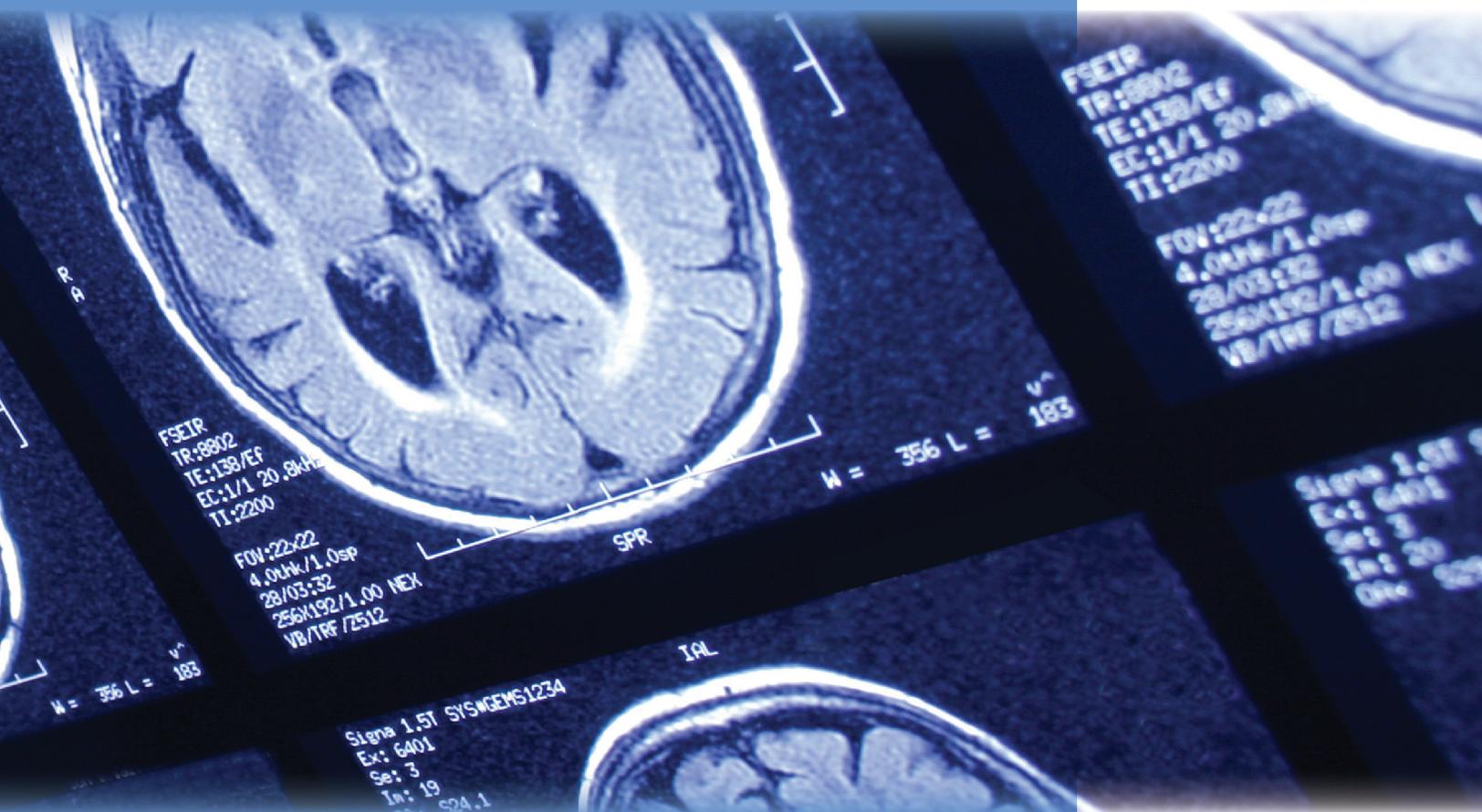


Digest of Council Actions 2022-2023

AMERICAN COLLEGE OF RADIOLOGY



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AMERICAN COLLEGE OF RADIOLOGY

DIGEST OF COUNCIL ACTIONS

2013-2022

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SECTION I
ORGANIZATIONAL AND OPERATIONAL POLICIES

SECTION I

A. GENERAL

1. ACR DISTINGUISHED ACHIEVEMENT AWARD

The Gold Medal of the ACR be awarded only to radiologists, radiation oncologists, medical physicists and other distinguished scientists.

The ACR Awards and Honors Committee establish eligibility criteria for an ACR Distinguished Achievement Award.

The American College of Radiology may award one or more ACR Distinguished Achievement Awards each year, the recipients to be determined by the Awards and Honors Committee, based on nominations; adopted 2011, 2021 (Res. 2-a).

2. HONORING THE CHICAGO RADIOLOGICAL SOCIETY ON THEIR CENTENNIAL MEETING

The Council of the American College of Radiology commends the Chicago Radiological Society for 100 years of imaging excellence. The Council of the American College of Radiology extends to the Chicago Radiological Society best wishes for a hugely successful centennial meeting in 2013; adopted 2013 (Res. 38).

3. HONORING JACR TENTH ANNIVERSARY

The Council of the American College of Radiology congratulates the *JACR* for 10 years of successful publication. The Council of the American College of Radiology extends its appreciation to *JACR* Editor-in-Chief Bruce J. Hillman, MD, FACR for his unique contribution to the creation, preservation and success of the *JACR*; adopted 2013 (Res. 39).

4. HONORING THE MASSACHUSETTS RADIOLOGICAL SOCIETY ON THEIR GOLDEN ANNIVERSARY

The Council of the American College of Radiology commends the Massachusetts Radiological Society for 50 years of Imaging Excellence and extends to the Massachusetts Radiological Society best wishes for a hugely successful golden anniversary in 2015; adopted 2015 (Res. 28).

5. NEIMAN HELATH POLICY INSTITUTE NAMED FELLOWSHIP

The ACR shall name, rename, or establish a Neiman Health Policy fellowship or grant that will be named in honor of Richard Duszak, Jr. M.D.; adopted 2022 (Res. 40).

6. COUNCIL CONSULTATION REGARDING FINANCES

That the Board of Chancellors consult and communicate with the Council regarding financial affairs; adopted 1978, 1988, 1998, 2008, 2018 (Res. 1-a).

7. GREATER INVOLVEMENT OF YOUNG PROFESSIONALS IN THE ACR

The ACR will provide \$1,000 per chapter to those chapters that designate an additional young professional Member Alternate Councilor.

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The ACR bylaws will be amended to add an additional appointed young physician member to the Council Steering Committee.

Other existing ACR Commissions and Committees will be encouraged to have representation from this important and unique demographic group; adopted 2007, amended 2017 (Res. 24-a).

8. ADVOCACY ON BEHALF OF RADIOLOGY

The Board of Chancellors will identify and develop the most effective means for promulgation of the role of radiology before the public, government, and third parties. The Board of Chancellors will identify and develop the capability for effective advocacy on behalf of radiology in the areas of economical and sociological concern; adopted 1979, 1989, 1999, 2009, 2019 (Res. 1-a).

9. ACR ADVOCACY NETWORKS

The ACR will continue to assist state chapters with their state government relations issues.

The ACR encourages all chapters and practices to:

- i. Develop and support advocacy networks;
- ii. Coordinate their advocacy through the Radiology Advocacy Network of the Government Relations Commission;

The ACR encourages all chapters to:

- i. Establish or maintain a state government relations program to meet the demands of increased legislative and regulatory activity;
- ii. To add and maintain an advocacy network position on their Executive Committees/Boards

The ACR encourages other radiology, radiation oncology, nuclear medicine, interventional radiology, and medical physics societies to:

- i. Work with the ACR and the ACR Radiology Advocacy Network to optimize our collective advocacy efforts. adopted 2012, amended 2022 (Res. 28-a).

10. COMMITMENT TO PROFESSIONALISM

Professionalism is defined as a duty to those we serve, our patients; a duty to those at whose pleasure we serve, our society; and a duty to those with whom we serve, our colleagues and thus our profession itself ([Appendix N](#)).

The American College of Radiology reaffirms its commitment to upholding and promoting high standards of professionalism in all its policymaking, advocacy, and educational programs; adopted 2015 (Res. 13).

11. DIVERSITY IS CENTRAL TO OUR MISSION

The American College of Radiology affirms that diversity of our membership, and of the radiological professions in general, strengthens our organization and enhances our ability to achieve our mission.

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The American College of Radiology affirms that diversity of our membership is a central objective and that opportunities to continually measure and assess our membership diversity should be promoted; adopted 2015 (Res. 14).

B. CHAPTERS

1. ADDRESS FOR DIRECTORY

The American College of Radiology requests the members and fellows to use the address of their principal practice location, and telephone number, fax number, and e-mail address for listing in the annual Membership Directory. The ACR encourages all members to update their membership profiles to ensure continuity of service and targeted benefits; adopted 1987, amended 1997, 2007, amended 2017 (Res. 24-b).

2. IDENTIFICATION OF RADIOLOGY GROUP PRACTICES

The American College of Radiology state chapters shall assist the College by helping the national office to update a listing of all radiology group practices within their geographical boundaries, the groups' mailing addresses, the names of radiologists associated with those groups, and the specialty or subspecialty of each radiologist; adopted 1987, amended 1997, 2007, 2017 (Res. 24-c).

3. RESIDENT AND FELLOW SECTION

The American College of Radiology encourages chapter resident and fellow sections and will continue to assist in their formation; adopted 1985, amended 1995, 2005 (Res. 12).

The Chapters should provide residents and fellows the opportunity for membership and access to policy program development and implementation through the development of Chapter resident and fellow sections; adopted 1984, 1994, amended 2004, 2014 (Res. 1-a).

The American College of Radiology encourages each state chapter to establish or maintain a Resident and Fellow Section for physicians and medical physicists; and that material and personnel be made available to the chapters for that purpose; adopted 1983, 1993, 2003, amended 2013 (Res. 23-a).

4. YOUNG AND EARLY CAREER PROFESSIONAL SECTION (YPS)

The ACR shall have a Young and Early Career Professional Section (YPS). A young or early career professional shall be defined as a Member who is age 40 or younger, or who is within the first 8 years of practice after completion of training.

The YPS shall be led by an executive committee elected by the Section. The elected Chair and Vice Chair (Chair-Elect) of the YPS executive committee shall serve as councilors during their respective terms leading the YPS, to represent the voice of young and early career professionals of the ACR. The ACR will make available, to each chapter, an additional alternate council seat earmarked for a young or early career professional. The ACR will provide \$1,000 per chapter to those chapters that designate an additional young or early career professional Council member.

The ACR encourages state chapters to facilitate greater involvement by young and early career professionals. The YPS shall work in coordination with the Commission on Membership and Communications to increase membership and volunteerism in the ACR by young and early career

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professionals and ACR Commissions and Committees will be encouraged to have representation from this important and unique demographic group.

The YPS shall provide an annual report to the ACR Council regarding its activities, and provide progress reports upon request to the Board of Chancellors, Council Steering Committee, and Commission on Membership and Communications.; adopted 2012, amended 2017, 2022 (Res 28-b).

5. INTRODUCE UNDERGRADUATE STUDENTS TO THE PROFESSIONS OF RADIOLOGICAL CARE

The ACR, ACR chapters and ACR members are encouraged to create programs to introduce undergraduate students to the specialties of radiology, radiation oncology, interventional radiology, nuclear medicine and medical physics; adopted 2018 (Res. 22)

6. LEAD CONTACT FOR CSC OUTREACH

Each ACR chapter is encouraged to select an individual to be the primary contact with whom the CSC liaison communicates to encourage optimal dialogue between the chapter and the CSC; adopted 2015 (Res. 39).

C. COMMISSIONS AND COMMITTEES

1. APPOINTMENTS TO COMMISSIONS AND COMMITTEES

The Board of Chancellors shall regularly canvas all members to solicit the names of individuals who deserve consideration for and who would be interested in working on ACR Commissions and/or Committees.

Non-Members shall be used on College commissions and committees only when the talent needed is not available from the ACR membership; 1980, 1990, 2000, amended 2010, 2020 (Res. 1-a).

2. REPRESENTATION OF RELATED ORGANIZATIONS

The ACR encourages inclusion of representatives of other radiological organizations as members on ACR commissions and committees; adopted 1980, 1990, 2000, amended 2010, 2020 (Res. 1-b).

3. CODE OF ETHICS

The Code of Ethics of the ACR is intended to aid the radiology community, individually and collectively, in maintaining a high level of ethical conduct. The code is not a set of laws but rather a framework by which radiologists may determine the propriety of conduct in their relationship with patients, the public, colleagues, and members of allied professions.

PRINCIPLES OF ETHICS

The Principles of Ethics form the first part of the Code of Ethics of the College. They serve as goals of exemplary professional conduct for which members of the College should constantly strive.

The principal objective of the medical profession is to render service to people with full respect for human dignity and in the best interest of the patient. Members should merit the confidence of patients

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entrusted to their care, rendering to each a full measure of service and commitment.

Members should strive continually to improve their medical knowledge and skill and make these improvements available to their patients and colleagues.

Members should at all times be aware of their limitations and be willing to seek consultations in clinical situations where appropriate. These limitations should be appropriately disclosed to patients and referring physicians.

The medical profession should safeguard the public and itself against physicians deficient in moral character or professional competence by reporting, to the appropriate body, without hesitation, perceived illegal or unethical conduct of members of the medical profession. Members should uphold all laws, uphold the dignity and honor of the medical profession and accept its self-imposed discipline and deal honestly and fairly with patients and colleagues.

The honored ideals of the medical profession imply that responsibilities of members extend to society in general as well as their patients. These responsibilities include the interest and participation of members in activities that improve the health and well-being of the individual and the community.

Members may not reveal confidences entrusted to them in the course of medical attendance, or deficiencies they may observe in the character of patients, unless they are required to do so by law, or unless it becomes necessary to protect the welfare of the individual or of the community.

A physician who has not personally interpreted the images obtained in a radiological examination should not sign a report or take attribution of an interpretation of that examination rendered by another physician in a manner that causes the reader of a report to believe that the signing radiologist was the interpreter.

The decision to render a service by a diagnostic radiologist, radiation oncologist, interventional radiologist, nuclear medicine physician, or medical physicist is a matter of individual physician and patient choice governed by the best interest of the patient.

The traditional bond among diagnostic radiologists, radiation oncologists, interventional radiologists, nuclear medicine physicians, and medical physicists, particularly in their professional relationships with each other, is a powerful aid in the service of patients and should not be used for personal advantage.

RULES OF ETHICS

The Rules of Ethics form the second part of the Code of Ethics of the College. They are mandatory and directive of specific minimal standards of professional conduct for all members of the College.

Members' behavior should conform to high standards of ethical, legal, and professional conduct. Any activity that fails to conform to these standards compromises the member's personal integrity and casts aspersions on the College and the medical profession.

It is proper for a diagnostic radiologist to provide a consultative opinion on radiographs and other images regardless of their origin. A radiologist who regularly interprets radiographs and other

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images should reasonably participate in quality assurance, technology assessment, utilization review, and other matters of policy that affect the quality and safety of patient care.

It is proper for a radiation oncologist to provide a consultative opinion in the management of cancer and other disorders treated with radiation. A radiation oncologist should regularly treat patients only in settings where the radiation oncologist reasonably participates in the quality of patient management, utilization review, and matters of policy that affect the quality of patient care.

It is proper for an interventional radiologist to provide a consultative opinion in the management of conditions treated by interventional methods. An interventional radiologist should regularly treat patients only in settings where the interventional radiologist reasonably participates in the quality patient management, utilization review, and matters of policy that affect the quality of patient care.

It is proper for a nuclear medicine physician to provide a consultative opinion in the management of conditions treated by nuclear medicine. A nuclear medicine physician should regularly treat patients only in settings where the nuclear medicine physician reasonably participates in the quality patient management, utilization review, and matters of policy that affect the quality of patient care.

It is proper for a medical physicist to provide assistance to a physician in treating patients only in settings where the medical physicist reasonably participates in technical quality assurance.

Prior to practicing in a hospital or other health care entity, a diagnostic radiologist, radiation oncologist, interventional radiologist, nuclear medicine physician, or medical physicist shall apply, and be accepted, as a member of that entity's medical staff in accordance with the medical staff's bylaws and in the same manner as all other physicians.

The practice of physicians referring patients to health care facilities in which they have a financial interest is not in the best interest of patients. Self-referral may improperly influence the professional judgments of those physicians referring patients to such facilities. Members with ownership interests participating in such arrangements may be in violation of these Rules of Ethics.

Members shall relate to other members of the health care team with mutual respect and refrain from harassment or unfair discriminatory behavior.

Members should have the right to enter into whatever lawful contractual arrangements with health care systems they deem desirable and necessary but they should seek to ensure that the system of healthcare delivery in which they practice does not unduly influence the selection and performance of appropriate available imaging studies or therapeutic procedures.

Members should not enter into an agreement that prohibits the provision of medically necessary care or that requires care at below acceptable standards. Notwithstanding policies of a health plan, radiologists should advocate cost-effective appropriate studies or therapies that will benefit the patient, whose welfare is paramount.

Members should clearly and adequately respond to inquiries by patients regarding fees and/or any financial incentive. A radiologist should not participate in a billing arrangement that misleads

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patients or third-party payers concerning the fees charged by the radiologist. Radiologists shall not divide radiological fees either directly or by any subterfuge.

In providing expert medical testimony, members should exercise extreme caution to ensure that the testimony provided is non-partisan, scientifically correct, and clinically accurate. The diagnostic radiologist, radiation oncologist, interventional radiologist, nuclear medicine physician, or medical physicist shall not accept compensation that is contingent upon the outcome of litigation.

Radiologic research must be performed with integrity and be honestly reported.

Members should not claim as their intellectual property that which is not theirs. Plagiarism or the use of others' work without attribution is unethical.

Members should not publicize themselves through any medium or forum of public communication in an untruthful, misleading, or deceptive manner or in a fashion demeaning to the profession.

D. ANNUAL COUNCIL MEETING

1. COUNCIL MEETING REGISTRATION FEE

The registration fee for the Annual Meeting of the American College of Radiology will be eliminated for members; adopted 1988, 1998, 2008, 2018 (Res. 1-b).

2. ELIMINATE THE RESIDENT CONFERENCE REGISTRATION FEE

The \$50.00-\$100.00 resident registration fee for the ACR annual conference will be eliminated; adopted 2015 (Res. 29).

3. UNINTERRUPTED GOVERNANCE TIME AT ACR ANNUAL MEETING

In order to allow the Council to conduct critical ACR policy discussions without undue distraction, the Council affirms the decisions of the Board of Chancellors Executive Committee and Council Steering Committee to prioritize the governance activities at ACR 2018 and future annual meetings, such that there will be no concurrent CME or other educational sessions while governance portions of the Council meeting occur.

The Council Speaker and/or Vice-Speaker will designate the time periods for governance sessions in advance, and provide that information to Councilors and to meeting planners, so that Councilors will be present and CME and other educational sessions can be scheduled to avoid conflict.

The ACR shall continue to work toward a speedy return of the annual meeting format to one that focuses on governance and chapter leader development (i.e., an "AMCLC-like" meeting) in a fiscally responsive manner, recognizing existing contracts, commitments and schedules; adopted 2018 (Res. 41).

4. DEMOGRAPHIC INFORMATION OF ACR LEADERSHIP

The College will provide a report to the membership on an annual basis that provides demographic

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data on College leadership (Board of Chancellors, Council Steering Committee, Councilors and Alternate Councilors). Demographic self-reported information will include, but not be limited to, sex, age, years in practice, academic versus community-based practice, size of practice group, and size of location of practice (rural, suburban, or urban). This information shall be reported to the membership within six months of the annual meeting date; adopted 1998, 2008, amended 2018 (Res. 1-c).

5. EDUCATIONAL TOPICS FOR ACR MEETINGS

When planning educational sessions at the Annual Meeting, the Council Steering Committee and designated ACR commissions shall consider inclusion of topics deemed relevant to practice leadership and management, along with quality and safety issues; adopted 2000, amended 2010, amended 2020 (Res. 1-c).

6. ACR POLICY ON “ELECTIONEERING”

The Council Steering Committee will provide binding regulations for candidate communications and publish those regulations in the ACR Elections Manual as well as provide all candidates a copy of those regulations.

Any candidate who violates those Election Manual regulations may, at the discretion of a committee composed of the Speaker, Vice Speaker and Chair of the College Nominating Committee be declared ineligible for election in that year and have his or her name stricken from the ballot; adopted 2008, amended 2018 (Res. 1-d).

E. COUNCIL

1. COUNCIL REPRESENTATION

a. Criteria for Representation on the ACR Council

The Council may by resolution, in its sole discretion, grant a seat on the Council to other medical organizations that seek such a seat, and that meet the following criteria as a general guide:

1. Independent organization
2. National in scope
3. In existence for five years; if two or more societies are merging into a single society and one of the societies in the merger already had a seat on the Council, the new, merged society is exempt from having to be in existence for five (5) years.
4. Oriented primarily to the practice of radiology or its subspecialties
5. At least 300 members who are eligible for ACR/ACRa membership
6. Actual membership in the ACRA/ACR by 60% of those eligible; if due to a merging of two or more societies into a single society, membership does not meet the 60% criterion, the new society will have three (3)-year grace period to come into compliance.

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7. Every five (5) years, societies undergo re-evaluation (audit) to ensure they continue to meet the above criteria. Those not meeting the criteria will have a three (3)-year grace period to come into compliance.

The Council may by resolution, in its sole discretion, re-evaluate the seat on the Council of any such organization that later fails to meet the above criteria; adopted 2004, amended 2014 (Res. 1-b).

b. Society of Nuclear Medicine and Molecular Imaging Council Representation

The ACR will grant the Society of Nuclear Medicine and Molecular Imaging Council one Councilor on the Council of the American College of Radiology, effective at the 2015 ACR Annual Meeting and Chapter Leadership Conference.

The Bylaws Committee will prepare an amendment to the ACR Bylaws to codify this action to grant Council representation to the Society of Nuclear Medicine and Molecular Imaging; adopted 2014 (Res. 38).

c. The National Medical Association (NMA) Official Observer Representation to the ACR Council

The ACR will invite the National Medical Association to nominate an Official Observer to the ACR Council from the NMA's Section on Radiology; adopted 2014 (Res. 27).

2. RESOLUTIONS

a. Fiscal Note

All resolutions submitted to the Council of the American College of Radiology calling for or requiring appropriations by the ACR to properly carry out such proposals must be accompanied by a fiscal note. The fiscal note must be approved as appropriate for the proposal as determined by the Council Steering Committee; adopted 1985, 1995, amended 2005 (Res. 1-c).

b. Policy Manual and Annual Progress Report

The ACR staff shall maintain a policy manual; and will annually provide a progress report to Council; adopted 1973, 1974, 1987, 1997, 2007, amended 2017 (Res. 24-d).

c. Policy Progress Reporting

Staff, working with the Council Steering Committee, will provide the Council with a Policy Progress Report six months after the AMCLC and provide additional reports on the progress of Council-passed policies every six months thereafter until each policy's completion. The CSC will review and disseminate these Policy Progress Reports to the Council in a timely manner. The CSC may from time to time identify additional items of importance to be included in the Policy Progress Report; adopted 2013 (Res. 40).

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d. Pre-Council Dissemination of Resolutions

The College will continue to provide a summary of proposed resolutions to the general membership in a timely prior to the annual meeting; adopted 1988, 1998, 2008, amended 2018 (Res. 1-e).

e. Council Discussion of Standards

The Council of the American College of Radiology gives authority to the Council Speaker or Presiding Officer to limit changes to Practice Parameters or Technical Standards on the Council floor to substantive issues.

The Council of the American College of Radiology gives authority to the Speaker or Presiding Officer to determine whether a proposed change to a Practice Parameter or Technical Standard represents a substantive change.

The Council of the American College of Radiology retains the right to appeal from the decision of the Presiding Officer as per *The Standard Code of Parliamentary Procedure*; adopted 2001, amended 2011, 2021 (Res. 2-b).

f. RFS and YPS Standing to Submit ACR Resolutions

The ACR Bylaws Committee will draft a resolution for the ACR 2021 annual meeting to amend the bylaws to allow submission of resolutions by the RFS or YPS; adopted 2020 (Res. 35).

3. UNIFORM TERM LENGTH FOR ELECTED AND APPOINTED COUNCIL STEERING COMMITTEE (CSC) MEMBERS

The members of the Council Steering Committee (CSC) shall be allowed to serve up to a total of six (6) consecutive years. This maximum term length shall pertain to elected members, appointed members, and members who have been both elected and appointed to their positions at different times; adopted 2007, amended 2017 (Res. 24-e).

F. FINANCES

1. MEMBERSHIP DUES

a. Collection of Chapter Dues

All ACR dues and chapter dues may at the option of the chapter be collected by the ACR and the chapter dues be forwarded to the chapter secretary-treasurer as is the current procedure with new members. The ACR will assess the individual chapters involved for the cost of this service; adopted 1982, 1992, 2002, 2012, 2022 (Res. 28-c).

b. Transitional Member Fees for Medical Physicists

Medical physicist transitional dues are revised as follows:

Med. Phys. Year 1 \$60
Med Phys. Year 2 \$90

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Med. Phys. Year 3 \$145
Final Dues \$235

Adopted 2016 (Res. 33).

c. Membership Discounting

The ACR Commission on Membership and Communications may develop and implement incentive programs, including membership dues discounts, as part of initiatives to recruit additional members into the College. Such programs must provide a strong likelihood of additional net income to the College and must be approved by the Chief Executive Officer and approved in advance by the ACR Board of Chancellors and the Council Steering Committee; adopted 2011, 2021 (Res. 18-c).

d. Encourage Funding of ACR Membership for Radiologists, Radiation Oncologists and Medical Physicists

The leaders of all academic and private practice radiology and radiation oncology practice groups shall be encouraged to fund memberships in the ACR for their physicians and medical physicists from their practice group's revenues; adopted 1999, 2009, amended 2019 (Res. 1-b).

e. Difference in Member vs. Non-Member Cost of ACR Programs and Services

In an effort to increase ACR and state chapter membership through offerings of "essential benefits and other products and services", ACR leadership should evaluate the budgetary impact of offering as many of its products and services as possible at minimal or no additional cost to ACR members and report its findings and recommendations/actions to Council in 2019.

In the absence of minimal or no cost "essential benefits and other products or services" for all members, ACR should explore and implement a differential member vs. non-member price of all products and services offered to enhance the value of ACR membership.

The ACR should strive to minimize the cost of "essential benefits and other products and services" to individual ACR members and ineligible non-members associated with ACR members, but not so for eligible non-members.

In the absence of minimal or no cost "essential benefits, products or services" for all members, ACR leadership should explore reducing the overall cost of ACR benefits to groups where all membership-eligible individuals in a group practice (e.g. Single Tax Number (TIN)) are ACR members and report its findings and recommendations/actions to Council in 2019; adopted 2018 (Res. 10).

f. Membership Dues Decrease

The American College of Radiology will find ways to decrease the price of its dues. The Board of Chancellors will provide a detailed report of its findings and recommendations/actions to Council in 2019; adopted 2018 (Res. 11).

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G. MEMBERSHIP

1. MEMBERS

a. Assistance to Chapters in Membership Recruitment

The ACR will continue to refine its program to provide contact information about individual new graduates from radiology, radiation oncology, and medical physics residency programs to the ACR chapter to which the new graduates will be moving. The program will also provide contact information about others eligible for membership (e.g., graduates of fellowship programs, qualifying physicians and medical physicists) who have been in practice and are known to be relocating to another chapter area; adopted 2003, amended 2013 (Res. 23-b).

b. Graduated Dues

Each chapter is encouraged to establish or maintain a graduated dues system for new Members who have completed their Member-in-Training status and are being billed for the first time. The graduated dues system should mirror that of the ACR; adopted 2003, 2013 (Res. 23-c).

c. State Chapters: Introductory Category of Membership

Each state chapter that has not already done so shall be encouraged to add a category of membership equivalent to the ACR membership category entitled “introductory” whereby an individual who automatically becomes an introductory ACR member may become an introductory member of the State Chapter and is officially recognized as such by the State Chapter after appropriate review; adopted 1993 (Res.23).

d. Role of Patients in the American College of Radiology

The American College of Radiology will explore the feasibility of additional direct roles that patients and patient stakeholders can play in the ACR, such as conference attendee, conference presenter, member, and Board of Chancellor member; adopted 2017 (Res. 23).

H. ADVERTISING

1. ADVERTISING OF RADIOLOGICAL SERVICES

a. General

The basic reason for the existence of medical societies and associations is the enhancement of the welfare of the patient through improved practice.

Even though the major thrust of activities of such societies is usually scientific, it often also deals with the details of relationships between patients and physicians and between physicians themselves. Advice from professional societies to their membership must always have at its center, concern for the patient’s welfare.

It follows that advertising of physician services, which is now clearly legal and which cannot itself be considered unethical in the United States, must be conducted in such a way that the

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patient's welfare is enhanced. This may include his/her economic welfare as well as his/her more traditional physical and mental health welfare.

b. Community Relations

It is appropriate and commendable for physicians, including radiologists, to participate in health fairs, public screening programs and educational presentations by professional societies and news media.

Such participation should be conducted in the spirit of service to the state of health of all patients and should avoid any suggestions of solicitation of patients themselves or patient referrals by the physician who participates in such activities.

c. Precepts of Advertising Radiological Services

The avoidance of confusing, inaccurate, untrue, or misleading statements is fundamental.

Statements addressing expectations of diagnostic procedures or treatments must be supported by scientific literature.

Claims of unique skill(s) by physicians or claims of possession of unique equipment by physicians, hospitals, or other organizations which are not objectively verified are not a proper part of professional advertising.

Advertising or news releases by radiologists should be carried out in the spirit of concern for the overall welfare of the patient; 1984, 1994, 2004, amended 2014 (Res. 1-c).

d. Timely Communication Regarding Articles in Peer Review Journals

The ACR shall maintain liaison with peer review journals in an attempt to become informed prior to publication of articles which may cause significant alarm among the general public regarding diagnostic radiology and radiation oncology procedures.

When relevant, such information as well as any forthcoming official ACR responses shall be confidentially communicated by the ACR to chapters prior to publication. Thereby, appropriate responses and consistent information can be disseminated by all chapters whenever appropriate; adopted 2001, 2011, 2021 (Res. 18-a).

2. EXPANSION OF PUBLIC INFORMATION EFFORTS REGARDING THE ROLE OF RADIOLOGY IN THE PROVISION AND ECONOMICS OF HEALTH CARE

The American College of Radiology will continue to educate the public and all stakeholders about the role of radiology (including radiation oncology, nuclear medicine, interventional radiology, and medical physics) in the health care system and the cost effectiveness of appropriately utilized radiologic services; 1992, 2002, amended 2012, 2022 (Res. 28-d).

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- a. Public Awareness of the Role of Radiologists in Healthcare and Expansion of the ACR Web Site to Serve as a Resource for the General Public on Subjects Related to Radiology

The ACR shall maintain a program to sustain a public information campaign to educate patients and payers regarding the role and importance of radiologists in healthcare, including expanding the ACR website to provide information for the general public on a number of subjects related to radiology, such as: accurate descriptions of various radiologic examinations and procedures, and links to and from other reliable health-related websites.

The ACR Board of Chancellors shall allocate funding for this program and the development and implementation of a public awareness campaign.

The ACR shall continue working with other national radiologic organizations, such as the Radiological Society of North America and the American Roentgen Ray Society, in developing and implementing of public awareness campaigns and educational opportunities so that unnecessary and costly duplications of efforts will not occur for any of these radiologic organizations; 1998, amended 2008, 2018 (Res. 33-a).

I. RELATIONSHIPS TO OTHER ORGANIZATIONS

1. AMERICAN BOARD OF RADIOLOGY (ABR)

- a. ABR Policy Decisions

It is the ACR's position when the American Board of Radiology is performing its historic role of examining and certifying candidates, the ACR should in no way interfere. Whenever the American Board of Radiology considers policy decisions that affect the practice of radiology, it should consult with the ACR and with scientific societies which nominate members to the American Board of Radiology; adopted 1973, 1987, 1997, 2007, 2017 (Res. 24-f).

- b. ACR Representation on the American Board of Radiology

The ABR trustees nominated by the ACR shall be encouraged to support ACR policy in matters being considered by the ABR. The ABR trustees nominated by the ACR shall be encouraged to keep the ABR fully informed of ACR policy in all matters being considered by the ABR and said trustees shall be encouraged to keep the ACR informed of all proposed actions of the ABR which may involve ACR policy or interests; adopted 1995, 2005 (Res. 25).

2. ACR OPPOSITION TO AMA SUPPORT OF REVERSAL OF FEDERAL SELF-REFERRAL LEGISLATION

The American College of Radiology shall work with the American Medical Association to re-establish a strong ethical position on the prohibition of the practice of physician self-referral and extend its efforts to prohibit self-referral by non-radiologists for radiation oncology procedures.

The AMA should base its legislative position on its long-standing ethical policies; adopted 1999, amended 2009 (Res. 1-b).

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3. SUPPORT FOR ANTI SELF-REFERRAL LEGISLATION

The ACR continues to support efforts to defend anti self-referral statutes with both significant consultative input and strong financial support.

The ACR continues to make it a priority that self-referral in medicine remains a target for elimination because of its deleterious effects on patients, and for its inappropriate utilization of economic resources; adopted 2011, amended 2021 (Res. 2-e).

4. RECOGNITION AND RETENTION OF INTERVENTIONAL RADIOLOGY WITHIN RADIOLOGY

The American College of Radiology (ACR) recognizes interventional radiology as an important component within the specialty of radiology, with the attributes, rights and responsibilities of the other components (diagnostic radiology, radiation oncology, nuclear medicine, medical physics); adopted 2001, amended 2011, 2021 (Res. 2-d).

5. LEADERSHIP DEVELOPMENT

The American College of Radiology strongly endorses, supports, and encourages radiology practices to allow the time and provide the necessary resources for their radiologists, radiation oncologists, and medical physicists to participate in and serve as leaders in both radiological and other medical societies.; adopted 1999, 2009, amended 2019 (Res. 1-c).

6. LEADERSHIP IN RADIOLOGY AND RADIATION ONCOLOGY

The ACR promotes effective leadership training as a critical requisite for success of radiology and radiation oncology practices and for our profession as a whole.

Leadership experience, training and skills provide significant value and should be highly regarded as an area of expertise within our profession.

The ACR will promote the development, education and training of current and future leaders in radiology and radiation oncology; adopted 2011, 2021 (Res. 18-b).

7. RADIOLOGISTS VOLUNTEER SERVICES IN HEALTH ORGANIZATIONS

The American College of Radiology encourages all radiological professionals to volunteer for service in local, regional, and national health organizations and agencies; adopted 1999, 2009, amended 2019 (Res. 1-d).

8. DIAGNOSTIC RADIOLOGIST, INTERVENTIONAL RADIOLOGIST, NUCLEAR MEDICINE PHYSICIAN AND RADIATION ONCOLOGIST INVOLVEMENT IN THEIR STATE MEDICAL SOCIETIES

Each ACR state chapter shall encourage and support the activity of diagnostic radiologists, interventional radiologists, nuclear medicine physicians and radiation oncologists within each state medical society and that state's AMA delegation.

The members of the Council Steering Committee, in their state liaison roles, shall work with each

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state chapter to identify such individuals and facilitate such activity; adopted 2005, amended 2015 (Res. 1-b).

9. ELECTION OF MEMBER-IN-TRAINING REPRESENTATIVES TO THE INTERSOCIETY SUMMER CONFERENCE

The Resident and Fellow Section Nominating Committee will nominate the member-in-training candidates to be considered for the Intersociety Summer Conference representative positions. The American College of Radiology Resident and Fellow Section shall vote upon and elect the member-in-training representatives to the Intersociety Summer Conference; adopted 2015 (Res. 15).

10. AMA LIAISON FOR THE COUNCIL STEERING COMMITTEE

The Council Steering Committee (CSC) have a supporting role with the College's AMA delegation in assisting with advocacy efforts in dealing with state medical and specialty societies. The CSC will utilize its liaison role with ACR state radiology societies to develop state medical and specialty society relationships to facilitate the goals of increased ACR advocacy communications and initiative support on a national level. The Council Steering Committee will work to foster functional advocacy relationships between the ACR state radiology delegations and their local AMA counterparts including promoting radiologist representation on state medical society AMA delegations; adopted 2015 (Res. 40).

SECTION II
PROFESSIONAL AND PUBLIC POLICY STATEMENTS

SECTION III

A. EDUCATION

1. CREDENTIALING AND TRAINING

a. Certification and Credentialing of Physicians

The American College of Radiology endorses board certification, credentialing and delineation of clinical privileges for physicians. When Board certification is being considered in the credentialing of a physician for performing and interpreting imaging examinations only physician-administered certifying bodies which are members of the American Board of Medical Specialties (ABMS), the American Osteopathic Association (AOA), or the Royal College of Physicians and Surgeons of Canada (RCPSC), or Le College des Medecins du Quebec should be recognized; adopted 1995, 2005 (Res. 12).

b. Interventional Radiology Pathway

The American College of Radiology supports the proposed training program leading to dual primary certification in both interventional radiology and diagnostic radiology as an additional training option in interventional radiology; adopted 2011, amended 2021 (Res. 2-c).

c. Percutaneous Transluminal Angioplasty: Credentials Criteria

The American College of Radiology endorses the Position Statement for Maintenance of Privileges for Image-Guided Interventions (which replaces Guidelines for Percutaneous Transluminal Angioplasty developed by the Society of Interventional Radiology); adopted 1987, 1997, 2007, amended 2017 (Res. 12-a).

CREDENTIALS CRITERIA FOR PERIPHERAL, RENAL AND VISCERAL PERCUTANEOUS TRANSLUMINAL ANGIOPLASTY

Percutaneous transluminal angioplasty (PTA), without or with stents, has become established as effective therapy for selected patients with peripheral and renal vascular occlusive diseases. Extensive literature now documents the safety and efficacy of this procedure in the management of atherosclerotic stenoses and occlusions, as well as other arterial pathologies such as fibromuscular dysplasia and the intimal proliferative lesions that occasionally complicate surgical anastomoses. As with any invasive therapy, the patient is most likely to benefit only when the procedure is performed in an appropriate environment by experienced physicians.

THE PHYSICIAN

Physicians who perform angioplasty of the peripheral and renal vessels should have a thorough understanding of the clinical manifestations and natural history of peripheral and renovascular occlusive disease. They should be knowledgeable in the alternative therapies that are available including their risks and benefits. They should be competent to interpret diagnostic peripheral and renal angiographic examinations and competent to perform arteriographic procedures via either femoral (retrograde and antegrade), axillary, radial and translumbar approaches. In addition, the complex nature of angioplasty procedures requires further training beyond that necessary for routine diagnostic angiography. To assure the experience and competence needed to perform successful angioplasty, the physician should meet the following minimal criteria:

Completion of an approved residency program which includes:

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- Experience performing and interpreting peripheral arteriography and selective and subselective diagnostic vascular procedures.
- Training and experience in percutaneous interventions including a substantial number of peripheral and visceral arterial as well as venous endovascular recanalization procedures
- Expertise in vascular diagnostic procedures including diagnostic angiography, CTA, MRA and vascular ultrasound
- Instruction in radiation physics, radiation effects and protection with successful completion of a formal examination on these subjects.
- Both trainees and practicing physicians should keep a log of peripheral and renal angioplasties for a period of at least three years with documented success and complication rates within accepted limits. Participation in registries (when available) is encouraged to assist with documentation of outcomes.

Physicians who perform angioplasty should be competent in the recognition and initial management of complications specific to peripheral and renal angioplasty. The physician should participate in continuing medical education activities on an annual basis.

In lieu of residency training criteria, the physician should have performed a substantial number of peripheral and selective angiographic procedures and PTA/stent procedures for at least five years with acceptable complication rates and have expertise in vascular diagnostic procedures including diagnostic angiography, CTA, MRA and vascular ultrasound.

The Angiographic Facility

The angiographic examination required to assess a patient's suitability for percutaneous transluminal angioplasty should be equal to or exceed in quality that required for diagnostic angiography. The angiographic facility should have the following:

- High-resolution image intensifier and imaging chain.
- Physiologic monitoring devices including ECG and intra-arterial pressures.
- Facilities to manage and resuscitate unstable patients.
- Personnel trained to provide safe patient care, conscious sedation and operation of the equipment.
- Equipment necessary to diagnose and treat complications possibly arising from endovascular recanalization procedures.

