/or medical decision-making.
At the supervising radiologist's direction, the RRA may communicate the radiologist's findings and interpretation to the referring physician or an appropriate representative, consistent with the ACR policies on Communication of Diagnostic Imaging Findings

Documentation of any RRA's observations/findings on a diagnostic imaging examination as required by the institution, statute, or regulatory body, should describe the RRA's role and clearly state that the RRA did not interpret the imaging examination (preliminary, final, or otherwise). Documentation of any RRA's participation in a procedure should (1) describe the RRA's role in the procedure, (2) ~~clearly state~~ be clear that the RRA did not perform the procedure independently, and (3) include the name of the supervising radiologist.

The education of the RRA should be granted through nationally ~~recognized~~ ~~**accredited**~~ **recognized** academic programs that lead to certification through the ARRT. Advisory committees to such programs should include ~~representation of~~ radiologists.

The RRA should actively participate in a facility quality assurance program.

Any formal national**,** state**, or facility** certification **and/**or credentialing of RRA competency should include ~~the representation of~~ radiologists. ~~Any facility RRA credentialing process should involve radiologists.~~

The ACR believes that the advent of the RRA **working under the supervision of a radiologist and part of a radiologist-led team,** with defined responsibilities as described herein, will enhance ~~the performance of radiological procedures and~~ patient care and ~~also~~ provide a professionally satisfying career pathway for radiologic technologists.

~~1, 2The Centers for Medicare and Medicaid Services (CMS) direct supervision requirement states that the "physician is required on site and immediately available."~~

2. ACR POLICY ON DEVELOPMENT OF PRACTICE PARAMETERS AND TECHNICAL STANDARDS

ee. Registered Radiologist Assistant (RRA) Inclusion in Practice Parameters

The American College of Radiology will insert the following language describing the role of the RRA into the appropriate Practice Parameters of the various radiologic examinations in which an RRA might participate:

Registered Radiologist Assistant (RRA)

An RRA is an advanced level radiographer who is certified and registered as a "Registered Radiologist Assistant" by the American Registry of Radiologic Technologists (ARRT) after successful completion of an advanced academic program encompassing an ~~**ACR/ASRT**~~ **ASRT** (American Society of Radiologic Technologists) RRA curriculum and a radiologist-directed clinical preceptorship.

Under radiologist supervision, the RRA may perform patient assessment, patient management, and selected examinations as delineated in the ~~*Joint Policy Statement of the ACR and the ASRT*~~ **ACR policy** titled "Radiologist Assistant: Roles and Responsibilities" subject to state law. The RRA transmits to the supervising radiologist those observations that have a bearing on diagnosis. Performance of diagnostic interpretations (preliminary, final, or otherwise) remains outside the scope of practice of the RRA. **adopted 2006, 2016 (Res. 1-c).**

RRAs performing invasive or non-invasive procedures should function under radiologist supervision and as part of radiologist-led teams.

SECTION II

12. DEVELOPING A PROCESS FOR UPDATING THE ROLES AND RESPONSIBILITIES OF THE RADIOLOGIST ASSISTANT (RRA)

The American College of Radiology will continue to require that the tasks performed by the RRA **are** under radiologist supervision and that they should be well-defined and documented; **within the criteria and standards defined in the "ACR** ~~ASRT Joint~~ **Statement on Radiologist Assistant Roles and Responsibilities;"** and **that** the RRA will not **independently** interpret imaging studies **(preliminary, final, or otherwise). The RRA may identify imaging findings or observations and communicate those only to the supervising radiologist. Rendering interpretations of medical imaging studies (preliminary, final, or otherwise) is beyond scope of practice and is not the intended role of an RRA. Interpretations are distinguished from observations in that interpretations involve synthesizing imaging findings in the context of clinical histories, physical examination findings, laboratory testing, and/or comparison with prior or other imaging studies in a manner that leads to clinical impressions or conclusions, specific diagnoses, differential diagnoses, and/or medical decision-making.**

The ACR will ~~create~~ **have and follow** a process **to participate in** ~~enabling~~ the ~~expeditious~~ ongoing review of the roles and responsibilities of the RRA **and ensure communication of recommendations to the ACR Board of Chancellors and Council Steering Committee.** This process will incorporate an expert panel, including a member**(s)** ~~of the~~ **from an** ACR Commission **such as** ~~on~~ Quality and Safety, **Human Resources, or equivalent** to review and make ~~initial~~ recommendations for any changes in the roles and responsibilities of the RRA **over time**.