2. RESIDENT AND FELLOWSHIP TRAINING PROGRAMS

a. Medical Physics Residency Training Program

The American College of Radiology endorses the concept of a clinically oriented medical physics residency program which meets the requirements of the Commission on Accreditation

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of Medical Physics Education Programs (CAMPEP); adopted 1990, 2000, 2010, 2020 (Res. 1-d).

b. **Physics Training for Residents: Increased Emphasis on Principles of Imaging, Radiation Safety, and ALARA**

The physics training programs for residents in diagnostic radiology should include radiological physics concepts as they relate to image acquisition, image quality and image processing, including both analog and digital techniques used with ionizing and non-ionizing radiation. Clinical examples should be routinely employed to demonstrate these concepts in the training curriculum. The curriculum should also include more emphasis on: a) radiation reduction techniques for all types of imaging equipment; b) the concept of ALARA; c) the role of the computer and digital techniques in PACS and imaging equipment; d) information relating to equipment selection, specification and purchasing; and e) radiation risks of high dose fluoroscopy (including erythema and epilation doses). Additional material covering equipment selection criteria, acceptance testing, quality control and the roles of the medical physicist, service engineer and technologist should be included in the training program to assist the resident in understanding and appreciating the depth and diversity of resources available for pursuing a successful practice; 1986, amended 1996, 2006, amended 2016 (Res. 1-a).

c. **Radiation Effects and Protection Education for Medical Students**

A minimum of two hours of instruction on the biological effects of ionizing radiation and the principles of radiation safety be included in the course of medical school study and that this instruction be provided by the radiology faculty.

The American College of Radiology encourages the deans and chairs of radiology departments throughout the United States to implement these curriculum additions; adopted 1987, 1997, 2007, amended 2017 (Res. 24-g).

d. **Radiation Oncology Residency Matching Program**

The American College of Radiology supports the use of the National Residency Matching Program as the vehicle for radiation oncology residency matching; 1992, 2002, amended 2012, amended 2022 (Res. 28-e).

e. **Residency Programs in Socioeconomics**

The members of the American College of Radiology Council and all chapters reaffirm commitment to the socioeconomic education of residents and fellows. Directors of radiologic and radiation oncology residency programs shall strive to provide regular programs on socioeconomics and practice management. The program directors shall also encourage residents to attend ACR-sponsored educational meetings; 1990, 2000, amended 2010, amended 2020 (Res. 1-e).

Each chapter should work with the ACR Resident and Fellow Section to host a resident practice workshop or to assure that the residents training within the chapter's geographical boundaries are provided the opportunity to attend a resident practice workshop.

Each chapter should make personal contact with radiology and radiation oncology residency and fellowship program directors within its state or jurisdiction to encourage them to support

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ACR resident workshops. Support from program directors should include active promotion and encouragement from the program directors regarding attendance at these educational forums; adopted 1987, 1997, 2007, 2017 (Res. 24-h).

f. Training Programs: Educational Material

The ACR shall continue to assist all training programs in radiology by providing educational materials including AIRP and other educational forums; adopted 1976, 1987, 1997, 2007, amended 2017 (Res. 24-i).

g. Coordination of National Board Examination and Fellowship Interviewing

The American College of Radiology will work with stake-holders, including the American Board of Radiology (ABR), the Association of Program Directors in Diagnostic Radiology (APDR), Association of Program Directors in Interventional Radiology (APDIR), the Society of Chairs of Academic Radiology Departments (SCARD), the National Resident Matching Program (NRMP), Society of Interventional Radiology (SIR), and American Society of Neuroradiology (ASNR) to optimize scheduling of fellowship interviews and fellowship match in a manner to minimize disruptions in resident education; adopted 2015 (Res. 41).

h. Start Date for Radiology, Interventional Radiology, and Radiation Oncology Fellowships

The American College of Radiology will make a statement to support the fact that radiology, interventional radiology, and radiation oncology fellowships should not begin before July 1, inclusive of all required onsite program and institutional orientation activities.

ACR Leadership will work with the leaders of other radiology, interventional radiology, and radiation oncology societies to implement this requirement; adopted 2021 (Res. 26).

i. Supporting Parental, Caregiver, and Medical Leave during Training

The ACR supports that diagnostic radiology, interventional radiology, radiation oncology, nuclear medicine and medical physics residency programs adopt a policy that “allows a resident who is in compliance with clinical competency, and Initial Certification requirements as well as is in good standing within their program to:

1. Take 12 weeks of family/medical leave during the course of residency (in addition to 4 weeks of vacation per year), while still remaining eligible to both sit for the Core/Qualifying Examinations and to graduate without extension of training.
2. Take additional family/medical leave if approved by the program director without extension of training (to be considered on a case by case basis), in keeping with the ABR Initial Certification requirements and Leaves of Absence policy currently in place [REF 1]; adopted 2021 (Res. 48).

REFERENCE: 1- Magudia K, Ng TSC, Campbell SR, Balthazar P, Dibble EH, Hassanzadeh CJ, Lall N, Merfeld EC, Esfahani SA, Jimenez RB, Fields EC, Lightfoote JB, Ackerman SJ, Jeans EB, Englander MJ, DeBenedictis CM, Porter KK, Spalluto LB, Deitte LA, Jagsi R, Arleo EK. Family/Medical Leave for Diagnostic Radiology, Interventional Radiology, and Radiation Oncology Residents in the United States: A Policy Opportunity. *Radiology*. 2021 Apr 13:210798. doi: 10.1148/radiol.2021210798. Epub ahead of print. PMID: 33847521.

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3. CONTINUING EDUCATION AND COMPETENCE

a. Continuing Competence

Documenting Continuing Competence

The American College of Radiology will continue to develop standards of radiologic practice and quality assurance programs which lead to continued improvement in patient care and which in the future will serve as the basis for objective evaluation of radiologist continuing competence.

The ACR will be prepared to develop medical education programs which will address identified areas of deficiencies.

The ACR will provide radiological input to other organizations in the development of national standards of patient care; adopted 1989, 1999, 2009, 2019 (Res. 1-e).

Professional Competence

The American College of Radiology will take positive steps to assume on behalf of its members leadership and responsibility for (1) perception and definition of needs for continuing education in radiology; (2) initiation, development and coordination of opportunities for extended professional education, and (3) recognition for individual efforts to sustain a high level of personal professional competence through multiple alternative mechanisms characterized by both practicality and authoritative credibility. The ACR will seek counsel, encouragement and active participation of radiological organizations, academic societies, and university training programs, as well as the ACR chapters in the achievement of this task; 1973, 1987, amended 1997, 2007, amended 2017 (Res. 24-j).

b. Evaluate and Coordinate the Continuing Experience and Continuing Medical Requirements for ACR Accreditation

The Commission on Quality and Safety and the Chairs of the various Committees on Accreditation be directed to evaluate and coordinate the CE and CME accreditation requirements for all programs to ensure that the criteria are appropriate for all practice models.

The accreditation programs utilize user groups from various practice models to offer feedback and suggest program improvements; adopted 2011, amended 2021 (Res. 18-d).

c. Review of Evidence Concerning the Patient Care Impact of ABR MOC/CC Participation, Costs of Participation, and Optimization of Member Participation

The ACR, on behalf of its members, collaborate with the ABR to create tools for members to more easily fulfill Maintenance of Certification/Continuous Certification (MOC/CC) requirements, particularly regarding Practice Quality Improvement (PQI) modules, that may provide evidence of improving patient care and fulfill legislated Merit-Based Incentive Payment System (MIPS) requirements; adopted 2015 (Res. 38).

d. Continuing Certification

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The Council of the American College of Radiology strongly, fully, and enthusiastically supports the ACR Board Chair's decision to appoint a Task Force on Continuing Certification in Radiology. The Council of the American College of Radiology strongly and fully supports the volunteer members who have agreed to serve on this critically important and timely body. The American College of Radiology shall strongly and fully support those task force members, in whatever manner necessary (e.g., through legal counsel, ethics committee, etc.) to ensure that they can diligently carry out their requested duties in an unimpeded manner without fear of undue influence; adopted 2019 (Res. 12).

4. MISCELLANEOUS EDUCATION POLICIES

a. Chapter Officers-Annual Education Session

An educational session will be conducted annually for state chapter elected leadership; adopted 1973, 1987, 1997, 2007, amended 2017 (Res. 24-k).

b. Qualifications of Non-Physician Personnel Who Provide Radiologic and Radiation Oncologic Services

The American College of Radiology supports state licensure, certification or appropriate methods designed to assure the qualifications of all personnel who provide the technical aspects of medical imaging and/or radiation therapy procedures.

Non-physician personnel, may provide those aspects of radiological or therapeutic procedures for which they have appropriate education, training and experience as defined in the appropriate current American College of Radiology Practice Parameters and Technical Standard(s), and then only under the supervision of a licensed physician(s) who has the qualifications described in those Practice Parameters and Technical Standards; 2000, amended 2010, amended 2020 (Res. 1-f).

c. Subspecialty Certification

The American College of Radiology endorses the following statement of the American Board of Medical Specialties Annual Report & Reference Handbook–1992 (page 57) which states:

“There is no requirement or necessity for a diplomate in a recognized specialty to hold special certification in a subspecialty of that field in order to be considered qualified to include aspects of that subspecialty within a specialty practice. Under no circumstances should a diplomate be considered unqualified to practice within an area of a subspecialty solely because of lack of subspecialty certification.

Specialty certification in a subspecialty field is of significance for physicians preparing for careers in teaching, research, or practice restricted to that field. Such special certification is recognition of exceptional expertise and experience and has not been created to justify a differential fee schedule or to confer other professional advantages over other diplomates not so certified.”

The American College of Radiology endorses the following statement from the American Board of Medical Specialties Annual Report and Reference Handbook–1992 (pages 52-53) which states:

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“It should be emphasized that there is no specific requirement for a diplomate in a recognized specialty to hold certification in a subspecialty of that field in order to include aspects of that subspecialty within the range of privileges”; 1992, 2002, amended 2012 (Res. 12-b).

Diagnostic radiology certification by the American Board of Radiology is a prerequisite for subspecialty certification in radiology; 1973, 1987, amended 1997, 2007, amended 2017, 2022 (Res. 28-f).

d. **Standard Early Radiology Education for Medical Students by Radiologists**

The ACR will form a taskforce to investigate avenues for introducing all medical students to radiology (diagnostic radiology, interventional radiology, and radiation oncology) taught by radiologists and/or radiation oncologists throughout their first through third years, and/or a longitudinal radiology curriculum, to allow medical students the opportunity to select diagnostic radiology, interventional radiology or radiation oncology early enough as their career preference and be able to match successfully into the corresponding residency program those seeking a career in other areas of medicine to have an appreciation of radiology’s central role. The taskforce will report to the Council at its 2021 meeting; adopted 2020 (Res. 34).

B. DRUGS AND EQUIPMENT

1. **ACR-NEMA DIGITAL IMAGING AND COMMUNICATIONS STANDARDS**

The ACR endorses this Committee’s activities in the development of ACR-NEMA Digital Imaging and Communications Standard(s); adopted 1984, 1994, 2004, 2014 (Res. 28-a).

2. **MEDICAL DEVICES: FDA APPROVAL FOR MEDICAL DEVICES, DRUGS AND CONTRAST AGENTS**

The ACR, through direct efforts with the FDA and possible legislative initiatives, will try to accelerate and simplify the process of approval of new diagnostic and therapeutic devices and drugs including contrast agents; adopted 1986, 1996, 2006, 2016 (Res. 12-a).

3. **PORTABLE IMAGE MEDIA (CDS AND DVDS)**

The ACR strongly encourage the nation’s PACS vendors to adopt the IHE standards-based profiles; adopted 2010, 2020 (Res. 12-a).

4. **RADIATION ONCOLOGY**

a. **External Beam Radiation Oncology Equipment**

The use of radiation therapy external beam equipment shall be the responsibility solely of the radiation oncologist; adopted 1973, 1987, 1997, 2007, 2017 (Res. 37-a).

b. **Safe Equipment and User Training for Radiation Oncology**

The American College of Radiology will develop lines of communications with representatives of other concerned groups including federal agencies and manufacturers of radiation therapy

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equipment, to promote the necessary user training and equipment design to assure patient safety. The conclusions and recommendations of these interchanges will be regularly communicated by the American College of Radiology to the radiation oncology community for the most rapid implementation possible; adopted 1987, 1997, 2007, 2017 (Res. 37-b).

5. RADIOGRAPHICALLY IDENTIFIABLE MARKERS ON MEDICAL DEVICES

The American College of Radiology recommends that manufacturers include radiographic markers that are identifiable in vivo on all devices designed for use in the body; 1990, 2000, amended 2010, 2020 (Res. 12-b).

6. SUPERVISION OF IMAGING AND RADIATION ONCOLOGY EQUIPMENT

The College recommends to all governmental agencies, including those local regulatory agencies responsible for certificate of need programs, or other programs to distribute equipment, that all imaging equipment, should be under the direction of a radiologist or radiation oncologist in order to provide the highest level of patient care, including radiation protection; adopted 1975, 1987, 1997, 2007, 2017 (Res. 37-c).

7. UNIFORM TERMINOLOGY

The ACR urges manufacturers to develop uniform terminology for use in the preparation of descriptions and specifications of radiologic equipment and its components; adopted 1975, 1987, 1997, 2007, 2017 (Res. 37-d).

C. LEGISLATIVE – GOVERNMENT

1. NATIONAL INSTITUTE OF BIOMEDICAL IMAGING AND BIOENGINEERING AT THE NATIONAL INSTITUTES OF HEALTH

The American College of Radiology shall use its political resources to actively support the maintenance of the National Institute of Biomedical Imaging and Bioengineering at the National Institutes of Health; adopted 1997, 2007, amended 2017 (Res. 37-e).

2. FUNDING

The ACR in conjunction with the Academy of Radiology Research will continue to lobby federal agencies and Congress to adequately fund the National Institute of Biomedical Imaging and Bioengineering and the Biomedical Imaging Program within the National Cancer Institute, as well as the Advanced Research Projects Agency for Health (ARPAH) of the National Institutes of Health; 2002, amended 2012, amended 2022 (Res. 28-g).

3. WASTE DISPOSAL SITES

Recognizing the need for safe and economical low-level radioactive waste disposal sites, the American College of Radiology urges the development and licensing of such sites consistent with state regulation and in accordance with applicable federal laws; 1983, 1993, amended 2003, 2013 (Res. 41-a).

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4. NRC RADIATION SAFETY TRAINING REQUIREMENTS AND CLINICAL EXPERTISE IN NUCLEAR MEDICINE PRACTICE

The American College of Radiology affirms and promulgates the fact that training required for safe handling of radioactive materials in medical practice does not imply clinical expertise.

Training for radiation safety in the medical use of radioactive materials obtained to meet the training requirements of the NRC or Agreements States should only be obtained in programs approved by the Accreditation Council for Graduate Medical Education, Single GME Accreditation System, the Royal College of Physicians and Surgeons of Canada (RCPSC), the College des Médecins du Québec or courses accredited by the Accreditation Council for Continuing Medical Education; 1998, amended 2008, amended 2018 (Res. 33-b).

5. ACR Position on Legislation Regarding Payment of Registered Radiologist Assistants

The official policy of the ACR is that for MARCA (and related legislation pertaining to payments for Registered Radiologist Assistants) the ACR will neither support nor oppose such legislation; adopted 2022 (Res. 1).

D. PROFESSIONAL LIABILITY

1. NON-COMPETE CLAUSES IN RESIDENCY AND FELLOWSHIP CONTRACTS

The American College of Radiology strongly oppose resident/fellowship contractual restrictions on future employment by all institutions sponsoring post-graduate radiology training; adopted 1998, 2008, 2018 (Res. 12-a).

2. HOSPITAL RISK MANAGEMENT COMMITTEES AND THEIR IMPACT ON RADIOLOGY

State legislation and regulations promulgated to require risk management programs should provide, at a minimum, the same type of confidentiality protection from disclosure in professional liability litigation as that given to the file of peer review committees; 1986, 1996, amended 1997, 2007, 2017 (Res. 37-f).

3. MEDICAL LIABILITY REFORM

The American College of Radiology supports federal and state legislative initiatives for medical liability reforms to reduce the burden of unwarranted claims and unjustified damage awards on the nation's physicians. Such reforms might include:

- limitations on recovery of non-economic damages;
- the mandatory offset of collateral sources of plaintiff compensation;
- decreasing sliding scale regulation of attorney contingency fees;
- periodic payment for future awards of damages;
- limiting the period of suspension of statutes of limitations for minors to no more than six years;

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- a certificate of merit requirement as a condition to filing medical liability suits; and
- the imposition of regulation of expert witness qualifications; 1990, 2000, amended 2010, amended 2020 (Res. 12-c).

The American College of Radiology joins with other national medical specialty societies and with the American Medical Association in supporting meaningful tort reform.

The American College of Radiology encourages its state chapters to support legislation requiring that an affidavit be filed with every professional liability lawsuit against a physician certifying the fact that the case is meritorious. The affidavit would contain a statement by the plaintiff's attorney that he or she has consulted a physician in full time practice limited to the same specialty as the defendant, and that the reviewing physician has determined in a written report, after a review of the medical record and other relevant material involved in the particular action, that there is a reasonable and meritorious cause for filing the lawsuit; 1987, amended 1997, 2007, 2017 (Res. 24-m).

E. WORKFORCE

1. FEDERAL/STATE RESTRICTIONS

The ACR believes it to be contrary to the public interest for federal and/or state authorities to:

- arbitrarily or artificially manipulate or restrict postgraduate training in various medical specialties; or
- dictate or restrict freedom of choice of medical practice opportunities by arbitrary or artificial means; 1980, 1990, 2000, amended 2010, 2020 (Res. 12-d).

2. GRADUATE MEDICAL EDUCATION FUNDING

The ACR supports funding for both direct and indirect graduate medical education costs from all payers for health care services; adopted 1996, 2006, amended 2016 (Res. 1-b).

3. JOB MARKET IN RADIOLOGY

The American College of Radiology shall continue and improve its analysis of the issues of human resource supply and demand in radiology. The ACR shall critically evaluate the number of diagnostic radiology, interventional radiology and radiation oncology residency positions and their relationship to available practice opportunities. In order to further strengthen the unity of the profession, the College shall stand ready to offer assistance to help residents and fellows address concerns and strategies for achieving employment; 1995, amended 2014 (Res. 1-d).

4. WORKFORCE STUDIES (*SEE ALSO* WORKFORCE IN RADIOLOGIC TECHNOLOGY)

The ACR reaffirms its support for the conduct of periodic workforce studies to anticipate the future demand for diagnostic radiologists, radiation oncologists, interventional radiologists, nuclear medicine physicians and medical physicists; adopted 1986, 1996, 2006, amended 2016 (Res. 23-a).

The ACR reaffirms its support for the conduct of periodic workforce studies of physicians, medical physicists, allied health workers in radiology, technologists, and non-physician radiology providers

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(NPRPs); 1981, 1992, 2002, amended 2012, amended 2022 (Res. 28-h).

The Board of Chancellors, through the appointed Commission on Human Resources, will continue surveillance of professional workforce needs in all branches of radiology, and that the results of this surveillance shall be translated into reports to the Council of the American College of Radiology at its annual meeting each year; 1974, 1987, amended 1997, 2007, amended 2017 (Res. 24-n).

5. IMPORTANCE OF RADIOLOGY RESEARCH

We recognize the importance of research to the future of radiology. The ACR shall promote, encourage, and participate in partnership with other radiological organizations to educate radiologists, radiology chairs, other academic department chairs, and deans regarding the importance of radiology research; 2002, amended 2012, amended 2022 (Res. 28-i).

F. RADIATION ONCOLOGY

1. CARROS' ROLE IN PRACTICE ENVIRONMENT CONCERNS WITHIN THE AMERICAN COLLEGE OF RADIOLOGY

CARROS will be recognized as one of the primary resources of information and personnel for appointments, assignments and recommendations to work groups regarding practice and economic matters which affect radiation oncology; adopted 1986, 1996, 2006, 2016 (Res. 34-a).

2. FOLLOW-UP EVALUATION OF RADIATION ONCOLOGY PATIENTS

The American College of Radiology strongly supports the concept that radiation oncologists must have the opportunity to follow, and should endeavor to follow, as appropriate, all patients they have treated to document the outcome of therapy, including the efficacy (tumor control and survival) and significant sequelae. The ACR strongly encourages financing intermediaries to make provisions for continued follow-up care with the radiation oncologist who provided the initial care; adopted 1994, 2004, 2014 (Res. 28-b).

3. HYPERTHERMIA GUIDELINES

The Council of the American College of Radiology accepts and endorses the guidelines for the qualifications of physicians prescribing, and supervising hyperthermia (Appendix A); adopted 1987, 1997, 2007, 2017 (Res. 37-f).

4. INTEGRATED MULTIDISCIPLINARY CARE OF PATIENTS

The American College of Radiology strongly endorses the concept of integrated multidisciplinary care for patients; adopted 1989, 1999, 2009, amended 2019 (Res. 35-a).

5. OUTCOME ANALYSIS

The American College of Radiology shall continue to assist radiation oncologists to perform outcome analyses of the patients under their care with respect to survival, local control, and quality of life; adopted 1995, 2005 (Res. 12).

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6. RADIATION ONCOLOGIST DEFINED

A radiation oncologist shall be considered to be a physician with certification in radiology by the American Board of Radiology who confines his/her professional practice to radiation oncology or certification in radiation oncology or therapeutic radiology by the BAR, the American Osteopathic Board of Radiology, the Royal College of Physicians and Surgeons of Canada, or the College des Medecins du Quebec.; adopted 1987, 1997, 2007, amended 2017 (Res. 37-h).

7. RADIATION RESEARCH PROGRAM FUNDING

The American College of Radiology will continue to encourage national funding agencies to support radiation research and to resist efforts to decrease or eliminate funds for such research; adopted 1986, 1996, 2006, 2016 (Res. 34-b).

8. ELECTRONICALLY-GENERATED, LOW-ENERGY RADIATION SOURCES (ELS)

The ACR state chapters should contact their state regulators to adopt the Suggested State Regulations (SSRs) for electronic brachytherapy developed by the Conference of Radiation Control Program Directors; adopted 2012, amended 2022 (Res 3-a).

9. RECOGNITION OF INTERVENTIONAL ONCOLOGY AND ONCOLOGIC IMAGING BY RADIOLOGY

The American College of Radiology will recognize Interventional Oncology as an important subspecialty in the treatment of cancer as practiced by interventional radiologists and radiation oncologists.

The American College of Radiology will promote education of diagnostic radiologists and radiation oncologists on the advances of Interventional Oncology therapies that may be offered within their own group(s), and on the need to promote communication between diagnostic radiologists, radiation oncologists and interventional radiologists to attain best patient care.

The American College of Radiology will promote research in Interventional Oncology.

The American College of Radiology will promote Interventional Oncology in radiology and radiation oncology residencies, and in the MOC curriculum; adopted 2007, 2017 (Res. 37-i).

10. SEALED SOURCE APPLICATION

The use of sealed sources, whether by intracavitary, surface application or interstitial implantation, shall be the responsibility solely of the radiation oncologist. Intravascular delivery of yttrium 90 (Y-90) microspheres may be administered by a radiation oncologist or another Authorized User as recognized by the NRC or agreement state; 1973, 1987, 2003, amended 2013 (Res. 41-b).

G. PEER REVIEW AND PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS

The American College of Radiology supports continued involvement by the medical community in health planning and the utilization review process on a local and regional level; adopted 1981, 1991, 2001, 2011, 2021 (Res. 27-a).

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H. PUBLIC HEALTH AND RADIATION PROTECTION

1. BIOLOGICAL EFFECTS OF RADIATION

The American College of Radiology maintains a continuing emphasis on optimizing the risk/benefit ratio regarding the use of ionizing radiation and will continue its efforts to provide to radiologists, medical physicists and technologists, up-to-date information concerning techniques to provide optimum image quality in diagnostic radiology and optimize the therapeutic ratio in radiation oncology, with minimum risk; adopted 1977, 1987, amended 1997, 2007, 2017 (Res. 37-j).

2. COMPUTED TOMOGRAPHY RADIATION DOSE

The ACR strongly encourages all radiologists to be aware of the radiation dose in CT examinations and to take the steps necessary to optimize the dose to patients, especially pediatric patients.

The ACR shall continue to support both Image Gently and Image Wisely initiatives to further raise this awareness; adopted 2001, amended 2011, 2021 (Res.27-b).

3. DEATHS AND INJURIES RELATED TO FIREARMS AS A MAJOR PUBLIC HEALTH CONCERN

The ACR recognizes that deaths and injuries related to firearms are a major public health concern; adopted 2015 (Res. 57).

4. DISPOSAL OF LOW-LEVEL RADIOACTIVE WASTE

The American College of Radiology encourages its chapters to actively support state and regional efforts to find safe, cost-effective, and technically sound methods of disposing of low-level radioactive waste. The American College of Radiology will continue to work with the public and other interested bodies to foster understanding and acceptance of the need for the responsible handling of low-level radioactive waste. The American College of Radiology will continue to join with other interested medical organizations in reaffirming support for the timely development of low-level radioactive waste disposal sites in accordance with federal law; adopted 1992, amended 2002, 2012, amended 2022 (Res. 3-b).

5. GONADAL SHIELDS

The American College of Radiology endorses guidelines for the use of gonadal shields in appropriately selected diagnostic radiologic examinations as promulgated by the Center for Devices and Radiologic Health; adopted 1976, 1987, 1997, 2007, 2017 (Res. 37-k).

6. MEDICAL RADIATION SHIELDING DESIGN LIMITS FOR THE GENERAL PUBLIC

The American College of Radiology adopts the position statement on medical radiation shielding. (Appendix H); adopted 2004, amended 2014 (Res. 28-c).

7. TOBACCO CESSATION

The ACR endorses the reduction and elimination of cigarette smoking and other forms of tobacco use; adopted 2014 (Res. 8).

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8. ACR PATIENT ADVOCACY LIAISON PROGRAM

The ACR continue to explore ways to enhance existing relationships and build liaisons with the leading patient advocacy groups in the United States; adopted 2015 (Res. 12).

9. PNEUMOCONIOSIS

The ACR shall continue to support the National Institute of Occupational Safety and Health under suitable contracts; 1981, 1991, 2001, amended 2011, 2021 (Res. 27-c).

The ACR and its constituent chapters will aid the National Institute of Occupational Safety and Health and the Department of Labor in quality control by whatever means may be most appropriate to local circumstances; adopted 1979, 1989, 1999, 2009, 2019 (Res. 13-a).

10. PROBABILITY OF CAUSATION AS A METHOD FOR ESTIMATING CANCER RISK ASSOCIATED WITH RADIATION EXPOSURE

The American College of Radiology emphasizes that medical uses of ionizing radiation to diagnose and treat disease represent a benefit-risk judgment for patients and physicians in which the demonstrated benefits to the patient must be balanced against the far less explicit possibility that the radiation exposure might enhance the risk of induction of cancer in that individual at some future date. The National Institutes of Health (NIH) and the National Academy of Sciences (NAS) have published radioepidemiological tables and computer programs relating probability of causation to absorbed dose.; adopted 1985, 1995, 2005 (Res. 12).

Causation estimations are often expressed by effective dose estimations. Effective dose estimates are not individual-specific and contain large uncertainties at the radiation exposure levels commonly used in diagnostic imaging. The ACR agrees with the statement of the International Council of Radiological Protection (ICRP), which states: "The use of effective dose for assessing the exposure of patients has severe limitations that must be considered when quantifying medical exposure", and "The assessment and interpretation of effective dose from medical exposure of patients is very problematic when organs and tissues receive only partial exposure or a very heterogeneous exposure which is the case especially with x-ray diagnostics" (ICRP Report 103, published 2007); 1985, 1995, 2005, amended 2015 (Res. 43-b).

11. RADIATION SAFETY OFFICER (RSO) TRAINING

The ACR, in collaboration with the American Association of Physicists in Medicine (AAPM) and other stakeholders, will provide models and educational materials for medical physicists, radiologists, radiation oncologists, and nuclear medicine physicians who provide RSO services; adopted 2012, amended 2022 (Res. 3-c).

12. THERAPEUTIC USE OF UNSEALED RADIONUCLIDE SOURCES

It is the position of the American College of Radiology that nuclear medicine physicians, radiation oncologists and specifically trained interventional radiologists are particularly qualified by training and experience to administer unsealed radionuclide sources for the treatment of cancer and can do so independently. Often, the preferred approach is for the nuclear medicine physician and radiation oncologist or nuclear medicine physician and interventional radiologist to work together as a physician team. The approach that is chosen may vary from patient to patient depending on the type of cancer being treated, local expertise, and patient-related issues. Whichever approach is used, it is

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important that patient selection, as well as overall treatment planning and follow-up, be performed by physicians with training and expertise in cancer management, basic radiation safety, and radiation physics; 1994, 2004, amended 2014 (Res. 28-d).

13. THE AMERICAN OPIOID CRISIS

The ACR will study the possibility of issuing a formal position statement, developing policies, and/or developing guidelines for its members to address the opioid crisis; adopted 2018 (Res. 21).

14. ABUSIVE HEAD TRAUMA

The ACR affirms that shaking of young infants and children with force, other than that of the normal handling of an infant or child, can potentially cause significant injury to the brain. The ACR affirms that there is a public health concern created by mischaracterization of diagnosis of abusive head trauma. The ACR affirms that providing options and testimony regarding abusive head trauma, unsupported by the medical evidence, poses a risk to infants and children by undermining child abuse prevention efforts (i.e., by falsely suggesting that shaking is not dangerous) and deterring parents and caregivers from seeking medical care (i.e., by falsely suggesting that child abuse is over-diagnosed); adopted 2019 (Res. 11).

15. FIREARM INJURY PREVENTION CONSENSUS STATEMENTS

The ACR endorses the Consensus Statements included in “Proceedings from the Medical Summit on Firearm Injury Prevention: A Public Health Approach to Reduce Death and Disability in the United States;” adopted 2019 (Res. 45).

16. ENVIRONMENTAL SUSTAINABILITY AND CLIMATE CHANGE

The ACR will join the Medical Society Consortium on Climate and Health, an organization with dozens of member medical societies which have come together to advance the goals of sustainability and climate change action. The ACR will create a task force on radiology’s environmental impact and climate change mitigation and adaptation strategies for radiology. This ACR task force will collaborate with other interested stakeholders to develop a resource for radiology practice self-assessment of environmental impact of radiology applicable to the diverse practices of ACR members, as well as the ACR itself. Also, the task force will identify measures to address and mitigate the deficiencies found in the self-assessment and disseminate these measures to the ACR members. The task force will present an interim report in December 2022 and will report its progress to the ACR Council at the 2023 annual meeting; adopted 2022 (Res. 14).

I. RADIOLOGICAL PRACTICE AND ETHICS

1. ACCREDITATION

a. ACR Accreditation Information

The American College of Radiology shall post on its web site information related to practice parameters and technical standards and accreditation programs so that it is easily available in a user- friendly format at all times to all ACR members. This downloadable information would include practice parameters and technical standards, and accreditation information; adopted 1999, 2009, amended 2019 (Res. 24-a).

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b. Accreditation Programs: Council Approval

The Council recognizes the success of the existing ACR accreditation programs. Future accreditation programs in radiology shall be approved by the ACR Council prior to their development. Each completed accreditation program shall be presented to the Council Steering Committee for comment prior to presentation to the Board of Chancellors for final approval prior to implementation; 1994, amended 2004, 2014 (Res. 21-a).

Once a completed accreditation program has been reviewed by the Council Steering Committee and approved by the Board of Chancellors, that program may only be modified by the accreditation committee which developed it, either acting on its own volition to improve the program based on annual or more frequent review, or by a majority vote of the accreditation committee members in response to an appropriately filed, written appeal (Appendix B) by any active or eligible participant. 2000, amended 2010, amended 2020 (Res. 12-e).

c. Business Plans for ACR Accreditation Programs

Any future resolutions presented to the ACR Council regarding development of new accreditation programs will include a business plan that demonstrates development costs, operational costs and number of participating facilities needed to be cost-effective. Such a business plan may also include the results of a survey of a sample of ACR membership that shows whether there will be an adequate number of applicants to reach the required level of participation to be cost-effective; 2003, amended 2013 (Res. 4-a).

d. Certificates of Accreditation

Certificates of accreditation are valid for three (3) years at which time radiologists will be invited to apply for reinspection; adopted 1987, 1997, 2007, 2017 (Res. 1-a).

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

a. New Process for Comment and Approval of Practice Parameters and Technical Standards

Starting with the 2024 Annual Meeting there will be a new process for approval of Practice Parameters and Technical Standards (PP&TS) which will apply to all PP&TS, including those sponsored by multiple organizations, trialed for a period of not less than two (2) years. At the end of the trial period, the ACR Council Steering Committee will gather specific comments from the leadership of each collaborative society involved in the trial PP&TS process. Resolutions that are not PP-TS will continue to follow the current meeting structure with reference committee hearings at the Annual ACR Meeting.

The new process will be inclusive of the following –

- All PP&TS will be made available during the field review process for ACR member comment simultaneously, with a common deadline. The comment period will be at least 6 weeks in length and no more than 12 weeks;

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- A virtual PP&TS meeting open to all ACR members will be created which will occur at least 3 weeks before the Annual Meeting, with the structure of this meeting mirroring existing reference committee open sessions. Depending on the number of PP&TS up for approval, a small number of dedicated PP&TS reference committee(s) will be formed which will hear testimony on proposed PP&TS language at the dedicated PP&TS meeting;
- After hearing testimony at the dedicated, virtual PP&TS meeting, the reference committee(s) will formulate a final draft version of all PP&TS being considered which will be distributed to Council and to co-sponsoring organizations at least one week prior to the Annual Meeting;
- The final draft version of the PP&TS will be presented to Council as a consent agenda. Persistent ACR member concerns may be resolved by extraction of an individual PP&TS by an ACR Councilor after a motion. Unextracted PP&TS will be passed with the consent agenda after a simple majority vote by Council;
- An extracted PP&TS will go through the reconciliation process again for presentation at the next Annual Meeting unless Council determines, by a simple majority vote, that the PP&TS in question needs to be discussed at the current Annual Meeting due to the importance of having an active/updated PP&TS on the subject;
- Should an extracted PP&TS be determined to warrant discussion at the current Annual Meeting, standard parliamentary procedure states that any discussion point not previously brought up during the dedicated, virtual PP&TS meeting is out of order; and
- Extracted PP&TS will revert to the most recently approved version, until superseded by a newer version approved by Council; adopted 2022 (Res. 2).

b. ACR–AAPM Collaborative Medical Physics Practice Parameters and Technical Standards

ACR staff, working with the ACR Commissions on Medical Physics and Quality and Safety, will adopt a methodology for the expedited approval of appropriate ACR-AAPM Collaborative medical physics practice parameters and technical standards. The ACR Council Steering Committee and Board of Chancellors will provide final review and approval of the document(s) on behalf of the College; adopted 2015 (Res. 54).

c. ACR Radiation Oncology Practice Parameters and Technical Standards

After completion of field review and the CSC chaired conference call, the proposed collaborative radiation oncology practice guideline or technical standard work product will then be reviewed by the ACR Commission on Radiation Oncology and ACR Commission on Medical Physics.

After review and approval by the ACR Commission on Radiation Oncology and the ACR Commission on Medical Physics, it will next be reviewed by the ACR Council Steering Committee.

After review and approval by the ACR Council Steering Committee it will be sent to the ACR Board of Chancellors for final review and approval by the College; adopted 2010, 2020 (Res. 23-a).

d. Changes to Physician Qualifications Section in the American College of Radiology Interventional Radiology Practice Parameters

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The ACR will edit the Qualifications and Responsibilities of Personnel section of the IR practice parameter documents to maintain language appropriate for AOBR and RCPSC certification but include the ABR's new IR/DR board certification. The ACR will notify the collaborating societies that worked on the IR practice parameter documents of these changes. If a society wants to be removed from the document because of the changes, it will be allowed to do so; adopted 2018 (Res. 44).

e. Expedited Review of ACR Practice Parameters and Technical Standards

The ACR Commission on Quality and Safety will establish a deliberative process, whereby a particular ACR Practice Parameters and Technical Standards Committee, with Council Steering Committee (CSC) and Board of Chancellors (BOC) representatives, may deem that particular ACR Practice Parameters and Technical Standards are appropriate for expedited review.

The CSC will act on behalf of the Council to address such ACR Practice Parameters and Technical Standards deemed urgent for expedited review as follows:

1. ACR members will have an open comment period to allow them to participate in the expedited review process;
2. After the comment period, the Speaker will call a meeting of the CSC to deliberate and decide upon that particular Practice Parameters and Technical Standards;
3. The CSC will inform the BOC of the approved Practice Parameters and Technical Standards;
4. Once received by the BOC, the Practice Parameters and Technical Standards will become effective immediately;
5. The ACR will immediately publish and also inform the Council of expedited Practice Parameters and Technical Standards at the next annual meeting.

The expedited review process will incorporate standard Conflict of Interest attestation and will not be used on a routine basis, nor will it preclude collaborative societies' participation; adopted 2015 (Res. 27).

f. Extension of Review Cycle for Eight Practice Parameters

The review cycle for the practice parameters listed below is hereby extended by one additional year and that these practice parameters are to be presented for consideration at the 2017 ACR Annual Meeting:

1. ACR Practice Parameter for the Performance of Hysterosalpingography
2. ACR Practice Parameter for the Performance of the Modified Barium Swallow
3. ACR Practice Parameter for Performing and Interpreting Diagnostic Computed Tomography (CT)
4. ACR-SPR Practice Parameter for the Performance of Chest Radiography

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5. ACR–SPR Practice Parameter for the Performance of Portable (Mobile Unit) Chest Radiography

6. ACR–SPR–SRU Practice Parameter for Performing and Interpreting Diagnostic Ultrasound Examinations

7. ACR Practice Parameter for the Performance of Total Body Irradiation

8. ACR Practice Parameter for Performing and Interpreting Magnetic Resonance Imaging (MRI); adopted 2015 (Res. 55).

g. Extend the ACR-SPR Practice Parameter for the Performance of Pediatric Computed Tomography (CT)

Based on the recommendation of the ACR Guidelines Committee on Pediatric Radiology of the Commission on Pediatric Radiology, the ACR-SPR Practice Guideline for the Performance of Pediatric Computed Tomography (CT) is hereby extended for one-year until revised and presented for adoption at the 2014 AMCLC; adopted 2013 (Res. 18).

h. Extend the ACR-AIUM Practice Parameter for the Performance of Vascular Ultrasound for Postoperative Assessment of Dialysis Access

Based on the recommendation of the ACR Guidelines Committee on Ultrasound of the Commission on Ultrasound, the ACR-AIUM Practice Guideline for the Performance of Vascular Ultrasound for Postoperative Assessment of Dialysis Access is hereby extended for one-year until revised and presented for adoption at the 2014 AMCLC; adopted 2013 (Res. 19).

i. Sunset the ACR-ACS-CAP-SSO Practice Parameter for Management of Ductal Carcinoma In-Situ of the Breast

Based on the recommendation of the ACR Commission on Breast Imaging and the ACR Committee on Breast Imaging for Appropriateness Criteria and Practice Parameters, the ACR-ACS-CAP-SSO Practice Guideline for Management of Ductal Carcinoma In-Situ of the Breast is hereby sunset and will be replaced by ACR Practice Guideline for the Imaging Management of DCIS and Invasive Breast Carcinoma; adopted 2013 (Res. 20).

j. Sunset the ACR–ACS–CAP–SSO Practice Parameter for Breast Conservation Therapy in the Management of Invasive Breast Carcinoma

Based on the recommendation of the ACR Commission on Breast Imaging and the ACR Committee on Breast Imaging for Appropriateness Criteria and Practice parameters, the ACR-ACS-CAP-SSO Practice Guideline for Breast Conservation Therapy in the Management of Invasive Breast Carcinoma is hereby sunset and will be replaced by ACR Practice Guideline for the Imaging Management of DCIS and Invasive Breast Carcinoma; adopted 2013 (Res. 21).

k. Extend the ACR–SIR Practice Parameter for Radioembolization with Microsphere Brachytherapy Device (RMBD) for Treatment of Liver Malignancies

Based on the recommendation of the ACR Guidelines Committee on Interventional Radiology of the Commission on Interventional Radiology, the ACR–SIR Practice Guideline for

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Radioembolization with Microsphere Brachytherapy Device (RMBD) for Treatment of Liver Malignancies is hereby extended for one-year until revised and presented for adoption; adopted 2013 (Res. 36).

1. Extend the ACR—SIR Practice Parameter for the Performance of Angiography, Angioplasty, and Stenting for the Diagnosis and Treatment of Renal Artery Stenosis in Adults

Based on the recommendation of the Parameters Committee on Interventional Radiology of the Commission on Interventional Radiology the ACR—SIR Practice Parameter for the Performance of Angiography, Angioplasty, and Stenting for the Diagnosis and Treatment of Renal Artery Stenosis in Adults is hereby extended for one-year until revised and presented for adoption; adopted 2014 (Res. 19)

- m. Maintenance of Competence in ACR Practice Parameters and Technical Standards

The Practice Parameters and Technical Standards' Maintenance of Competence section will be based on methods and criteria other than number of procedures, whenever possible; procedure volumes will be used only if there is strong evidence that requires use of such volumes. In addition, the Practice Parameters and Technical Standards' Maintenance of Competence section will be written consistent with the 2019 ACR Policy on Imaging Guided Procedures Core Privileges; adopted 2002, amended 2012, amended 2022 (Res. 3-d).

- n. Practice Parameters and Technical Standards

The qualifications and responsibilities of personnel section for the ACR PP& TS documents will no longer require a number of procedures that must be performed or reported within a specified time-frame to demonstrate proficiency, or if numbers are an absolute mandate, a reasonable alternate pathway will be designated to achieve compliance.

The Committee on Practice Parameters and Technical Standards will request collaborating societies to include representatives from community-based practices.

The Commission on Quality and Safety will oversee the committee on Practice Parameters and Technical Standards development and implementation of a blueprint to orient and train committee chairs, principal drafters, and collaborative committee members about the process, scope and purpose of the PP & TS documents, and the role of committee chairs to enforce the program standards prior to the start of each review cycle.

The Commission on Quality and Safety will report back to the Board of Chancellors, in consultation with the Council Steering Committee at the ACR 2019 meeting; adopted 2018 (Res. 43).

- o. Name of ACR Practice Parameters

Based on recommendations from the Board-appointed Task Force on Evaluation of Guidelines Methodology the name of the "ACR Practice Guidelines and Technical Standards" will be changed to "ACR Practice Parameters and Technical Standards". ACR Staff will implement the editorial change in all appropriate documents; adopted 2014 (Res. 39).

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p. Name and Construct of ACR Standards

The name “ACR Standards” has been changed to “ACR Practice Guidelines and Technical Standards.” Other recommendations of the Task Force regarding procedures for developing, approving, and disseminating these ACR documents have been implemented and will continue to be reviewed. The “Purpose and Intended Use Statement” and the “Preamble”, as proposed by the Task Force on the Name and Construct of ACR Standards, are adopted, and should be included with the Practice Parameters and Technical Standards (Appendix F); 2003, amended 2013 (Res. 4-b). *

q. Amend the Titles to 11 Existing Practice Guidelines

The titles to the 11 Practice Guidelines below will be revised to delete the words “pediatric and adult” or “adults and children” from their titles.

1. ACR–SPR Practice Guideline for the Performance of Chest Radiography (2011)
2. ACR–SPR Practice Guideline for the Performance of Portable (Mobile Unit) Chest Radiography (2011)
3. ACR Practice Guideline for the Performance of Thoracic CT (2008)
4. ACR–SSR–SPR Practice Guideline for the Performance of Radiography of the Extremities (2008)
5. ACR–ASNR–SNIS–SPR Practice Guideline for the Performance of Cervicocerebral MRA (2010)
6. ACR Practice Guideline for the Performance of CT of the Extracranial Head and Neck (2011)
7. ACR–NASCI–SPR Practice Guideline for the Performance of Body MRA (2010)
8. ACR–SPR Practice Guideline for the Performance of Hepatobiliary Scintigraphy (2008)
9. ACR–SNM–SPR Practice Guideline for the Performance of Pulmonary Scintigraphy (2009)
10. ACR–SNM–SPR Practice Guideline for the Performance of Radionuclide Cystography (2010)
11. ACR–SPR Practice Guideline for the Performance of Renal Scintigraphy (2008); adopted 2012 (Res. 8).

r. Practice Parameters and Technical Standards and Malpractice Litigation

The Board of Chancellors and/or the appropriate ACR committee shall continue to monitor the impact of ACR Practice Parameters and Technical Standards on Malpractice Litigation in radiology. adopted 1994, 2004, amended 2014 (Res. 21-b).

s. Pregnant Women: Facility Policy on Imaging Pregnant Women

The following statement regarding pregnancy is to be included in all of the Practice Parameters and Technical Standards of the American College of Radiology involving the use of ionizing radiation, with the exception of Radiation Oncology. All existing ACR Practice Parameters and Technical Standards involving ionizing radiation will be revised to include this statement.

“For the pregnant or potentially pregnant patient, see the ACR–SPR Practice Parameter for Imaging Pregnant or Potentially Pregnant Adolescents and Women with Ionizing Radiation.”; adopted 1995, 2005, amended 2015 (Res. 1-c).

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- t. Quality Control and Improvement, Safety, Infection Control, and Patient Education Concerns

The American College of Radiology has adopted the following principles relating to the issues of quality control and improvement, infection control, safety, and patient education. These principles shall be included in the publication of the ACR Practice Parameters and Technical Standards and be referenced in each document:

ACR POSITION STATEMENT

Quality Control and Improvement, Safety, Infection Control, and Patient Education Concerns

The American College of Radiology (ACR) continually promotes among its membership high regard for issues of quality and safety in radiologic procedures as they relate to the patients receiving the services, the personnel providing those services, and the equipment used to perform them as well as the education of patients regarding these matters. The statements that follow have been developed in support of that philosophy.

Equipment Quality Control

Ionizing Radiation

Each imaging facility should have documented policies and procedures for monitoring and evaluating the effective management, safety, and operation of equipment involved in the use of ionizing radiation for therapy, diagnosis and imaging. The quality control program should be designed to minimize patient, personnel, and public radiation risks and to maximize the quality of the diagnostic information or therapeutic benefit.

Equipment performance should be monitored and typical patient dose estimates should be made by a qualified medical physicist as described in the appropriate ACR-AAPM Technical Standard for Physics Equipment Performance Monitoring. Typical patient dose estimates should be compared against national benchmarks or diagnostic reference levels (DRLs), if available, and protocols should be reviewed if doses exceed DRLs. Routine quality control testing should be conducted by properly trained individuals with review at least annually by the supervising physician and qualified medical physicist as described in the appropriate ACR-AAPM Technical Standard for Physics Equipment Performance Monitoring.

Magnetic Resonance Imaging

Each facility should have documented policies and procedures for monitoring and evaluating the effective management, safety, and proper performance of magnetic resonance imaging equipment. Equipment performance should be monitored by a qualified medical physicist or a qualified MR Scientist as described in the ACR-AAPM Technical Standard for Diagnostic Medical Physics Performance Monitoring of Magnetic Resonance Imaging (MRI) Equipment. A documented quality control program shall be maintained at the MR site. Routine quality control testing should be conducted by properly trained individuals with review at least annually by the supervising physician and qualified medical physicist as described in the ACR-AAPM Technical Standard for Diagnostic Medical Physics Monitoring of Magnetic Resonance Imaging (MRI) Equipment.

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Ultrasound

Each facility should have documented policies and procedures for monitoring and evaluating the effective management, safety, and proper performance of ultrasound imaging equipment. Equipment performance should be monitored by properly trained individuals under the supervision of a qualified medical physicist as described in the ACR-AAPM Technical Standard for Diagnostic Medical Physics Performance Monitoring of Real Time Ultrasound Equipment. The quality control program should be designed to maximize the quality of the diagnostic information. Routine quality control testing should be conducted by properly trained individuals with review at least annually by the supervising physician and qualified medical physicist as described in the ACR-AAPM Technical Standard for Diagnostic Medical Physics Monitoring of Real Time Ultrasound Equipment.

Infection Control

Each facility should have policies and procedures in place to control the spread of infection among patients and personnel. These should include adherence to universal precautions and the use of clean or aseptic techniques as warranted by the procedure or intervention being performed.

Safety

Each facility should have in place policies and procedures to provide for the safety of patients and personnel. These should include attention to the physical environment, the proper use, storage, and disposal of medications and hazardous materials and their attendant equipment, and methods for addressing medical and other emergencies.

Patient Education

Each facility should have in place policies and procedures for educating and informing patients about procedures and/or interventions to be performed and facility processes for the same. This should include appropriate instructions for patient preparation and aftercare, if any. This information should be provided in an appropriate form to the patient and family, such as that provided on the ACR-RSNA website, www.RadiologyInfo.org.

Quality Improvement

Examinations should be systematically reviewed and evaluated as part of the overall quality improvement program at the facility. Monitoring should include evaluation of the accuracy of interpretation as well as the appropriateness of the examination. Complications and adverse events should be recorded and periodically reviewed in order to identify opportunities to improve patient care. These data should be collected in a manner that complies with statutory and regulatory peer-review procedures in order to ensure the confidentiality of the peer-review process; 1998, amended 2008, amended 2018 (Res. 33-v).

u. Revision of Practice Parameters and Technical Standards Review Cycle

ACR practice parameters and technical standards will be reviewed by the Council every five years, or sooner if directed by the Council Steering Committee, the Board of Chancellors or the Commission on Quality and Safety; 2000, amended 2010, 2020 (Res. 23-b).

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- v. Minor Modification of Standardized Language or Approved Policies/Resolutions Embedded in Practice Parameters and Technical Standards

The ACR Commission on Quality and Safety adopt the procedure below to modify standardized language or approved policies/resolutions embedded within existing Practice Parameters and Technical Standards-only when the standardized language or existing policies meet one or more of the following criteria:

1. When editorial review suggests that specific words or phrases no longer accurately represent the intent of the adopted practice parameter, technical standard or policy/resolution;
2. When new words or phrases have been approved by the Council and/or have developed since the adoption of the practice parameter, technical standard or policy/resolution that more accurately represent the meaning and intent of the practice parameter, technical standard or policy/resolution;
3. When a minor correction to specific language will improve understanding of the practice parameter, technical standard or policy/resolution so that it better addresses quality.

Procedure

- All existing Practice Parameters and Technical Standards which contain the standardized language to be modified will be identified.
- The suggested modification to the standardized language will be drafted and presented for review, along with the original standardized language and the list of the Practice Parameters and Technical Standards that contain the standardized language, to the Speaker, Vice-Speaker, Vice Chair of Quality and Safety for Parameters and Standards, and the Chair of the Commission on Quality and Safety.
- If there is agreement to recommend modification of the standardized language, the change will be sent to the Council Steering Committee for final approval.

If approved by the Council Steering Committee, the standardized language will be modified within each pertinent existing ACR practice parameter and/or technical standard to be published in the ACR Practice Parameters and Technical Standards on the ACR Website at the next publication. The document(s) will reflect the amendment and the effective date.

The ACR Commission on Quality and Safety shall annually report such changes; adopted 2008, 2018 (Res. 33-c).

- w. Standards: Implementation

The Commission on Quality and Safety will submit Radiologic Practice Parameters and Technical Standards, as they are developed, to the Council Steering Committee for review and recommendation to the ACR Council; adopted 1989, amended 1999, 2009, amended 2019 (Res. 24-b).

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x. Standards: Sunsetting Process

The ACR Commission on Quality and Safety adopt the following procedure to sunset existing practice parameters and technical standards when review of the literature indicates that a procedure or therapy is no longer considered effective or efficacious, or has been replaced by other procedure, technology, practice or treatment:

- The revising committee will write a proposal with justification of why the procedure or therapy should be sunset, for review by the practice parameter committee and the relevant commission.
- If the relevant committee and commission concur in the recommendation to sunset the practice parameter or technical standard, the proposal and justification will be submitted for review to the Speaker, Vice-Speaker, Vice Chair of Quality and Safety for Practice Parameters and Technical Standards, and the Chair of the Commission on Quality and Safety.
- If there is overall agreement to recommend sunsetting the practice parameter or technical standard, the sponsoring committee will draft a resolution for presentation to the Council that is sponsored by the Council Steering Committee.
- If approved by the Council, the practice parameter or technical standard will be removed from publication on the ACR Website, and the title of the practice parameter or technical standard will remain in the list of practice parameters and technical standards that have been sunset with the effective date; adopted 2007, amended 2017 (Res. 1-b).

y. Practice Parameters and Technical Standards: Written with Other Organizations

For practice parameters and technical standards written with other medical specialty organizations or societies, the ACR Council will follow the ACR Process for Amending Draft Collaborative Guidelines after submission to the ACR Annual Meeting; 1992, 2002, 2012, amended 2022 (Res. 3-e).

z. Collaborative and Conflicting Society Parameters and Standards

The ACR shall remove from a collaborative parameter or standard the name of any collaborating society that has produced, or produces in the future, an independent guideline or standard (subsequent to the production of the collaborative ACR parameter or standard) that conflicts with the ACR collaborative parameter or standard; adopted 2012, 2022 (Res. 3-f).

aa. Practice Parameters and Technical Standards: Uniform CME Statements

ACR practice parameters and technical standards will not include a specific number of required CME hours, except when required by the FDA or other government regulatory bodies. The CME section appearing in every ACR practice parameter or technical standard dealing with CME shall state: "The physician should follow the ACR Practice Parameter for Continuing Medical Education." The physician should include CME in whatever system or modality the practice parameter or technical standard addresses as is appropriate to their needs; adopted 1992, 2002, 2012, amended 2022 (Res. 3-g).

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bb. Revised Radiation Safety Language in Imaging Practice Parameters

The ACR will use the following language regarding radiation safety in all appropriate X-ray, fluoroscopy, interventional radiology, CT, and nuclear medicine ACR Practice Parameters and Technical Standards:

Radiation Safety in Imaging

Radiologists, medical physicists, registered radiologist assistants, radiologic technologists, and all supervising physicians have a responsibility for safety in the workplace by keeping radiation exposure to staff, and to society as a whole, “as low as reasonably achievable” (ALARA) and to assure that radiation doses to individual patients are appropriate, taking into account the possible risk from radiation exposure and the diagnostic image quality necessary to achieve the clinical objective. All personnel that work with ionizing radiation must understand the key principles of occupational and public radiation protection (justification, optimization of protection and application of dose limits) and the principles of proper management of radiation dose to patients (justification, optimization and the use of dose reference levels). [http://www-pub.iaea.org/MTCD/Publications/PDF/p1531interim_web.pdf].

[This paragraph applies to nuclear medicine Practice Parameters and Technical Standards only]. Facilities and their responsible staff should consult with the radiation safety officer to ensure that there are policies and procedures for the safe handling and administration of radiopharmaceuticals and that they are adhered to in accordance with ALARA. These policies and procedures must comply with all applicable radiation safety regulations and conditions of licensure imposed by the Nuclear Regulatory Commission (NRC) and by state and/or other regulatory agencies. Quantities of radiopharmaceuticals should be tailored to the individual patient by prescription or protocol.

Nationally developed guidelines, such as the ACR’s Appropriateness Criteria®, should be used to help choose the most appropriate imaging procedures to prevent unwarranted radiation exposure.

[This paragraph applies to x-ray imaging Practice Parameters and Technical Standards only] Facilities should have and adhere to policies and procedures that require varying ionizing radiation examination protocols (plain radiography, fluoroscopy, interventional radiology, CT) to take into account patient body habitus (such as patient dimensions, weight, or body mass index) to optimize the relationship between minimal radiation dose and adequate image quality. Automated dose reduction technologies available on imaging equipment should be used whenever appropriate. If such technology is not available, appropriate manual techniques should be used.

Additional information regarding patient radiation safety in imaging is available at the Image Gently® for children (www.imagegently.org) and Image Wisely® for adults (www.imagewisely.org) websites. These advocacy and awareness campaigns provide free educational materials for all stakeholders involved in imaging (patients, technologists, referring providers, medical physicists, and radiologists).

Radiation exposures or other dose indices should be measured and patient radiation dose estimated for representative examinations and types of patients by a Qualified Medical Physicist in accordance with the applicable ACR Technical Standards. Regular auditing of patient dose indices should be performed by comparing the facility’s dose information with national

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benchmarks, such as the ACR Dose Index Registry, the NCRP Report No. 172, Reference Levels and Achievable Doses in Medical and Dental Imaging: Recommendations for the United States or the Conference of Radiation Control Program Director's National Evaluation of X-ray Trends; 2006, 2009, amended 2013 (Res. 52).

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

The American College of Radiology will insert the following language describing the role of the Registered Radiologist Assistant (RRA) into the appropriate Practice Parameters for the Performance and Interpretation of the various radiologic examinations in which a Registered Radiologist Assistant 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 having successfully completed an advanced academic program encompassing an ASRT (American Society of Radiologic Technologists) radiologist assistant curriculum and a radiologist-directed clinical preceptorship.

Under radiologist supervision, the radiologist assistant may perform patient assessment, patient management and selected examinations as delineated in the ACR policy titled "Radiologist Assistant: Roles and Responsibilities" and as allowed by state law. The radiologist assistant transmits to the supervising radiologists those observations that have a bearing on diagnosis. Performance of diagnostic interpretations remains outside the scope of practice of the radiologist assistant; adopted 2006, 2016, amended 2020 (Res. 11).

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

dd. "Request for Examination" Language in Practice Parameters

The American College of Radiology will use the following language regarding the request for examination in all appropriate Practice Parameters:

The written or electronic request for (title of exam) should provide sufficient information to demonstrate the medical necessity of the examination and allow for the proper performance and interpretation of the examination.

Documentation that satisfies medical necessity includes 1) signs and symptoms and/or 2) relevant history (including known diagnoses). The provision of additional information regarding the specific reason for the examination or a provisional diagnosis would be helpful and may at times be needed to allow for the proper performance and interpretation of the examination.

The request for the examination must be originated by a physician or other appropriately licensed health care provider. The accompanying clinical information should be provided by a physician or other appropriately licensed health care provider familiar with the patient's clinical problem or question and consistent with the state scope of practice requirements; adopted 2006, 2016 (Res. 12-b).

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ee. Extension of Review Cycle for Two Practice Parameters

The review cycle for the practice parameters listed below is hereby extended by one additional year and that these practice parameters are to be presented for consideration at the 2018 ACR Annual Meeting:

1. ACR-ASNR-SCBT-MR Practice Parameter for the performance of MRI of the Adult Spine
2. ACR-ASNR-SPR Practice Parameter for the Performance of MRI of the Head and Neck; adopted 2016 (Res. 31).

ff. Imaging Guided Procedures Core Privileges

The ACR supports and encourages the use of core privileging methodology for physician privileging and re-privileging in the performance of imaging guided procedures by diagnostic radiologists and interventional radiologists.

Should procedural experience numbers be used for privileging and re-privileging, the numbers should be inclusive of a global compilation of an individual radiologist's imaging guided procedural experience, applicable to the spectrum of the core privileges.

A core privileging statement will be included in present & future relevant ACR imaging guided procedural practice parameter qualification sections.

The ACR will prepare and regularly update a library of core privileging templates based on a compilation of institutional and national organizational core privileging documents provided as a resource for ACR members to use in their individual privileging and re-privileging environments; adopted 2019 (Res. 23).

gg. Supervising Radiologist Understanding for Imaging Indication

The language in the ACR MRI practice parameter documents will be revised to include the word "imaging" before the word examination to clarify that this phraseology is intended to indicate complete familiarity with the imaging examination being performed rather than the individual patient being examined, and therefore read as follows "The supervising radiology physicians must understand the indications, risks, and benefits of the imaging examination, as well as alternative imaging procedures."

Working with the appropriate ACR members, staff will identify all relevant practice parameters in which the edits should be implemented; adopted 2020 (Res. 19).

hh. Extension of Review Cycle for One Practice Parameter

The review cycle for the practice parameter listed below is hereby extended by one additional year and this practice parameter is to be presented for consideration at the 2022 ACR Annual Meeting, adopted 2020 (Res. 20):

- (a) ACR-ASNR-ASSR-SPR Practice Parameter for the Performance of Computed Tomography (CT) of the Spine

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- ii. Sunset the ACR-SPR Practice Parameter for the performance of Liver and Spleen Scintigraphy

In the event that the ACR-ACNM-SNMMI-SPR Practice Parameter for the Performance of Gastrointestinal Tract, Hepatic, and Splenic Scintigraphy is adopted or adopted as referred by ACR Council, the ACR-SPR Practice Parameter for the Performance of Liver and Spleen Scintigraphy is hereby sunset; adopted 2020 (Res. 18).

3. POSITION STATEMENTS

- a. Benefits and Limitations of Mammography

The American College of Radiology reaffirms its position, consistent with its current ACR Practice Guideline for the Performance of Screening and Diagnostic Mammography, that all women 40 years of age or older should have an annual screening mammogram. The American College of Radiology will continue its educational programs with the ACR membership and the American public that discuss and review the indications, efficacy, benefits, and limitations of mammography; 2002, amended 2012, 2022 (Res. 41-a).

- b. Colorectal Cancer Screening

The American College of Radiology supports the practice of screening for colorectal cancer (CRC) as outlined in the articles: Lin JS, Perdue LA, Henrikson NB, Bean SI, Blasi PR. Screening for colorectal cancer: updated evidence report and systematic review for the US Preventive Services Task Force. (JAMA 2021; JAMA. 2021;325(19):1978-1998); Knudsen AB, Rutter CM, Peterse EFP, et al. Colorectal cancer screening: a collaborative modeling study for the US Preventive Services Task Force. (JAMA 2021;325(19):1965-1977); Levin B, Lieberman DA, McFarland B, et.al. Screening and Surveillance for the Early Detection of Colorectal Cancer and Adenomatous Polyp 2008: A joint guideline from the American Cancer Society, the U.S. Multi-Society Task Force on Colorectal Cancer, and the American College of Radiology (*CA Cancer J Clin* 2008; 58:130-160); 1992, 2002, amended 2012, amended 2022 (Res. 41-b).

- c. Endorsing AIUM's Clinical Safety and Prudent Use in Obstetrics Statements

The American College of Radiology supports and endorses the following AIUM Clinical Safety Statement; adopted 1999, 2009, 2019 (Res. 24-c).

Prudent Use and Clinical Safety approved March 19, 2007

Diagnostic ultrasound has been in use since the late 1950s. Given its known benefits and recognized efficacy for medical diagnosis, including use during human pregnancy, the American Institute of Ultrasound in Medicine herein addresses the clinical safety of such use:

No independently confirmed adverse effects caused by exposure from present diagnostic ultrasound instruments have been reported in human patients in the absence of contrast agents. Biological effects (such as localized pulmonary bleeding) have been reported in mammalian systems at diagnostically relevant exposures but the clinical significance of such effects is not yet known. Ultrasound should be used by qualified health professionals to provide medical benefit to the patient.

Prudent Use in Obstetrics approved March 19, 2007

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The AIUM advocates the responsible use of diagnostic ultrasound and strongly discourages the non-medical use of ultrasound for entertainment purposes. The use of ultrasound without a medical indication to view the fetus, obtain a picture of the fetus or determine the fetal gender is inappropriate and contrary to responsible medical practice. Ultrasound should be used by qualified health professionals to provide medical benefit to the patient.

d. Lung Cancer Screening Programs

The ACR shall continue to develop and maintain practice parameters, imaging appropriateness criteria, quality metrics, communication standards, and educational programs for a safe and effective lung cancer screening program.

The ACR will provide information to policy makers to assist in the implementation of payment policy decisions on lung cancer screening. The ACR will also promote lung cancer screening programs to patients and the medical community; adopted 2014 (Res. 9).

e. Mammography: Diagnostic Mammography Arising from Screening Mammography

The American College of Radiology will continue to work diligently with CMS, the Congress, and other payers to modify their policies so that screening and diagnostic mammography can be provided in a way that permits appropriate and efficient medical care without jeopardizing quality patient care; adopted 1992, amended 2002, 2012, 2022 (Res. 41-c)..

f. Multidisciplinary Evaluation of Prostate Cancer

If a diagnosis of localized prostate cancer is made, men should be offered multidisciplinary consultation regarding treatment options. This should include referral to a radiation oncologist to discuss the role of radiation therapy (external beam, brachytherapy, or combined modality therapy) as an option in definitive treatment. If a diagnosis of metastatic prostate cancer is made, multidisciplinary consultation should also include a nuclear medicine physician and/or radiation oncologist to discuss the role of radiation therapy and/or radiopharmaceutical therapy (e.g. Ra-223, Lu-177 PSMA) as options in treatment as appropriate; adopted 2001, 2011, amended 2021 (Res. 38-a).

g. Multidisciplinary Management of Early-Stage Breast Cancer

If a diagnosis of breast cancer is made women should be offered a multidisciplinary consultation regarding treatment options. This should include referral to a radiation oncologist to discuss the role of radiation as an option in conservative breast management; adopted 2002, 2012, 2022 (Res. 41-d).

h. Mobile X-Ray Services Guidelines

In order to achieve maximum patient benefit and diagnostic quality radiographs, mobile x-ray services should be under the direction of a qualified radiologist.

Radiologic technologists should work under the supervision of a radiologist to assure maintenance of diagnostic radiographic quality and safe operation of the x-ray equipment.

Ownership of the x-ray equipment and the submission of the total bill by the radiologist should eliminate the possibility of self-referral, fee splitting and over-utilization.

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The physician ordering the x-ray consultation should provide the radiologist with a brief medical history, physical findings, working diagnosis, and the reason for the mobile examination. Mobile studies should not be used for administrative convenience but for patients for whom it is clinically inadvisable to be transported to a fixed machine. It is especially important in providing radiologic services to nursing home or extended care facility patients that a verbal and/or written consultation between the referring physician and the radiologist be utilized to its fullest extent; adopted 1977, 1987, amended 1997, 2007, amended 2017 (Res. 1-c).

i. Pre-Admission Testing

The ACR supports pre-admission testing as one means to reduce length and cost of hospital stay wherever feasible and medically appropriate and, in addition, supports reimbursement for preadmission testing. Pre-admission testing is defined to include the performance of the following services within a reasonable, physician-determined interval prior to admission: (1) Radiology services provided by a physician qualified to offer the same service to in-patients under TJC standards which are also acceptable to the medical staff of an individual hospital. (2) Laboratory services provided in a facility which participates in a proficiency testing program which meets the standards set under TJC for the same services provided in an accredited hospital; adopted 1973, 1987, 1997, 2007, amended 2017 (Res. 1-d).

j. Position Statement on Non-operative Spinal/Paraspinal Ultrasound in Adults

The American College of Radiology adopts the following position statement on Non-Operative Spinal/Paraspinal Ultrasound in Adults, dated May 2001.

Over the past several years the successful application of ultrasound to the musculoskeletal system has been documented by multiple research studies in well-respected peer-reviewed journals. Ultrasound is useful in diagnosing abnormalities of tendons, joints, ligaments, muscles, and bursae. Spinal ultrasound is useful in neonates to assess for cord abnormalities and in adults for procedures such as lumbar puncture. However, as a diagnostic outpatient procedure in adults there is little to support use of ultrasound for assessment of the spinal/paraspinal regions. Due to the ubiquitous nature of back pain, there has also been interest in developing the use of ultrasound technology to evaluate the spine and paraspinal regions. However, this application of ultrasound technology has not been as promising.

Until such time as adequate research studies have been carried out and published in peer-reviewed journals which establish the efficacy of ultrasound evaluation of spinal and paraspinal regions, individuals performing these studies should be considered to be performing investigational procedures. Such investigation procedures do not fit under existing Physicians' Current Procedural Terminology (CPT) codes already established for ultrasound imaging of the musculoskeletal system, soft tissues of the neck or general abdomen. Practitioners performing these investigational procedures should not charge patients directly or indirectly for these costs.

Qualified physicians should be encouraged to carry out appropriate clinical research to prove the efficacy of ultrasound imaging on the spine and paraspinal regions. Patients should only have these procedures performed within the framework of clinical trials until their efficacy has been established; 2001, amended 2011, 2021 (Res. 38-b).

The use of diagnostic spinal ultrasound for the evaluation of pain or radiculopathy syndromes (facet joints and capsules, nerve and fascial edema, and other subtle paraspinal abnormalities)

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has no proven clinical utility as a screening, diagnostic or adjunctive imaging tool; adopted 1995, 2005 (Res. 25).

k. Screening CT Exams

The ACR Council adopts the following statement on Screening CT Exams until such time as additional data from scientific study is available. The American College of Radiology (ACR) recognizes that an increasing number of screening computed tomography (CT) examinations are being performed in the United States. Much screening CT is targeted at specific diseases, such as lung scanning for cancer in current and former smokers, coronary artery calcium scoring as a predictor of cardiac events and CT colonography (virtual colonoscopy) for colon cancer. However, the ACR does not believe there is sufficient evidence to justify recommending total body screening CT for patients with no symptoms or family or personal history suggesting disease. To date, there is no evidence that total body screening CT is cost efficient or effective in prolonging life. The ACR is concerned that this procedure will expose patients to ionizing radiation and lead to the discovery of numerous findings that will not ultimately affect patients' health; whole body screening CT may cause patient anxiety and may result in unnecessary follow-up examinations and treatments and significant wasted expense. The ACR will continue to monitor scientific studies concerning these procedures; adopted 2003, amended 2013 (Res. 4-c).

l. Sonographic Evaluations

The American College of Radiology supports the following:

- that ultrasound studies shall be supervised and sonographic interpretations must be rendered by a physician with appropriate training and experience in the specific area of sonography, and
- that registered sonographers are trained to assist and obtain information for supervising physicians, and
- that the rendering of a diagnosis from ultrasound studies represents the practice of medicine and is outside the responsibility of sonographers, and
- that the interpretations of the supervising physician must be recorded and results communicated in a timely manner to the referring physician; 1992, amended 2002, 2012, 2022 (Res. 41-e).

m. Support for Mammography and Study of Screening Modality Options

The American College of Radiology Council adopted the statement titled, "The ACR Remains Committed to Mammography and Supports Study of Screening Modality Options" (Appendix E); adopted 2003, amended 2013 (Res. 4-d).

n. Point of Care Ultrasound

Targeted point of care ultrasound can be useful as a limited bedside adjunct to the physical examination but is fundamentally different from comprehensive diagnostic ultrasound examinations such as those ordered by clinicians and performed in radiology departments with interpretation by radiologists.

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The American College of Radiology recognizes that training and credentialing and ongoing quality assurance are vitally important for all health care providers performing and interpreting sonographic examinations.

The American College of Radiology believes that targeted point of care ultrasound examinations without formal training, adequate standards, and documentation can be detrimental to patient care, including the risk of the patient receiving an incorrect diagnosis from an improperly performed sonographic examination; adopted 2013 (Res. 22).

o. Use of Diagnostic Ultrasound Equipment for Non-diagnostic Fetal Portraiture

1. Non-diagnostic Fetal Portraiture

The American College of Radiology (ACR) opposes all uses of diagnostic ultrasound equipment (including 3-D options) for non-diagnostic fetal portraiture; adopted 2001, amended 2011, 2021 (Res. 38-c).

2. Fetal Keepsake Videos for Entertainment Only

The ACR supports the FDA position that fetal ultrasound be performed only for medical purposes with a prescription from an appropriately licensed provider. Please refer to the ACR-ACOG-AIUM-SRU Practice Guideline for the Performance of Obstetrical Ultrasound.; adopted 2004, amended 2014 (Res. 21-c).

p. Whole Body MRI Screening Exams

The ACR adopted the attached Statement on Whole Body MRI Screening Exams. (Appendix I); 2004, amended 2014 (Res. 21-d).

q. Mammography CME Requirements and Due Process

The American College of Radiology will make it a priority to advocate for a change to federal mammography law so that the three year requirement for 15 hours CME credit is based on the calendar year instead of inspection dates. The American College of Radiology will also make it a priority to advocate for a change to the federal mammography regulations so that if a radiologist is found to be out of compliance on the CME requirements, he or she will have a minimum of 5 working days to show proof of having fulfilled the requirements or to cure the problem before his or her privileges to read mammograms can be removed; adopted 2006, 2016 (Res. 34-c).

r. ACR Position on Certifying Boards in Radiology

The official position of the ACR is that any boards certifying 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.

The official position of the ACR is that any boards certifying diagnostic radiologists, interventional radiologists, nuclear medicine physicians, radiation oncologists, and medical

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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.

The official position of the ACR is that any boards certifying diagnostic radiologists, interventional radiologists, nuclear medicine physicians, radiation oncologists, and medical physicists should share drafts of such participation agreements with all candidates and diplomats with sufficient time and a defined process to consider their input in advance of any final decisions concerning such participation agreements; adopted 2020 (Res. 50).

4. RADIOLOGY BY RADIOLOGISTS

a. Diagnostic Radiology

The fields of ultrasound, computed tomography, magnetic resonance imaging, positron emission tomography, PET-CT and PET-MR shall be considered as technology to be incorporated in the existing areas of radiology; adopted 1976, 1987, 1997, 2007, amended 2017 (Res. 1-e).

b. Radiology Is Best Practiced by Radiologists

Diagnostic or therapeutic techniques which utilize ionizing radiation should be under the direction of a qualified diagnostic radiologist, radiation oncologist, or interventional radiologist trained in the biologic effects of such energy forms on the human body and in their medical use. In general, the use of all modalities for morphologic and physiologic imaging in medical diagnosis will be optimized by concentrating these under the direction of radiologists specially trained in medical imaging.

The traditional referral basis of radiology practice derives from the above conviction that patients' needs for radiological services are best served by physicians wholly committed to this discipline.

These judgments are to be communicated to appropriate medical organizations, third parties and individuals; adopted 1975, 1987, 1997, 2007, 2017 (Res. 1-f).

Radiology is a specialty branch of the practice of medicine in which illness or disease is diagnosed or treated using various techniques or modalities, including radiant energy or ionizing radiation, ultrasound and magnetic resonance, among others. The education and training for the practice of radiology includes extensive study in the physics of radiant energy and the physics of medical imaging, radiation protection and the application of ionizing radiation in the diagnosis and treatment of disease. Radiologists have special expertise in the selection and utilization, as well as the sequencing of radiological procedures and techniques. The performance of radiological procedures or treatments by those with less training than that provided by approved radiology residency programs has been shown to lead to an increase in utilization and decrease in quality of care and cost-effectiveness. Diagnostic radiology, interventional radiology, and radiation oncology should be performed by qualified radiologists, interventional radiologists, and radiation oncologists, respectively, and these services should include consultation, supervision, performance of procedures, when required, and interpretation with a final report. Radiology and radiation oncology facilities should be staffed by and under the total supervision of qualified radiologists, interventional radiologists, and radiation oncologists. Patients, referring physicians, allied health care professionals, third party payers, HMOs, IPAs and PPOs, business and industry, and governmental agencies should be informed

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of the safety, quality, cost-effectiveness and desirability of the performance of radiology by qualified diagnostic radiologists, interventional radiologists, and radiation oncologists, and that this resolution become a policy statement of the American College of Radiology and be published as such; adopted 1986, 1996, 2006, 2016 (Res. 1-d).

c. Supporting Diagnostic Imaging Interpretations by Physicians

The ACR reaffirms its policy that only appropriately trained physicians may interpret diagnostic imaging examinations by providing reasonable and necessary support to its State Chapters for advocacy activities related to non-physician scope of practice expansion proposals related to the interpretation of diagnostic imaging; adopted 2015 (Res. 25).

d. Radiologist as Part of the Clinical Care Team

Radiologists in clinical practice diagnose and/or treat patients and are part of the clinical care team. “Requests” for consultation as opposed to “orders” may be used to indicate the process for referring health care professionals to obtain radiologists’ consultative and/or therapeutic services. Where appropriate, the terms “request” and “referring practitioner” should be used in ACR documents; adopted 2016 (Res. 32).

e. Nonphysicians and Interpretation

Existing ACR policy regarding nonphysician interpretation shall be modified to state that “rendering interpretations of medical imaging studies (preliminary, final, or otherwise) is beyond the scope of practice and is not the intended role of nonphysician members of the healthcare team, including NPRPs, radiologic technologists, nurses, and others, or any other but excluding physicians in training. Nonphysicians should not be permitted to render interpretations of medical imaging studies, whether under physician supervision or as an independent nonphysician healthcare provider;” adopted 2021 (Res. 16).

f. Nonphysician Interpretation

All existing and future ACR policies and practice parameters will reflect that an “interpretation” of an imaging procedure is the action of an individual and not defined by the location of their contributions in the report. Interpretations may appear anywhere in a radiology report or elsewhere in the medical record (e.g. findings, impression, or otherwise). Nonphysician members of the healthcare team, including radiologic technologists, nurses and others, should not be involved in the interpretation of an imaging examination regardless of where their observations are located in the report or medical record.

All existing and future ACR policies and practice parameters will reflect that an “interpretation” is not defined by the availability of a report to other healthcare providers, but rather by its content and the nature of intellectual activity which produced it. Specifically, reports and/ or notes in the medical record in any stage of completion by a nonphysician when that nonphysician was not directly involved in the acquisition of the medical images being interpreted or procedure which was performed, may all be considered interpretations, depending on their content. Such a report or note is considered an interpretation whether it is a draft (available only to a radiologist), a preliminary report, a final report, or any other written form.

Nonphysicians such as NPRPs and radiologic technologists may provide observations to the radiologist regarding targeted real-time image acquisitions or invasive procedures in which they

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were involved. Examples include a technologist providing observations from real-time targeted ultrasound or fluoroscopic image acquisitions and an NPRP describing a needle procedure they performed. Observations from a nonphysician who acquired medical images should be provided to the radiologist in a draft form only and should be limited to observations made during the acquisition of images (such as a sonographer worksheet). Observations from a nonphysician who performed or assisted in an invasive procedure may be provided to the radiologist in any portion of the radiology report and/ or medical record, and may be in any stage of completion as permitted by local institutional policy. It is not appropriate for nonphysicians to routinely provide observations on imaging studies and/ or procedures when they were not directly involved in the performance of the procedure or acquisition of the images (e.g. radiographs, mammography, CT scans, MRI scans, and nuclear imaging); adopted 2021 (Res. 17).

5. MISCELLANEOUS RADIOLOGIC PRACTICE AND ETHICS POLICIES

a. ACR to Educate Radiology Community and Others Regarding Unethical and Illegal Business Practices

The American College of Radiology will help to educate the radiological community, third party payers and the public on what may constitute unethical or illegal diagnostic imaging and radiation oncology business practices.

The Board of Chancellors will develop and implement a strategy to accomplish this mission; adopted 2007, 2017 (Res. 1-g).

b. Breast Imaging Reporting and Data System (BI-RADS™) for Scientific Purposes

The American College of Radiology shall encourage radiologists to utilize the reporting lexicon and the audit contained in the Breast Imaging Reporting and Data System (“BI- RADS™”); adopted 1993, 2003, amended 2013 (Res. 4-e).

c. Business Community Involvement

The American College of Radiology encourages radiologists to join and become active in their local business organizations; adopted 1991, 2001, amended 2011, 2021 (Res. 27-d).

d. Chiropractors: Statement of Interprofessional Relations with Doctors of Chiropractic

ACR declares that, except as provided by law, there are and should be no ethical or collective impediments to interprofessional association and cooperation between doctors of chiropractic and medical radiologists in any setting where such association may occur, such as in a hospital, private practice, research, education, care of a patient or other legal arrangement. Individual choice by a radiologist voluntarily to associate professionally or otherwise cooperate with a doctor of chiropractic should be governed only by legal restrictions, if any, and by the radiologist’s personal judgment as to what is in the best interest of a patient or patients.

Radiologists, with their expertise, are urged to be sensitive to and consider the legitimate radiologic needs of all licensed members of the healing arts, including doctors of chiropractic. In determining whether to associate professionally or consult with a doctor of chiropractic, a medical radiologist should take into account the type of studies requested and the purpose of the request. Doctors of chiropractic utilize x-rays for diagnostic purposes, for determining such

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things as leg lengths, anatomical abnormalities, contraindications to spinal adjusting and the need for referral to other licensed health care providers.

Finally, ACR reiterates its long-standing commitment to responsible use of radiation as a diagnostic tool and pledges to criticize irresponsible use of radiation, whether by medical doctors, doctors of chiropractic, or other members of the healing arts. Any prior statements of the ACR inconsistent with this position statement are rescinded; adopted 1987, 1997, 2007, 2017 (Res. 1-i).

e. Clinical Data

In order to optimize value and guide the most appropriate medical imaging for the care of our patients, the ACR supports and encourages its members, requesting providers, and their institutions to ensure the availability of accurate, pertinent, and expedient clinical information at the time that imaging services are requested, performed and interpreted. Clinical Decision Support and other systems that use *Provider-led entity (PLE) developed* Appropriate Use Criteria (AUC) can be particularly valuable tools in accomplishing this objective; adopted 1979, 1989, 1999, 2009, amended 2019 (Res. 24-d).

f. Direct Patient Communication

Radiologists are encouraged to increase direct communication with their patients in a manner appropriate to the clinical circumstances and in accordance with the patient's wishes; adopted 2000, 2010, amended 2020 (Res. 23-c).

g. Distribution of Imaging Reports

The American College of Radiology recommends that all imaging reports should be available to the patient in the interest of added value and personalized medicine.

The review of the ACR Practice Parameter for Communication of Diagnostic Imaging Findings will be undertaken as soon as possible rather than in 2015; adopted 2013 (Res. 37).

h. Electronic Health Record Interoperability

The ACR adopts the policy that “interoperability” and free exchange of patient imaging data across diverse RIS/PACS and EHR systems and among providers who are not economically aligned is essential to “patient centered medicine” and good patient care and to the maximization of the benefits of digital health care information, and is incumbent upon those who have received federal or state subsidies and/or been granted exemptions from the Stark laws with respect to EHRs.

The ACR will work to educate governmental agencies, payers, patient advocacy groups, and legislators of the above.

The ACR will make legislative and regulatory mandates for “interoperability” a priority in its advocacy groups, and legislators of the above.

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The ACR will explore avenues for legal action on behalf of radiologists when providers or provider organizations actively or passively restrict avenues to exchange of health information about mutual patients; adopted 2013 (Res. 53).

i. Implementation of the Clinical Practice of Interventional Radiology (IR) and Interventional Neuroradiology (INR)

The ACR works with SIR and SNIS to continually enhance and promote the growth and sustainability of IR and INR clinical services within the practice of radiology and within the health care system.