The ACR representatives to the Intersocietal Commission on the Radiologist Assistant (ICRA) will present for review and recommendation to the ACR Council Steering Committee and ACR Board of Chancellors ~~only~~ **any** ~~those~~ changes recommended by the expert panel and agreed to by all members of ICRA.

Only approval of the ICRA recommendations by the CSC and BOC will be sufficient to permit implementation of changes in the roles and responsibilities of the RRA**; adopted 2008 (Res. 39).**

Resolution No. 14 **ACR–ACNM–SNMMI–SPR Practice Parameter for the Performance of Neuroendocrine Tumor Scintigraphy** ~~**(with Gamma Cameras)**~~

(Lines, 133-134)

For I-123-iodide MIBG, breastfeeding should be discontinued for **3 days. (Add Reference - https://www.nrc.gov/docs/ML1817/ML18177A451.pdf)** ~~**2 hours (4 mCi dosage) or 24 hours (10 mCi dosage).**~~

(Lines144-146)

Patient Preparation: For In111-pentetreotide imaging **discontinuation of breastfeeding for 6 days is recommended. (Add Reference - https://www.nrc.gov/docs/ML1817/ML18177A451.pdf)** ~~**interruption of breastfeeding is usually unnecessary because a radiation dose to the child is unlikely to exceed 100 mrem.**~~

Resolution No. 17 **ACR–ACNM–ASTRO–SNMMI Practice Parameter for Lutetium-177 (Lu-177) DOTATATE Therapy**

(Lines, 19-20)

The goal of therapy with Lu-177 DOTATATE is to **slow disease progression, to palliate symptoms, or even to extend life,** ~~**provide either cure, extended time to disease progression, or effective palliation of disease**~~ while minimizing untoward side effects and complications

(Line 53)

General: Abdominal pain, nausea, and vomiting can occur typically within 24 hours of treatment. In addition, patients can also experience fatigue~~**, and**~~ diarrhea**, alopecia and cough**. **(Add existing reference #7-Strosberg)** In most cases, these symptoms are self-limiting and rarely require more than supportive therapy.

(Line 125)

The treating physician's initial evaluation of the patient must include review of the patient's history, physical examination, pertinent diagnostic studies, laboratory reports, and complete history of all **available records of** previous pertinent therapies, including, but not limited to, myelosuppressive systemic therapy and/or radiotherapy.

(Line 367)

It can be administered via gravity method, infusion pump method or via automated syringe pump injector, as detailed with illustrative figure at the available link: **http://jnm.snmjournals.org/content/60/7/937/F3.expansion.html** [26].

(Line 415)

C. Post-therapy **Management** ~~**Survey**~~

Resolution No. 23 **Ten Year Extension of Policies**

(f) **J. TECHNOLOGISTS AND ALLIED HEALTH PROFESSIONS**
7. OTHER NON-PHYSICIAN RADIOLOGY PROVIDERS (NPRP) PERFORMING FLUOROSCOPIC PROCEDURES

It is the policy of the American College of Radiology that ~~other ancillary personnel~~ **Non-Physician Radiology Providers (NPRP)** who are qualified and duly licensed or certified under applicable state law may, under supervision by a radiologist **or other qualified physician,** ~~or other qualified physician,~~ perform fluoroscopic examinations or fluoroscopically guided imaging procedures. Supervision by a radiologist **or other qualified physician** ~~or other qualified physician must be direct or personal, and~~ must comply with local, state, and federal regulations.