The ACR Radiology Leadership Institute (RLI) should consider the necessity of a longitudinal patient care model for IR and INR in designing its curriculum and include the appropriate course content to address that need.

The ACR, in partnership with the SIR and SNIS, should embark upon an educational campaign to promote and demonstrate the value of IR and INR clinical practices to patients, physicians, allied health providers, radiology practices, public and private third-party payors, government agencies, legislative representatives, and health care organization leaders; including but not limited to web-based information, printed materials, audio/visual media, and targeted conferences.

The ACR works with the SIR and SNIS to disseminate to radiology practices the existing support tools that facilitate the implementation of optimal IR and INR clinical practices; adopted 2012, amended 2022 (Res. 15-a).

j. Proprietary Clinical Pathways Policy

The ACR recognizes that properly constructed clinical pathways are educational and research tools that may assist physicians in clinical decision-making. However, the ACR opposes proprietary clinical pathways, or any utilization ‘product,’ that has not been the subject of independent external review by relevant physician organizations and by actively practicing physicians with specialty expertise relevant to the product and that may be used by third party payers to recommend, suggest or compel, directly, indirectly or implied, the use of such pathways. Use of clinical pathways in the hospital setting should be in compliance with policies and procedures set by the organized medical staff. 2002, amended 2012, amended 2022 (Res. 41-g).

k. Radiologist Admitting Privileges

Radiologists should have access to admitting privileges in hospitals where they practice; adopted 2002, 2012, 2022 (Res. 41-h).

l. Support of Clinical Patient Management by Vascular and Interventional Radiologists

The American College of Radiology (ACR) recognizes the importance of the development of a clinical service by interventional radiologists in order to appropriately manage patients.

The ACR opposes any attempt to prohibit vascular and interventional radiologists from being granted admitting and other clinical privileges based solely on their designation as radiologists.

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The ACR affirms the importance of vascular and interventional radiologists establishing physician-patient relationships that are also customarily maintained by other physicians who provide comparable services.

The ACR encourages and supports the establishment of interventional radiology clinical services within the practice of radiology groups including the following:

- Establishment of an adequate clinical team.
- Dedicate adequate space for clinical visits.
- Inpatient admitting service.
- Dedicated time for seeing inpatients and patients in a clinic.
- Noninvasive vascular laboratory.
- Clerical services for scheduling, insurance authorization and billing of procedures and evaluation/ management services.
- Support for time and materials for promotional and educational efforts; adopted 1999, 2009, 2019 (Res. 13-b).

m. ACR Conflict of Interest Policy

The Council of the American College of Radiology adopts the revised Conflict of Interest Policy in lieu of the Conflict of Interest Disclosure provision adopted in 2011 as Resolution 47-h.

n. Conflict of Interest Disclosure

All ACR leaders (including BOC and CSC members and those running for office in the above) must comply with the disclosure requirements of ACR Conflict of Interest Policies, with such required disclosures, including, but not limited to, all management, board membership or ownership relationships with companies that consult with hospitals or provide radiology services. These disclosures should be listed prominently in the election manual and ACR meeting materials; adopted 2010, 2020 (Res. 23-d).

o. Delineation of Privileges in Radiology

The American College of Radiology shall approve the dissemination of the document entitled “Delineation of Privileges in Diagnostic Radiology and Nuclear Medicine” (Appendix C) to ACR members as a resource document; adopted 1986, 1996, 2006, 2016 (Res. 12-c).

p. Department Practices, Recommended

The following management techniques, educational programs, and policies can be used by radiology departments to cut operational costs, reduce radiation exposures, and discourage over-utilization or inappropriate utilization of x-ray examinations without discounting premium radiologic consultation and performance:

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- Establish quality assurance programs in all hospitals and ambulatory facilities.
- Implement goals.
- Review policy and procedures of the department.
- Analyze replacement and new equipment needs.
- Educate the referring physician; 1979, 1989, 1999, amended 2009 (Res. 1-c).

q. Efficacy

1. Efficacy Studies

The ACR will continue to sponsor studies evaluating appropriateness, outcomes, and value; adopted 1979, 1989, 1999, 2009, amended 2019 (Res. 24-e).

2. Thermography Efficacy

The position of the American College of Radiology is that thermography has not been demonstrated to have value as a screening, diagnostic, or adjunctive imaging tool; adopted 1990, 2000, 2010, 2020 (Res. 23-e).

r. Family Leave Policy

The ACR supports the development of family leave policies in radiology facilities consistent with federal and state laws; adopted 2001, amended 2011, 2021 (Res. 38-d).

s. Paid Family/Medical Leave in Radiology, Interventional Radiology and Radiation Oncology

The ACR recommends that diagnostic radiology, interventional radiology, radiation oncology, medical physics, and nuclear medicine practices, departments and training programs strive to provide 12 weeks of paid family/medical leave in a 12-month period for its attending physicians, medical physicists, and members in training as needed; adopted 2022 (Res. 13).

t. Health Care Delivery Systems

Organization of health care delivery systems must include careful consideration of the adequacy of professional staffing and facilities for radiological service; adopted 1987, 1997, 2007, 2017 (Res. 1-i).

u. Independent Practice

In the independent practice of hospital radiology, the radiologist should have full responsibility and authority for the performance and interpretation of procedures for which he/she, and not the hospital, bills and receives a professional fee for services from patients or agencies responsible for paying physicians.

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The ACR favors independent practice as a preferred way of practicing radiology, which includes separate billing and open staff. The ACR recommends that the practice of radiology in a hospital or institution be conducted according to the open staff principles as they exist in the hospital or institution; adopted 1976, 1987, 1997, 2007, amended 2017 (Res. 1-j).

v. Informed Consent

The American College of Radiology recommends that informed consent should be obtained from patients on whom radiological procedures with a significant incidence of serious complications are to be performed. Where consent is to be obtained for procedure, the radiologist, radiation oncologist or interventional radiologist or his or her designee, should be involved on a personal level with the patient, family, or guardian as clinical circumstances warrant. There is no recognized consensus as to whether or not radiologists should obtain informed consent from patients for a procedure with a low incidence of serious complications. In deciding whether or not to obtain informed consent for these procedures, the radiologist should be knowledgeable about the statutory and/or common law for the particular practice setting; 1987, amended 1997, 2007, 2017 (Res. 31-k).

w. Interpretation of Radiologic Examinations Not Directly Supervised or Monitored by the Radiologist.

The ACR will continue to monitor the legal, ethical, professional liability and state licensure aspects of medical imaging interpretation when off site within a state and particularly in other states remote from the practical site.

Interpretation of these cases should be in compliance with the ACR—AAPM—SIIM Technical Standard for Electronic Practice of Medical Imaging, the ACR Practice Parameter for Communication of Diagnostic Findings, and the Report of the ACR Task Force on Teleradiology Practice (2013); adopted 1992, 2002, 2012, amended 2014, 2022 (Res. 15-b).

x. Managed Health Care

The American College of Radiology shall continue its efforts to study the trends in managed care to develop plans of action, and to communicate this information to its membership in a timely fashion. The ACR supports appropriate federal and state legislation which prohibits unreasonable restriction of diagnostic radiologists, radiation oncologists interventional radiologists, nuclear medicine physicians and medical physicists from participation in managed care plans, and which guarantees patient access to radiologic services; 1993, 2003, amended 2013 (Res. 41-c).

The American College of Radiology actively advises radiologists that they need to become informed of their legal rights and obligations before they enter into any health care contract. The American College of Radiology will continue to gather data regarding radiologists' participation in new payment models; adopted 1992, 2002, amended 2012, amended 2022 (Res. 15-c).

y. Medical Staff Privileges, Exclusive Contracts, and Economic Credentialing

Quality in Hospital Clinical Privileges

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The American College of Radiology reaffirms its current policies on medical staff privileges, exclusive contracts, and economic credentialing (Appendix C); 1986, amended 1996, 2016 (Res. 34-d).

The American College of Radiology will work with its state chapters, the American Medical Association, and state medical associations in seeking state legislation that incorporates the following principles:

- A physician or medical physicist's medical staff appointment and clinical privileges include the right of access to hospital equipment, facilities, personnel, and other resources as usually provided to exercise those privileges.
- Hospitals should not deny, restrict, revoke, or terminate medical staff membership or clinical privileges primarily on the basis of economic criteria unrelated to a practitioner's qualifications and professional responsibilities.
- Medical staff appointments and clinical privileges should only be curtailed, restricted, or terminated upon formal recommendation of the medical staff and for reasons related to professional competence, adherence to appropriate standards of medical care, health status, or other parameters agreed upon by the medical staff, and in accordance with the due process protections contained in the federal Health Care Quality Improvement Act of 1986 or hospital medical staff bylaws.
- Hospitals should not attempt to circumvent or suppress due process protections in hospital medical staff bylaws through written contract or by bylaws and policy amendments; adopted 1996, 2006, 2016 (Res. 23-b).

Hospital Medical Staff Bylaws

The ACR expresses concern over hospital efforts to make changes in medical staff bylaws which reduce or eliminate fair hearing rights. The ACR will make available model medical staff bylaws and sources of appropriate legal counsel to represent hospital medical staffs; adopted 1992, amended 2002, 2012, 2022 (Res. 15-d).

Medical Staff Privileges, Exclusive Contracts, and Economic Credentialing

The ACR adopts as policy the following statement on medical staff privileges, exclusive contracts, and economic credentialing.

ACR Policy on Medical Staff Privileges, Exclusive Contracts, and Economic Credentialing

Medical Staff Privileges

The American College of Radiology believes that all physicians who are members of the hospital medical staff have the same rights. Principles including procedural due process should be applicable to physicians providing services to managed care organizations, health care maintenance organizations, and other third-party payers.

In the absence of an exclusive contract, hospital governing boards should abridge a physician's privileges only upon a recommendation of the medical staff after the completion of a peer review

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process for reasons related to professional competence, adherence to appropriate standards of medical care, health status or other parameters agreed on by the medical staff.

Exclusive Contracts

The College recognizes exclusive contracts may be an appropriate and beneficial method in ensuring high quality, 24-hour care for hospital patients. However, groups may need to collaborate with other providers to improve or expand the services they offer and strengthen contracts with their hospitals. Therefore, groups holding exclusive contracts should be open to exploring relationships (e.g. sub-contracts, affiliations, etc.) that may benefit patients in their community, and whenever appropriate, may allow independent IR physicians limited admitting and treating privileges so as to optimize continuity of patient care.

Economic Credentialing

The College opposes the use of economic credentialing, which is the use of economic criteria unrelated to quality of care or professional competency in determining an individual's qualifications for initial or continuing hospital medical staff membership or privileges. Properly negotiated and freely entered exclusive contracts should be based primarily on ensuring high-quality, 24-7 care for all hospital patients and thus are not a form of economic credentialing even when they may affect the privileges of other physicians seeking to perform radiological procedures at that facility.

Because the hospital medical staff is an independent, self-governing entity that has the primary responsibility for assuring quality patient care within the hospital, the College believes that it is the responsibility of the medical staff to ensure the integrity of the credentialing and privileging processes.

Support for State Legislation

The American College of Radiology supports efforts to enact legislation at the state level that prohibits the practice of any form of economic credentialing and exclusive contracting decisions that deprive physicians of their due process rights; 1991, 2001, 2011, 2022 (Res. 26 and 27).

Physician Bill of Rights

The American College of Radiology endorses the following principles with respect to the role of the physician in managed care:

- No physician shall be dropped from a provider panel for advocating for his or her patient, which includes being allowed to practice to the full extent of professional licensure and credentialing as well as comprehensive discussion and provision of medically necessary services to patients.
- Provider panel members shall assist plan management in developing (a) procedures for telephone triage and referral of patients seeking diagnostic evaluations; (b) criteria for assessing medical necessity, for reviewing and appealing payment decisions, and for establishing qualifications of clinical reviewers; and (c) necessary qualifications and numbers of clinical personnel on provider panels.
- No provider panel member shall be subject to retribution for “whistle blowing.”

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- Due process protections, including the right to a hearing and the right to appeal, shall be afforded to providers who are dropped from a panel.
- Provider panel members should be able to legally organize and bargain collectively.
- “Hold harmless” clauses in managed care contracts should be explicitly identified and radiologists should review the implications of such clauses with legal counsel.

The American College of Radiology shall establish and disseminate these principles in a “Bill of Rights for Physicians” and in model legislation when appropriate and feasible; adopted 1996, 2006, 2016 (Res. 34-d).

z. Ownership, Retention and Patient Access to Medical Records

The ACR adopted suggestions and rationales for policy statements about medical record retention, ownership, and access (Appendix D); adopted 1990, 1992, amended 1993, 2003, 2013 (Res. 41-d).

aa. Physics

Definition of a Qualified Medical Physicist (QMP)

The American College of Radiology adopts the following Definition of a Qualified Medical Physicist as revised:

A Qualified Medical Physicist is an individual who is competent to practice independently in one or more of the subfields in medical physics. The American College of Radiology considers certification, continuing education and experience in the appropriate subfield(s) to demonstrate that an individual is competent to practice one or more of the subfields in medical physics, and to be a Qualified Medical Physicist. The ACR strongly recommends that the individual be certified in the appropriate subfield(s) by the American Board of Radiology (ABR), the Canadian College of Physics in Medicine, the American Board of Science in Nuclear Medicine (ABSNM), or the American Board of Medical Physics (ABMP).

A qualified medical physicist should meet the ACR Practice Guideline for Continuing Medical Education (CME).

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The subfields of medical physics are¹:

- Therapeutic Medical Physics

This pertains to (1) the therapeutic applications of x-rays, of gamma rays, of electrons and charged particle beams, of neutrons, of radiations from sealed and unsealed radionuclide sources, (2) the equipment associated with their production, use, measurement and evaluation, (3) the quality of information and images resulting from their production and use, and (4) associated patient and personnel radiation safety issues.

- Diagnostic Medical Physics

This pertains to (1) the diagnostic applications of x-rays, or gamma rays from sealed and unsealed sources, of ultrasound, of radiofrequency radiation, of magnetic fields, (2) the equipment associated with their production, use, measurement and evaluation, (3) the quality of information and images resulting from their production and use, and (4) associated patient and personnel radiation safety issues.

- Nuclear Medical Physics

This pertains to (1) the therapeutic and diagnostic applications of radionuclides (except those used in sealed sources for therapeutic purposes), (2) the equipment associated with their production, use, measurement and evaluation, (3) the quality of information and images resulting from their production and use, and (4) associated patient and personnel radiation safety issues.

The ACR shall review all appropriate guidelines and technical standards to ensure that each contain this definition of Qualified Medical Physicists where indicated; 1996, 2006, 2008, amended 2012, amended 2022 (Res. 41-f).

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Previous medical physics certification categories including radiological physics, therapeutic radiological physics, medical nuclear physics, diagnostic radiological physics and diagnostic imaging physics are also acceptable.

bb. Self-Referral

Physician Self-Referral Through Hospital Credentialing

The American College of Radiology supports legislative efforts that will eliminate economic credentialing by hospitals or other health care organizations. The College is particularly concerned about credentialing changes initiated by physicians who threaten to send their patients to other facilities unless they are allowed to charge for interpretation of imaging studies or performance of procedures carried out on their patients; 1994, amended 2004, 2014 (Res. 10-b).

Self-Referral

The position of the American College of Radiology is that the practice of self-referral of patients for a diagnostic or therapeutic medical procedure may not be in the best interests of the patient. Accordingly, referring physicians should not have a direct or indirect financial interest in diagnostic or therapeutic facilities to which they refer patients. The American College of Radiology will support legislative efforts prohibiting reimbursement for any diagnostic or therapeutic procedure carried out in a facility in which the referring physician has a direct or indirect financial interest; adopted 1988, 1998, 2008, 2018 (Res. 12-b).

cc. Radiologic Identification of Unidentified and Missing Children

The American College of Radiology recognizes the activities of the National Center for Missing and Exploited Children and the Federal Bureau of Investigation's National Crime Information Center and the College offers its scientific expertise. The American College of Radiology will apprise its membership of the nationwide problem and determine appropriate cooperative actions so that the imaging records available in each community can be made accessible to this nationwide effort of gathering data on missing children; adopted 1985, 1997, 2007, amended 2017 (Res. 1-l).

dd. Radiology as Practice of Medicine

Diagnosis and treatment of patients in hospitals are in fact the practice of medicine by physicians and not the rendering of "hospital services."

The ACR will strengthen its continuing effort to educate the general public and the public's opinion makers toward the recognition of this reality; adopted 1975, 1987, 1997, 2007, 2017 (Res. 1-m).

ee. Referral Practice of Radiology

The ACR adopts as policy the following statement on the referral practice of radiology; adopted 1991, 2001, amended 2011, 2021 (Res. 38-d).

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REFERRAL PRACTICE OF RADIOLOGY

Radiology is best practiced by radiologists. The interests of both patients and referring physicians are best served when all radiologic examinations are supervised and interpreted by qualified radiologists.

Diagnostic radiology, interventional radiology, nuclear medicine and radiation oncology continually require the application of new treatment and imaging modalities. Diagnostic and therapeutic techniques that use ionizing radiation and other forms of radiant energy should be performed under the direction of a qualified diagnostic radiologist or radiation oncologist trained in their medical uses and biological effects on the human body.

IMAGING TECHNOLOGY AND THE REFERRAL PRACTICE

Medical and technological advances in radiology are so rapid that only a qualified diagnostic radiologist can reasonably be expected to maintain the high degree of proficiency necessary to supervise and interpret radiological procedures. The referral practice of radiology gives patients access to highly specialized consultative physician services that are necessary if the complex array of diagnostic and therapeutic procedures are to be adequately supervised and interpreted. This cost-effective practice also involves the evaluation of the appropriateness, necessity, and sequencing of exams and procedures. Maximal benefits result from this method of service utilization.

THE HOSPITAL PRACTICE

In hospitals, diagnostic radiologists and radiation oncologists should be credentialed by the medical staff and approved by the governing body. Privileges in diagnostic radiology, interventional radiology, nuclear medicine and radiation oncology must be awarded on the basis of the training, experience, qualifications (including board certification in radiology/diagnostic radiology/radiation oncology), and reputation of the applicant in diagnostic radiology, interventional radiology, nuclear medicine or radiation oncology and their subspecialties. Within this framework, the criteria used for evaluating radiologists should be used for all applicants for privileges in diagnostic radiology, interventional radiology, nuclear medicine or radiation oncology. Only those physicians with delineated clinical privileges in diagnostic radiology should supervise and interpret radiological studies. Only those physicians with delineated privileges in radiation oncology or nuclear medicine should supervise the administration of therapeutic doses of ionizing radiation.

THE OFFICE PRACTICE

In an office practice, diagnostic radiologists, interventional radiologists, nuclear medicine physicians and radiation oncologists offer the same consultative services as in the hospital setting. Consultative diagnostic radiologists, interventional radiologists, nuclear medicine physicians and radiation oncologists equip their offices with technologically sophisticated equipment so that modern imaging services and/or therapeutic treatments are provided cost-effectively. The interest of the public is best served when primary physicians and other specialists refer patients to qualified diagnostic radiologists, interventional radiologists, nuclear medicine physicians and radiation oncologists for radiologic procedures.

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REDUCING ECONOMIC INCENTIVES THROUGH REFERRAL

Not only does the referral of patients to qualified radiologists reduce radiation risks but it also has been shown to reduce economic incentives in the performance of radiologic procedures (see the Hillman et al. study, New England Journal of Medicine, December 6, 1990).

REFERRAL AND SPECIALIZATION

The development of medical specialties and certifying boards is an important advance that has improved the health of Americans. Radiology is a referral specialty providing consultative services.

CONCLUSION

The American College of Radiology, which represents the specialties of diagnostic radiology and radiation oncology, is devoted to protecting the health of the public through the referral practice of diagnostic radiology and radiation oncology (see the Hillman et al. study, New England Journal of Medicine, December 6, 1990); adopted 1991 (Res. 22).

ff. Telemedicine

The American College of Radiology adopts as policy that states and their medical boards should require a full and unrestricted medical license in the state in which the examination originates with no differentiation by specialty, for physicians who wish to practice telemedicine; adopted 1996, 2006, amended 2016 (Res. 23-c).

gg. ACR Revised Statement on the Interpretation of Radiology Images Outside of the U.S.

The American College of Radiology adopts the attached ACR Revised Statement on the Interpretation of Radiology Images Outside the United States. The white paper from the ACR Task Force on International Teleradiology will be filed and made available to the ACR membership and other interested parties (Appendix J); 2004, updated 2006, 2016 (Res. 23-d).

hh. Off-Site Radiology

The American College of Radiology endorses efforts by state licensing boards to require licensure of out-of-state physicians who provide official authenticated written radiological interpretations of examinations that are performed on patients in the licensing state but interpreted in another jurisdiction, provided that such law or regulation does not restrict the ability of radiologists to provide second opinion radiological consultations requested by physicians in states in which the consulting radiologist is not licensed; adopted 1994, 2004, 2014 (Res. 10-c).

TELERADIOLOGY

The American College of Radiology encourages the appropriate use of teleradiology in accordance with the ACR-AAPM-SIIM Technical Standard for Electronic Practice of Medical Imaging and as described as best practice in the ACR Task Force Report on Teleradiology Practice, 2013 (Appendix M); 1993, 2003, amended 2014 (Res. 10-d)

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PROVISION OF TELERADIOLOGY SERVICES

The American College of Radiology regards care by on-site radiologists preferable to teleradiology, the latter being most useful as a supplement to on-site care for purposes such as subspecialty consultation and to provide coverage for underserved areas where the physical presence of a radiologist is not feasible.

The Council reaffirms that cooperative and noncompetitive relationships between academic and private practice groups best serve the needs of the patients, and the future of this specialty; adopted 2007, 2017 (Res. 1-n).

ii. Independent Medical Judgement

Diagnostic radiologists, radiation oncologists, interventional radiologists, nuclear medicine physicians, and medical physicists should be free to exercise their personal and professional judgment in voting, speaking, and advocating on any matter regarding patient care interests, the profession, health care in the community, and the independent exercise of medical judgment.

Diagnostic radiologists, radiation oncologists, interventional radiologists, and nuclear medicine physicians should always make treatment and referral decisions based on the best interests of their patients; adopted 2019 (Res. 42).

jj. Burnout

The ACR Commission on Human Resources will develop a definition of burnout.

The ACR Board of Chancellors and Council Steering Committee will provide a list of resources or interventions that can be used by members to address identified burnout issues.

The ACR Board of Chancellors and Council Steering Committee encourage diagnostic radiology, radiation oncology, interventional radiology, nuclear medicine, and physics specialty societies to promote the use of interventions to reduce identified burnout among their membership.

The ACR Board of Chancellors will perform a second measurement approximately 18 months after the initial assessment to determine whether these interventions have reduced member burnout; adopted 2019 (Res. 43).

kk. Partnership Track Associates and Substantial Changes in Practice Structure or Ownership

The ACR recommends –

- Transparency and professionalism in the hiring process;
- That partnership track associates should receive at least some proportional monetary compensation and should be included in discussions related to substantial changes in practice structure or ownership as legally permissible; and
- That in the event of a substantial change in or control of ownership or structure of the practice, any restrictive covenant in an associate's current employment contract should be waived.

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The ACR will contribute legal and government relations resources to suggest model language for state legislative initiatives to effectuate statutory changes to restrictive covenants.

The ACR delegation to the American Medical Association (AMA) will submit a similar resolution for consideration by the AMA House of Delegates; adopted 2022 (Res. 25).

J. TECHNOLOGISTS AND ALLIED HEALTH PROFESSIONS

1. Update to Existing ACR Policies on Radiologist Assistants

The Council of the American College of Radiology adopts 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 G, adopted in 2003 as Resolution 2 and renewed by resolution 41-e in 2013.

The ACR will work with ASRT to get approval for a revised statement using this blueprint to develop a new ACR ASRT Joint Statement on Radiologist Assistant Roles and Responsibilities.

The Council of the American College of Radiology adopts 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.

The Council of the American College of Radiology adopts 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; adopted 2020 (Res. 11).

2. Non-Physician Radiology Providers (NPRP) – Definitions

For the purposes of ACR policy the term “Non-Physician Radiology Provider (NPRP)” will be defined as “all Non-Physician Providers (e.g. RRA, RPA, RA, PA, NP, ...) who assist with or participate in portions of the practice of a radiologist-led team (Radiologists = diagnostic, interventional, neurointerventional radiologists, radiation oncologists, and nuclear medicine physicians). The term “NPRP” does not include radiology, CT, US, NM MRI technologists, radiation therapists, who have specific training for radiology related tasks (e.g. Acquisition or images, operation of imaging and therapeutic equipment) that are not typically performed by Radiologists.

The term 'Radiologist-led team' is defined as a team supervised by a radiologist (i.e. Diagnostic, interventional, neurointerventional radiologist, radiation oncologist, and nuclear medicine physician) and consists of additional healthcare providers including RRAs, PAs, NPs, and other personnel critical to the provision of the highest quality of healthcare to patients.

Existing and future ACR policies and practice parameters will be reviewed, modified and written to incorporate the term “non-physician radiology provider” (NPRP).

Existing and future ACR policies and practice parameters concerning NPRPs or NPRP-issues will be reviewed, modified, and written as necessary to address the intention of the policy and practice

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parameter by referring separately and specifically to each particular NPRP (e.g. NP, PA, RRA, and any other specific NPRP impacted by the policy or practice parameter).

Any existing and future ACR policies and practice parameters concerning NPRP or NPRP-issues that are intended to apply broadly and generically to all NPRPs should explicitly state this intention.

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; adopted 2020 (Res. 8).

3. Roles of Non-Physician Radiology Providers (NPRP) – Policies, Parameters and Legislation/Regulations

The ACR will continue to oppose any legislation or regulation permitting NPRPs (e.g. NPS, PAs, RRAs, ...) to provide interpretations (preliminary, final, or otherwise) of diagnostic imaging examinations.

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. 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.

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.

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

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

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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.

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; adopted 2020 (Res. 9).

4. POLICY STATEMENT ON ROLES AND RESPONSIBILITIES OF THE RADIOLOGIST ASSISTANT

The American College of Radiology adopted a statement on Radiologist Assistant – Roles and Responsibilities (Appendix G); adopted 2003, 2013, amended 2020 (Res. 11).

5. DEVELOPING A PROCESS FOR UPDATING THE ROLES AND RESPONSIBILITIES OF THE RADIOLOGIST ASSISTANT

The American College of Radiology will continue to require that the tasks performed by the Radiologist Assistant are under radiologist supervision be well-defined and documented; within the criteria and standards defined in the “ACR 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 have and follow a process to participate in the 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) from an ACR Commission such as Quality and Safety, Human Resources, or equivalent to review and make 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 any 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; amended 2020 (Res. 11).

6. INTERIM SUPPORT POSITION FOR RRA LEGISLATION AND REGULATION

The ACR supports its RRA policies as approved by Council in 2003 (and renewed in 2013), 2006, and 2008.

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

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.

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; adopted 2020 (Res. 10a).

7. ACR ENDORSEMENT OF THE AMERICAN REGISTRY OF DIAGNOSTIC MEDICAL SONOGRAPHY AND THE AMERICAN REGISTRY OF RADIOLOGIC TECHNOLOGISTS

The American College of Radiology endorses the American Registry of Diagnostic Medical Sonography (ARDMS) and the American Registry of Radiologic Technologists (ARRT) as the most appropriate agencies for the certification of ultrasound technologists; adopted 1987, 1997, 2007, 2017 (Res. 12-b).

8. AMERICAN REGISTRY OF RADIOLOGIC TECHNOLOGISTS

The ACR supports the examinations for certification in nuclear medicine technology given by the American Registry of Radiologic Technologists (ARRT); adopted 1978, 1988, 1998, 2008, 2018 (Res. 23-c).

9. BUSINESS MANGEMENT ASSOCIATION

The ACR urges all radiologists and radiation oncologists to encourage their business managers and administrators to become or remain members of the Radiology Business Management Association or the Society of Radiation Oncology Administrators. Recognizing that these associations will benefit radiology, the ACR continues to support their broadening membership bases and attendance at educational seminars; 1982, 1992, 2002, amended 2012, amended 2022 (Res. 15-e)..

10. EDUCATIONAL PROGRAMS

Educational programs in Radiologic Technology seeking to demonstrate or develop innovation in the educational process should document the need and justification for such a program; structure the program so that the currently established essentials are not diminished; and submit the plans for such programs to the appropriate Joint Review Committee and/or other certifying agency for evaluation and review prior to initiation; adopted 1980, 1990, 2012, amended 2022 (Res. 15-f)..

11. FLUOROSCOPY

The American College of Radiology approves of the practice of certified and/or licensed radiologic technologists performing fluoroscopy in a facility or department as a positioning or localizing procedure only, and then only if monitored by a supervising physician who is personally and immediately available*. There must be a written policy or process for the positioning or localizing procedure that is approved by the medical director of the facility or department/service and that includes written authority or policies and processes for designating radiologic technologists who may perform such procedures; adopted 1987, 1997, 2007, 2017 (Res. 12-c).

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*For purposes of this guideline, “personally and immediately available” is defined in manner of the “personal supervision” provision of CMS—a physician must be in attendance in the room during the performance of the procedure. Program Memorandum Carriers, DHHS, HCFA, Transmittal B-01-28, April 19, 2001.

12. OTHER ANCILLARY PERSONNEL PERFORMING FLUOROSCOPIC PROCEDURES

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

All non-physician radiology providers (NPRP) using fluoroscopy should be credentialed for those fluoroscopic examinations or procedures and should have CME 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 sufficient clinical experience supervised by a radiologist 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 for NPRP performing fluoroscopy should include education in radiation dosimetry, radiation protection, and equipment performance related to the use of fluoroscopy; adopted 2010, amended 2020 (Res. 23-f).

13. WORKFORCE IN RADIOLOGIC TECHNOLOGY

The American College of Radiology will continue its commitment to working collaboratively with allied organizations in identifying current and long-term technology workforce needs and in developing and implementing strategies for addressing the identified needs; 1988, amended 1998, 2008, amended 2018 (Res. 23-b).

14. MEDICAL DOSIMETRIST CERTIFICATION BOARD (MDCB)

The American College of Radiology recognizes the Medical Dosimetrist Certification Board (MDCB) as the most appropriate agency for certifying Medical Dosimetrists; adopted 1994, 2004, 2014 (Res. 21-e).

15. NUCLEAR MEDICINE ADVANCED ASSOCIATE (NMAA)

The American College of Radiology accepts and endorses the statement “Nuclear Medicine Advanced Associate (NMAA) – Roles and Responsibilities”; adopted 2011, amended 2021 (Res. 18-e). Refer to Appendix L.

16. PROGRAM DIRECTOR OF AN ACCREDITED EDUCATIONAL PROGRAM IN RADIOLOGIC TECHNOLOGY: MINIMUM EDUCATIONAL REQUIREMENTS

The American College of Radiology encourages the continued improvement of the quality of the profession of Radiologic Technology by supporting the requirement of a master’s degree as the minimum educational requirement for the Program Director of an accredited educational program in radiography/radiation therapy; 1988, 1998, amended 2008, 2018 (Res. 23-d).

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17. RADIOLOGIC TECHNOLOGISTS AND RADIATION THERAPISTS

The Radiologic Technologist, Nuclear Medicine Technologist, Radiologist Assistant and Radiation Therapist are qualified by education and the achievement of technical skills to provide patient care in diagnostic radiological and radiation oncologic modalities under the direction of radiologists, interventional radiologists, radiation oncologists, and nuclear medicine physicians. In the performance of their duties, the application of proper radiologic techniques and radiation protection measures involves both initiative and independent professional judgment by the radiologic technologists and radiation therapists. In as much as it is both desirable and necessary for all disciplines of radiologic technology to be recognized as professionals by government and other agencies, the ACR supports this position and recognizes the radiologic technologist, Nuclear Medicine Technologist, Radiologist Assistant, and radiation therapist as professional members of the health care team; 1980, 1990, 2000, amended 2010, amended 2020 (Res. 36-a).

18. RADIOLOGIST EXTENDERS

In the interest of quality patient care, radiologist extenders must function under the direction of qualified radiologists, interventional radiologists, nuclear medicine physicians, or radiation oncologists. The ACR will participate only with national organizations of physician extenders that agree to jointly design:

- role delineations, specifically to exclude image interpretation (preliminary, final or otherwise) or independent prescription of and delivery of radiation oncology treatment services
- level of radiologist, interventional radiologist, radiation oncologist and nuclear medicine physician oversight
- education, certification and licensure requirements
- credentialing and privileging guidelines in the hospital setting; 2004, amended 2014 (Res. 21-f).

19. RADIOLOGY TECHNOLOGY MODEL SCHOLARSHIP AGREEMENT

The ACR encourages radiology practices, local societies, state chapters, and other radiological organizations to establish radiologic technologists scholarship programs. The ACR suggests an updated model for such scholarships to be used as the practice deems necessary; 1992, amended 2002, 2012, 2022 (Res. 15-g).

20. STATE LICENSURE OF MEDICAL PHYSICISTS

The American College of Radiology strongly supports the concept of state licensure or equivalent rulemaking that recognizes board certification for medical physicists; adopted 1989, 1999, 2009, amended 2019 (Res. 13-c).

21. STATE LICENSURE OF RADIOLOGIC TECHNOLOGISTS

The American College of Radiology supports licensure, certification or other appropriate methods designed to assure the qualifications of all persons operating equipment emitting ionizing radiation; adopted 1986, 1996, 2006, 2016 (Res. 12-d).

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22. SUPERVISION OF RADIOLOGIC TECHNOLOGISTS

The policy of the American College of Radiology is to seek and/or support appropriate legislation that provides that certified and/or licensed radiologic technologists may use equipment emitting ionizing or non-ionizing radiation for diagnostic or treatment only by prescription of and under the direct supervision of a fully licensed physician. A student radiologic technologist must be under the supervision of a certified and/or licensed radiologic technologist in an accredited allied health educational program; adopted 1987, 1997, 2007, 2017 (Res. 12-d).

K. TESTIMONY

1. TESTIMONY GUIDELINES

The American College of Radiology adopted the following statement setting forth guidelines for testimony by College officers, commission and committee members and employees.

AMERICAN COLLEGE OF RADIOLOGY GUIDELINES

Testimony by College Officers, Commission and Committee Members and Employees

An individual holding an official capacity with the College who gives evidence for use in litigation must exercise great care to distinguish between his or her personal opinion on the merits of the matter at issue and the policy positions of the College.

The policies of the College are a matter of public record and, if relevant, may be appropriately cited in testimony. Also, the fact that an individual holds an official position with the College may be an appropriate part of his or her qualifications as an expert witness. However, the College, except pursuant to specific action by the Board of Chancellors, does not take a position on the merits of particular cases. A witness who holds an official capacity with the College must therefore be at pains to make clear that his or her testimony expresses his or her personal views, and must not state or imply in a written opinion or deposition or trial testimony that he or she is speaking as a representative of the College or is testifying to the views of the College on the merits of a particular case; adopted 1987, 1997, 2007, 2017 (Res. 12-e).

2. EXPERT WITNESS AFFIRMATION

The American College of Radiology will develop an Expert Witness Affirmation which declares that the witness will uphold certain professional tenets (as outlined in attached ACR guideline, ACR policy, and ACR Code of Ethics) in providing expert witness testimony.

The American College of Radiology will maintain an Expert Witness Affirmation which declares that the witness will uphold certain professional tenets (as outlined in attached ACR guideline, ACR policy, and ACR Code of Ethics) in providing expert witness testimony; adopted 2008, amended 2018 (Res. 12-c).

The ACR adopts the attached voluntary Expert Witness Affirmation (Appendix K) for implementation by the Board of Chancellors by January 1, 2010.

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L. CODING, REIMBURSEMENT, PAYMENT AND COVERAGE

1. ACR ACTION ON THE CMS PROFESSIONAL COMPONENT (PC) MULTIPLE PROCEDURAL PAYMENT REDUCTION (MPPR)

The ACR shall continue to dedicate appropriate resources to ensure that CMS provide the information considered when implementing the PC MPPR. The ACR shall also evaluate this data to identify any shortcomings which may lead to reversal of this flawed PC MPPR policy; adopted 2015 (Res. 26).

2. ACR CARRIER ADVISORY COMMITTEE NETWORKS

The American College of Radiology shall develop a state model for coordination and communication of local Carrier Advisory Committee (CAC) activities.

The American College of Radiology shall encourage, assist and coordinate the maintenance of local sub-specialty advisory panels to aid local CAC members in the review of local carrier policies.

The American College of Radiology shall act as the central repository of communication and information for the radiology and radiation oncology CAC networks; adopted 1999, 2009, 2019 (Res. 13-d).

3. APPLICABLE CPT CODES FOR PATIENT EVALUATION AND CLINICAL MANAGEMENT

The American College of Radiology supports the ability of radiologists to use the appropriate CPT or other system codes for patient evaluation and clinical management. The ACR strongly opposes the restrictions of compensation for clinical care solely because that care is rendered by a radiologist; 1990, amended 2000, 2010, amended 2020 (Res. 36-b).

4. BALANCE BILLING

The American College of Radiology opposes in principle any limitation on balance billing and the ACR urges its members to set fees carefully, equitably and appropriately. The American College of Radiology urges its members to continue to show compassion and understanding for financially disadvantaged patients, forgiving all or part of any balance due from such patients, as appropriate to the individual patient's circumstances; in compliance with applicable laws and regulations; 1990, amended 2000, 2010, 2020 (Res. 36-c).

5. CENTRAL ACR RESOURCE FOR MEDICARE REIMBURSEMENT POLICIES

The American College of Radiology (ACR) should continue to develop the mechanism whereby all Medicare reimbursement policies, both implemented and under development, related to radiology and radiation oncology, be made available to all radiologists who serve as Carrier Advisory Committee members and the general membership for reference and comment; adopted 1997, 2007, 2017 (Res. 12-f).

6. COMPENSATION

Radiology should be regarded and compensated on the same basis as are the services of all other physicians. Radiologists should be treated in the same manner as other physicians in all matters, including the prerogative to bill patients directly for their professional services in any practice setting;

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adopted 1973, 1987, 1997, 2007, 2017 (Res. 12-g).

The ACR strongly advises that radiology and the public are in most circumstances best served by independent practice and separate billing by radiologists in most hospitals and that radiology services should not be billed by others at rates higher than those paid to the radiologist; 1979, 1989, amended 1999, 2009, 2019 (Res. 35-b).

7. COST EFFECTIVENESS OF RADIOLOGIC PROCEDURES

The ACR shall use its resources to collect and distribute information on the cost effectiveness of radiologic procedures and to participate in the evaluation of new technologies; 1993, amended 2003, 2013 (Res. 23-d).

8. CPT CODE REVISIONS

The American College of Radiology, through its CPT advisory committee, shall maintain an active role in insuring that future editions of CPT include codes for all current radiological procedures; adopted 1987, 1997, 2007, 2017 (Res. 12-h).

9. CPT CODING IN HOSPITAL AND NON-HOSPITAL SETTINGS

The American College of Radiology will use its best efforts to promote coding systems that ensure appropriate reporting of services provided both in hospital and non-hospital settings; 1989, amended 1999, 2009, 2019 (Res. 35-c).

10. MEDICARE/MEDICAID BUNDLING EDITS

The American College of Radiology opposes onerous commercial, Medicare and Medicaid bundling edits and shall take whatever measures are necessary to delay or prevent their implementation.

The American College of Radiology actively opposes the use of secret, proprietary edits and opposes any restrictions on disclosure of such edits in any public payment system, including Medicare and Medicaid; 1998, amended 2008, 2018 (Res. 12-d).

11. ERISA PRE-EMPTION OF STATE LAW 1995

ACR favors efforts to remove barriers created by the Employee Retirement Income Security Act (ERISA) to state oversight of employer-sponsored self-funded health insurance plans, including the right to bring contract and tort claims against such plans; adopted 1995, 2005 (Res. 1).

12. EVALUATION OF THE EFFECT OF SELF-REFERRAL ON COST CONTAINMENT

The ACR urges third party payers to initiate or continue an in-depth review of the scope of the practice of self-referral of imaging procedures by non-radiologists and its effect on the cost of medical care, and the data obtained be presented to governmental agencies, all third party payers, and industry representatives, as appropriate; 1984, 1994, amended 2004, 2014 (Res. 10-e).

13. INDEPENDENT PRACTICE

The basic tenets of the independent practice of radiology (diagnostic radiology, radiation oncology,

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interventional radiology, nuclear medicine and medical physics) include the establishment of credentials by satisfactory completion of prescribed training, certification of such training by successful completion of a qualifying examination, membership on hospital medical staff subject to the same restrictions and procedures established by its bylaws as all other physicians and medical professionals, and the independent establishment and billing fees for professional services.

PRINCIPLES OF INDEPENDENT PRACTICE

Credentials and Practice Settings

Radiologists practice their specialty by providing consultative radiologic services in hospitals, clinics and private offices where they serve the needs of referring physicians and their patients.

The first mark of radiologists in independent practice is the quality of their professional credentials which may include board certification by the American Board of Radiology or an equivalent certifying organization.

In hospitals and other facilities where privileges to practice must be granted, radiologists seek and earn the privilege to practice in the same manner and are subject to the same general requirements and qualifications as all other physicians.

Radiologists who practice in an office, clinic or other outpatient setting should have the same professional qualifications as those who restrict their practice to hospitals. Radiologists earn their right to provide radiologic services in hospitals and other settings in the same way they earn the respect of referring physicians: by demonstration of diligence and sound medical judgment. Radiologists deserve the independence they assert to practice their specialty without unwarranted interference and with the same independence provided other physicians.

Compensation Methods

Radiology and radiation oncology services are recognized as significant medical services by public and private insurance programs throughout the United States. Insurers and private patients place a compensable value on the professional services rendered by radiologists and radiation oncologists.

Radiologists and radiation oncologists are subject to reasonable review of their charges as may be imposed by prudent buyers of medical services.

In separate billing, radiologists establish reasonable fees based on the cost of providing the service and the level of skill required for the procedure.

Where radiologists practice in settings in which they incur technical costs as well, they are entitled to charge for both the professional fee and the technical component (i.e. charge a global fee). This method of compensation is modeled on the broad tradition of fee-for-service recognized in American medicine.

However, the method of compensation chosen by a radiologist or radiation oncologist is a statement of professional preference and is not regarded by the American College of Radiology as a matter of review under the Principles of Ethical Radiological Practice.

The concept of independent practice does not exclude the participation of radiologists in innovative

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health care delivery systems. Radiologists should be cognizant of the ethics of radiologic practice. The American College of Radiology strongly urges all radiologists to carefully evaluate any health care delivery system or arrangement which might unfairly profit from the professional services of the radiologists and radiation oncologists, at the expense of acceptable quality care.

Separate Billing

Independent practice with separate billing is recommended for all radiologists by the American College of Radiology. In independent practice, radiologists are reimbursed in the same manner as other physicians for professional services rendered to patients.

Fee-for-service is the most prevalent method of compensation of radiologists and radiation oncologists in the United States. Other methods of compensation may exist in accord with local custom and with regard to special considerations.

The majority of radiologists and radiation oncologists collect their professional fees by separating their professional charges from the technical cost incurred by the hospital for radiologic and radiation oncology procedures.

Simply stated, separate billing means that radiologists establish fees and direct the preparation of insurance claim forms and patient billing statements for their professional services. The radiologist or radiation oncologist should be free to choose the method of billing most appropriate to his/her needs, and, furthermore, have the right to employ whatever billing agent they choose.

Prerogatives of Radiologists and Radiation Oncologists in Different Practice Models

Radiologists and Radiation Oncologists who practice within hospitals or other facilities are subject to the medical staff bylaws, rules and regulations of that hospital or facility. Radiologists and radiation oncologists accept the obligations of those bylaws and also are entitled to their protection. The College recognizes that some radiologists and/or radiation oncologists have signed exclusive contracts with hospitals that waive the medical staff due process rights of the radiologists and/or radiation oncologists as a condition for obtaining or retaining their hospital contract. Such an action significantly reduces medical staff protections for radiologists and radiation oncologists, but it is neither unethical nor illegal.

Radiologists and radiation oncologists in independent practice do not ordinarily agree to let any institutional authority exercise unreasonable and capricious review of, or control over, professional fees.

Radiologists and radiation oncologists in any practice model should participate fully in key decisions made within hospitals and other facilities which affect equipment acquisition, expansion of services, quality assurance procedures, key personnel management decisions and other administrative and medical matters which are central to the provisions of effective radiology services.

Radiologists and radiation oncologists in any practice model should participate fully in the medical staff affairs of the hospitals where they practice. This involvement should include attendance at regular conferences, service on committees, and similar organizational responsibilities shared with other staff physicians.

Radiologists and radiation oncologists in independent practice may elect to receive compensation from public and private insurance programs which recognize the value of administrative and

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supervisory services provided by radiologists.

Radiologists and radiation oncologists in independent practice are free to make business decisions which enable them to practice their specialty on a high professional level and with a view toward efficiency of operation. The College does recognize that some radiologists and/or radiation oncologists have signed non-compete agreements with hospitals and/or other facilities. While these agreements restrict the activities of radiologists and radiation oncologists, they are with some exceptions neither unethical nor illegal.

In addition to working as independent practitioners, many radiologists and radiation oncologists have chosen other professional employment arrangements. These include, but are not limited to, the following: a) employment by a university or medical school, b) employment by a hospital or clinic, c) employment by a multi-specialty practice or clinic, and d) employment by an entrepreneurial company. Each of these arrangements potentially has both advantages and disadvantages. It is important that radiologists and radiation oncologists understand the benefits and the limitations of the professional employment relationship that they choose.

Radiologists and radiation oncologists in any work arrangement should respect all laws, courts and authorities which may govern the practice of medicine in the United States of America.

Conclusion

Independent practice and separate billing are still the professional model of choice for the vast majority of radiologists and radiation oncologists. This model well serves the interests of patients, referring physicians, and radiologists. There are other models that have emerged that can be professionally satisfying and also serve the needs of our patients and referring physicians. These models can limit the independent action of radiologists and radiation oncologists, but in most cases, they are both legal and ethical; adopted 1983, 1993, 2003, amended 2013 (Res. 41-f).

14. MAMMOGRAPHY SCREENING: INSURANCE COVERAGE

The ACR urges all insurance carriers to cover screening mammography studies at the time schedule recommended by the ACR and to reimburse for the procedure at a fair and equitable level; adopted 1990, 2000, 2010, amended 2020 (Res. 36-d).

15. MEDICARE FUNDING FOR RADIOLOGY PROCEDURES

The ACR will encourage Congress and the Centers for Medicare and Medicaid Services to take into account training, experience, certification, and quality assurance when funding radiology procedures performed by untrained, noncertified practitioners to ensure that Medicare patients receive the best quality radiology available for the taxpayers' dollars.

Payment should be rendered only for those studies for which a separate official interpretation is rendered; 1989, amended 1999, 2009, 2019 (Res. 35-d).

16. MEDICARE/MEDICAID PROGRAMS

The ACR joins the American Medical Association in condemning and deploring all acts of fraud and wrong doing in the Medicare and Medicaid programs. If the ACR can be of assistance to federal agencies in this area, it will be pleased to do so; 1977, 1987, amended 1997, 2007, 2017 (Res. 12-i).

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17. MEDICARE REIMBURSEMENT

The American College of Radiology, through appropriate commissions, committees, members and staff, will continue to respond to the membership in gathering and disseminating information designed to identify and correct regional inconsistencies in the interpretation and implementation of reimbursement policies by Medicare carriers and intermediaries, and continue to actively seek revision of these policies; adopted 1985, 1997, 2007, 2017 (Res. 12-j).

18. OUTPATIENT REIMBURSEMENT

The American College of Radiology supports the principle that reimbursement for any outpatient radiologic procedure should be made based upon medical validity and necessity for a given examination whether performed in a hospital or non-hospital setting; adopted 1987, 1997, 2007, 2017 (Res. 12-k).

19. ACCOUNTABLE CARE ORGANIZATIONS: OPPOSITION TO MANDATED CONTRACTING THROUGH ACOS

The American College of Radiology shall promote a legal and regulatory climate-either by ACR Board decisions to participate in selected legal cases as a friend of the court or through enactment of appropriate state legislation to permit radiologists and other physicians to contract directly rather than being exclusively bound to contracting efforts of accountable care organizations; adopted 1995, 2005 (Res. 35).

20. PHYSICIAN PAYMENT

The American College of Radiology opposes the implementation of any program that may result in the rationing of the delivery of medical care; 1989, amended 1999, 2009, amended 2019 (Res. 35-e).

21. RADIATION ONCOLOGY CENTERS

The ACR supports the concept that qualified community radiation oncology centers, whether publicly or privately financed, be treated equally by third-party carriers; adopted 1976, 1987, 1997, 2007, 2017 (Res. 37-l).

22. RADIOLOGISTS, RADIATION ONCOLOGISTS, AND SELF-REFERRAL

The American College of Radiology adopts the following policy on self-referral:

The practice of physicians referring patients to health care facilities in which they have a financial interest is not in the best interest of patients. This practice of self-referral may also serve as an improper economic incentive for the provision of unnecessary treatment or services. Even the appearance of such conflicts or incentives can compromise professional integrity. Disclosing referring physicians' investment interests to patients or implementing other affirmative procedures to reduce, but not completely eliminate, the potential for abuse created by self-referral is not sufficient.

In accordance with these views, the American College of Radiology supports current and future federal and state legislation and regulatory action designed to prohibit self-referral or restrict its influence on patient care decisions.

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The American College of Radiology believes that radiologists and radiation oncologists should make efforts to restructure the ownership interests in existing imaging or radiation therapy facilities, if not already done, because self-referral may improperly influence the professional judgments of those physicians referring patients to such facilities; 1992, 2002, amended 2012, 2022 (Res. 15-h)..

23. ADVOCACY FOR HIGH QUALITY, APPROPRIATE AND ETHICAL IMAGING AND RADIATION ONCOLOGY

In accordance with the philosophy of the ACR Code of Ethics, the practice of healthcare providers referring patients to imaging facilities in which they have a financial interest is self-referral and may not be in the best interest of patients. Financially motivated self-referral commonly results in unnecessary treatment and services with associated increased costs. This may also result in unnecessary radiation exposure to the public. The College should continue to educate policymakers and others regarding the adverse effects of self-referral.

The College shall advocate with the Congress, appropriate Federal agencies and third party payors that medical imaging procedures, image guided interventional procedures, and radiation oncology services, be reimbursed only if appropriate and if provided by qualified physicians in facilities that have met defined quality and safety standards, and that the ACR Code of Ethics, Practice Parameters and Technical Standards, Appropriateness Criteria, Clinical Decision Support, and accreditation programs serve as the foundation for the development of this reimbursement policy; 2005, amended 2015 (Res. 43-c).

24. RADIOLOGY AND RADIATION ONCOLOGY BILLING PRACTICES STUDY

The American College of Radiology shall, as an ongoing function, study the patterns of coding for reimbursement for diagnostic radiology, radiation oncology, interventional radiology, nuclear medicine and medical physics services; 1993, amended 2003, 2013 (Res. 41-g).

25. REIMBURSEMENT FOR RADIOLOGY AND RADIATION ONCOLOGY SERVICES

Reimbursement for radiology and radiation oncology services should appropriately reflect the expertise, time and expenses required for the provision of those services.

Any payor fee schedule for those services should be determined and re-evaluated with input by representatives of those physicians who will perform services for the patients contracting with that payor.

The ACR endorses contractual and legislative provisions that ensure prompt and equitable payment for provision of radiology and radiation oncology services, as well as appropriate appeals processes for claims disputes; adopted 2000, 2010, 2020 (Res. 36-e).

26. RETROACTIVE DENIAL OF REFERRED SERVICES

Retroactive denial of referred services is an inappropriate method to control utilization of radiologic services; adopted 1973, 1987, 1997, 2007, 2017 (Res. 12-l).

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**SECTION III
CHRONOLOGICAL LISTING OF
APPROVED COUNCIL ACTIONS:
2013-2022**

SECTION III

~~-2022-~~

ACR–SPR Practice Parameter for the Use of Intravascular Contrast Media

ACR Practice Parameter for Continuing Medical Education (CME)

ACR Practice Parameter on the Physician Expert Witness in Radiology and Radiation Oncology

ACR Practice Parameter for the Performance of Hysterosalpingography

ACR Practice Parameter for Performing and Interpreting Magnetic Resonance Imaging (MRI)

ACR–SPR Practice Parameter for Performing and Interpreting Diagnostic Computed Tomography (CT)

ACR–SPR–STR Practice Parameter for the Performance of Chest Radiography

ACR–SPR–STR Practice Parameter for the Performance of Portable (Mobile Unit) Chest Radiography

ACR–SIR Practice Parameter for Endovascular Management of the Thrombosed or Dysfunctional Dialysis Access

ACR–SIR–SPR Practice Parameter for the Performance of Arteriography

ACR–SIR–SPR Practice Parameter for the Creation of a Transjugular Intrahepatic Portosystemic Shunt (TIPS)

ACR–ASNR–ASSR–SIR–SNIS Practice Parameter for the Performance of Vertebral Augmentation

ACR–ASNR–SPR Practice Parameter for the Performance of Computed Tomography (CT) in the Evaluation and Classification of Traumatic Brain Injury

ACR–ASNR–SPR Practice Parameter for the Performance of functional Magnetic Resonance Imaging (fMRI) of the Brain

ACR–ASNR–SPR Practice Parameter for the Performance of Computed Tomography (CT) Perfusion in Neuroradiologic Imaging

ACR–ASNR–ASSR–SPR Practice Parameter for the Performance of Computed Tomography (CT) of the Spine

ACR–ASNR–SPR Practice Parameter for the Performance of Intracranial Magnetic Resonance Perfusion Imaging

ACR–AIUM–SRU Practice Parameter for the Performance of Penile Ultrasound

ACR–AIUM–SIR–SRU Practice Parameter for the Performance of Physiologic Evaluation of Extremity Arteries

ACR–AIUM–SPR–SRU Practice Parameter for the Performance of Transcranial Doppler Ultrasound

ACR–AIUM–SPR–SSR–SRU Practice Parameter for the Performance of the Musculoskeletal Ultrasound Examination

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ACR–AIUM–SPR–SRU Practice Parameter for the Performance and Interpretation of Diagnostic Ultrasound of the Thyroid and Extracranial Head and Neck

ACR–SABI–SPR–SSR Practice Parameter for the Performance of Magnetic Resonance Imaging (MRI) of the Wrist

ACR–NASCI–SPR Practice Parameter for the Performance of Quantification of Cardiovascular Computed Tomography (CT) and Magnetic Resonance Imaging (MRI)

ACR–ASSR–SPR–SSR Practice Parameter for the Performance of Spine Radiography

ACR Practice Parameter for the Performance of Molecular Breast Imaging (MBI) Using a Dedicated Gamma Camera

ACR–ACNM–SNMMI Practice Parameter for the Performance of Dopamine Transporter (DaT) Single Photon Emission Computed Tomography (SPECT) Imaging for Movement Disorders

ACR–ACNM–SPR Practice Parameter for the Performance of Renal Scintigraphy

ACR–SPR Practice Parameter for the Safe and Optimal Performance of Fetal Magnetic Resonance Imaging (MRI)

ACR–AAPM–SIIM Practice Parameter for Determinants of Image Quality in Digital Mammography

ACR–AAPM–SIIM–SPR Practice Parameter for Digital Radiography

ACR–AAPM–SIIM Technical Standard for Electronic Practice of Medical Imaging

Sunset the ACR–SPR Practice Parameter for General Radiography

Extension of Review Cycle for Two Practice Parameters

Extension of Review Cycle for One Practice Parameters

ACR Position on Registered Radiology Assistants Legislation

New Process for Comment and Approval of Practice Parameters and Technical Standards

Paid Family/Medical Leave in Radiology, Interventional Radiology and Radiation Oncology

Environmental Sustainability and Climate Change

Partnership Track Associates and Substantial Changes in Practice Structure or Ownership

Reinstating the Statement on Medical Staff Privileges, Economic Credentialing and Support for State Legislation

Exclusive Contrast (*Res. 2f 2021 Response*)

Neiman Health Policy Institute Named Fellowship

Ten-Year Extension of Policies

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Bylaws Amendment – Article X Rules of Order

Bylaws Amendment – Article II, Section I Membership

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ACR–ASNR–SIR–SNIS Practice Parameter for the Performance of Endovascular Embolectomy
Thrombectomy and Revascularization in Acute Stroke

ACR–ASNR–SIR–SNIS Practice Parameter for the Performance of Diagnostic Cervicocerebral Catheter
Angiography in Adults

ACR–ASNR–SPR Practice Parameter for the Performance of Computed Tomography (CT) of the
Extracranial Head and Neck

ACR–SIR Practice Parameter for the Performance of Angiography, Angioplasty, and Stenting for the
Diagnosis and Treatment of Renal Artery Stenosis in Adults

ACR–SIR–SPR Practice Parameter on Informed Consent for Image-Guided Procedures

ACR–SIR–SPR Practice Parameter for the Performance of Inferior Vena Cava (IVC) Filter Placement for
the Prevention of Pulmonary Embolism

ACR–SIR–SPR Practice Parameter for the Performance of Percutaneous Nephrostomy
Nonphysicians and Interpretation

Nonphysician Interpretation

ACR–ACNM–SNMMI–SPR Practice Parameter for the Performance of Single Photon Emission Brain
Perfusion Imaging (Including SPECT and SPECT/CT)

ACR–ACNM–SNMMI–SPR Practice Parameter for Performing FDG-PET/CT in Oncology

ACR–ACNM–SNMMI–SPR Technical Standard Practice Parameter for the Use of Radiopharmaceuticals
in Diagnostic Procedures Using Radiopharmaceuticals

ACR–ACNM–SNMMI–SPR Practice Parameter for the Performance of Hepatobiliary Scintigraphy

ACR–ACNM–SNMMI–SPR Practice Parameter for the Performance of Skeletal Scintigraphy (Bone Scan)

Start Date for Radiology, Interventional Radiology and Radiation Oncology Fellowships

ACR Practice Parameter for the Performance of Preoperative Image-Guided Localization in the Breast

ACR Practice Parameter for the Performance of Magnetic Resonance Imaging-Guided Breast Interventional
Procedures

ACR Practice Parameter for the Performance of a Diagnostic Breast Ultrasound Examination

ACR Practice Parameter for the Performance of Ultrasound-Guided Percutaneous Breast Interventional
Procedures

ACR–AIUM–SPR–SRU Practice Parameter for the Performance of an Ultrasound Examination of the
Abdomen and/or Retroperitoneum

ACR–AIUM–SPR–SRU Practice Parameter for the Performance of an Ultrasound Examination of the
Extracranial Cerebrovascular System

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ACR–AIUM–SPR–SRU Practice Parameter for the Performance of an Ultrasound Examination of the Neonatal and Infant Spine

ACR–AIUM–SRU Practice Parameter for the Performance of Preoperative Ultrasound Vessel Mapping Prior to Dialysis Access Surgery

ACR–SPR Practice Parameter for the Performance of Pediatric Fluoroscopic Contrast Enema Examinations

ACR–SPR Practice Parameter for the Performance and Interpretation of Skeletal Surveys in Children

ACR–SAR–SPR Practice Parameter for the Performance of Abdominal Radiography

ACR–SPR–SSR Practice Parameter for the Performance and Interpretation of Magnetic Resonance Imaging (MRI) of the Hip and Pelvis for Musculoskeletal Disorders

ACR–SPR–SSR Practice Parameter for the Performance and Interpretation of Magnetic Resonance Imaging (MRI) of the Elbow

ACR–NASCI–SPR Practice Parameter for the Performance and Interpretation of Cardiac Magnetic Resonance Imaging (MRI)

ACR–SPR–SSR Practice Parameter for the Performance and Interpretation of Magnetic Resonance Imaging (MRI) of Bone, Joint, and Soft Tissue Infections in the Extremities

ACR–SPR–SSR Practice Parameter for the Performance and Interpretation of Magnetic Resonance Imaging (MRI) of the Ankle and Hindfoot

ACR–NASCI–SPR Practice Parameter for the Performance and Interpretation of Cardiac Computed Tomography (CT)

ACR–SABI–SAR–SPR Practice Parameter for the Performance of Computed Tomography (CT) of the Abdomen and Computed Tomography (CT) of the Pelvis

ACR–NASCI–SIR–SPR Practice Parameter for the Performance and Interpretation of Body Computed Tomography Angiography (CTA)

Supporting Parental, Caregiver, and Medical Leave During Training

Ten-Year Extension of Policies

Bylaws Amendments: Article VI, Section 2(h); Article VII, Section 8; Article VIII, Section 5; Article VIII, Section 13; Article IX, Section 7

~~2020~~

ACR-ACOG-AIUM-SRU Practice Parameter for the performance of Sonohysterography and Hysterosalpingo-Contrast-Sonography (HyCoSy)

ACR-AIUM-SPR-SRU Practice Parameter for the Performance of Scrotal Ultrasound Examinations

ACR-AIUM-SPR-SRU Practice Parameter for the Performance of Ultrasound Evaluation of the Prostate (and Surrounding Structures)

ACR-AIUM-SRU Practice Parameter for the Performance of Diagnostic and Screening Ultrasound of the Abdominal Aorta in Adults

Non-Physician Radiology Providers (NPRP) – Definitions

Roles of Non-Physician Radiology Providers (NPRP) – Policies, Parameters and Legislation/Regulations

Interim Support Position for RRA Legislation and Regulation

Update to Existing ACR Policies on Radiologist Assistants

ACR-AAPM-ACNM-SNMMI Practice Parameter for Reference Levels and Achievable Administered Activity for Nuclear Medicine and Molecular Imaging

ACR-ACNM-SNMMI-SPR Practice Parameter for the Performance of Radionuclide Cystography

ACR-ACNM-SNMMI-SPR Practice Parameter for the Performance of Gastrointestinal Tract, Hepatic, and Splenic, Scintigraphy

ACR-ACNM-ASTRO-SNMMI Practice Parameter for Lutetium-177 (Lu177) DOTATATE Therapy

Sunset the ACR-SPR Practice Parameter for the Performance of Liver and Spleen

Supervising Radiologist Understanding for Imaging Indication

Extension of Review Cycle for One Practice Parameter

ACR Conflict of Interest Policy

ACR-SAR-SPR Practice Parameter for the Performance of Computed Tomography (CT) Enterography

ACR-SAR-SPR Practice Parameter for the Performance of Magnetic Resonance Imaging (MRI) of the Abdomen (Excluding the Liver)

ACR-SAR-SPR Practice Parameter for the Performance of Magnetic Resonance (MR) Enterography

ACR-SAR-SPR Practice Parameter for the Performance of Magnetic Resonance Imaging (MRI) of the Liver

ACR-SAR-SPR Practice Parameter for the Performance of Magnetic Resonance Imaging (MRI) of the Soft-Tissue Components of the Pelvis

ACR-NASCI-SPR Practice Parameter for the Performance of Body Magnetic Resonance Angiography (MRA)

ACR-SPR-SSR Practice Parameter for the Performance and Interpretation of Magnetic Resonance Imaging (MRI) of Bone and Soft-Tissue Tumors

ACR–SPR–SSR Practice Parameter for the Performance and Interpretation of Magnetic Resonance Imaging (MRI) of the Knee

ACR–SPR–SSR Practice Parameter for the Performance and Interpretation of Magnetic Resonance Imaging (MRI) of the Shoulder

ACR–STR Practice Parameter for the Performance of High-Resolution Computed Tomography (HRCT) of the Lungs in Adults

Mandatory Early Radiology Education for Medical Students by Radiologists

RFS & YPS Standing to Submit ACR Resolution

ACR Practice Parameter for Communication of Diagnostic Imaging Findings

ACR–SAR Practice Parameter for the Performance of Adult Cystography and Urethrography

ACR–SIR Practice Parameter for Minimal and/or Moderate Sedation/Analgesia

ACR–ACNM–ASNR–SNMMI Practice Parameter for Brain PET-CT Imaging in Dementia

ACR–ASNR–SPR Practice Parameter for the Performance and Interpretation of Cervicocerebral Computed Tomography Angiography (CTA)

ACR–ASNR–SNIS–SPR Practice Parameter for the Performance of Cervicocerebral Magnetic Resonance Angiography (MRA)

ACR–ASNR–SPR Practice Parameter for the Performance of Computed Tomography (CT) of the Head
Brain

ACR Position on Certifying Bodies in Radiology

Ten Year Extension of Policies

Bylaws amendments: Article IX, Sections 1, 3, 5, 6, and 8; Article VIII, Section 4

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ACR Practice Parameter for Communication of Diagnostic Imaging Findings

ACR–SAR–SCBT-MR Practice Parameter for the Performance of Computed Tomography (CT) Colonography in Adults

ACR–STR Practice Parameter for the Performance of Reporting of Lung Cancer Screening Thoracic Computed Tomography (CT)

ACR–ASNR–SPR Practice Parameter for the Performance of Magnetic Resonance Imaging (MRI) of the Pediatric Spine

ACR–ASER–SCBT-MR–SPR Practice Parameter for the Performance of Pediatric Computed Tomography (CT)

ACR–SPR–SSR Practice Parameter for the Performance of Radiography for Scoliosis in Children

ACR Practice Parameter for the Performance of Esophagrams and Upper Gastrointestinal Examinations in Adults

ACR Practice Parameter for the Performance of Excretory Urography

ACR–SPR Practice Parameter for the Performance of Fluoroscopic and Sonographic Voiding Cystourethrography in Children

Abusive Head Trauma

Continuing Certification

ACR–ASNR–ASSR–SIR–SNIS Practice Parameter for the Performance of Image-Guided Epidural Steroid Injection

ACR–SIR–SNIS–SPR Practice Parameter for the Clinical Practice of Interventional Radiology

ACR–ASNR–SPR Practice Parameter for the Performance and Interpretation of Magnetic Resonance Spectroscopy of the Central Nervous System

ACR–ASNR–SPR Practice Parameter for the Performance and Interpretation of Magnetic Resonance Imaging (MRI) of the Brain

ACR–ASNR Practice Parameter for the Performance of Non-Breast Magnetic Resonance Imaging (MRI)-Guided Procedures

ACR–ASNR–SPR Practice Parameter for the Performance of Myelography and Cisternography

ACR–SIR–SPR Practice Parameter for the Reporting and Archiving of Interventional Radiology Procedures

ACR–ABS–ACNM–ASTRO–SIR–SNMMI Practice Parameter for Selective Internal Radiation Therapy (SIRT) or Radioembolization for Treatment of Liver Malignancies

ACR–AAPM–SIIM Practice Parameter for Electronic Medical Information Privacy and Security

Imaging Guided Procedures Core Privileges

Firearm Injury Prevention Consensus Statements

ACR–AIUM–SRU Practice Parameter for the Performance of Contrast Enhanced Ultrasound

ACR–SRU Practice Parameter for the Performance of Ultrasound Elastography

ACR–ACOG–AIUM–SPR–SRU Practice Parameter for the Performance of Ultrasound of the Female Pelvis

ACR–AIUM–SPR–SRU Practice Parameter for the Performance of Neurosonography in Neonates and Infants

ACR–AIUM–SPR–SRU Practice Parameter for the Performance of Peripheral Venous Ultrasound Examination

ACR–AIUM–SPR Practice Parameter for the Performance of Peripheral Arterial Ultrasound Using Color and Spectral Doppler

ACR–AIUM–SRU Practice Parameter for the Performance of Vascular Ultrasound for Postoperative Assessment of Hemodialysis Access

ACR–AIUM–SPR–SRU Practice Parameter for the Performance of Duplex Sonography

ACR–AIUM–SPR–SRU Practice Parameter for the Performance of an Ultrasound Examination of Solid Organ Transplants

ACR Practice Parameter for the Performance of Whole-Breast Ultrasound for Screening and Staging

ACR–NASCI–SNMMI–SPR–STR Practice Parameter for the Performance of Cardiac Scintigraphy

ACR–ACNM–ASTRO–SNMMI–SPR Practice Parameter for Treatment of Benign and Malignant Thyroid Disease with I-131 Sodium Iodide

ACR–SPR Practice Parameter for the Performance of Parathyroid Scintigraphy

ACR–ACNM–ASTRO–SNMMI Practice Parameter for the Performance of Therapy with Radium-223

ACR–SNMMI–SPR Practice Parameter for the Performance of Scintigraphy and Uptake Measurements for Benign and Malignant Thyroid Disease

ACR–ACNM–ASTRO–SNMMI Practice Parameter for the Performance of Therapy with Unsealed Radiopharmaceutical Sources

Independent Medical Judgement

Burnout

Bylaws Amendment; Article II, Section 1

Ten Year Extension of Policies

-2018-

ACR Practice Parameter for the Performance of Fluoroscopic Contrast Enema Examination in Adults

ACR–SPR Practice Parameter for the Performance of a Contrast Small Bowel Examination

ACR–SPR–SSR Practice Parameter for the Performance and Interpretation of Magnetic Resonance Imaging (MRI) of the Fingers and Toes

ACR–SPR–SSR Practice Parameter for the Performance of Radiography of the Extremities

ACR–SCBT-MR–SPR–STR Practice Parameter for the Performance of Thoracic Computed Tomography (CT)

ACR–SPR–SSR Practice Parameter for the Performance of Dual-Energy X-Ray Absorptiometry (DXA)

ACR–SPR–SSR Practice Parameter for the Performance of Musculoskeletal Quantitative Computed tomography (QCT)

ACR–SIR–SPR Practice Parameter for Specifications and Performance of Image-Guided Percutaneous Drainage/Aspiration of Abscesses and Fluid Collections (PDAFC)

ACR–SIR–SPR Practice Parameter for the Performance of Image-Guided Percutaneous Needle Biopsy (PNB)

ACR–SIR Practice Parameter for the Performance of Diagnostic Infusion Venography

ACR–ASNR–SPR Practice Parameter for the Performance of Magnetic Resonance Imaging (MRI) of the Head and Neck

ACR–ASNR–SPR Practice Parameter for the Performance and Interpretation of Magnetic Resonance Spectroscopy of the Central Nervous System

ACR–ASNR–SIR–SNIS Practice Parameter for the Performance of Endovascular Embolectomy and Revascularization in Acute Stroke

ACR–ASNR–SCBT-MR–SSR Practice Parameter for the Performance of Magnetic Resonance Imaging (MRI) of the Adult Spine

ACR–SPR Practice Parameter for the Performance of Magnetic Resonance Imaging (MRI) of the Pediatric Spine

ACR–AIUM–SPR–SRU Practice Parameter for the Performance of the Ultrasound Examination for Detection and Assessment of Developmental Dysplasia of the Hip

ACR–AIUM–SPR–SRU Practice Parameter for the Performance and Interpretation of Diagnostic Ultrasound of the Extracranial Head and Neck

ACR–ACOG–AIUM–SMFM–SRU Practice Parameter for the Performance of Standard Diagnostic Obstetrical Ultrasound

ACR Practice Parameter for the Performance of Scintigraphy for Inflammation and Infection

ACR–SPR–STR Practice Parameter for the Performance of Pulmonary Scintigraphy

ACR–ACNM Practice Parameter for the Performance of Fluorine-18 Fluciclovine-PET/CT for Recurrent Prostate Cancer

ACR Practice Parameter for the Performance of Gallium-68 DOTATATE PET/CT Neuroendocrine Tumors

ACR Practice Parameter for the Performance of Contrast-Enhanced Magnetic Resonance Imaging (MRI) of the Breast

ACR Practice Parameter for the Performance of Screening and Diagnostic Mammography

ACR Practice Parameter for the Performance of Digital Breast Tomosynthesis (DBT)

ACR Practice Parameter for Radiologist Coverage of Imaging Performed in Hospital Emergency Departments

ACR–SPR Practice Parameter for General Radiography

ACR–SPR Practice Parameter for Imaging Pregnant or Potentially Pregnant Adolescents and Women with Ionizing Radiation

ACR–AAPM–SPR Practice Parameter for Diagnostic Reference Levels and Achievable Doses in Medical X-Ray Imaging

Extension of Practice Parameter

Changes to Physician Qualifications Section in the American College of Radiology Interventional Radiology Practice Parameters

Difference in Member vs. Non-Member Cost of ACR Programs and Services

Introduce Undergraduate Students to the Professions of Radiological Care

Membership Dues Decrease

Ten Year Extension of Policies

The American Opioid Crisis

Uninterrupted Governance Time at ACR Annual Meeting

-2017-

ACR Practice Parameter for Continuing Medical Education (CME)

ACR Practice Parameter for Performing and Interpreting Diagnostic Computed Tomography (CT)

ACR Practice Parameter for Performing and Interpreting Magnetic Resonance Imaging (MRI)

ACR Practice Parameter for the Performance of Hysterosalpingography

ACR Practice Parameter for the Performance of Molecular Breast Imaging (MBI) Using a Dedicated Gamma Camera

ACR Practice Parameter on Informed Consent – Radiation Oncology

ACR Practice Parameter on the Physician Expert Witness in Radiology and Radiation Oncology

ACR–AAPM–SIIM Practice Parameter for Determinants of Image Quality in Digital Mammography

ACR–AAPM–SIIM Technical Standard for Electronic Practice of Medical Imaging

ACR–AAPM–SIIM–SPR Practice Parameter for Digital Radiography

ACR–AAPM–SPR Technical Standard for Therapeutic Procedures Using Radiopharmaceuticals

ACR–ACNM Practice Parameter for the Performance of Dopamine Transporter (DaT) Single Photon Emission Computed Tomography (SPECT) Imaging for Movement Disorders

ACR–AIUM–SIR–SRU Practice Parameter for the Performance of Physiologic Evaluation of Extremity Arteries

ACR–AIUM–SPR–SRU Practice Parameter for the Performance of an Ultrasound Examination of the Abdomen and/or Retroperitoneum

ACR–AIUM–SPR–SRU Practice Parameter for the Performance of the Musculoskeletal Ultrasound Examination

ACR–AIUM–SPR–SRU Practice Parameter for the Performance of Transcranial Doppler Ultrasound

ACR–ASNR–ASSR–SIR–SNIS Practice Parameter for the Performance of Vertebral Augmentation

ACR–ASNR–SPR Practice Parameter for the Performance of Computed Tomography (CT) Perfusion in Neuroradiologic Imaging

ACR–ASNR–SPR Practice Parameter for the Performance of functional Magnetic Resonance Imaging (fMRI) of the Brain

ACR–ASNR–SPR Practice Parameter for the Performance of Intracranial Magnetic Resonance Perfusion Imaging

ACR–ASSR–SPR–SSR Practice Parameter for the Performance of Spine Radiography

ACR–NASCI–SPR Practice Parameter for the Performance of Quantification of Cardiovascular Computed Tomography (CT) and Magnetic Resonance Imaging (MRI)

ACR–SCBT-MR–SPR–SSR Practice Parameter for the Performance of Magnetic Resonance Imaging (MRI) of the Wrist

ACR–SIR Practice Parameter for Endovascular Management of the Thrombosed or Dysfunctional Dialysis Access

ACR–SIR–SPR Practice Parameter for Performance of Arteriography

ACR–SIR–SPR Practice Parameter for the Creation of a Transjugular Intrahepatic Portosystemic Shunt (TIPS)

ACR–SPR Practice Parameter for the Performance of Hepatobiliary Scintigraphy

ACR–SPR Practice Parameter for the Performance of Renal Scintigraphy

ACR–SPR Practice Parameter for the Performance of Skeletal Scintigraphy (Bone Scan)

ACR–SPR Practice Parameter for the Performance of the Modified Barium Swallow

ACR–SPR Practice Parameter for the Use of Intravascular Contrast Media

ACR–SPR–SRU Practice Parameter for Performing and Interpreting Diagnostic Ultrasound Examinations

ACR–SPR–STR Practice Parameter for the Performance of Cardiac Positron Emission Tomography – Computed Tomography (PET/CT) Imaging

Appoint Two Young or Early Career Professional Members to the ACR CSC

Bylaws Amendments; Article II, Section 1; Article IV, Section 2; b. Article V, Section 2, 9

Extension of Review Cycle for Four Practice Parameters

Role of Patients in the American College of Radiology

Undergraduates as Members-in-Training

Young and Early Career Professional Section (YPS)

-2016-

ACR–SPR Practice Parameter for the Performance of Abdominal Radiography

ACR Practice Parameter for 3D External Beam Radiation Planning and Conformal Therapy

ACR Practice Parameter for Continuing Medical Education (CME)

ACR Practice Parameter for Intensity Modulated Radiation Therapy (IMRT)

ACR Practice Parameter for the Performance of a Breast Ultrasound Examination

ACR Practice Parameter for the Performance of Brain Stereotactic Radiosurgery

ACR Practice Parameter for the Performance of Magnetic Resonance Imaging-Guided Breast Interventional Procedures

ACR Practice Parameter for the Performance of Stereotactic-Guided Breast Interventional Procedures

ACR Practice Parameter for the Performance of Ultrasound-Guided Percutaneous Breast Interventional Procedures

ACR–AIUM–SPR–SRU Practice Parameter for the Performance of an Ultrasound Examination of the Extracranial Cerebrovascular System

ACR–AIUM–SPR–SRU Practice Parameter for the Performance of an Ultrasound Examination of the Neonatal and Infant Spine

ACR–AIUM–SRU Practice Parameter for the Performance of Ultrasound Vascular Mapping for Preoperative Planning of Dialysis Access

ACR–ASNR–ASSR–SPR Practice Parameter for the Performance of Computed Tomography (CT) of the Spine

ACR–ASNR–SIR–SNIS Practice Parameter for the Performance of Diagnostic Cervicocerebral Catheter Angiography in Adults

ACR–ASNR–SPR Practice Parameter for the Performance of Computed Tomography (CT) of the Extracranial Head and Neck

ACR–NASCI–SIR–SPR Practice Parameter for the Performance and Interpretation of Body Computed Tomography Angiography (CTA)

ACR–NASCI–SPR Practice Parameter for the Performance and Interpretation of Cardiac Computed Tomography (CT)

ACR–NASCI–SPR Practice Parameter for the Performance and Interpretation of Cardiac Magnetic Resonance Imaging (MRI)

ACR–SIR Practice Parameter for Endovascular Management of the Thrombosed or Dysfunctional Dialysis Access

ACR–SIR–SPR Practice Parameter for the Performance of Inferior Vena Cava (IVC) Filter Placement for the Prevention of Pulmonary Embolism

ACR–SIR–SPR Practice Parameter for the Performance of Percutaneous Nephrostomy

ACR–SIR–SPR Practice Parameter on Informed Consent for Image-Guided Procedures

ACR–SPR Practice Parameter for Performing FDG-PET/CT in Oncology

ACR–SPR Practice Parameter for the Performance of Computed Tomography (CT) of the Abdomen and Computed Tomography (CT) of the Pelvis

ACR–SPR Practice Parameter for the Performance of Pediatric Fluoroscopic Contrast Enema Examinations

ACR–SPR Practice Parameter for the Performance of Single Photon Emission Computed Tomography (SPECT) Brain Perfusion Imaging, Including Brain Death Examinations

ACR–SPR Practice Parameters for the Performance and Interpretation of Skeletal Surveys in Children

ACR–SPR Technical Standard for Diagnostic Procedures Using Radiopharmaceuticals

ACR–SPR–SSR Practice Parameter for the Performance and Interpretation of Magnetic Resonance Imaging (MRI) of Bone, Joint, and Soft Tissue Infections in the Extremities

ACR–SPR–SSR Practice Parameter for the Performance and Interpretation of Magnetic Resonance Imaging (MRI) of the Ankle and Hindfoot

ACR–SPR–SSR Practice Parameter for the Performance and Interpretation of Magnetic Resonance Imaging (MRI) of the Elbow

ACR–SPR–SSR Practice Parameter for the Performance and Interpretation of Magnetic Resonance Imaging (MRI) of the Hip and Pelvis for Musculoskeletal Disorders

ACR–SPR–STR Practice Parameter for the Performance of Cardiac Positron Emission Tomography – Computed Tomography (PET/CT) Imaging

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ACR–AAPM Collaborative Medical Physics Practice Parameters and Technical Standards

ACR–AAPM Practice Parameter for Reference Levels and Achievable Administered Activity for Nuclear Medicine and Molecular Imaging

ACR–AAPM Technical Standard for the Performance of High-Dose-Rate Brachytherapy Physics

ACR–AAPM Technical Standard for the Performance of Low-Dose-Rate Brachytherapy Physics

ACR–AAPM Technical Standard for the Performance of Radiation Oncology Physics for External Beam Therapy

ACR–ACOG–AIUM–SRU Practice Parameter for the Performance of Sonohysterography

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ACR–AIUM–SPR–SRU Practice Parameter for the Performance of Peripheral Venous Ultrasound Examination

ACR–AIUM–SPR–SRU Practice Parameter for the Performance of Scrotal Ultrasound Examinations

ACR–AIUM–SRU Practice Parameter for the Performance of Diagnostic and Screening Ultrasound of the Abdominal Aorta in Adults

ACR–AIUM–SRU Practice Parameter for the Performance of Ultrasound Evaluation of the Prostate (and Surrounding Structures)

ACR–ASNR Practice Parameter for Brain PET/CT Imaging in Dementia

ACR–ASNR–SNIS–SPR Practice Parameter for the Performance of Cervicocerebral Magnetic Resonance Angiography (MRA)

ACR–ASNR–SPR Practice Parameter for the Performance and Interpretation of Cervicocerebral Computed Tomography Angiography (CTA)

ACR–ASNR–SPR Practice Parameter for the Performance of Computed Tomography (CT) of the Brain

ACR Commitment to Professionalism

ACR–NASCI–SPR Practice Parameter for the Performance of Body Magnetic Resonance Angiography (MRA)