All ~~ancillary personnel~~ **non-physician radiology providers (NPRP)** using fluoroscopy should be credentialed for those fluoroscopic examinations or procedures and should have completed **40 hours of didactic education or its equivalent.** ~~40 hours of didactic education or its equivalent~~ ~~**CME**~~ **accredited education** **that meets applicable state or other laws and regulations** **to become competent** in **the following**: digital image acquisition and display, contrast media, fluoroscopic unit operation and safety, image analysis, radiation biology, radiation production and characteristics, and radiation protection**. Additionally, NPRP using fluoroscopy should have 40 hours of 40** ~~hours of~~. ~~**Additionally, NPRP using fluoroscopy should have sufficient clinical**~~ experience and be supervised by a radiologist ~~or medical physicist~~ **to demonstrate competency in those fluoroscopic examinations or procedures for which they are credentialed.** Medical physicists should be involved in the radiation safety and image quality aspects of fluoroscopy. Required ~~**CME**~~ **education** for ~~other~~ ~~ancillary personnel~~ **NPRP** performing fluoroscopy should include education in radiation dosimetry, radiation protection, and equipment performance related to the use of fluoroscopy; adopted 2010 (Res. 52).

Resolution No. 25 **ACR–SAR–SPR Practice Parameter for the Performance of Magnetic Resonance Imaging (MRI) of the Abdomen (Excluding the Liver)**

(Lines 135-137)

The physician should be familiar with relevant **prior** ancillary studies ~~**that the patient may have undergone**~~. The physician performing MRI interpretation must have a clear understanding and knowledge of the **relevant** anatomy and pathophysiology ~~**relevant to the MRI examination**~~.

(Lines 147-150)

The physician responsible for the examination should supervise patient selection and preparation and be available ~~**in person or by phone**~~ for consultation ~~**by the technologist performing the examination**~~ **by direct communication**. Patients and any family members or others who will accompany the patient into the MRI suite must be screened and interviewed prior to the examination to exclude individuals who may **have contraindications to MRI, in which the risks may outweigh the benefits** ~~**be at risk by exposure to the MR environment**~~. All sites should have an established and documented screening mechanism for establishing MRI compatibility.

Resolution No. 26 **ACR–SAR–SPR Practice Parameter for the Performance of Magnetic Resonance (MR) Enterography**

(Lines 55-57)

The physician should be familiar with relevant **prior** ancillary studies ~~**that the patient may have undergone**~~. The physician performing the MRI interpretation must **be knowledgeable about** ~~have a clear understanding and knowledge of~~ the **relevant** anatomy and pathophysiology ~~**relevant to the MRI examination**~~.

(Lines 79-81)

The physician responsible for the examination should supervise patient selection and preparation and be available ~~**in person or by phone**~~ for consultation **by direct communication**. Patients must be screened and interviewed prior to the examination to exclude individuals who may **have contraindications to MRI, in which the risks may outweigh the benefits** ~~**be at risk by exposure to the MR environment**~~.

Resolution No. 27 **ACR–SAR–SPR Practice Parameter for the Performance of Magnetic Resonance Imaging (MRI) of the Liver**

(Lines 57-59)

The physician should be familiar with relevant **prior** ancillary studies ~~**that the patient may have undergone**~~. The physician performing MRI interpretation must have a clear understanding and knowledge of the **relevant** anatomy and pathophysiology ~~**relevant to the MRI examination**~~.

(Lines 70-72)

The physician responsible for the examination should supervise patient selection and preparation and be available ~~**in person or by phone**~~ for consultation **by direct communication**. Patients must be screened and interviewed prior to the examination to exclude individuals who may **have contraindications to MRI, in which the risks may outweigh the benefits** ~~**be at risk by exposure to the MR environment**~~ (see the ACR Guidance Document on MR Safe Practices: 2003 [**2**]).

Resolution No. 28 **ACR–SAR–SPR Practice Parameter for the Performance of Magnetic Resonance Imaging (MRI) of the Soft-Tissue Components of the Pelvis**

(Lines 263-265)

High-field (3T) MRI has been more widely implemented for body-imaging applications, providing improved signal-to-noise ratio (SNR), spatial resolution, and anatomic detail as well as faster scanning techniques but with specific limitations due to magnetic susceptibility and motion artifacts and concerns about radiofrequency power deposition [19]. Parallel imaging techniques significantly increase ~~SNR with reasonable specific absorption rates while markedly speeding up~~ acquisition ~~at 3T body~~ speed, allowing for improved imaging efficiency, although this results in decreasing signal to noise~~[19]~~.