ACR–NASCI–SPR–STR Practice Parameter for the Performance of Cardiac Scintigraphy

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ACR Practice Parameter for the Performance of Therapy with Unsealed Radiopharmaceutical Sources

ACR–SAR Practice Parameter for the Performance of Adult Cystography and Urethrography

ACR–SAR–SPR Practice Parameter for the Performance of Computed Tomography (CT) Enterography

ACR–SAR–SPR Practice Parameter for the Performance of Magnetic Resonance Imaging (MRI) of the Abdomen (Excluding the Liver)

ACR–SAR–SPR Practice Parameter for the Performance of Magnetic Resonance Imaging (MRI) of the Liver

ACR–SAR–SPR Practice Parameter for the Performance of Magnetic Resonance Imaging (MRI) of the Soft-Tissue Components of the Pelvis

ACR–SAR–SPR Practice Parameter for the Performance of Magnetic Resonance (MR) Enterography

ACR–SIR Practice Parameter for Sedation/Analgesia

ACR–SIR Practice Parameter for the Performance of Angiography, Angioplasty, and Stenting for the Diagnosis and Treatment of Renal Artery Stenosis in Adults

ACR–SPR Practice Parameter for the Performance of Contrast Esophagrams and Upper Gastrointestinal Examinations in Infants and Children

ACR–SPR Practice Parameter for the Performance of Gastrointestinal Scintigraphy

ACR–SPR Practice Parameter for the Performance of Liver and Spleen Scintigraphy

ACR–SPR Practice Parameter for the Performance of Radionuclide Cystography

ACR–SPR Practice Parameter for the Performance of Tumor Scintigraphy (with Gamma Cameras)

ACR–SPR Practice Parameter for the Safe and Optimal Performance of Fetal Magnetic Resonance Imaging (MRI)

ACR–SPR–SSR Practice Parameter for the Performance and Interpretation of Magnetic Resonance Imaging (MRI) of Bone and Soft Tissue Tumors

ACR–SPR–SSR Practice Parameter for the Performance and Interpretation of Magnetic Resonance Imaging (MRI) of the Knee

ACR–SPR–SSR Practice Parameter for the Performance and Interpretation of Magnetic Resonance Imaging (MRI) of the Shoulder

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Diversity is Central to Our Mission

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Eliminate the Resident Conference Registration Fee

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Extension of Review Cycle for Eight Practice Parameters

Honoring the Massachusetts Radiological Society on Their Golden Anniversary

Lead Chapter Contact for CSC Outreach

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Supporting Diagnostic Imaging Interpretations by Physicians

Ten Year Extension of Policies

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ACR Practice Parameter for Communication of Diagnostic Imaging Findings

ACR Practice Parameter for the Performance of Stereotactic Guided Breast Interventional Procedures

ACR Practice Parameter for the Performance of Ultrasound-Guided Percutaneous Breast Interventional Procedures

ACR—AAPM Technical Standard for Diagnostic Medical Physics Performance Monitoring of Magnetic Resonance Imaging (MRI) Equipment

ACR—AAPM Technical Standard for Medical Physics Performance Monitoring of Image-Guided Radiation Therapy (IGRT)

ACR—AAPM Technical Standard for Medical Physics Performance Monitoring of SPECT-CT Equipment

ACR—AAPM—SIIM Practice Parameter for Electronic Medical Information Privacy and Security

ACR—ACOG—AIUM—SPR—SRU Practice Parameter for the Performance of Ultrasound of the Female Pelvis

ACR—AIUM—SPR—SRU Practice Parameter for the Performance of Neurosonography in Neonates and Infants

ACR—AIUM—SPR—SRU Practice Parameter for the Performance of an Ultrasound Examination of Solid Organ Transplants

ACR—AIUM—SRU Practice Parameter for the Performance of Peripheral Arterial Ultrasound Using Color and Spectral Doppler

ACR—AIUM—SRU Practice Parameter for the Performance of Vascular Ultrasound for Postoperative Assessment of Dialysis Access

ACR—ASER—SCBT-MR—SPR Practice Parameter for the Performance of Pediatric Computed Tomography (CT)

ACR—SAR Practice Parameter for the Performance of an Enteroclysis Examination in Adults

ACR—SAR Practice Parameter for the Performance of Excretory Urography

ACR—SAR—SCBT-MR Practice Parameter for the Performance of Computer Tomography (CT) Colonography in Adults

ACR—SIR Practice Parameter for Radioembolization with Microsphere Brachytherapy Device (RMBD) for Treatment of Liver Malignancies

ACR—SIR—SNIS—SPR Practice Parameter for Interventional Clinical Practice and Management

ACR—SIR—SPR Practice Parameter for the Reporting and Archiving of Interventional Radiology Procedures

ACR—SPR Practice Parameter for the Performance of Parathyroid Scintigraphy

ACR—SPR Practice Parameter for the Performance of Scintigraphy and Uptake Measurements for Benign and Malignant Thyroid Disease

ACR—SPR Practice Parameter for the Performance of Scintigraphy for Inflammation and Infection

ACR—SPR Practice Parameter for the Performance of Voiding Cystourethrography in Children

ACR—SPR—SSR Practice Parameter for the Performance of Radiography for Scoliosis in Children

ACR—SPR—STR Practice Parameter for the Performance of Pulmonary Scintigraphy

ACR—STR Practice Parameter for the Performance and Report of Lung Cancer Screening Thoracic Computed Tomography (CT)

Extend: ACR—SIR Practice Parameter for the Performance of Angiography, Angioplasty, and Stenting for the Diagnosis and Treatment of Renal Artery Stenosis in Adults

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Name of ACR Practice Guidelines

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~~2013~~

ACR Practice Guideline for Radiologist Coverage of Imaging Performed in Hospital Emergency Departments

ACR Practice Guideline for the Imaging Management of DCIS and Invasive Breast Carcinoma

ACR Practice Guideline for the Performance of a Barium Small Bowel Examination in Adults

ACR Practice Guideline for the Performance of a Fluoroscopic Contrast Enema Examination in Adults

ACR Practice Guideline for the Performance of Contrast-Enhanced Magnetic Resonance Imaging (MRI) of the Breast

ACR Practice Guideline for the Performance of Esophagrams and Upper Gastrointestinal Examinations in Adults

ACR Practice Guideline for the Performance of Screening and Diagnostic Mammography

ACR–AAPM Practice Guideline for Diagnostic Reference Levels and Achievable Doses in Medical X-Ray Imaging

ACR–AAPM Practice Guideline on the Expert Witness in Medical Physics

ACR–AAPM Technical Standard for Management of the Use of Radiation in Fluoroscopic Procedures

ACR–AAPM Technical Standard for Medical Nuclear Physics Performance Monitoring of Gamma Cameras

ACR–AAPM Technical Standard for Medical Physics Performance Monitoring of PET/CT Imaging Equipment

ACR–AAPM Technical Standard for the Performance of Proton Beam Radiation Therapy

ACR–ACOG–AIUM–SRU Practice Guideline for the Performance of Obstetrical Ultrasound

ACR–AIUM–SPR–SRU Practice Guideline for the Performance of a Thyroid and Parathyroid Ultrasound Examination

ACR–AIUM–SPR–SRU Practice Guideline for the Performance of Native Renal Artery Duplex Sonography

ACR–AIUM–SPR–SRU Practice Guideline for the Performance of the Ultrasound Examination for Detection and Assessment of Developmental Dysplasia of the Hip

ACR–ASNR Practice Guideline for the Performance of Non-Breast Magnetic Resonance Imaging (MRI) Guided Procedures

ACR–ASNR–SPR Practice Guideline for the Performance and Interpretation of Magnetic Resonance Imaging (MRI) of the Brain

ACR–ASNR–SPR Practice Guideline for the Performance and Interpretation of Magnetic Resonance Spectroscopy of the Central Nervous System

ACR–ASNR–SPR Practice Guideline for the Performance of Myelography and Cisternography

ACR–SCBT–MR–SPR Practice Guideline for the Performance of Thoracic Computed Tomography (CT)

ACR–SIR Practice Guideline for the Performance of Diagnostic Infusion Venography

ACR–SIR–SPR Practice Guideline for Specifications and Performance of Image-Guided Percutaneous Drainage/Aspiration of Abscesses and Fluid Collections (PDAFC)

ACR–SIR–SPR Practice Guideline for the Performance of Image-Guided Percutaneous Needle Biopsy (PNB)

ACR–SPR Practice Guideline for General Radiography

ACR–SPR Practice Guideline for Imaging Pregnant or Potentially Pregnant Adolescents and Women with Ionizing Radiation

ACR–SPR Practice Guideline for the Performance of Hepatobiliary Scintigraphy

ACR–SPR Practice Guideline for the Performance of Pediatric Contrast Examinations of the Small Bowel

ACR–SPR Practice Guideline for the Performance of Renal Scintigraphy

ACR–SPR Practice Guideline for the Performance of Skeletal Scintigraphy (Bone Scan)

ACR–SPR–SSR Practice Guideline for the Performance and Interpretation of Magnetic Resonance Imaging (MRI) of the Fingers and Toes

ACR–SPR–SSR Practice Guideline for the Performance of Dual-Energy X-Ray Absorptiometry (DXA)

ACR–SPR–SSR Practice Guideline for the Performance of Radiography of the Extremities

ACR–SPR–SSR Practice Guideline for the Performance of Quantitative Computed Tomography (QCT) Bone Densitometry

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Extend: ACR–AIUM Practice Guideline for the Performance of Vascular Ultrasound for Postoperative Assessment of Dialysis Access

Extend: ACR–SIR Practice Guideline for Radioembolization with Microsphere Brachytherapy Device (RMBD) for Treatment of Liver Malignancies

Extend: ACR–SPR Practice Guideline for the Performance of Pediatric Computed Tomography (CT)

Honoring JACR Tenth Anniversary

Honoring the Chicago Radiological Society on their Centennial Meeting

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Proposed Bylaws Changes (Format)

Proposed Bylaws Changes (Substantive)

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Sunset: ACR–ACS–CAP–SSO Practice Guideline for the Management of Ductal Carcinoma In-Situ of the Breast

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-2012-

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ACR Practice Guideline on Physician Expert Witness in Radiology and Radiation Oncology

Amend the Titles to 11 Existing Practice Guidelines

Bylaws Amendment: Article IX, Section 7

Collaborating and Conflicting Society Guideline

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Definition of a Qualified Medical Physicist

Distribution of Imaging Reports

Extend: ACR–ACS–CAP–SSO Practice Guideline for Breast Conservation Therapy in the Management of Invasive Breast Carcinoma

Extend: ACR–ACS–CAP–SSO Practice Guideline for the Management of Ductal Carcinoma In-Situ of the Breast (DCIS)

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ACR–AAPM–SIIM Practice Guideline for Determinants of Image of Quality in Digital Mammography

ACR–AAPM–SIIM Practice Guideline for Digital Radiography

ACR–SPR Practice Guideline for Performing FDG-PET/CT in Oncology

ACR–SIR–SPR Practice Guideline for the Creation of a Transjugular Intrahepatic Portosystemic Shunt (TIPS)

ACR–AIUM–SPR–SRU Practice Guideline for the Performance of an Ultrasound Examination of the Abdomen and/or Retroperitoneum

ACR–ASNR–SPR Practice Guideline for the Performance of Computed Tomography (CT) Perfusion in Neuroradiologic Imaging

ACR–SIR–SPR Practice Guideline for the Performance of Diagnostic Arteriography

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ACR–ASNR–SPR Practice Guideline for the Performance of Functional Magnetic Resonance Imaging (MRI) of the Brain

ACR–ASNR–SPR Practice Guideline for the Performance of Intracranial Neuroradiologic Magnetic Resonance Bolus Perfusion Imaging

ACR–ASNR–SCBT-MR Practice Guideline for the Performance of Magnetic Resonance Imaging (MRI) of the Adult Spine

ACR–ASNR–SPR Practice Guideline for the Performance of Magnetic Resonance Imaging of the Head and Neck

ACR–SCBT-MR–SPR–SSR Practice Guideline for the Performance of Magnetic Resonance Imaging (MRI) of the Wrist

ACR–NASCI–SPR Practice Guideline for the Performance of Quantification of Cardiovascular Computed Tomography (CT) and Magnetic Resonance Imaging (MRI)

ACR–AIUM–SIR–SRU Practice Guideline for the Performance of Physiologic Evaluation of Extremity Arteries

ACR–SPR Practice Guideline for the Performance of Single Photon Emission Computed Tomography (SPECT) Brain Perfusion and for Brain Death Examinations

ACR–SPR Practice Guideline for the Performance of Skeletal Scintigraphy (Bone Scan)

ACR–ASSR–SPR–SSR Practice Guideline for the Performance of Spine Radiography

ACR–AIUM–SPR–SRU Practice Guideline for the Performance of the Musculoskeletal Ultrasound Examination

ACR–AIUM–SPR–SRU Practice Guideline for the Performance of Transcranial Doppler Ultrasound

ACR–ASNR–ASSR–SIR–SNIS Practice Guideline for the Performance of Vertebral Augmentation

ACR–SPR Practice Guideline for the Use of Intravascular Contrast Media

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Sunset: ACR Practice Guideline for the Performance of Coronary Vascular Brachytherapy (CVBT)

Sunset: ACR Technical Standard for the Performance of Brachytherapy Physics: Intravascular Applications Using Catheter-Based Systems (IVBT)

ACR–AAPM Technical Standard for Diagnostic Medical Physics Performance Monitoring of Computed Tomography (CT) Equipment

ACR–AAPM–SIIM Technical Standard for Electronic Practice of Medical Imaging

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ACR Distinguished Achievement Award

ACR Practice Guideline for Continuing Medical Education (CME)

ACR Practice Guideline for Performing and Interpreting Diagnostic Computed Tomography (CT)]

ACR Practice Guideline for Performing and Interpreting Magnetic Resonance Imaging (MRI)

ACR Practice Guideline for the Performance of a Breast Ultrasound Examination

ACR Practice Guideline for the Performance of Hysterosalpingography

ACR Practice Guideline for the Performance of Magnetic Resonance Imaging-Guided Breast Interventional Procedures

ACR Practice Guideline for the Performance of the Modified Barium Swallow

ACR Technical Standard for Diagnostic Medical Physics Performance Monitoring of Radiographic and Fluoroscopic Equipment

ACR Technical Standard for Diagnostic Medical Physics Performance Monitoring of Real Time Ultrasound Equipment

ACR Technical Standard for Medical Nuclear Physics Performance Monitoring of PET Imaging Equipment

Dues Language Change

Evaluate and Coordinate the Continuing Experience and Continuing Medical Education Requirements for ACR Accreditation

Extend ACR-ACS-CAP-SSO Practice Guideline for the Management of Ductal Carcinoma In-Situ of the Breast (DCIS); and the ACR-ACS-CAP-SSO Practice Guideline for Breast Conservation Therapy in the Management of Invasive Breast Carcinoma

Extend the Practice Guideline for the Performance of MRI of the Spine (ACR-ASNR)

Inserting Policy Language for Other Ancillary Personnel Performing Fluoroscopic Procedures in the ACR Technical Standard for Management of the Use of Radiation in Fluoroscopic Procedures

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ACR-SIR Practice Guideline for Endovascular Management of Thrombosed or Dysfunctional Dialysis Access

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ACR–SPR–SRU Practice Guideline for Performing and Interpreting Diagnostic Ultrasound Examinations

ACR–SPR Practice Guideline for Skeletal Surveys in Children

ACR–NASCI–SIR–SPR Practice Guideline for the Performance and Interpretation of Body Computed Tomography Angiography (CTA)

ACR–NASCI–SPR Practice Guideline for the Performance and Interpretation of Cardiac Computed Tomography (CT)

AR–NASCI–SPR Practice Guideline for the Performance and Interpretation of Cardiac Magnetic Resonance Imaging (MRI)

ACR–SPR–SSR Practice Guideline for the Performance and Interpretation of Magnetic Resonance Imaging (MRI) Bone, Joint, and Soft Tissue infections in the Extremities

ACR–SPR–SSR Practice Guideline for the Performance and Interpretation of Magnetic Resonance Imaging (MRI) of the Ankle and Hindfoot

ACR–SPR–SSR Practice Guideline for the Performance and Interpretation of Magnetic Resonance Imaging (MRI) of the Elbow

ACR–SPR–SSR Practice Guideline for the Performance and Interpretation of Magnetic Resonance Imaging (MRI) of the Hip and Pelvis for Musculoskeletal Disorders

ACR–SPR Practice Guideline for the Performance and Interpretation of Pediatric Magnetic Resonance Imaging (MRI)

ACR–SPR Practice Guideline for the Performance of Abdominal Radiography

ACR–AIUM–SRU Practice Guideline for the Performance of an Ultrasound Examination of the Extracranial Cerebrovascular System

ACR–AIUM–SPR–SRU Practice Guideline for the Performance of an Ultrasound Examination of the Neonatal Spine

ACR–SPR Practice Guideline for the Performance of Computed Tomography (CT) of the Abdomen and Computed Tomography (CT) of the Pelvis

ACR–ASNR–SPR Practice Guideline for the Performance of Computed Tomography (CT) of the Extracranial head and Neck in Adults and Children

ACR–ASNR–ASSR–SPR Practice Guideline for the Performance of Computed Tomography (CT) of the Spine

ACR–ASNR–SIR–SNIS Practice Guideline for the Performance of Diagnostic Cervicocerebral Catheter Angiography in Adults

ACR–SPR Practice Guideline for the Performance of Pediatric and Adult Chest Radiography

ACR–SPR Practice Guideline for the Performance of Pediatric and Adult Portable (Mobile Unit) Chest Radiography

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ACR–SPR Practice Guideline for the Performance of Pediatric Fluoroscopic Contrast Enema Examinations

ACR–SIR–SPR Practice Guideline for the Performance of Percutaneous Nephrostomy

ACR–ACOG–AIUM–SRU Practice Guideline for the Performance of Sonohysterography

ACR–AIUM–SRU Practice Guideline for the Performance of Ultrasound Vascular Mapping for Preoperative Planning of Dialysis Access

ACR–ASNR–ASSR–SIR–SNIS Practice Guideline for the Performance of Vertebral Augmentation

ACR–SIR Practice Guideline on Informed Consent for Image-Guided Procedures

ACT–ASTRO Practice Guideline for 3D External Beam Radiation Planning and Conformal Therapy

ACR–ASTRO Practice Guideline for Intensity-Modulated Radiation Therapy (IMRT)

ACR–ASTRO Practice Guideline for the Performance of Stereotactic Radiosurgery

ACR–ASTRO Practice Guideline for the Performance of Total Body Irradiation

Refer to the North American Consensus Guidelines for Administration of Radiopharmaceutical Activities in Children and Adolescents Paper in the Nuclear Medicine Guidelines

Revisions to ACR Bylaws

Speaker and Vice Speaker as Elected Members of the Council Steering Committee

Society of Computed Body Tomography and Magnetic Resonance Representation on the ACR Council

Standardization of Relative Exposure Unit of Measure for Digital Diagnostic Radiologic Equipment

Sunset the ACR Practice Guideline for the Performance of CT for the Detection of Pulmonary Embolism in Adults, and the Practice Guideline for the Performance and Interpretation of Computed Tomography Angiography (CTA)

Support for Maryland Anti Self-Referral Legislation

Technical Standard for Procedures Using Radiopharmaceuticals (ACR–SNM)

Ten Year Extension of Policies

The Royal College of Physicians and Surgeons of Canada (RCPSC) and the College des Médecins du Québec Residency Equivalency Language in Practice Guidelines and Technical Standards for Diagnostic Radiology

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ACR Practice Guideline for Communication of Diagnostic Imaging Findings

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ACR Practice Guideline for the Performance of Adult Cystography and Urethrography – assistance from the Society of Uroradiology

ACR Practice Guideline for the Performance of High-Resolution Computed Tomography (HRCT) of the Lungs in Adults

ACR Practice Guideline for the Performance of Magnetic Resonance Imaging-Guided Breast Interventional Procedures

ACR Practice Guideline for the Performance of Magnetic Resonance Imaging (MRI) of the Abdomen (Excluding the Liver)

ACR Practice Guideline for the Performance of Magnetic Resonance Imaging (MRI) of the Liver

ACR Practice Guideline for the Performance of Magnetic Resonance Imaging (MRI) of the Soft Tissue Components of the Pelvis

ACR Radiation Oncology Practice Guidelines and Technical Standards

ACR Technical Standard for the Performance of High-Dose-Rate-Brachytherapy Physics – assistance from the American Association of Physicists in Medicine

ACR Technical Standard for the Performance of Low-Dose-Rate Brachytherapy Physics – assistance from the American Association of Physicists in Medicine

ACR Technical Standard for the Performance of Radiation Oncology Physics for External Beam Therapy – assistance from the American Association of Physicists in Medicine

Addition of a Category of Fellowship for Long-Term Associate Members

Developing Ultrasound Applicability in PACS

Early Sunset of Policies Determined to Have Been Fulfilled

Extend ACR Practice Guideline for Continuing Medical Education

Extend ACR Practice Guideline for the Performance of Computed Tomography (CT) for the Detection of Pulmonary Embolism in Adults and the ACR Practice Guideline for the Performance and Interpretation of Computed Tomography Angiography (CTA)

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ACR–SIR Practice Guideline for Sedation/Analgesia

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ACR–ASNR Practice Guideline for the Performance and Interpretation of Cervicocerebral Computed Tomography Angiography (CTA)

ACR–SSR Practice Guideline for the Performance and Interpretation of Magnetic Resonance Imaging (MRI) of Bone and Soft Tissue Tumors

ACR–SSR Practice Guideline for the Performance and Interpretation of Magnetic Resonance Imaging (MRI) of the Knee

ACR–SSR Practice Guideline for the Performance and Interpretation of Magnetic Resonance Imaging (MRI) of the Shoulder

ACR–SPR–SNM Practice Guideline for the Performance of Adult and Pediatric Radionuclide Cystography

ACR–ASNR Practice Guideline for the Performance of Computed Tomography (CT) of the Brain

ACR–SPR Practice Guideline for the Performance of Contrast Esophagrams and Upper Gastrointestinal Examinations in Infants and Children

ACR–AIUM–SRU Practice Guideline for the Performance of Diagnostic and Screening Ultrasound of the Abdominal Aorta in Adults

ACR–SNM–SPR Practice Guideline for the Performance of Gastrointestinal Scintigraphy

ACR–ASTRO Practice Guideline for the Performance of High-Dose-Rate Brachytherapy

ACR–SIR Practice Guideline for the Performance of Inferior Vena Cava (IVC) Filter Placement for the Prevention of Pulmonary Embolism

ACR–SPR–SNM Practice Guideline for the Performance of Liver/Spleen Scintigraphy

ACR–ASTRO Practice Guideline for the Performance of Low-Dose-Rate Brachytherapy

ACR–NASCI–SPR Practice Guideline for the Performance of Pediatric and Adult Body Magnetic Resonance Angiography (MRA)

ACR–ASRN–SNIS–SPR Practice Guideline for the Performance of Pediatric and Adult Cervicocerebral Magnetic Resonance Angiography (MRA)

ACR–AIUM–SRU Practice Guideline for the Performance of Peripheral Arterial Ultrasound Using Color and Spectral Doppler

ACR–AIUM–SRU Practice Guideline for the Performance of Peripheral Venous Ultrasound Examination

ACR–AIUM–SRU Practice Guideline for the Performance of Scrotal Ultrasound Examination

ACR–ASTRO Practice Guideline for the Performance of Therapy with Unsealed Radiopharmaceutical Sources

ACR–SPR Practice Guideline for the Performance of Tumor Scintigraphy (with Gamma Cameras)

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ACR–AIUM–SRU Practice Guideline for the Performance of Ultrasound Evaluation of the Prostate (and Surrounding Structures)

ACR–SPR Practice Guideline for the Safe and Optimal Performance of Fetal Magnetic Resonance Imaging (MRI)

ACR–ASTRO Practice Guideline for Transperineal Permanent Brachytherapy of Prostate Cancer Revisions to ACR Bylaws

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ACR Practice Guideline for Communication: Radiation Oncology

ACR Practice Guideline for Radiation Oncology

ACR Practice Guideline for the Performance of an Enteroclysis Examination in Adults

ACR Practice Guideline for the Performance of Computed Tomography (CT) Colonography in Adults

ACR Practice Guideline for the Performance of Excretory Urography

ACR Practice Guideline for the Performance of Scrotal Scintigraphy

ACR Practice Guideline for the Performance of Stereotactic-Guided Breast Interventional Procedures

ACR Practice Guideline for the Performance of Ultrasound-Guided Percutaneous Breast Interventional Procedures

ACR Technical Standard for Diagnostic Medical Physics Performance Monitoring of Real Time Ultrasound Equipment

ACR Technical Standard for Diagnostic Medical Physics Performance Monitoring of Magnetic Resonance Imaging (MRI) Equipment

ACR Technical Standard for Medical Physics Performance Monitoring of Image-guided External Beam Radiation Therapy (IGRT)

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Practice Guideline for the Performance of Angiography, Angioplasty, and Stenting for the Diagnosis and Treatment of Renal Artery Stenosis in Adults (collaborative with SIR)

Practice Guideline for the Performance of Cardiac Scintigraphy (collaborative with SNM and SPR)

Practice Guideline for the Performance of Computed Tomography (CT) of the Brain (collaborative with ASNR)

Practice Guideline for the Performance of Neurosonography in Neonates and Infants (collaborative with AIUM, SPR, and SRU)

Practice Guideline for the Performance of Parathyroid Scintigraphy (collaborative with SNM and SPR)

Practice Guideline for the Performance of Pelvic Ultrasound (collaborative with AIUM, ACOG, and SRU)

Practice Guideline for the Performance of Pulmonary Scintigraphy in Adults and Children (collaborative with SNM and SPR)

Practice Guideline for the Performance of Radiography for Scoliosis in Children (collaborative with SPR)

Practice Guideline for the Performance of Scintigraphy for Inflammation and Infection (collaborative with SNM and SPR)

Practice Guideline for the Performance of Stereotactic Body Radiation Therapy (collaborative with ASTRO)

Practice Guideline for the Performance of Thyroid Scintigraphy and Uptake Measurements (collaborative with SNM and SPR)

Practice Guideline for the Performance of Vertebroplasty (collaborative with ASNR, ASSR, SNIS, and SIR)

Practice Guideline for the Performance of Voiding Cystourethrography in Children (collaborative with SPR)

Practice Guideline for the Reporting and Archiving of Interventional Radiology Procedures (collaborative with SIR)

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ACR Policy on “Electioneering”

ACR Practice Guideline for Diagnostic Reference Levels in Medical X-Ray Imaging (Revision)

ACR Practice Guideline for Imaging Pregnant or Potentially Pregnant Adolescents and Women with Ionizing Radiation (New)

ACR Practice Guideline for Radiologist Coverage of Imaging Performed in Hospital Emergency Departments (Revision)

ACR Practice Guideline for the Performance of a Barium Enema Examination in Adults (Revision)

ACR Practice Guideline for the Performance of Barium Small Bowel Examinations in Adults (Revision)

ACR Practice Guideline for the Performance of Contrast-Enhanced Magnetic Resonance Imaging (MRI) of the Breast (Revision)

ACR Practice Guideline for the Performance of Esophagrams and Upper Gastrointestinal Examinations in Adults (Revision)

ACR Practice Guideline for the Performance of Pediatric and Adult Thoracic Computed Tomography (CT) (Revision)

ACR Practice Guideline for the Performance of Quantitative Computed Tomography (QCT) Bone Densitometry (New)

ACR Practice Guideline for the Performance of Renal Artery Duplex Sonography (New)

ACR Practice Guideline for the Performance of Screening and Diagnostic Mammography (New)

ACR Practice Guideline for the Performance of the Ultrasound Examination for Detection and Assessment of Developmental Dysplasia of the Hip (Revision)

ACR Technical Standard for Management of the Use of Radiation in Fluoroscopic Procedures (Revision)

ACR Technical Standard for Medical Nuclear Physics Performance Monitoring of PET-CT Imaging Equipment (Revision)

ACR Technical Standard for Medical Nuclear Physics Performance Monitoring of Gamma Cameras (Revision)

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Practice Guideline for General Radiography (Revision)

Practice Guideline for Radioembolization with Microsphere Brachytherapy Device (RMBD) for Treatment of Liver Malignancies (New)

Practice Guideline for Specifications and Performance of Image-Guided Percutaneous Drainage/Aspiration of Abscesses and Fluid Collections (PDAFC) in Adults (Revision)

Practice Guideline for the Performance and Interpretation of Magnetic Resonance Imaging (MRI) of the Brain (Revision)

Practice Guideline for the Performance and Interpretation of Magnetic Resonance Spectroscopy of the Central Nervous System (Revision)

Practice Guideline for the Performance of Adult and Pediatric Hepatobiliary Scintigraphy (Revision)

Practice Guideline for the Performance of Adult and Pediatric Renal Scintigraphy (Revision)

Practice Guideline for the Performance of Diagnostic Infusion Venography (Revision)

Practice Guideline for the Performance of Dual-Energy X-Ray Absorptiometry (DXA) (Revision)

Practice Guideline for the Performance of Image-Guided Percutaneous Needle Biopsy (PNB) in Adults (Revision)

Practice Guideline for the Performance of Myelography and Cisternography (Revision)

Practice Guideline for the Performance of Non-Breast Magnetic Resonance Imaging (MRI) Guided Procedures (New)

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Practice Guideline for the Performance of Pediatric Contrast Examinations of the Small Bowel (Revision)

Practice Guideline for the Performance of Radiography of the Extremities in Adults and Children (Revision)

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ACR Practice Guideline for Performing FDG-PET/CT in Oncology

ACR Practice Guideline for the Performance of a Breast Ultrasound Examination

ACR Practice Guideline for the Performance of a Thyroid and Parathyroid Ultrasound Examination (Collaborative)

ACR Practice Guideline for the Performance of Adult and Pediatric Skeletal Scintigraphy (Bone Scan)

ACR Practice Guideline for the Performance of an Ultrasound Examination of the Abdomen and/or Retroperitoneum (Collaborative)

ACR Practice Guideline for the Performance of an Ultrasound Examination of the Extracranial Cerebrovascular System

ACR Practice Guideline for the Performance of an Ultrasound Examination of the Neonatal Spine (Collaborative)

ACR Practice Guideline for the Performance of Coronary Vascular Brachytherapy (CVBT)

ACR Practice Guideline for the Performance of Obstetrical Ultrasound (Collaborative)

ACR Practice Guideline for the Performance of Single Photon Emission CT (SPECT) Brain Perfusion and Brain Death Studies

ACR Practice Guideline for the Performance of Sonohysterography (Collaborative)

ACR Practice Guideline for the Performance of Spine Radiography in Children and Adults

ACR Practice Guideline for the Performance of the Musculoskeletal Ultrasound Examination (Collaborative)

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ACR Practice Guideline for the Performance of Vascular Ultrasound for Postoperative Assessment of Dialysis Access (Collaborative)

ACR Practice Guideline for the Use of Intravascular Contrast Media

ACR Practice Guideline on Informed Consent – Radiation Oncology

ACR Practice Guideline on the Expert Witness in Radiology and Radiation Oncology

ACR Technical Standard for Diagnostic Medical Physics Performance Monitoring of CT Equipment

ACR Technical Standard for Electronic Practice of Medical Imaging

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ACR Technical Standard for the Performance of Brachytherapy Physics: Intravascular Applications Using Catheter-Based System (IVBT)

ACR to Educate Radiology Community and Others Regarding Unethical and Illegal Business Practices

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Practice Guideline for Digital Radiography (Collaborative)

Practice Guideline for Intensity-Modulated Radiation Therapy (IMRT) (Collaborative)

Practice Guideline for the Creation of a Transjugular Intrahepatic Portosystemic Shunt (TIPS) (Collaborative)

Practice Guideline for the Performance of CT Perfusion in Neuroradiologic Imaging (Collaborative)

Practice Guideline for the Performance of Diagnostic Arteriography in Adults (Collaborative)

Practice Guideline for the Performance of Dual-Energy X-Ray Absorptiometry (DXA) (Collaborative)

Practice Guideline for the Performance of Functional Magnetic Resonance Imaging of the Brain (Collaborative)

Practice Guideline for the Performance of Intracranial Magnetic Resonance Bolus Perfusion Imaging (Collaborative)

Practice Guideline for the Performance of Magnetic Resonance Imaging (MRI) of the Head and Neck (Collaborative)

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ACR Practice Guideline for the Performance and Interpretation of Cardiac Computed Tomography

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ACR Practice Guideline for the Performance of Hysterosalpingography

ACR Practice Guideline for the Performance of Abdominal Radiography

ACR Practice Guideline for the Performance of an Ultrasound Examination of the Abdomen and/or Retroperitoneum (Collaborative)

ACR Practice Guideline for the Performance of CT of the Abdomen and/or CT of the Pelvis

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ACR Practice Guideline for the Performance of FDG-PET Scintigraphy Oncology

ACR Practice Guideline for the Performance of Modified Barium Swallow in Adults

ACR Practice Guideline for the Performance of Pediatric and Adult Chest Radiography

ACR Practice Guideline for the Performance of Pediatric and Adult Portable (Mobile Unit) Chest Radiography

ACR Practice Guideline for the Performance of Pediatric Contrast Examination of the Upper GI Tract

ACR Practice Guideline for the Performance of Pediatric Fluoroscopic Contrast Enema Examinations

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ACR Practice Guideline for the Performance of Peripheral Venous Ultrasound Examination (Collaborative)

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ACR Practice Guideline for the Performance of Scrotal Ultrasound Examinations (Collaborative)

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ACR Practice Guideline for the Use of Intravascular Contrast Media

ACR Practice Guideline on Informed Consent for Image-Guided Procedures

ACR Revised Statement on Interpretation of Radiology Images Outside the U.S.

ACR Technical Standard for Diagnostic Medical Physics Performance Monitoring of Radiographic and Fluoroscopic Equipment

ACR Technical Standard for Diagnostic Procedures Using Radiopharmaceuticals

ACR Technical Standard for Medical Nuclear Physics Performance Monitoring of PET Imaging Equipment

ACR Technical Standard for Medical Nuclear Physics Performance Monitoring of PET-CT Imaging Equipment

American Osteopathic Association (AOA) Residency Equivalency Language in Practice Guidelines and Technical Standards for Diagnostic Radiology

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Mammography CME Requirements and Due Process

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Practice Guideline for Breast Conservation Therapy in the Management of Invasive Breast Carcinoma (Collaborative)

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Practice Guideline for the Performance and Interpretation of MRI of the Elbow (Collaborative)

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Practice Guideline for the Performance of Total Body Irradiation (Collaborative)

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“Request for Examination” Language in Practice Guidelines

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ACR Practice Guideline for Communication of Diagnostic Imaging Findings

ACR Practice Guideline for Continuing Medical Education (CME)

ACR Practice Guideline for Pediatric Sedation/Analgesia

ACR Practice Guideline for the Performance and Interpretation of CT Angiography (CTA)

ACR Practice Guideline for the Performance of Adult Cystography and Urethrography

ACR Practice Guideline for the Performance of Computed Tomography (CT) for the Detection of Pulmonary Embolism in Adults

ACR Practice Guideline for the Performance of Computed Tomography (CT) Colonography in Adults

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ACR Practice Guideline for the Performance of Diagnostic and Screening Ultrasound of the Abdominal Aorta

ACR Practice Guideline for the Performance of Gastrointestinal Scintigraphy

ACR Practice Guideline for the Performance of High-Dose-Rate Brachytherapy

ACR Practice Guideline for the Performance of High-Resolution Computed Tomography (HRCT) of the Lungs in Adults

ACR Practice Guideline for the Performance of Liver/Spleen Scintigraphy

ACR Practice Guideline for the Performance of Low-Dose-Rate Brachytherapy

ACR Practice Guideline for the Performance of Magnetic Resonance Imaging (MRI of the Liver)

ACR Practice Guideline for the Performance of Magnetic Resonance Imaging (MRI) of the Soft Tissue Components of the Pelvis

ACR Practice Guideline for the Performance of Magnetic Resonance Imaging (MRI) of the Abdomen (excluding the liver)

ACR Practice Guideline for the Performance of Pediatric and Adult Body Magnetic Resonance Angiography (MRA)

ACR Practice Guideline for the Performance of Ultrasound Evaluation of the Prostate (and Surrounding Structures) (collaborative)

ACR Practice Guideline for the Performing and Interpreting Diagnostic Ultrasound Examinations

ACR Technical Standard for Teleradiology

ACR Technical Standard for the Performance of Brachytherapy Physics: Manually Loaded Temporary Implants

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Addition to ACR Policy on Self-Referral Imaging

Advocacy for High Quality, Appropriate and Ethical Medical Imaging and Radiation Therapy

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Practice Guideline for the Performance and Interpretation of Magnetic Resonance Imaging (MRI) of the Knee (collaborative)

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Practice Guideline for the Performance of Diagnostic Cervicocerebral Angiography in Adults (collaborative)

Practice Guideline for the Performance of Pediatric and Adult Cerebrovascular Magnetic Resonance Angiography (MRA) (collaborative)

Practice Guideline for the Performance of Percutaneous Inferior Vena Cava (IVC) Filter Placement for the Prevention of Pulmonary Embolism (collaborative)

Practice Guideline for the Performance of Therapy with Unsealed Radiopharmaceutical Sources (collaborative)

Practice Guideline for Transperineal Permanent Brachytherapy of Prostate Cancer (collaborative)

Radiologist and Radiation Oncologist Involvement in Their State Medical Societies

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ACR Practice Guideline for Communication: Radiation Oncology

ACR Practice Guideline for Radiation Oncology

ACR Practice Guideline for the Performance of an Enteroclysis Examination in Adults

ACR Practice Guideline for the Performance of Cardiac Scintigraphy

ACR Practice Guideline for the Performance of Excretory Urography

ACR Practice Guideline for the Performance of Magnetic Resonance Imaging (MRI) of the Breast

ACR Practice Guideline for the Performance of Neurosonography in Neonates and Young Children

ACR Practice Guideline for the Performance of Parathyroid Scintigraphy

ACR Practice Guideline for the Performance of Pelvic Ultrasound in Females

ACR Practice Guideline for the Performance of Pulmonary Scintigraphy

ACR Practice Guideline for the Performance of Radiography for Scoliosis in Children

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ACR Practice Guideline for the Performance of Screening Mammography

ACR Practice Guideline for the Performance of Scrotal Scintigraphy

ACR Practice Guideline for the Performance of Thyroid Scintigraphy and Uptake Measurements

ACR Practice Guideline for the Performance of Voiding Cystourethrography in Children

ACR Statement on Whole Body MRI Screening Exams

ACR Technical Standard for Diagnostic Medical Physics Performance Monitoring of Magnetic Resonance Imaging (MRI) Equipment

ACR Technical Standard for Diagnostic Medical Physics Performance Monitoring of Real Time Ultrasound Equipment

ACR Technical Standard for the Performance of Radiation Oncology Physics for External Beam Therapy

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Practice Guideline for Electronic Medical Information Privacy and Security

Practice Guideline for Interventional Clinical Practice

Practice Guideline for Specifications and Performance of Image-Guided Percutaneous Drainage/Aspiration of Abscesses and Fluid Collections (PDAFC) in Adults

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ACR Standard for Medical Nuclear Physics Performance Monitoring of Nuclear Medicine Imaging Equipment

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ACR Standard for the Performance of a Shoulder Ultrasound Examination

ACR Standard for the Performance of a Thyroid and Parathyroid Ultrasound Examination

ACR Standard for the Performance of Adult and Pediatric Hepatobiliary Scintigraphy

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ACR Standard for the Performance of Antepartum Obstetrical Ultrasound

ACR Standard for the Performance of Esophagrams and Upper Gastrointestinal Examinations in Adults

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ACR Standard for the Performance of Brachytherapy Physics: Intravascular Applications Using Catheter Based Systems

ACR Standard for the Performance of Breast Ultrasound Examination

ACR Standard for the Performance of Cerebral Scintigraphy for Brain Death

ACR Standard for the Performance of Coronary Vascular Brachytherapy

ACR Standard for the Performance of Diagnostic Mammography

ACR Standard for the Performance of Per Oral Barium Small Bowel Examination in Adults

ACR Standard for the Performance of Saline Infusion Sonohysterosalpingography

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ACR Standard for the Performance of Single Photon Emission Computed Tomography (SPECT) Brain Perfusion Imaging

ACR Standard for the Performance of Spine Radiography in Children and Adults

ACR Standard for the Performance of Ultrasound Examination of the Extracranial Cerebrovascular System

ACR Standard on Informed Consent – Radiation Oncology

ACR Standard on the Expert Witness in Radiology

American College of Radiology Guidance for Radiologists in Managed Care Negotiations

American Society of Interventional and Therapeutic Neuroradiology Representation on the ACR Council

American Society of Spine Radiology Representation on the ACR Council

Association of Program Directors in Radiology Representation on the ACR Council

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Colorectal Cancer Screening

Commendation for Exemplary Service - Marie Zinninger

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Disposal Of Low Level Radioactive Waste

Expansion of Public Information Efforts Regarding the Role Of Radiology in the Provision and Economics of Health Care