(Lines 893-894)

Imaging should be performed at either 1.5T or 3T. The fundamental advantage of 3T over 1.5T is increased spectral resolution and improved SNR, ~~which improves the~~ that can be used to achieve better spatial~~,~~ and/or temporal~~, and spectral~~ resolution.

Resolution No. 29 **ACR–NASCI–SPR Practice Parameter for the Performance of Body Magnetic Resonance Angiography (MRA)**

(Line 373)

This technique is best suited for imaging vessels that exhibit pulsatile flow **and therefore may be limited in evaluation of distal extremity circulation when severe inflow disease diminishes distal pulsatility**. Ref A, B.

(Lines 558-559)

A. Miyazaki M, et al. Non-contrast-enhanced MR angiography using 3D ECG-synchronized half-Fourier fast spin echo. J Magn Reson Imaging. 2000;12(5):776–83)

(Lines 561-563)

B. Miyazaki M, et al. Peripheral MR angiography: separation of arteries from veins with flow-spoiled gradient pulses in electrocardiography—triggered three dimensional half-Fourier fast spin-echo imaging. Radiology 2003; 227: 890– 896

Resolution No. 30 **ACR–SPR–SSR Practice Parameter for the Performance and Interpretation of Magnetic Resonance Imaging (MRI) of Bone and Soft-Tissue Tumors**

(Line 42)

2. Follow-up and re-evaluation of tumors

(Lines 121-122)

An interslice gap may be ~~chosen to decrease signal loss due to cross talk [71]~~ used but ~~in general should be no more than one-half of the slice width and~~ should not impair complete visualization of the mass.

(Lines 154)

Coverage of the tumor **must** ~~ideally should~~ include all of the anterior, posterior, medial, lateral, superior, and inferior margins of the mass**, unless clinically/**~~radiographically~~ **impractical** [21,23,44].

(Lines 248-249)

The report should address the presence or absence of a mass, the size of the lesion and **description of anatomic extent,** ~~its~~ composition (hemorrhage, necrosis, etc), signal intensity, and enhancement characteristics when intravenous contrast is administered.

(Lines 462-463)

~~71. Kneeland JB, Shimakawa A, Wehrli FW. Effect of intersection spacing on MR image contrast and study time. Radiology 1986;158:819-22.~~

Resolution No. 31 **ACR–SPR–SSR Practice Parameter for the Performance and Interpretation of Magnetic Resonance Imaging (MRI) of the Knee**

(Lines 114-116)

The physician should be familiar with relevant **prior** ancillary studies ~~that the patient may have undergone~~. The physician performing the MRI interpretation must have a clear understanding and knowledge of the **relevant** anatomy and pathophysiology ~~relevant to the MRI examination~~.

(Lines 125-127)

The physician responsible for the examination should supervise patient selection and preparation and be available ~~in person or by phone~~ for consultation **by direct communication**. Patients must be screened and interviewed by qualified personnel prior to the examination to exclude individuals who may ~~be at risk by exposure~~ **have contraindication** to **MRI, in which** the ~~MR environment~~ **risks may outweigh the benefits**.

(Lines 189-191)

An interslice gap can ~~decrease signal loss due to cross talk [110] but should typically be no more than 33% to 50% of the slice width~~ **be used – with its size dependent on equipment, time considerations, and need for anatomic coverage – but** ~~and~~ should not impair complete visualization of the intra-articular structures.

(Lines 281-283)

In knees containing large metallic implants, a combination of longer echo trains, increased receiver bandwidth, decreased FOV, **decreased slice thickness,** increased matrix size in the frequency-encoding direction, and control of the phase and frequency encoding directions will reduce, but typically not completely eliminate, metal artifacts [83,88 **additional reference**].

(Lines 544-545)

89. Harris CA, White LA. Metal Artifact Reduction in Musculoskeletal Magnetic Resonance Imaging. Orthop Clin N Am 2006; 37: 349-359

(Lines 595-596)

~~110. Kneeland JB, Shimakawa A, Wehrli FW. Effect of intersection spacing on MR image contrast and study time. Radiology 1986;158:819-22.~~

Resolution No. 32 **ACR–SPR–SSR Practice Parameter for the Performance and Interpretation of Magnetic Resonance Imaging (MRI) of the Shoulder**

(Lines 26-27)

~~Sonography can be used to evaluate the rotator cuff and biceps tendon and has the advantage of imaging during physiologic motion [3-7].~~

(Lines 119-121)

The physician should be familiar with relevant **prior** ancillary studies ~~that the patient may have undergone~~. The physician performing MRI interpretation must have a clear understanding and knowledge of the **relevant** anatomy and pathophysiology ~~relevant to the MRI examination~~.