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Interpretation of Radiologic Examinations Not Directly Supervised or Monitored by the Radiologist

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ACR Standard for 3-D External Beam Radiation Planning and Conformal Therapy

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ACR Standard for Communication: Diagnostic Radiology

ACR Standard for Diagnostic Medical Physics Performance Monitoring of Radiographic and Fluoroscopic Equipment

ACR Standard for Diagnostic Procedures Using Radiopharmaceuticals

ACR Standard for Digital Image Data Management

ACR Standard for Medical Nuclear Physics: Performance Monitoring of PET Imaging Equipment

ACR Standard for Performing and Interpreting Diagnostic Computed Tomography (CT)

ACR Standard for Performing and Interpreting Magnetic Resonance Imaging (MRI)

ACR Standard for Skeletal Surveys in Children

ACR Standard for the Performance of Abdominal Radiography

ACR Standard for the Performance of an Ultrasound Examination of the Abdomen or Retroperitoneum

ACR Standard for the Performance of Cardiovascular MRI

ACR Standard for the Performance of Computed Tomography (CT) of the Abdomen and Computed Tomography of the Pelvis

ACR Standard for the Performance of Computed Tomography (CT) of the Extracranial Head and Neck in Adults and Children

ACR Standard for the Performance of Hysterosalpingography

ACR Standard for the Performance of Magnetic Resonance (MR) Imaging of the Adult Spine

ACR Standard for the Performance of Pediatric and Adult Bedside Chest Radiography (Portable Chest Radiography)

ACR Standard for the Performance of Pediatric and Adult Chest Radiography

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ACR Standard for the Performance of Pediatric Contrast Examinations of the Upper Gastrointestinal Tract

ACR Standard for the Performance of Peripheral Arterial Ultrasound Examination Using Pulsed Doppler

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ACR Standard for the Performance of the Modified Barium Swallow in Adults

ACR Standard for the Performance of Total Body Irradiation

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ACR Standard for Continuing Medical Education (CME)

ACR Standard for General Radiography

ACR Standard for Percutaneous Management of the Thrombosed or Dysfunctional Dialysis Access (PMDA)

ACR Standard for Performing and Interpreting Diagnostic Ultrasound Examinations

ACR Standard for Performing and Interpreting Magnetic Resonance Imaging (MRI)

ACR Standard for Radiologist Coverage of Imaging Performed in Hospital Emergency Departments

ACR Standard for the Performance of Adult Cystography and Urethrography

ACR Standard for the Performance of Brachytherapy Physics: Manually-Loaded Temporary Implants

ACR Standard for the Performance of Brachytherapy Physics: Remotely-Loaded HDR Sources

ACR Standard for the Performance of Cardiovascular MRI

ACR Standard for the Performance of Computed Tomography for the Detection of Pulmonary Embolism in Adults

ACR Standard for the Performance of FDG-PET Scintigraphy in Oncology

ACR Standard for the Performance of Gastrointestinal Scintigraphy

ACR Standard for the Performance of High Resolution Computed Tomography (HRCT) of the Lungs in Adults

ACR Standard for the Performance of High-Dose-Rate Brachytherapy

ACR Standard for the Performance of Liver/Spleen Scintigraphy

ACR Standard for the Performance of Low-Dose-Rate Brachytherapy

ACR Standard for the Performance of Pediatric and Adult Neurovascular Magnetic Resonance Angiography (MRA)

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ACR Standard for the Performance of Percutaneous Permanent Inferior Vena Cava (IVC) Filter Placement for the Prevention of Pulmonary Embolism

ACR Standard for the Performance of Percutaneous Vertebroplasty

ACR Standard for the Performance of Radiography of the Lumbosacral Spine

ACR Standard for the Performance of Radiography of the Thoracic Spine

ACR Standard for the Performance of Radionuclide Cystography

ACR Standard for the Performance of Stereotactically Guided Breast Interventional Procedures

ACR Standard for the Performance of Therapy with Unsealed Radiopharmaceutical Sources

ACR Standard for the Performance of Tumor Scintigraphy (with Gamma Cameras)

ACR Standard for the Performance of Ultrasound Evaluation of the Prostate (and Surrounding Structures)

ACR Standard for the Performance of Ultrasound Guided Percutaneous Breast Interventional Procedures

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ACR Opposition to AMA Support of Reversal of Federal Self-Referral Legislation

ACR Standard for Communication: Diagnostic Radiology

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ACR Standard for Image-Guided Percutaneous Needle Biopsy (PNB) in Adults

ACR Standard for Performance of Adult Esophagrams and Upper Gastrointestinal Examinations

ACR Standard for Radiation Oncology

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ACR Standard for Specifications and Performance of Image-Guided Percutaneous Drainage/Aspiration of Abscesses and Fluid Collections (PDAFC) in Adults

ACR Standard for the Diagnostic Medical Physics Performance Monitoring of Real Time B-Mode Ultrasound Equipment

ACR Standard for the Diagnostic Medical Physics Performance Monitoring of MRI Equipment

ACR Standard for the Performance of Adult Barium Enema

ACR Standard for the Performance of Adult Enteroclysis Examinations

ACR Standard for the Performance of Antepartum Obstetrical Ultrasound

ACR Standard for the Performance of Cardiac Scintigraphy

ACR Standard for the Performance of Cerebral Scintigraphy for Brain Death

ACR Standard for the Performance of Diagnostic Arteriography in Adults

ACR Standard for the Performance of Diagnostic Cervicocerebral Angiography in Adults

ACR Standard for the Performance of Excretory Urography

ACR Standard for the Performance of Parathyroid Scintigraphy

ACR Standard for the Performance of Pediatric Neurosonology

ACR Standard for the Performance of Per Oral Barium Small Bowel Examinations in Adults

ACR Standard for the Performance of Pulmonary Scintigraphy

ACR Standard for the Performance of Radiography of the Cervical Spine in Children and Adults

ACR Standard for the Performance of Scintigraphy for Infections and Inflammation

ACR Standard for the Performance of Screening Mammography

ACR Standard for the Performance of Scrotal Scintigraphy

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ACR Standard for the Performance of Voiding Cystourethrography in Children

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ACR Standard for Diagnostic Medical Physics Performance Monitoring of Computed Tomography Equipment

ACR Standard for Diagnostic Procedures Using Radiopharmaceuticals

ACR Standard for Digital Image Data Management

ACR Standard for Medical Nuclear Physics Performance Monitoring of Nuclear Medicine Imaging Equipment

ACR Standard for Myelography and Cisternography

ACR Standard for Pediatric Sedation/Analgesia

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Quality Assurance Program with AHA

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Radiologic Technologists Innovative Educational Programs

Radiologic Technologists – Professional Health Care Member

Radiology Department Managers

Soliciting Names to Serve on Commissions

Sound Relationship of Officers

Summit Meeting of National Organizations

Task Force on Pneumoconiosis

SECTION V
CHRONOLOGICAL LIST OF PAST COUNCIL ANNUAL MEETINGS AND COUNCIL SPEAKERS
(1972–Present)

**PAST COUNCIL ANNUAL MEETINGS
AND COUNCIL SPEAKERS**

Year	City, State Hotel	Speaker
1972 (Spring)	Miami, FL Fontainebleau Hotel	Fred Lake, M.D. (1971-1973)
1973	San Francisco, CA St. Francis	
1974	New Orleans, LA Roosevelt-Fairmont	Jack Harris, M.D. (1973-1975)
1975	Portland, OR Hilton	
1976	Washington, DC Hilton	Hal Mueller, M.D. (1975-1977)
1977	Houston, TX Shamrock	
1978	San Diego, CA Town & Country	Al Dunn, M.D. (1977-1979)
1979 (Fall)	Chicago, IL Marriott	
1980	New Orleans, LA Fairmont	Tom Meaney, M.D. (1979-1981)
1981	Las Vegas, NV Caesar's Palace	
1982	Boston, MA Sheraton	John Lohnes, M.D. (1981-1983)
1983	Denver, CO Marriott	
1984	Los Angeles, CA Century Plaza	Frank Angell, M.D. (1983-1985)
1985	Montreal, Canada Queen Elizabeth	
1986	Baltimore, MD Omni International	K.K. Wallace, Jr., M.D. (1985-1987)
1987	San Diego, CA InterContinental Hotel	
1988	Cincinnati, OH Hyatt Regency	Murray L. Janower, M.D. (1987-1989)
1989	Seattle, WA Westin Hotel	
1990	Nashville, TN Opryland Hotel	Milton Gallant, M.D. (1989-1991)
1991	Minneapolis, MN Hyatt Regency	
1992	Phoenix, AZ Phoenician	Abner M. Landry, Jr., M.D. (1991-1993)
1993	Orlando, FL Hyatt Grand Cypress	

Year	City, State Hotel	Speaker
1994	New Orleans, LA New Orleans Hilton Riverside	Kay H. Vydareny, M.D. (1993-1995)
1995	Boston, MA Westin Copley Place Hotel	
1996	San Antonio, TX Marriott Rivercenter	Roger A. Hyman, M.D. (1995-1997)
1997	Atlanta, GA Atlanta Hilton and Towers	
1998	Pittsburgh, PA Pittsburgh Hilton and Towers	John A. Knote, M.D. (1997-1999)
1999	Washington, DC Washington Hilton and Towers	
2000	New York, NY Hilton New York and Towers	Barry D. Pressman, M.D. (1999-2001)
2001	San Francisco, CA Hilton San Francisco	
2002	Miami Beach, FL Loews Miami Beach Hotel	R. Terrell Frey, M.D. (2001-2003)
2003	Washington, DC Hilton Washington and Towers	
2004	Washington, DC Hilton Washington and Towers	Paul H. Ellenbogen, M.D. (2003-2005)
2005	Washington, DC Hilton Washington and Towers	
2006	Washington, DC Hilton Washington and Towers	Albert L. Blumberg, M.D. (2005-2007)
2007	Washington, DC Hilton Washington and Towers	
2008	Washington, DC Hilton Washington and Towers	David C. Kushner, M.D. (2007-2009)
2009	Washington, DC Hilton Washington and Towers	
2010	Washington, DC Hilton Washington and Towers	Alan D. Kaye, M.D. (2009-2011)
2011	Washington, DC Hilton Washington and Towers	
2012	Washington, DC Hilton Washington and Towers	Howard B. Fleishon, M.D. (2011-2013)
2013	Washington, DC Hilton Washington and Towers	
2014	Washington, DC Hilton Washington and Towers	Kimberly E. Applegate, M.D. (2013-2015)
2015	Washington, DC Marriott Wardman Park	
2016	Washington, DC Marriott Wardman Park	William T. Herrington, M.D. (2015-2017)
2017	Washington, DC Marriott Wardman Park	
2018	Washington, DC Marriott Wardman Park	Timothy L. Swan, M.D. (2017-2019)
2019	Washington, DC	

Year	City, State Hotel	Speaker
	Marriott Wardman Park	
2020	Virtual Meeting (COVID-19)	Richard Duszak Jr., MD, FACR (2019-2021)
2021	Virtual Meeting (COVID-19)	
2022	Washington DC Hilton Washington and Towers	Amy L. Kotsenas, MD, FACR (2021-2023)

SECTION VI
APPENDICES

APPENDIX A

HYPERTHERMIA GUIDELINES

The Council of the American College of Radiology accepts and endorses the guidelines for the qualifications of physicians prescribing, and supervising hyperthermia 1987, 1997, 2007 (Res. 12-F).

BACKGROUND

For more than ten years, hyperthermia has attracted the research interests of major universities and other academic centers as a potential treatment modality against cancer. Indeed, both laboratory tests and clinical trials have demonstrated the powerful in vivo and in vitro potentiating effect of hyperthermia to radiation or chemotherapy and entrepreneurs have responded by forming high technology companies, especially in the fields of microwave and radiofrequency engineering. As marketing approval for hyperthermic devices became increasingly probable, the Center for Devices and Radiological Health (CDRH) of the Food and Drug Administration (FDA) awarded a contract to the University of Washington to develop educational guidelines for the training of hyperthermia equipment operators. At about the same time, they also requested the American Society for Therapeutic Radiology and Oncology (ASTRO) to examine the training requirements for physicians in the treatment of patients with hyperthermia.

These steps were taken in anticipation of progressively increasing numbers of patients being treated by practitioners with local, regional or systemic hyperthermia in medical centers and private offices in order to establish minimum standards for practice.

INITIATIVE

In September 1984, the American College of Radiology passed a resolution concerning hyperthermia as follows:

“Whereas, no guidelines exist for technicians who administer hyperthermia treatment or for physicians who prescribe and oversee the treatment, and

Whereas, the establishment of standards for physicians and technicians involved in the administration of hyperthermia is essential to ensure that it is used safely and effectively; therefore,

Be it resolved, that the American College of Radiology is concerned that non-existent or inadequate standards may result in harm to patients, and

Be it further resolved, that the American College of Radiology will, in collaboration with other interested societies, encourage establishment of guidelines for qualifications and training standards for physicians who prescribe and supervise and technicians who supervise and administer hyperthermia.”

The Quality Assessment Committee, chaired by Dr. Gerald Hanks, who charged by the College to develop a document concerning physician qualifications to conduct hyperthermia. In addition to Dr. Hanks, the physicians and scientists who initially contributed or were invited to the discussion include Dr. J. Robert Cassady (University of Arizona), Dr. James R. Oleson (Duke University), Dr. Kenneth H. Luk (City of Hope National Medical Center), Dr. Carlos A. Perez (Washington University) and Dr. Gilbert Nussbaum (Washington University), Dr. J. Robert Stewart (University of Utah), Dr. M.A. Bagshaw (Stanford University), Dr. Dennis Leeper (Thomas Jefferson University), and Dr. Prakash H. Shrivastava (Allegheny General Hospital). As other interested organizations were identified, Dr. Richard A. Stoves (University of Wisconsin) was added to the discussion group. This composite group thus contains representatives of ASTRO, NAHG, Radiation Research Society, ACR, International Clinical Hyperthermia Society, Hyperthermia Physics Quality Assurance Group and AAPM.

CRITERIA

GENERAL

The fact that hyperthermia is medical treatment to be delivered either in the hospital or in an office dictates that the physician who prescribes and supervises such treatments should be a clinician. Therefore, the most basic requirement is that the practitioner be a graduate of an accredited medical school, who is licensed to practice medicine, and is a member in good standing of the local medical community. Furthermore, because hyperthermia is a specialized and advanced form of treatment to be offered to cancer patients, the physician should be a person with specialty training in an oncologic discipline. Such specialty oncologic training could be in radiation oncology, medical oncology, or surgical oncology. Certification by an oncologic specialty board would be the minimum recognition of completion of such training where such certification exists. For the purpose of this document prepared for the American College of Radiology, only board certification in the field of radiation oncology will be considered. The field of medical oncology also offers certification by their subspecialty board, and since there is no oncology board certification available, at least two years of formal oncology training experience is recommended beyond completion of a general surgery residency.

It should be pointed out that there are broad areas of common interest between radiation oncology and hyperthermic oncology. The radiation biologists were the first to explore the mechanisms and interactions of heat with radiation and drugs, and medical physicists and electronic engineers primarily in radiation oncology departments have pioneered equipment development and quality control/assurance procedures for effective therapy.

Specific

The following broad areas of specialized knowledge must be possessed by the physician who prescribes and supervises hyperthermia treatments:

- (1) **THERMOBIOLOGY:** This requires understanding of the basic cellular, tissue and organ biology of treatment with hyperthermia. This information includes but is not limited to mechanisms of thermal damage, factors which influence heat effect (such as pH, nutrient environment, heat shock proteins, etc.). The influence of hyperthermia on the effects of radiation, chemotherapeutic and nonchemotherapeutic drugs, the importance of the sequence and duration of heat delivery, and the phenomenon of thermal tolerance should be understood by the physician prescribing hyperthermia treatments.
- (2) **BASIC PHYSICS & PHYSIOLOGY & INSTRUMENTATION:** Because so many of the procedures of hyperthermia are related to electronic technology and instrumentation, the physician should have a good knowledge of the physics and engineering aspects of hyperthermia equipment. The steady state temperature distributions produced in a given application of clinical hyperthermia will be governed by the distributions of local absorbed power (SAR, watts/kg) and local heat transfer via thermal conduction and blood flow-related convection. Therefore, the physician must have an adequate understanding of the physics and physiology of tissue heating. Specifically, the physician should possess a satisfactory body of knowledge on SAR distributions produced in tissue-like static phantoms by a variety of electromagnetic and ultrasonic applicators. The physician should also possess satisfactory knowledge of the effects of various blood flows (perfusion rate) in tumors and normal tissues, at both normal and elevated temperatures. Moreover, the physician should have a good understanding of the way in which temperature distributions are influenced by levels of and changes in tumor and normal tissue perfusion rates. As new techniques of heat deposition are developed, (e.g., ultrasound) the practitioner will need to become familiar with these emerging approaches.
- (3) **RESPONSE OF NORMAL & TUMOR TISSUES:** In patient treatment, it is important to know the expected response of tumor tissue to heat in addition to normal tissue effects and damage. The physician must have a clear idea and utilize techniques to measure the thermal distribution produced by the equipment to be used, and the energy deposition within the tissue to be heated. The selection of certain tumors for hyperthermia treatment depends on many features including the histological type, location of

the tumor, and previous history of radiation therapy or chemotherapy. In general, hyperthermic treatment should be utilized at this time in clinical settings where conventional treatment approaches are suboptimal, either due to inadequate tumor control rates or treatment toxicity. Certain regional hyperthermia approaches may result in systemic heating or other physiologic changes such as tachycardia and blood pressure changes, and these possibilities require careful monitoring and management. When complications result, the physician should be able to properly assess the situation, make the required referrals and/or institute suitable intervention immediately.

- (4) **INVASIVE TECHNIQUES FOR THERMOMETRY & INTERSTITIAL THERMORADIATION:** Interstitial radiation combined with hyperthermia requires the technical skill and experience to perform interstitial planar and volume implants and the qualities of judgment and experience to determine where these methods are of value. Invasive thermometry is still needed to monitor temperatures and, therefore, the techniques of invasive placement of catheters for temperature probes should be well known to the physician.
- (5) **EFFECTS OF EXTERNAL BEAM IRRADIATION:** The common use of hyperthermia in combination with external beam radiation, including electron beam therapy requires a basic understanding of the effects of irradiation on tissues and the basic techniques for administering such therapy to common tumor sites.
- (6) **CONTINUING EDUCATION:** The American College of Radiology and other interested specialty organizations should sponsor continued medical education programs at various levels so that physicians participating in hyperthermia can maintain skill in this rapidly evolving technical field. If these continuing medical education programs are well established, then certification of attendance at these programs may be of value for demonstrating the maintenance of continued competence in administration of hyperthermia.

CERTIFICATION

One method of ensuring the qualifications of physicians who prescribe and supervise hyperthermia is by a certification process such as that given by the American Board of Radiology in Radiation Oncology. This certification now includes written and oral examination in the basic principles of hyperthermia. The examinations currently offered by the American Board of Radiology should be expanded to ensure the qualifications of physicians who practice hyperthermia.

Until hyperthermia becomes a more widely utilized feature of oncology practice, and training program directors incorporate essential aspects of hyperthermia into the educational program for residents and fellows, hyperthermia should remain a subspecialty requiring at least six months of additional training beyond the three-year program approved by the American Board of Radiology.

Alternate pathways for demonstrating competence will include documentation of clinical experience and research, participation in tutorial courses, preceptorships, fellowships, or other forms of specialized instruction in hyperthermia. The net result of these alternate pathways must accomplish the educational and experience requirements described in this document.

RECOMMENDATION FOR ACTION BY THE AMERICAN COLLEGE OF RADIOLOGY

The Council of the American College of Radiology adopts these guidelines for the qualification of physicians prescribing and supervising hyperthermia; 1987, 1997, 2007 (Res. 12-F)

APPENDIX B

White Paper on Referred Resolution 39, 1999

Resolution 39, put forward at the 1999 annual meeting of the ACR, called for a modification of the breast biopsy accreditation programs by providing an alternate pathway for meeting the physician qualifications (specifically, that in communities where there is no other ACR accredited biopsy program, a detailed quality assurance report could replace the annual requirement for on an average of at least 12 biopsies per year/physician). This resolution was discussed in Reference Committee and on the floor of the Council, and because of concerns raised regarding politicization of the ACR accreditation programs, was referred to the Board of Chancellors.

By direction of the Chairman of the Board of Chancellors, on March 2, 2000, the chairs of Commission on Standards and Accreditation and the Commission on Rural and/or Small Practices convened a meeting with the Chairs of the ACR accreditation program committees. Following a lengthy discussion, the participants decided that there were basically two issues:

1. the specific resolution to remove numerical requirements for ongoing physician qualifications and
2. the process whereby previously approved accreditation programs could be modified.

With regard to the numerical requirement, this is based on the ACR standards for ultrasound and stereotactic-guided breast biopsies. These Standards were subject to the deliberations of the Council, and the required number of 12 biopsies per year is indeed the number approved in the standards by Council. This ad hoc committee unanimously agreed it would not be wise to change the number nor to permit different scoring criteria in a given accreditation program

The issue of how ACR accreditation programs can be modified is far more substantive, and has significant legal implications. The current ACR accreditation development process is designed in part to help protect the College from antitrust liability. Because an accreditation program is an agreement between physician specialists that, in effect, excludes others, the Justice Departments and Federal Trade Commission will evaluate whether it unreasonably restrains competition. The key issue is whether the accreditation program is based on sound medical or scientific information and is derived through a fair and objective process. The ACR believes that its accreditation programs would withstand scrutiny because of the rigorous and inclusive committee procedure with many opportunities for input, including an appeals process. Because the process by which Council deliberates and votes is less rigorous and objective, permitting the Council to overrule this objective process could expose the ACR to charges of bias and politicization of the accreditation system.

However, the ad hoc committee recognized the need for regular review of the programs, broad representation on accreditation committees, and a defined appeals process. To this end, the following have already been implemented:

- Each accreditation program will undergo annual (or more frequent) review by its parent committee, and modified as necessary based on that review.
- Each accreditation committee will include at least one member from a rural and/or small practice.
- Any active or eligible participant in an accreditation program may request modification of that program through a formal appeals process that has been defined as:

“This appeal is initiated by a letter outlining the concern regarding the program addressed to the Chair, Commission on Standards and Accreditation. The issue will be considered by the appropriate accreditation committee and its decision given to the Commission Chair, who will respond to the appellant. Committee responses which are felt to have ramifications for other programs or which seem unreasonable will be addressed by the entire Committee of Accreditation Chairs.”

Finally, the ad hoc committee felt that Resolution 42, passed in 1994 (Digest of Council Actions 1990-99, Section II.I.1.b, page 86) requiring Council approval of accreditation programs before their development or implementation, by explicitly granting the Council Steering Committee and the Board of Chancellors the responsibility to review and approve the completed program, implicitly removed the accreditation programs from the political process of change by resolution on the floor of the Council. However, this may not be sufficiently clear. Therefore, Resolution No. 2, sponsored by the Board of Chancellors, seeks to modify by addition the original Resolution 42, 1994, to reflect that viewpoint and thereby to protect the accreditation programs from a political process that has the potential to weaken them and to increase the exposure of the ACR to antitrust or other liability

APPENDIX C

Delineation of Privileges in Diagnostic Radiology and Nuclear Medicine**INTRODUCTION**

The American College of Radiology approves the dissemination of the document entitled “Delineation of Privileges in Diagnostic Radiology and Nuclear Medicine” to ACR members as a resource document; 1986, 1996, amended 2006 (Res. 16-e).

Medical staff requirements for the credentialing of physicians and delineation of clinical privileges are intended to ensure quality patient care and protect patients from unqualified or incompetent physicians. Certain standards must be met by all who seek clinical privileges. The granting of privileges in radiology is dependent upon a review of the individual’s qualifications as evidenced by training, experience and competence in radiology as demonstrated by completion of an accredited residency program which may be further substantiated by certification by the American Board of Radiology or American Osteopathic Board of Radiology or the American Board of Nuclear Medicine for those who include nuclear radiology in their practices. Non radiologists desiring privileges in medical imaging must also demonstrate evidence of training, experience and competence in those specific privilege areas requested. Documentation of specialized post-graduate training and/or experience is essential to meet these requirements.

DIAGNOSTIC RADIOLOGY

Radiologists engaged in the practice of diagnostic radiology are trained in medical imaging and related interventional techniques. Medical imaging is the science of portraying the internal structures of the human body for the purpose of detecting and determining the extent of disease. Imaging is accomplished through various techniques or modalities, including radiant energy or ionizing radiation, ultrasound and magnetic resonance, among others. The term radiologist has been traditionally applied to those physicians specializing in the imaging of the human body. Imaging techniques can use multi-dimensional display of three dimensional body structures and organs, which can result in the potential for artifacts that may be mistaken for pathology, requiring great expertise to recognize. Radiologists are trained to be aware of the potential hazards that may harm the patient and must be avoided, as well as the variable sensitivity and specificity of each imaging technique in the detection of disease processes. The radiologist must know the indications and contraindications relating to factors intrinsic to patients, their disease, and the relative merits and cost of a particular imaging technique to be considered in the selection of the appropriate imaging modality.

Education and Training

Currently, postgraduate medical education in diagnostic radiology is at least four years in length which is preceded by one or more years of postgraduate training in another clinical specialty. Those radiologists certified in radiology with the previously shorter residency period have been supplemented by many years of clinical experience in radiology.

Training consists of studies in normal anatomy and its variants, the morbid anatomy and pathophysiology of disease as well as the acquisition of skills in imaging techniques to detect and define disease processes. A radiologist learns to select and utilize the imaging technique that will best answer the clinical question at hand. Because radiologists are not restricted to a single imaging technology or body system, they are at liberty to select the most clinically effective means of diagnostic imaging in any particular clinical setting. Inherent to the training of diagnostic radiologists is the need to apply the technology to the entire spectrum of disease and injury and not to restrict its use to a specific disease process or subspecialty interest. With a knowledge of both disease processes and the various imaging techniques, the radiologist is skilled in the proper sequencing of examinations inherent in arriving at the correct diagnosis in the most expeditious manner.

Technical Expertise

Knowledge of disease processes includes the most likely sites of involvement of disease, its method of spread and its appearance on other imaging techniques. An understanding of the requirements of an imaging technology necessitates learning: the fundamental principles of the technique, how varying parameters affect this technique and the image, how to vary the parameters to maximize informational content, and how the appearance of the image relates to the disease process. The radiologist is aware of the potential complications and how they can be avoided or prevented, the indications and contraindications for the procedure and the role of this particular technique in comparison to other available options. Inherent in the use of any technology is the requirement for quality control. The radiologist, because of his/her specialized training in medical imaging physics, is uniquely qualified to supervise and perform imaging procedures and to be responsible for a quality improvement program.

Continuing Education

Radiologists stay abreast of the rapidly changing technology and skills required for new modalities as they develop. As such technologies and procedures are introduced; they are routinely added into residency training. Radiologists who previously completed training master new imaging techniques more quickly than other medical specialists due to their knowledge of disease and comprehensive understanding of the general requirements of imaging. The diagnostic radiologist is the only physician specialist who is dedicated full time to the imaging of disease and injury and has the best background and opportunity to become proficient in a new imaging modality. New skills are acquired by review of current scientific publications, and attendance at scientific meetings and specific courses devoted to the new modalities and techniques. Knowledge of new techniques is also acquired by participation in programs at the institutions where the leading research by radiologists has led to the introduction of new imaging techniques. Recent graduates of radiology training programs are required to obtain training, experience, and skills in all current imaging modalities and related interventional techniques. It can be justifiably assumed that previously certified radiologists have a basic understanding of imaging, but documentation of study, training, and experience in a newly developed technology should be required before clinical privileges are approved, dependent upon the variance of the technology from their previous training and experience in radiology.

NUCLEAR MEDICINE

In addition to training in diagnostic radiology, radiologists have acquired specialty training in the diagnostic uses of administered radiopharmaceuticals. Radiologists are trained in the integral diagnostic management of patients using all imaging modalities but have additional training in the physics, instrumentation, radiochemistry, radiation safety and biology, quality improvement and interpretation of imaging studies obtained after the administration of radiolabeled tracers. Competency in the practice of nuclear radiology is acquired in a standard diagnostic radiology training program. Radiologists specializing in the field of nuclear radiology require completion of an approved training program in nuclear radiology or nuclear medicine. Certification by the American Board of Radiology with special competence in nuclear radiology and/or certification by the American Board of Nuclear Medicine is recommended. Current training in the subspecialty of nuclear radiology is at least one year either in addition to the training program in diagnostic radiology. As with training in diagnostic radiology alone, it can be assumed that previously certified nuclear radiologists have a basic understanding of imaging, but documentation of study, training, and experience in a newly developed application of the specialty may be required before clinical privileges are approved, dependent upon the variance of the application from their previous training and experience. Since the intensity of training in therapeutic nuclear radiology varies among training programs, clinical privileges for the therapeutic use of unsealed sources should be judged on a case by case basis dependent upon the training and experience of the nuclear radiologist.

Model Application for Privileges

The delineation of hospital privileges is typically unique to a community, the services offered, and the availability of trained personnel. There is no one form that is suitable for all practices. Included are examples of hospital delineation of privileges forms, including one from a small rural hospital and another from a large tertiary care center. These may be useful as templates to develop an appropriate delineation of privileges form for use at your health care entity.

_____ HOSPITAL

DELINEATION OF MEDICAL STAFF PRIVILEGES

CLINICAL AREA: RADIOLOGY

NAME: _____

R-Requested N-Not approved

PRIVILEGE	R	N	PRIVILEGE	R	N
Diagnostic Imaging			Interventional Procedures		
Mammography			Myelography (including Lumbar Puncture)		
Mammography with Needle Localization			Needle Biopsies (fine and core)		
Diagnostic Imaging (including intravenous injection of contrast media)			Abscess Drainage		
Ultrasonography			Cholangiography and Drainage		
Cardiovascular (CT or MRI)			Urologic Intervention and Drainage		
CT					
MRI			Other		
CT and/or MR arteriography			Administration of Conscious Sedation		
Nuclear Medicine					
Fluoroscopic Examinations					
Arthrography					
Gastrointestinal					
Genitourinary Tract (including hysterosalpingography)					
Neurological					
Skeletal System					

Additions/Modifications: _____

Requesting Physician's Signature _____

Comments: _____

Approval Signature _____ Date _____

- D Initial appointment
R Reappointment

If any privileges are covered by an exclusive contract or an employment contract, practitioners who are not a party to the contract are not eligible to request the privilege(s), regardless of education, training, and experience. Exclusive or employment contracts are indicated by [EC]

Applicant: Check off the “Requested” box for each privilege requested. Applicants have the burden of producing information deemed adequate by the Hospital for a proper evaluation of current competence, current clinical activity, and other qualifications and for resolving any doubts related to qualifications for requested privileges.

Department Chair/Chief: Check the appropriate box for recommendation on the last page of this form. If recommended with conditions or not recommended, provide condition or explanation on the last page of this form.

Other Requirements

- Note that privileges granted may only be exercised at the site(s) and setting(s) that have the appropriate equipment, license, beds, staff, and other support required to provide the services defined in this document. Site-specific services may be defined in hospital or department policy.
- This document is focused on defining qualifications related to competency to exercise clinical privileges. The applicant must also adhere to any additional organizational, regulatory, or accreditation requirements that the organization is obligated to meet.

QUALIFICATIONS FOR DIAGNOSTIC RADIOLOGY

To be eligible to apply for core privileges in diagnostic radiology, the initial applicant must meet the following criteria:

- Successful completion of an Accreditation Council for Graduate Medical Education (ACGME) – or American Osteopathic Association (AOA)–accredited residency in diagnostic radiology.
- Current licensure to practice as a physician as approved by the State of _____
- Current certification or active participation in the examination process with achievement of certification; leading to certification in radiology by the American Board of Radiology or the American Osteopathic Board of Radiology.
- Required previous experience: Applicants for initial appointment must be able to demonstrate performance and interpretation of an adequate volume of experience in radiologic tests or procedures, reflective of the scope of privileges requested, or demonstrate successful completion of an ACGME- or AOA-accredited residency, clinical fellowship, or research in a clinical setting within the past 24 months.

QUALIFICATIONS FOR VASCULAR AND INTERVENTIONAL RADIOLOGY (VIR)

To be eligible to apply for core privileges in vascular and interventional radiology, the initial

applicant must meet the following criteria:

- Successful completion of an accredited ACGME or AOA residency in diagnostic radiology **OR** IR/DR pathway residency **OR** successful completion of an ACGME-accredited fellowship in vascular and interventional radiology.
- Current subspecialty certification or active participation in the examination process with achievement of certification within 5 years of completion of training by the American Board of Radiology.
- Current licensure to practice as a physician as approved by the State of _____.
- Required previous experience: Applicants for initial appointment must be able to demonstrate the performance of an adequate volume of experience in vascular and interventional radiology procedures, reflective of the scope of privileges requested, or demonstrate successful completion of an ACGME- or AOA-accredited residency, clinical fellowship, or research in a clinical setting within the past 24 months.

OBSERVATION / FPPE AND OPPE REQUIREMENTS:

Performance of provisional appointee is monitored through the departmental focused professional performance evaluation and ongoing professional performance evaluations, quality assessment and improvement activities.

DIAGNOSTIC RADIOLOGY CORE PRIVILEGES – [EC]**[] Requested**

Perform general diagnostic radiology (radiographs, radionuclides, ultrasound, and MR) to diagnose and treat diseases of patients of all ages.

TELERADIOLOGY CORE PRIVILEGES – [EC]**[] Requested**

Perform general diagnostic radiology (radiographs, radionuclides, ultrasound, and MR) to diagnose diseases of patients of all ages via a teleradiography link.

VASCULAR AND INTERVENTIONAL RADIOLOGY (VIR) CORE PRIVILEGES – [EC]**[] Requested**

Admit, evaluate, diagnose, and treat patients of all ages by various radiologic imaging modalities (fluoroscopy, digital radiography, CT, sonography, and MRI). May provide care to patients in the intensive care setting. Assess, stabilize, and determine disposition of patients with emergency. The core privileges in this specialty include the procedures on the attached procedures list and such other procedures that are extensions of the same techniques and skills.

CORE PROCEDURE LIST

This list is a sampling of procedures included in the core. This is not intended to be an all-encompassing list but rather reflective of the categories/types of procedures included in the core.

To the applicant: If you wish to exclude any procedures, please strike through those procedures that you do not wish to request, initial, and date.

Diagnostic Radiology

- Performance of history and physical exam
- Bone densitometry
- CT of the head, neck, spine, body, chest ([including/excluding] cardiac) abdomen, pelvis and extremities and their associated vasculatures
- Diagnostic nuclear radiology of the head, neck, spine, body, chest (including the heart), abdomen, pelvis, and extremities and their associated vasculatures
- MRI of the head, neck, spine, body, chest ([including/excluding] cardiac) abdomen, pelvis and extremities and their associated vasculatures
- Mammography (in accordance with Mammography Quality System Regulation [MQSR] required qualifications)
- Routine imaging (e.g., interpretation of radiographs, IV or retrograde pyelography, fluoroscopy, and chest/abdomen, pelvis/gastrointestinal, and genitourinary diagnostic and therapeutic procedures)
- Image-guided biopsy, cyst aspiration, and procedures (e.g., lumbar puncture)
- Ultrasound of the head, neck, spine, body, chest, abdomen, pelvis and extremities and their associated vascular structures
- Diagnostic nuclear radiology of the head, neck, spine, body, chest (including the hear), abdomen, pelvis, and extremities and their associated vasculature
- Arthrography

Teleradiology

- CT of the head, neck, spine, body, chest ([including/excluding] cardiac) abdomen, pelvis and extremities and their associated vasculatures
- MRI of the head, neck, spine, body, chest ([including/excluding] cardiac) abdomen, pelvis and extremities and their associated vasculatures, and muscular skeletal structures, etc.
- Routine imaging (e.g., interpretation of radiographs, IV or retrograde pyelography, fluoroscopy, and chest/abdomen, pelvis/gastrointestinal, and genitourinary diagnostic and therapeutic procedures)
- Ultrasound of the head, neck, spine, body, chest, abdomen, pelvis and extremities and their associated vascular structures

Vascular and Interventional Radiology

- Arthrography
- Insertion and management of central venous and dialysis access line
- Myelography

SPECIAL NONCORE PRIVILEGES

If desired, noncore privileges are requested individually in addition to requesting the core. Each individual requesting noncore privileges must meet the specific threshold criteria governing the exercise of the privilege requested including training, required previous experience, and for maintenance of clinical competence.

MODERATE SEDATION

[] Requested

See Hospital Policy for Sedation and Analgesia by Non-Anesthesiologists

ACKNOWLEDGEMENT OF PRACTITIONER

I understand that it is my responsibility to clearly, legibly, completely, and in a timely fashion describe each service provided to a patient in the hospital and describe relevant observations. Standard rules regarding authentication of, necessary content of, and required time frames for preparing and completing the medical record and portions thereof are applicable to all entries made as according to the Medical Staff Bylaws, Rules and Regulations, and hospital policy and procedures.

I have requested only those privileges for which by education, training, current experience, and demonstrated performance I am qualified to perform and that I wish to exercise at Hospital, and I understand that:

- In exercising any clinical privileges granted, I am constrained by Hospital and Medical Staff policies and rules applicable generally and any applicable to the particular situation.
- Any restriction on the clinical privileges granted to me is waived in an emergency situation and in such situation my actions are governed by the applicable section of the Medical Staff Bylaws or related documents.

Signature: _____

Date: _____

Privileges effective from: ___/___/___

DEPARTMENT CHAIR/CHIEF'S RECOMMENDATION

I have reviewed the requested clinical privileges and supporting documentation for the above-named applicant and make the following recommendation(s):

- Recommend all requested privileges.
- Recommend privileges with the following conditions/modifications:
- Do not recommend the following requested privileges:

<i>Privilege</i>	<i>Condition/Modification/Explanation</i>
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____

Notes

Department Chair/Chief Signature: _____ *Date:* _____

**RADIOLOGY
PRIVILEGE FORM**

NAME: _____

To request Privileges, please place an “X” in the appropriate column. If the condition/privilege you desire is not included on this form, please submit a separate written request for the privilege along with appropriate documentation of training and/or experience.

In-Patient Request	Out-Patient Request		In-Patient Approved	Out-Patient Approved
RADIOLOGY CORE PRIVILEGES				
		Diagnostic Radiology: Performance of a variety of diagnostic imaging techniques, including all aspects of x-ray diagnosis, diagnostic ultrasound (exclusive of echocardiography), computed tomography (CT), and magnetic resonance imaging (MR). Includes naso-oro-enteric tube placement.		
		Interventional Radiology: Hospital Admitting Privileges		
		Nuclear Radiology: Diagnostic imaging techniques in the body of radionuclides for diagnosis of disease.		
		Nuclear Radiology: Use of radionuclides for therapeutic procedures, such as thyroid ablation and tumor radioembolization. (Must be on Hospital’s Nuclear License)		
		Non-Vascular Interventional Radiology: Diagnosis and treatment of disease using percutaneous methods guided by imaging such as percutaneous biopsy, cyst puncture, percutaneous draining, etc.		
		Procedural Sedation		
		Fluoroscopy		
ENDOVASCULAR PRIVILEGES				
*Non-core privileges that require proof of additional training or experience.				
		Standard Angiography Privileges		
		Standard Endovascular Intervention		
		Visceral Endovascular Intervention		
		Extracranial Neurovascular Intervention		
		Intracranial Neurovascular Intervention		
		Endovascular Abdominal or Thoracic Stent Graft		

BODY ANGIO DIAGNOSTIC/INTERVENTINAL PROCEDURES				
Procedures that may not be part of residency/fellowship training, and/or may require proof of additional training or experience.				
		Imaging guided biopsy, cyst puncture, abscess drainage		
		Imaging guided percutaneous tumor ablation		
		IVC filter placement or retrieval		
		Percutaneous biliary drainage, stone extraction, stent placement, percutaneous cholecystostomy		
		Percutaneous cholangiography		
		Percutaneous gastrostomy/gastrojejunostomy tube placement		
		Percutaneous intra-arterial chemotherapy		
		Percutaneous nephrostomy for drainage, stone extraction, or stent placement		
		Percutaneous transhepatic portal vein catheterization		
		PICC and other venous access, including tunneled catheter and port placement		
In-Patient Request	Out-Patient Request		In-Patient Approved	Out-Patient Approved
BODY ANGIO DIAGNOSTIC/INTERVENTINAL PROCEDURES (continued)				
Procedures that may not be part of residency/fellowship training, and/or may require proof of additional training or experience.				
		Radioembolization		
		TIPS (Percutaneous transjugular portasystemic shunt)		
NEUROINTERVENTIONAL				
Procedures that may not be part of residency/fellowship training, and/or may require proof of additional training or experience				
		Discography		
		Myelography		
		Pain Management, including nerve block, facet block, epidural injection, SI joint injection, periarticular injection, and denervation procedure		
		Percutaneous Vertebral Augmentation		
		Embolization, aneurysm coiling, AVM gluing, intracranial or extracranial cerebrovascular system, arterial or venous interventions		
		Spinal angiography		
MUSCULOSKELETAL INTERVENTION				
Procedures that may not be part of residency/fellowship training, and/or may require proof of additional training experience.				
		Arthrography		
CARDIOVASCULAR IMAGING				

Procedures that may not be part of residency/fellowship training, and/or may require proof of additional training experience.			
		Cardiac Computed Tomography (CT)	
		Cardiac Magnetic Resonance Imaging (MRI)	
BREAST INTERVENTION AND DIAGNOSIS			
Procedures that may not be part of residency/fellowship training, and/or may require proof of additional training experience.			
		Diagnostic Mammography (MQSA)	
		Magnetic resonance imaging (MRI) guided lesion localization	
		Magnetic resonance imaging (MRI) guided percutaneous breast lesion biopsies	
		Percutaneous stereotactic breast biopsies	
		Ultrasound guided lesion localization	
		Ultrasound guided percutaneous breast biopsies	
		X-ray guided lesion localization	

Acknowledgement of Practitioner:

I understand that in exercising privileges granted, I am constrained by the Medical Staff By-laws, Credentialing Plan and Policies.