(Lines 130-132)

The physician responsible for the examination should supervise patient selection and preparation and be available ~~in person or by phone~~ for consultation **by direct communication**. Patients must be screened and interviewed prior to the examination to exclude individuals who may ~~be at risk by exposure~~ **have contraindications** to **MRI, in which** the ~~MR environment~~ **risks may outweigh the benefits**.

495 **(Lines 203-206)**
496 ~~An~~ The size of an interslice gap ~~may be selected to decrease signal loss due to cross talk [115] but should be,~~ if used,
497 would depend on hardware, software, time considerations, and need for anatomic coverage. Imaging with
498 no gap has the ~~slice width. Two interleaved scans may allow~~ advantage of imaging ~~without gaps at the expense~~
499 all of ~~an increase~~ the anatomy in ~~scan time~~ the covered field of view.
500
501 **(Line 306)**
502 At a minimum, the report should address the condition of the rotator cuff muscles and tendons, supraspinatus
503 outlet (as defined in Section II. A. 3), biceps tendon, and labrum.
504
505 **(Lines 634-635)**
506 ~~115. Kneeland JB, Shimakawa A, Wehrli FW. Effect of intersection spacing on MR image contrast and~~
507 ~~study time. Radiology 1986;158:819-22.~~
508
509 **Resolution No. 34** ~~Mandatory~~ Standard **Early Radiology Education for Medical Students by**
510 **Radiologists**
511 **BE IT RESOLVED,**
512 **that the ACR form a taskforce to investigate avenues for introducing all medical**
513 **students to ~~mandatory~~ radiology ~~clerkships~~ (diagnostic radiology, interventional**
514 **radiology, and radiation oncology) taught by radiologists and/or radiation**
515 **oncologists ~~during~~ throughout their ~~second~~ first ~~or~~ through third years, and/or a**
516 **longitudinal radiology curriculum, to allow medical students the opportunity to**
517 **select diagnostic radiology, interventional radiology or radiation oncology early**
518 **enough as their career preference and be able to match successfully into ~~a~~ the**
519 **corresponding ~~diagnostic radiology/interventional radiology~~ residency program,**
520 **~~and to allow~~ those seeking a career in other areas of medicine to have an**
521 **appreciation of radiology's central role. The taskforce will report to the Council at**
522 **its 2021 meeting.**
523
524
525 **Resolution No. 36** **Ten Year Extension of Policies**
526
527 **(a)** **B. TECHNOLOGISTS AND ALLIED HEALTH PROFESSIONS**
528
529 **14. RADIOLOGIC TECHNOLOGISTS AND RADIATION THERAPISTS**
530
531 The Radiologic Technologist, **Nuclear Medicine Technologist, Radiologist Assistant**
532 and Radiation Therapist are qualified by education and the achievement of technical skills
533 to provide patient care in diagnostic radiological and radiation oncologic modalities under
534 the direction of radiologists~~, and~~ **interventional radiologists, radiation oncologists,**
535 **and nuclear medicine physicians**. In the performance of their duties, the application of
536 proper radiologic techniques and radiation protection measures involves both initiative
537 and independent professional judgment by the radiologic technologists and radiation
538 therapists. In as much as it is both desirable and necessary for all disciplines of radiologic
539 technology to be recognized as professionals by government and other agencies, the ACR
540 supports this position and recognizes the radiologic technologist, **Nuclear Medicine**
541 **Technologist, Radiologist Assistant**, and radiation therapist as professional members of
542 the health care team; 1980, 1990, 2000, amended 2010 (Res. 1-e).
543

Resolution No. 37 **ACR Practice Parameter for Communication of Diagnostic Imaging Findings**

(Lines 85-87)

e. Any known significant adverse event involving the patient that occurred in relation to performance of the study should be ~~described in the body of the report and/or in the institutional electronic medical record, and~~ briefly noted in the impression.

(Line 133)

The archived preliminary report should contain the name of the person or office that received the report, if applicable and the date and time that the report was provided.

(Line 183)

Inclusion of the **date and** time, method of communication, and the name of the person to whom the communication was delivered is an example of such documentation.

Resolution No. 38 **ACR–SAR Practice Parameter for the Performance of Adult Cystography and Urethrography**

(Lines 136-137)

~~Contiguous axial~~ CT scan~~s~~ through the pelvis **from the iliac crests to the lesser trochanter ~~are~~ is** obtained [15,16].

Resolution No. 39 **ACR–SIR Practice Parameter for Minimal and/or Moderate Sedation/Analgesia**

(Lines 89-91)

Similarly, the Mallampati score is a simple test that can be a good predictor of sleep apnea and difficulty with bag mask ventilation and intubation, should it be necessary. In addition patients with Mallampati Class III or IV should be given additional consideration.

(Line 156-157)

This should include evaluation and documentation of ASA and Mallampati score.

(Line 283)

The equipment **may be in a code cart and** should include the following:

(Lines 427-434)

Appendix D

Modified Mallampati Score

- **Class I: Soft palate, uvula, fauces, pillars visible.**
- **Class II: Soft palate, major part of uvula, fauces visible**
- **Class III: Soft palate, base of uvular visible**
- **Class IV: Only hard palate visible**

Resolution No. 41 **ACR–ACNM–ASNR–SNMMI Practice Parameter for Brain PET-CT Imaging in Dementia**

(Lines 38-41)

1) the biomarkers of A-beta (Aß) amyloid accumulation~~:~~**;** abnormal radiopharmaceutical retention on amyloid PET imaging and low CSF Aß-42 peptide and

2) the biomarkers of neuronal degeneration or injury: elevated CSF tau protein (both total and phosphorylated tau); decreased ^{18}F fluorodeoxyglucose (FDG) uptake on PET in a specific topographic pattern involving posterior cingulate/precuneus and temporoparietal cortex; and atrophy on structural MR, again in a specific topographic pattern involving medial, basal, and lateral temporal lobes and medial and lateral parietal cortices [9].

3) Biomarkers of Aß amyloid are indicative of initiating upstream events that may deviate from normal before clinical symptoms manifest. Biomarkers of neuronal injury and neuronal dysfunction are indicative of downstream pathophysiological processes that temporally follow [9]. Current evidence suggests that amyloid biomarkers may become abnormal approximately 10 to 20 years before noticeable clinical symptoms. Progression of clinical symptoms closely parallels progressive worsening of neurodegenerative biomarkers [6,10,11]. Biomarkers of neurodegeneration are now being incorporated into clinical diagnostic criteria for specific disorders**, in particular for AD** [12-14].

(Lins 158-159)

3. Live or online education programs may be used to fulfill these requirements**; this may also be fulfilled through a nuclear medicine residency or fellowship training program.**

(Line 226)

c. Serum glucose analysis performed immediately prior to FDG administration (an ~~acceptable~~ **optimal** range is up to ~~150~~ 200 mg/dL)

(Line 253)

2. For ^{18}F-amyloid binding radiopharmaceuticals, the amount of administered activity should be 185 to 444 MBq (~~5-1210~~ **5-12** mCi) IV. **The recommended doses are 10 mCi, 5 mCi, and 8.1 mCi for florbetapir, flumetamol, and florbetaben, respectively [35-37].**

Resolution No. 43 **ACR–ASNR–SNIS–SPR Practice Parameter for the Performance of Cervicocerebral Magnetic Resonance Angiography (MRA)**

(Lines 378-379)

MR VWI may be performed solely or as a part of a MRI or MRA examination.

Resolution No. 48 **Article IX, Sections 1, 3, 5, 6, and 8**

ARTICLE IX – Meetings

Section 1

Meetings of the BOC

At least two (2) regular meetings of the BOC shall be scheduled each calendar year by the Executive Committee of the Board. Special meetings of the Board shall be called by the CEO upon written request of a majority of the chancellors or upon the unanimous direction of the Executive Committee of the BOC. Notice of a special meeting, together with a statement of the business to be transacted at such meetings, shall be sent to the members of the BOC not less than seven (7) calendar days before any such meeting. No business other than that specified in the notice of a special meeting shall be transacted at such meeting. ~~**Other meetings**~~ **Meetings** of the BOC may be conducted by electronic means ~~**as permitted by the laws of the state of California**~~.

Section 3

Meetings of the Council

The annual meeting of the Council shall be the annual meeting of the College ~~**and shall be held at such time and place as is ordered by the Council**~~. **Meetings of the Council may be conducted by electronic means.**

Section 5

Attendance of the Councilor, Alternate Councilor, or Substitute

~~**Attendance**~~ **Participation** of the councilor, alternate councilor, or a substitute certified by the president or secretary of the chapter at the annual and any special meetings of the Council is expected and is considered essential to the effective functioning of the Council. ~~**In the event of absence of the designated councilor or alternate councilor, the chapter shall be notified of such absence by the College office.**~~

Section 6

Council Special Meetings

Special meetings of the Council shall be called by the Speaker of the Council, Chairman of the BOC, or CEO upon the written request of thirty (30) voting councilors ~~**any such meeting to be held at a time and place designated by the speaker of the Council.**~~ **The speaker of the Council shall determine the time and place of any such special meeting.** Notice of a special meeting, together with a statement of the business to be transacted at such meeting, shall be sent to each voting member of the Council not less than fourteen (14) calendar days before such meeting. No business other than that specified in the notice of a special meeting shall be transacted at such meeting.

Section 8

Council Quorum and Voting

One-third of the Council shall constitute a quorum for the transaction of business at meetings of the **Council.** ~~**College, and only councilors actually present shall be counted in determining whether or not a quorum is present.**~~ ~~**Once a quorum is established, it shall be presumed to continue. Only a**~~ **A member serving as an appropriately credentialed councilor may vote during a meeting of the Council.** ~~**Councilors may vote at a meeting of the College only in person, and voting**~~ **Voting** by proxy ~~**shall**~~ **is** not ~~**be**~~ allowed. **The Credentials Committee shall determine members who are eligible to vote.**

~~**A councilor or their alternate councilor (or an accredited substitute) may vote. Within these guidelines, the Credentials Committee shall determine who will vote.**~~

The 2019 Speaker and Vice Speaker wish to thank the Council Members, Reference Committees, collaborating Societies, and visitors for their valuable contributions to these deliberations.

Resolution No. 50 **ACR Position on Certifying Boards ~~Bodies~~ in Radiology**

BE IT RESOLVED,

that the official position of the ACR is that any ~~bodies~~ boards certifying ~~radiology professionals~~ diagnostic radiologists, interventional radiologists, nuclear medicine physicians, radiation oncologists, and medical physicists should minimize power imbalance in decision-making between those professionals and the certifying body by committing to representative, inclusive, and transparent decision-making; and

BE IT FURTHER RESOLVED,

that the official position of the ACR is that any ~~bodies~~ boards certifying ~~radiology professionals~~ diagnostic radiologists, interventional radiologists, nuclear medicine physicians, radiation oncologists, and medical physicists should act in a manner to ensure appropriate balance between all parties, and never act in any manner that

directly, indirectly, or otherwise effectively requires radiology professionals to waive any of their fundamental due process rights; and

BE IT FURTHER RESOLVED,

that the official position of the ACR is that any ~~bodies~~ boards certifying ~~radiology professionals~~ diagnostic radiologists, interventional radiologists, nuclear medicine physicians, radiation oncologists, and medical physicists should seek and respond to input from the ACR Council Steering Committee as a ~~the~~ representative body of ~~ABR~~ candidates for certification and diplomates prior to creating, modifying, or implementing new and/or existing policies that affect candidates and diplomates (“participation agreements”); and

BE IT FURTHER RESOLVED,

that the official position of the ACR is that any ~~bodies~~ boards certifying ~~radiology professionals~~ diagnostic radiologists, interventional radiologists, nuclear medicine physicians, radiation oncologists, and medical physicists should share drafts of such participation agreements with all candidates and diplomates with sufficient time and a defined process to consider their input in advance of any final decisions concerning such participation agreements.

REFERRED

The following Resolution(s) presented to the 2020 Council of the American College of Radiology have been referred to BOC with instruction to report back to the 2021 Council:

*(The language is specified by line numbers which correspond to the resolution as noted in the Reference Committee Reports. Written amendments presented during the Open Hearing and recommended by the respective Reference Committee on Sunday, May 17, 2020 and Monday, May 18, 2020 are **bolded** reflecting ~~**strikethrough**~~ for deletions and **underline** for insertions in Blue. Language considered by the Council during deliberation on Tuesday, May 19, 2020 is reflected in RED.)*

Resolution No. 2 **ACR Practice Parameter for the Performance of Preoperative Image-Guided Localization in the Breast**

(Lines 7-11)

Preoperative localization with image-guided wire placement has been a standard of breast imaging diagnosis and treatment since its development in the 1970s **and remains a reliable and safe method for localization.** [1]. Several recent advancements in nonwire localization (NWL) techniques minimize limitations of wire localization ~~**have improved**~~ **and potentially improve** patient care and clinical workflow. **New technological approaches and devices are continually being developed and introduced that will expand the variety of localization tools.**

(Lines15-16)

Presurgical localization in the breast may be performed for patients with selected indications including**, and not limited to:**

(Lines 75-76,)

An important feature for wire localization is the potential opportunity for removal and reinsertion with another wire if improper localization has occurred.

(Lines 81-82)

Alternative forms of preoperative localization that do not use wire and mitigate wire localization limitations are now available and include radioactive seed, radiofrequency reflector, ~~**and**~~ magnetic seed, **and RFID, among others.**

(Lines 98-99)

748 Because the iodine-125–labeled seed half-life is 59.4 days, preoperative RSL using mammographic or sonographic
749 guidance **theoretically** can be performed up to several ~~days~~ **weeks prior to surgery, but is typically performed**
750 **within a few days** prior to surgery.
751
752 **(Lines 135-145)**
753 **d. Radiolfrequency identification tag**
754
755 **Radiofrequency identification (RFID) technology was introduced in 2017. The RFID tag comprises a copper-**
756 **wrapped ferrite rod and microprocessor within a glass casing enclosed within a polypropylene sheath to**
757 **prevent migration (Kapoor et al Radiographics 2019). The device absorbs, modifies and re-emits a 134.2-kHz**
758 **radiofrequency signal that is sent by the handheld reader device (Kapoor et al Radiographics 2019). An**
759 **integrated loop probe on the device has a 6-cm detection range while the disposable sterile surgical pencil-sized**
760 **probe has a 3-cm detection range. Like radar detector technology, the device provides audible and visual**
761 **indicators that increase in cadence and provide real-time distance to target information. A unique**
762 **identification number for an individual tag is able to be displayed on the device reader, which is useful to**
763 **distinguish between tags if multiple devices are implanted within the same breast.**
764
765 **(Lines 157-159)**
766 **A Geiger counter can be utilized to confirm** ~~radioactivity of a single radioactive single~~ **the presence of a**
767 **radioactive seed inserted within the breast using ultrasound alone. However, such confirmation with a Geiger**
768 **counter is not possible when more than one radioactive seed is placed or if the patient has already been**
769 **injected for lymphoscintigraphy (17).**
770
771 **(Lines 175-176)**
772 Conversely, the negative predictive value of clear margins on specimen radiography is low, **but may be improved**
773 **with the addition of orthogonal views or by performing specimen radiography with tomosynthesis. [Ref].**
774
775 **Resolution No. 10b. Interim Support Position for RRA Legislation and Regulation**
776
777 **BE IT FURTHER RESOLVED,**
778
779 **until the BOC and CSC review and approve ELCA and RRA scope of practice**
780 **documents consistent with existing ACR policy, the ACR shall suspend all activities**
781 **to promote, sponsor, or otherwise support MARCA; and**
782
783 **BE IT FURTHER RESOLVED THAT,**
784
785 **the ACR shall oppose legislation and regulations on the national, state, and local**
786 **levels that would in any way expand or modify RRA clinical activities beyond those**
787 **explicitly cited in ACR policy.**
788
789
790 The 2020 Speaker and Vice Speaker wish to thank the Council Members, Reference Committees,
791 collaborating Societies, and visitors for their valuable contributions to these deliberations.