Applicant Signature: _____ **Date:** _____

Department Chair Signature: _____ **Date:** _____

APPENDIX D

Ownership, Retention and Patient Access to Medical Records

The ACR adopted suggestions and rationales for policy statements about medical record retention, ownership, and access; 1990, amended 1992, amended 1993, 2003 (Res. 12-f). Because of the variability in federal and state requirements and the fact that some, but not all, states have record retention laws and regulations, no single retention period can be recommended. Other obstacles in specifying a single retention period include (1) regulations that prescribe different retention periods for x-rays as opposed to “medical records” per se and (2) the problem of deciding which health care providers must retain their patients’ records—most laws mention hospitals specifically, while others refer generally to “health care providers.”

In reading these suggestions, it is important to remember that unless otherwise specified by statute, the rules are the same for both hospital and office settings. Similarly, unless otherwise specified, the term “medical records” includes radiographs and other images produced in the course of radiological examinations.

RECORD RETENTION**Retention Periods**

Radiologists should investigate and comply with all pertinent federal and state laws and regulations regarding the retention of medical records. Hospital radiology records, including copies of reports, films, scans, and other image records, should be kept for five years, in compliance with Medicare regulations. Furthermore, all records and images produced by radiologists should be kept for the retention period required by law or regulation in each state. If a state has no required retention period, records and images should be kept at least for the maximum period that the state’s statute of limitations allows for the filing of medical malpractice actions. Some states have specific retention periods for mammograms. Optimally, medical records should be kept for whichever period is longer—the statute of limitations or the prescribed retention period.

Rationale

State laws concerning the retention of medical records and radiologic images vary considerably. In some states, the records of minors must be retained for as long as their 28th birthday. The scope of the “discovery rules” in other states means that records should conceivably be held indefinitely. Evidence of “fraud” could extend the statute of limitations indefinitely.

Federal regulations relating to radiologists generally require all relevant documents to be retained for three years, but hospitals participating in Medicare have to keep copies of reports, printouts, films, scans, and other images for at least five years. For workers regarded as being exposed to a designated list of “hazardous materials,” the federal Occupational Safety and Health Administration requires that health records be retained for the lifetime of patients plus 30 years. OSHA made no determination of whether “records” means examination reports or images.

The AMA recommends that physicians keep patients’ charts for five to seven years from the last office visit.

Some states require patient notification before mammograms are destroyed.

Microfilming or Digital Archiving

Micro-filmed and digital images are generally acceptable for record archiving and storage unless otherwise specified by state or federal law. Microfilming and digitization of chest radiographs used to detect pneumoconiosis or other dust retention respiratory diseases should comply with National Institute for Occupational Safety and Health (NIOSH) and International Labour Organization (ILO) regulations and guidelines on pneumoconiosis or other dust-related diseases. Microfilming or digitization of screen-film mammograms may not legally be done for retention purposes or final interpretation. The selection of other image storage techniques depends on the quality of the image in the alternative format.

Rationale

Microfilming of records is expressly allowed in many states and thus represents an acceptable record archiving and storage alternative. Most states view the micro-filmed record and the original as equivalents, either immediately or after a certain specified period.

Magnetic Tapes

Magnetic tapes containing the digital versions of MRI or CT studies are not permanent “medical records” and do not have to be retained for the statutory or recommended retention periods as long as a hard copy of the image (radiographic film) is placed in the patient’s permanent file and kept for the required or recommended period.

Rationale

No state expressly requires that original media from CT and MRI be retained as part of the medical record, nor does Medicare require them for reimbursement. In addition, media such as magnetic tapes deteriorate quickly and usually require special storage conditions to preserve the data. Therefore, as long as a digital hard copy of the study is placed in the record, retention of the original tapes is unnecessary.

Cessation of Practice

When a radiologist terminates his or her practice, the images produced should be retained according to paragraph 1 above, “Retention Periods.” Under extraordinary circumstances, if records must be destroyed before the expiration of the retention period, reasonable efforts should be made to contact the patient about the disposition of his or her records.

Rationale

Some states have laws requiring that hospitals or physicians try to contact the patient before his or her records are destroyed.

OWNERSHIP AND PATIENT ACCESS**Ownership**

ACR reaffirms that unless otherwise agreed by the parties or mandated by law, images produced by radiologists and interpretations should be regarded as the property of the hospital or the entity that produces them, subject to the right of the patient to access the information contained in the image and hospital records.

Rationale

According to most state laws and regulations, medical records and x-rays are the property of the hospital, subject to the patient’s interest in the information contained in the record. Some state regulations concern only “hospitals,” while other states’ record ownership and access rules cover “health providers” in general.

Confidentiality and Access

All radiological images, reports, and other related materials are confidential, and the information in them cannot be disclosed without the written consent of the patient or his or her representative, unless authorized otherwise by state law.

Rationale

Some states allow access only to the information in the record but not the record itself. The records of minors may be subject to other access rules.

Reproduction

If possible, original images should remain in the possession of the radiologist at the facility where they were made. However, in some circumstances clinicians may require the re-lease of the original images, and the radiologist should comply with this request. The FDA MQSA regulations require facilities to permanently or temporarily transfer the original mammograms and copies of the patient's reports to a medical institution or to a physician or healthcare provider of the patient's report to a medical institution, or to a physician or healthcare provider of the patient or to the patient directly. Careful notation should be made of the location of the original images.

In some circumstances, when requests are made by a patient or by his or her representative or attorney, copies of the images should be provided. The patient can be charged a reasonable fee for making the copies. If subpoenas are issued for original films, copies can be retained by the radiologist.

Rationale

This policy follows applicable laws and regulations in most states (e.g., California, Indiana, and Massachusetts); 1990 (Res. 29); amended 1992 (Res. 28); amended 1993, 2003, amended 2013 (Res. 41-d).

APPENDIX E

ACR Remains Committed to Mammography and Supports Study of Screening Modality Options

The American College of Radiology Council adopted the statement titled, “ACR Remains Committed to Mammography and Supports Study of Screening Modality Options”; 2003, amended 2013 (Res. 4-d).

For more than thirty years, despite robust scientific proof from the randomized, controlled trials that mammography screening saves lives, the value of mammography screening has been challenged. Both the lay and scientific press has questioned the efficacy of screening in the context of improvements in therapy, as well as the balance of benefits and harms. Other strong confirmatory evidence of mammography’s benefit comes from the observation that after mammography screening was introduced into the general population, the death rate from breast cancer began an abrupt decline that was in direct relationship to participation in screening. Simultaneously, radiologists providing screening services have faced difficult problems such as insufficient reimbursement, increased malpractice exposure and intermittent shortages of both radiologists and technologists.

According to the Institute of Medicine, mammography remains the most useful and best demonstrated screening modality for the reduction of breast cancer deaths available to women today. Therefore, the American College of Radiology strongly reaffirms its position that all women over age 40 should undergo annual screening mammography.

Other modalities, such as ultrasound and MRI, have shown the ability to improve the detection rate of mammographically occult breast cancers, especially in women with radiographically dense breasts and those at very high risk for developing breast cancer, due to carrying a predisposing mutation on a breast cancer susceptibility gene. The ACR strongly supports continued research on the best use of conventional and new technologies for the early detection of breast cancer. In the meantime, mammography remains the front line of breast cancer screening.

The ACR has worked to improve the quality of mammography techniques and interpretation. The ACR Mammography Accreditation Program ultimately became the standard for the Food and Drug Administration’s implementation of the Mammography Quality Standards Act. The ACR also has created and continues to update its Breast Imaging Reporting and Data System (BI-RADS®), which has helped to standardize the terminology used in breast imaging reports and increase the accuracy and clarity of mammographic interpretation. The ACR, through BI-RADS®, has for years, supported the collection and tracking of the results of breast imaging studies to assess the “outcomes” from these tests so that improvements can be made. The ACR has a long history of outstanding breast imaging education programs for radiologists and radiology residents. These programs include the breast imaging lectures at the American Institute of Radiologic Pathology (AIRP), breast imaging courses at the ACR Education Center, the National Conference on Breast Cancer, Continued Professional Improvement syllabi on breast imaging, and the Mammography Case Reviews, a self-assessment CD on breast imaging.

The introduction of mammography screening at a National level, in the U.S. is directly linked to the decline in breast cancer deaths that began for the first time in 50 years in 1990. The death rate from breast cancer is now down by over 30%. The ACR is committed to supporting high-quality mammography screening and providing breast imaging educational materials to radiologists, radiology residents and radiology technologists, as well as representing the College’s membership with third-party payers, federal agencies and the public. The ACR supports:

- continued efforts to ensure the utmost technical quality of mammography,
- educational programs to optimize the interpretation of mammograms and other breast imaging modalities,
- efforts to increase reimbursement for mammography to levels that more closely approximate the actual costs of these tests,

- medical liability reform,
- efforts to recruit more radiologists and radiology technologists into the field of breast imaging,
- public education regarding accurate expectations for mammography and other breast imaging modalities, and
- research in the use of other modalities, including MRI and ultrasound, for breast cancer screening.

Going forward, the ACR and its members will continue to support these and other efforts to provide high-quality breast cancer screening, diagnosis, treatment and research for the women of the United States.

APPENDIX F

ACR Practice Parameters and Technical Standards Purpose and Intended Use

The name “ACR Standards” has been changed to “ACR Practice Parameters and Technical Standards.” Other recommendations of the Task Force regarding procedures for developing, approving, and disseminating these ACR documents have been implemented and will continue to be reviewed. The “Purpose and Intended Use Statement” and the “Preamble”, as proposed by the Task Force on the Name and Construct of ACR Standards, are adopted, and should be included with the Practice Parameters and Technical Standards; 2003 (Res. 30).

ACR Practice Parameters and Technical Standards define principles and technical parameters of radiologic and radiation oncology practice which should generally produce desired health care outcomes. They describe a range of acceptable approaches for the diagnosis and/or treatment of disease for most patients in most circumstances. Given differences in training, experience, and local conditions, the ACR Practice Parameters and Technical Standards acknowledge the need for health care providers to exercise their independent medical judgment in making decisions regarding the use and specific details of any procedure.

ACR Practice Parameters and Technical Standards are educational tools designed to provide consensus-based scientifically valid and medically credible information to assist health care providers in delivering effective, efficient, consistent and safe medical care. They may be developed jointly with other professional organizations. Used in conjunction with the ACR Appropriateness Criteria™, it is expected that the ACR Practice Parameters and Technical Standards will increase the likelihood that appropriate procedures will be performed in a safe and acceptable manner and will help reduce unnecessary ones.

ACR Practice Parameters and Technical Standards are intended to be living documents that are regularly reviewed and revised to reflect changes in radiologic and radiation oncology practice.

PRACTICE PARAMETERS describe recommended conduct in specific areas of clinical practice. They are based on analysis of current literature, expert opinion, open forum commentary, and informal consensus. Guidelines are not intended to be legal standards of care or conduct and may be modified as determined by individual circumstances and available resources.

TECHNICAL STANDARDS describe technical parameters that are quantitative or measurable. They often include specific recommendations for patient management or equipment specifications or settings. Technical Standards are based on analysis of current literature, expert opinion, open forum commentary, and informal consensus. Technical Standards are intended to set a minimum level of acceptable technical parameters and equipment performance and may be modified as determined by individual circumstances and available resources.

PREAMBLE

These guidelines are an educational tool designed to assist practitioners in providing appropriate radiologic care for patients. They are not inflexible rules or requirements of practice and are not intended, nor should they be used, to establish a legal standard of care. For these reasons and those set forth below, the American College of Radiology cautions against the use of these guidelines in litigation in which the clinical decisions of a practitioner are called into question.

The ultimate judgment regarding the propriety of any specific procedure or course of action must be made by the physician or medical physicist in light of all the circumstances presented. Thus, an approach that differs from the guidelines, standing alone, does not necessarily imply that the approach was below the standard of care. To the contrary, a conscientious practitioner may responsibly adopt a course of action different from that set forth in the guidelines when, in the reasonable judgment of the practitioner, such course of action is indicated by the condition of the patient, limitations on available resources or advances in knowledge or technology subsequent to publication of the guidelines. However, a practitioner who employs an approach

substantially different from these guidelines is advised to document in the patient record information sufficient to explain the approach taken.

The practice of medicine involves not only the science, but also the art of dealing with the prevention, diagnosis, alleviation and treatment of disease. The variety and complexity of human conditions make it impossible to always reach the most appropriate diagnosis or to predict with certainty a particular response to treatment. It should be recognized; therefore, that adherence to these guidelines will not assure an accurate diagnosis or a successful outcome. All that should be expected is that the practitioner will follow a reasonable course of action based on current knowledge, available resources and the needs of the patient to deliver effective and safe medical care. The sole purpose of these guidelines is to assist practitioners in achieving this objective.

APPENDIX G

**ACR Statement on
Radiologist Assistant
Roles and Responsibilities**

The ACR will work with ASRT to get approval for a revised statement using this blueprint to develop a new ACR ASRT Joint Statement on Radiologist Assistant Roles and Responsibilities; adopted 2020 (Res. 11).

The American College of Radiology adopted a statement on Radiologist Assistant – Roles and Responsibilities; 2003, 2013 (Res. 41-e)

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. 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 contrast agents administered as part of radiology procedures
- Obtaining clinical history from patient or 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 under radiologist supervision
- Monitoring and tailoring selected exams under radiologist supervision (e.g. CT urogram, VCUg, retrograde urethrograms, and preparation and colonic insufflation for CT Colonography.)
- 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.

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) 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 academic programs that lead to certification through the ARRT. Advisory committees to such programs should include radiologists.

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

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

The ACR believes that the advent of the radiologist assistant, 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.

APPENDIX H

ACR Statement on Medical Radiation Shielding Design Limits for the General Public

The American College of Radiology adopts the position statement on medical radiation shielding; 2004 (Res. 15)

The American College of Radiology (ACR) Commission on Medical Physics and the American Association of Physicists in Medicine (AAPM) held a conference in October 2003 to examine the issue of Medical Radiation Shielding. Representatives from 15 interested organizations attended.

There has been extensive discussion in the regulatory community about reducing the design limit for radiation shielding for areas occupied by the public from 1 mSv to 0.25 mSv per year. Such a decrease in the Medical Radiation Shielding limit would increase both the amount of shielding necessary and the types of imaging facilities (e.g., Mammography, Dental, DEXA, etc.) which would require both additional and new shielding. The medical practice, socio-economic and patient safety consequences of such a decision would be enormous. Increased costs or the impossibility of altering existing structures could significantly limit patient access or make it impossible to provide needed medical services. In addition, the time for renovation would require that facilities not operate and thus not serve patients.

The conference did not identify any scientific basis for decreasing the current recommended shielding limits.

Since there are no scientific data to support lowering the current recommended Medical Radiation Shielding design limit for members of the general public and a lowering may have serious patient safety, medical practice, and socioeconomic effects; the ACR concludes that the limit for shielding designs should remain at 1 mSv per year for members of the general public.

Furthermore, the ACR will initiate further discussion with appropriate peer societies, private-sector organizations and regulatory agencies involved in the methodology used in preparing shielding calculations and estimating the dose to the members of the public.

The ACR Commission on Medical Physics reviewed this policy in July 2013; No changes.

APPENDIX I**ACR Statement on Whole Body MRI Screening Exams**

The ACR adopted the attached Statement on Whole Body MRI Screening Exams.; 2004, amended 2014 (Res. 21-d).

The American College of Radiology (ACR) recognizes that screening magnetic resonance imaging (MRI) examinations are being promoted and performed in the United States. To date, adequate research has not been performed to evaluate whether screening MRI examinations reduce mortality or in any way improve patients' health. There is currently no scientific evidence that screening MRI is either cost efficient or effective in prolonging life.

At this time, the ACR does not believe that there is sufficient evidence to justify screening MRI for patients without symptoms or without a specific family or personal history of disease.

The ACR remains concerned that this procedure will demonstrate numerous incidental findings, which will cause patient anxiety, additional follow-up examinations, unnecessary treatments, and attendant unwarranted expense.

The ACR will continue to monitor scientific studies regarding these procedures.

APPENDIX J

**Revised Statement on the Interpretation of Radiology Images
Outside the United States**

The ACR has become aware of several recent statements in the national and local media that promote outsourcing or sending of imaging exams of patients in the United States for interpretation in foreign countries. However, these statements have omitted a number of important conditions that are necessary to protect patients and to ensure the delivery of high quality radiological care.

As the leading organization for medical radiology, with a long record of dedication to ensuring quality patient care, the ACR is very concerned about the implications of overseas radiology and its potential effect on patient care in the United States. The ACR believes that physicians who interpret images by teleradiology should meet or exceed the same standards met by physicians practicing within the United States. Certification by the American Board of Radiology is the best means for the health care consumer to judge the qualifications of the radiologist. To achieve these standards, physicians who interpret images by teleradiology shall: (1) be licensed to practice medicine in the state where the imaging examination is originally obtained as well as possess any medical or other licensure required within the jurisdiction of the interpretation site; (2) be credentialed as a provider and maintain appropriate privileges in the health facility or hospital in the United States where the examination was obtained; (3) have appropriate medical liability coverage for the state in which the examination was obtained; and (4) be responsible for the quality of the images being interpreted. Physicians practicing outside the United States must willingly agree to submit to the jurisdiction of and be completely accountable to all applicable state and federal laws in the United States.

Radiology groups, hospitals and other entities in the United States should only enter into contracts for interpretation of imaging examinations provided from outside the United States with those physicians who meet the preceding criteria.

It is unethical and likely fraudulent for a physician who has not personally interpreted the images obtained in a radiologic examination to sign a report or to take attribution of an interpretation of that examination rendered by another physician in a manner that causes the reader of a report to believe that the signing radiologist was the interpreter. This practice, known as ghost reporting, should be strictly prohibited.

Facilities and physicians engaged in the practice of sending images to a site outside the country for interpretation should be prepared to immediately disclose that information to patients, upon request, along with the details indicating compliance with the above criteria.

Patients in the United States expect high-quality care and service from fully licensed and accountable medical practitioners. Patients also have the right to expect that all physicians who are providing their care, including radiologists, are practicing with a high level of skill and safety as provided by meeting state licensure and hospital credentialing requirements. Patients also expect that their physicians will be subject to all state and federal laws governing the practice of medicine and held accountable for their actions. As physicians, we must insist that all physician services be held to the same high standards to ensure the absolute best for our patients.

APPENDIX K

ACR Expert Witness Affirmation Statement

When serving as an expert witness, ACR members must present their own expertise and opinions. Testimony of ACR members does not represent the opinion or position of the ACR. This statement is a proactive and affirmative obligation.

As a member of the ACR, I will adhere to the following principles when providing expert witness testimony:

1. I am familiar with the qualifications, responsibilities and requisites of an expert witness specified in the ACR Practice Guideline on the Expert Witness in Radiology and Radiation Oncology.
2. I will always be truthful.
3. I will provide testimony that is objective, impartial, scientifically based, and clinically accurate.
4. I will have the appropriate education, training, and practical experience as well as the licensure and certification, to be deemed a true expert in the subject of the case.
5. I will be familiar with the applicable standard of care in the jurisdiction in which I may testify, and recognize that physicians with a different level of expertise may still practice within the standard of care.
6. I will review relevant materials sufficiently to assure an informed and fair opinion, and I will form opinions based on the information available at the time of the incident under review.
7. I will be familiar with and prepared to address the known or potential limitations of my opinion, as well as the degree to which that opinion is accepted in the medical community.
8. I will not accept compensation linked to the outcome of the case.
9. I will not present my personal opinions as representative of the policy positions of the ACR.
10. I understand that I can be held accountable for statements made during a legal proceeding, and that my testimony is subject to peer review.

ACR Member Printed Name: _____ ACR Member ID: _____

ACR Member Signature: _____ Date: _____

Please Note: ACR will not accept an Affirmation Statement that has been altered. Violation of the above principles may result in disciplinary review by the ACR Ethics Committee. This Affirmation Statement shall expire only upon a written rescinding of the signature.

APPENDIX L

**Nuclear Medicine Advanced Associate (NMAA)
Roles and Responsibilities**

As a category of non-physician radiology provider (NPRP), a Nuclear Medicine Advanced Associate (NMAA) is an advanced-level nuclear medicine technologist working under the supervision of a licensed physician, who is also an authorized user of radioactive materials, to enhance patient care in the diagnostic imaging and radiotherapy environments.

The Nuclear Medicine Advanced Associate is an NMTCB- or ARRT-certified nuclear medicine technologist who has successfully completed an advanced academic program encompassing a nationally recognized NMAA curriculum and a nuclear medicine physician-, nuclear cardiologist-, or radiologist-directed clinical preceptorship.

Under physician supervision, the NMAA performs patient assessment, patient management and selected nuclear medicine procedures as summarized below.

Perform and document a review of clinical information, such as pertinent lab work, including blood, urine and other tissue samples and pathology studies, as well as correlative imaging studies to facilitate optimal performance and interpretation of the nuclear medicine procedure by the supervising physician.

Perform, update, and document a 'history and physical' in the medical record, obtaining a relevant clinical history from the patient or medical record and a targeted physical exam to optimize the clinical value of the requested nuclear medicine procedure.

Assist the supervising physician in obtaining informed consent for invasive and/or therapeutic procedures, as well as procedures involving more than minimal risk, as defined by state law and institutional policy.

Administer medications that enhance diagnostic imaging and therapeutic procedures, as defined by state regulations and institutional policy.

Educate the patient undergoing invasive procedures, therapeutic procedures, and procedures involving more than minimal risk regarding pre-procedural preparation and post-procedural care, as defined by state law and institutional policy and documenting appropriately in the patient's medical record.

Perform pre- and post-procedure assessment and monitoring in patients undergoing invasive and therapeutic procedures, as well as procedures involving more than minimal risk, as defined by state law and institutional policy.

Monitor cardiac exercise or pharmacologic stress testing in association with diagnostic nuclear medicine imaging procedures as recognized through institutional policy and defined by state and federal law.

Assess imaging studies for appropriateness and quality, acquire additional views as necessary, and suggest additional diagnostic procedures to the supervising physician as necessary to provide additional information to optimize the nuclear medicine imaging studies.

Analyze the imaging, correlative and laboratory data provided and prepare a preliminary description of findings for use by the supervising physician when he/she interprets the results and formulates the written report.

Communicate report findings in the physician's finalized and authenticated reports to the referring physician and provide necessary documentation.

The NMAA will not perform interpretations (preliminary, final or otherwise) of any nuclear medicine procedure nor will he or she transmit observations other than to the supervising nuclear medicine physician or radiologist.

The NMAA should actively participate in practice-based improvement activities as well as facility quality assurance programs. They should be competent in overseeing compliance with all local, state, regional, and federal requirements for laboratory operations and accreditation, and provide education for technologists, students, and staff. They will be expected to participate in maintenance of certification (MOC) activities and be credentialed by the institution in which they practice.

The education of the nuclear medicine advanced associate is granted through nationally accredited academic programs offered at the master's degree level and that lead to certification through the ARRT/NMTCB. Advisory committees to such programs should include representation from the nuclear medicine medical community.

The nuclear medicine medical community should be represented in any formal national or state certification or licensure process and be actively involved in facility NMAA credentialing. In addition, with the practice of medicine rapidly changing, the SNMITS leadership will work with the SNM Leadership, the ACR and other appropriate stakeholders to assess new procedures that the NMAA may perform.

Appendix M**ACR Taskforce Report on Teleradiology****BACKGROUND****Introduction and Definitions**

The rapid evolution of the corporate business model and the absence of a public ACR statement on acceptable practices and quality standards for teleradiology companies impelled John A. Patti, MD, chairman of the ACR Board of Chancellors, to establish the ACR Task Force on Teleradiology Practice in January 2012. The outcome of our work is this white paper. Its goals are neither to commend nor to condemn the practice of teleradiology but to comment on the current status of domestic teleradiology, propose guidelines for best practice, and recommend possible actions to the ACR.

In taking on this responsibility, the task force considered any instance in which diagnostic images are transmitted for purposes of interpretation to a location in the United States, beyond the immediate vicinity of where the images were acquired, to represent domestic teleradiology. A teleradiologist is the physician providing these interpretive services, and a teleradiology company is an entity that employs multiple teleradiologists and engages in the management of workflow and image distribution. We refer to the site at which the images are actually acquired as the transmitting site. The site at which either a preliminary or a final interpretation is provided is the receiving site.

Prior ACR Comments on Teleradiology

Several extant ACR documents address the topic of teleradiology. In 1994, the ACR Council adopted a resolution concluding that state licensing boards should require licensure of out-of-state physicians who provide official, authenticated written radiological interpretations of examinations that are performed on patients in the licensing state but interpreted in another jurisdiction, provided that such law or regulation does not restrict the ability of radiologists to provide second opinion radiological consultations requested by physicians in states in which the consulting radiologist is not licensed. [1]

In 2005, the ACR Task Force on International Teleradiology studied legal, regulatory, reimbursement, insurance, quality assurance, and other issues associated with the practice of international teleradiology, whereby interpretations were generally outsourced and preliminary in nature [2]. The ACR, along with the American Association of Physicists in Medicine and the Society for Imaging Informatics in Medicine, recently adopted and issued an updated 2012 ACR technical standard for the electronic practice of medical imaging [3] that defines the goals and qualifications for the use of digital image data, including the electronic transmission of patient examinations from one location to another for the purposes of interpretation. The forthcoming ACR IT Reference Guide for the Practicing Radiologist provides IT and informatics guidance on a wide range of topics across the practice of radiology, many of which are particularly relevant to teleradiologists practicing in a remote setting.

Current State of Teleradiology

After the 2005 ACR publication on international teleradiology, the teleradiology model of outsourced, preliminary after-hours interpretations experienced continued growth, but evidence suggests that market penetration peaked in 2010 at 50% (ie, half of radiology practices in the United States outsourced their call).

Recent reports indicate that the preliminary interpretation market is decreasing as a sizable percentage of practices are “taking back the call” they previously outsourced [4].

In contrast to international teleradiology, in which the interpretations are preliminary, domestic teleradiology often provides final interpretations and represents a shift in the business model. Some domestic teleradiology providers offer a full complement of on-site and off-site imaging services, including procedures requiring the physical presence of a radiologist, subspecialty interpretations of images, and general management of the radiology department. This rapid evolution has led to the emergence of large public and private companies that often compete with established community and academic radiology group practices [5]. Some of these teleradiology companies are financially integrated subcontractors of larger health care systems [6]. These companies are under substantial pressure to demonstrate growth and profitability [4].

Given the saturated nature of the outsourced, preliminary teleradiology market and the need for large teleradiology companies to grow, the companies' focus has recently expanded to the acquisition of existing hospital radiology contracts [4]. For example, one company, Radisphere, sponsored a webinar titled “How to Run a Successful RFP Process,” which included templates of the documents necessary to initiate the process of displacing a radiology group [7].

Despite the aggressive behavior of some companies, their success is not assured. Virtual Radiologic (vRad), a major national teleradiology firm, recently announced that it would cut the pay of its contracted radiologists [8]. Uncertain market forces have compelled other teleradiology companies to rebrand or retrench [9, 10]. One example is the 2010 acquisition of NightHawk Radiology Inc by vRad, which merged the two biggest publicly traded teleradiology companies into one large private equity–controlled group [11].

Positives and Negatives of Teleradiology

Teleradiology has the potential to bring both positives and negatives to patient care. Radiologists have used teleradiology to simplify geographic and overnight coverage challenges as well as to strengthen subspecialty expertise. An important virtue of teleradiology is that many smaller hospitals that struggle to maintain adequate off-hour and subspecialty coverage can rapidly provide high-quality interpretations around the clock. Centralized image distribution hubs allow efficient access to qualified teleradiologists by hospitals and emergency departments needing quality reports for their imaging services. These hubs can also assist small groups to match manpower capacity with volume fluctuations or vacation coverage, obviating the need for more expensive on-site solutions.

Unfortunately, some teleradiology companies focus exclusively on report delivery. Besides devaluing our specialty and undermining the role of the radiologist as an independent expert in diagnostic imaging and a fully engaged member of the consulting team, this practice further commoditizes the product of our efforts [12].

The End Users

The principal end users of teleradiology services include hospitals, radiology groups, referring physicians, and patients. Among the largest of these are hospitals that directly contract with teleradiology service providers, typically providing a combination of on-site and teleradiology coverage. There is also a significant number of contractual relationships between radiology groups and teleradiology service providers whereby the teleradiology companies provide supplemental after-hours coverage or bolster subspecialty coverage that would otherwise be inadequate, intermittent, or nonexistent. Additionally,

radiology groups frequently participate in teleradiology off-site coverage arrangements with remote regional hospitals or local imaging centers. Referring physicians, including emergency room physicians, can be considered end users because they base clinical management decisions on teleradiology reports and conduct telephone and video consultations with teleradiology physicians. Additionally, there is a small but growing group of patients seeking direct access to interpreting radiologists or second opinions on their imaging studies [13, 14].

The variety of teleradiology end users and their complex interrelationships present a need for guiding principles that address most situations and are sufficiently precise and rigorous to ensure that a critical threshold of quality and safety is achieved in all arrangements. To satisfy this need, the task force defined 4 guiding principles that should underlie all teleradiology activities. These principles are consistent with the professional practice standards for any imaging activity. The recommendations that follow in this paper are based on these important principles:

1. Patients are the primary focus. First and foremost, all teleradiology relationships should be patient centered. Therefore, teleradiology relationships should adhere to the Institute of Medicine's [15] call for accessible, safe, accurate, and timely care. Secondary incentives, financial or otherwise, should never supersede patient primacy.
2. On-site coverage is preferred. Radiologists are the recognized experts in medical imaging, and their contribution to the health care team goes beyond simply providing interpretive reports [16]. Teleradiology services, ideally, are supplemental to a comprehensive on-site radiology practice. An intangible benefit of the on-site practice component is that the physician is tied to the community, providing motivation to deliver a higher level of care.
3. There should be a single high professional standard of quality for both teleradiology providers and on-site radiologists. Using different standards based on the location of the radiologist does not support the best patient care. Any model of radiology coverage, including teleradiology, should meet the standards of long-term, on-site coverage.
4. Teleradiology service should be incorporated into the local operations related to safety and quality within the radiology practice, hospital, or imaging center and be assimilated into the usual medical staff credentialing and privileging process.

TASK FORCE RECOMMENDATIONS

The Teleradiologist

A critical component of teleradiology services is the teleradiologist, who must possess and maintain appropriate professional qualifications. These qualifications relate to licensure, medical staff membership and privileges, board certification, and malpractice insurance coverage.

Licensure

States mandate and enforce medical licensure through legislation and regulation by the states' medical boards. To ensure that the full resources of a state are available for the protection of patients, medical practice is considered to occur at the location of the patient [17]. The task force endorses the ACR's 2012 Technical Standard for Electronic Practice of Medical Imaging [3] requirement that radiologists be familiar with the licensure requirements for providing teleradiology services at both the transmitting and receiving

sites and obtain licensure as appropriate. Under current law, that would typically involve licensure in the transmitting state, but not necessarily the receiving state.^{1,2}

The teleradiologist must maintain all appropriate licensures and should be in good standing with the appropriate state medical board(s), and any pending or closed malpractice cases should be disclosed to all parties, as should previous offenses incurred during the delivery of care. The teleradiologist should not have been excluded from any federal health care program. In any case, regulations should not restrict the ability of radiologists to provide second-opinion consultations when requested in a jurisdiction where the consulting radiologist is not licensed [1].

Medical Staff Membership and Privileges; Malpractice Coverage

The task force recommends that teleradiologists possess medical staff membership and appropriate privileges at all transmitting hospitals and facilities and have professional liability insurance coverage in the transmitting and receiving states.³

Board Certification

Teleradiologists should fulfill all requirements for initial training and maintenance of competence set forth in the applicable ACR practice guidelines and technical standards for the examinations they interpret [19].

Continued Quality Improvement

Teleradiologists, like all physicians, should participate in quality improvement initiatives. This includes meeting the requirements for continuing medical education (CME) and continuing experience (CE) required for state licensure and accreditation of facilities served by the teleradiologist.

Peer Review

The teleradiology provider should regularly participate in an established quality assurance program, including formal peer review, to ensure patient safety. Such programs should address physician education and error reduction, enable longitudinal follow-up, provide an opportunity for a second opinion when the local caregivers raise concern, and include a process of remediation for low-performing radiologists. A number of well-established approaches exist, notably the ACR's RADPEER™, which assesses the accuracy of diagnosis performed by colleague radiologists using prior studies. CMS, third-party payers, and The Joint Commission have also initiated radiology peer review programs [20].

The Teleradiologist's Work Environment

It is the responsibility of the teleradiology company to ensure the appropriate ergonomic conditions, monitor characteristics, and privacy and security protocols are in place for their teleradiologists.

Ergonomic Factors

With the now universal use of computer workstations to view images and generate imaging reports, the role of ergonomics must be considered. A well-designed work environment reduces fatigue and repetitive stress injuries, such as neck pain and carpal and cubital tunnel syndromes.

The positions of the work chair, workstation table, keyboard, mouse, and monitors, as well as environmental factors such as ambient room lighting, temperature, and noise, should be considered to

maximize comfort, efficiency, and accuracy of interpretations. Other applications, such as speech recognition software, electronic medical records, e-mail, and telecommunications, should be appropriately placed and integrated into the workstation. The recommendations of Harisinghani et al [21] and Goyal et al [22] are useful guides in these regards.

Monitor Characteristics

Currently, radiologists almost exclusively view imaging tests on computer monitors. Liquid crystal display monitors are preferable to cathode ray tube monitors, and a two-monitor PACS display setup is considered more functional. A third monitor can display radiology information system and speech recognition applications [23, 24, 25].

Viewing stations used by teleradiologists interpreting mammographic images fall under technical requirements set forth by the Mammography Quality Standards Act of 1992 [26], which states that a viewing workstation must follow the same quality control methods and technology as set forth by the medical manufacturer of the imaging modality. Image display calibration, monitor resolution size, and display calibration frequency on any remote diagnostic workstation must conform to the imaging modality manufacturer. To date, most imaging modalities that have applied for FDA [27] approval did so with 5-megapixel monitors.

Privacy and Security

Teleradiology groups are covered entities under the HIPAA privacy and security rules [28], which set standards for the electronic exchange of health information and for training, risk analysis, and security. Teleradiology providers must ensure compliance with the privacy and security rules, recognizing that teleradiology's unique nature may present compliance challenges. All equipment and transmittal interfaces should follow the security requirements mandated by HIPAA, regardless of the reading location or setting. This may be daunting for larger providers, who may have 100 or more interpreting radiologists, many of whom practice in their own homes.

Interpretive Services

The task force considered 3 important principles relevant to image interpretation: (1) the importance of patient primacy; (2) the requirement that all professional services and interpretations be accessible, safe, accurate, and timely; and (3) the condition that the teleradiologist be responsible for the quality of all images interpreted. Interpretive services provided by all radiologists, including teleradiologists, represent a continuum that begins before image acquisition and extends beyond the rendering of the report. Teleradiologists should be engaged at all points in this continuum. Specifically, teleradiologists should be engaged, directly or in a supervisory role, in the following activities before the actual acquisition of the study: selection of the appropriate imaging tests, supervision of the protocoling of studies and patient preparation, decisions regarding the use of intravenous contrast agents, and radiation safety.

After the image is acquired and interpreted, the teleradiologist should be engaged in the communication of results, particularly critical findings. A teleradiology provider should always be available for consultation with referring physicians or on-site radiologists, even if the request comes days after the date of interpretation. Moreover, peer review and quality improvement should continue long after the patient encounter. Importantly, this level of engagement requires trouble-free, reliable communication channels between teleradiologists and end users.

Ghost Reading

The ACR had previously commented on the practice of radiologists' signing reports initially read by teleradiologists without reviewing the images, so-called ghost reading. In response to reports of this practice, the Council addressed its ethical implications:

It is unethical and likely fraudulent for a physician who has not personally interpreted the images obtained in a radiologic examination to sign a report of that examination in a manner that causes the reader of that report to believe that the signing radiologist was the interpreter. This practice, known as ghost reporting, should be strictly prohibited. [29]

The task force believes that this definition should be updated to indicate that ghost reading is definitely fraudulent on the basis of the recent conviction of a radiologist on 40 counts of fraud and obstruction of justice related to signing thousands of radiology reports neither he nor another radiologist actually viewed [30].

Relevant Prior Imaging and Reports and Electronic Medical Record Integration

Interpretations should be made with complete availability of relevant collateral information, including previous imaging studies, electronic medical records, and details on the patient's clinical symptoms and suspected diagnoses. This recommendation creates unique challenges for teleradiology companies that provide services to outside organizations. Under these arrangements, teleradiologists may not have adequate access to prior reports, images, or other pertinent patient information. This shortcoming may negatively affect the teleradiologist's ability to determine whether a finding is important. The lack of proper comparisons and relevant information yields less value to the patient and potentially causes the patient to incur the unnecessary costs and anxiety of additional testing. To minimize this problem, all efforts should be made to ensure meaningful comparisons of imaging studies across all settings.

When this shortcoming occurs, radiologists, referring physicians, and patients should be made aware of this potential disparity between on-site and teleradiology interpretations in terms of completeness, quality, and overall value. It may be preferable in these circumstances for the teleradiologist to render a preliminary report only, outlining the limitation, which could be corrected in the final report.

Physician-to-Physician Communication

In general, communication between the interpreting radiologist and the referring provider or their representatives should be readily and bidirectionally available and consistent with the ACR Practice Guideline for Communication of Diagnostic Imaging Findings [31]. Pathways of easy and prompt communication should be well established, agreed upon, and facilitated by both parties. Although various delivery formats are available, including a landline telephone, smart phone, electronic medical record, e-mail, and voicemail, the delivery method should be the choice of the referring provider.

The communication of critical test results, a Joint Commission National Patient Safety Goal, is important to the practice of radiology because failures in this process can lead to patient morbidity and mortality. It is also one of the major contributors to malpractice claims in radiology [32, 33]. Different levels of acuity and criticality should be predefined and should include the time frame during which critical test results should be communicated. Some results may require synchronous (usually via telephone) physician-to-physician communication. Given the potential for delays and the importance of the information, teleradiologists should escalate their efforts to communicate when a provider cannot be reached immediately. The

parameters for escalation should be predetermined and the process terminated only when the appropriate provider acknowledges receipt of the report.

An important component of critical test result communication is an audit trail. This includes return receipt for all asynchronous communications and detailed documentation of communication in the finalized radiology report. If critical test result management software is used, it must store audit trails that include active acknowledgment of report receipt, as well as time and date.

There should be a defined process for resolving discrepancies between preliminary and final interpretations. The interpreting physician should be available for consultation with the ordering clinician and with local radiologists. A process should be in place to provide additional review upon obtaining additional historical examinations or clinical information, as well as the production of appropriate addenda to the final report. There should be a means to request an overread in a case in which a clinician or local radiologist has questions or concerns regarding the initial interpretation. The discordant interpretations should be incorporated into both the hospital and the teleradiology peer-review process.

Turnaround Times

Rather than setting a precise standard for the allowable time between imaging completion and interpretation communication (ie, turnaround time), the task force believes that turnaround times for teleradiology interpretations should be set in accordance with accepted hospital and departmental requirements. The provider may choose to define specific metrics determined by a multidisciplinary team that could include local radiologists, emergency department physicians, at-large members of the local medical staff, and hospital administration. Turnaround times should be commensurate with other intradepartmental policies and should not be more or less stringent than for on-site radiology except for compelling patient-centered reasons.

Communication Between Radiologists and Radiology Technologists (RTs)

The task force emphasizes that all RTs and sonographers must function under the supervision of a qualified licensed physician. Therefore, maintaining communication between the radiologist and RT or sonographer is critical to the teleradiologist's role across the imaging enterprise. Such communications are critical to ensuring overall quality and patient safety by fulfilling 3 critical needs: (1) quality control, (2) transmission of relevant patient information, and (3) addressing RT or sonographer queries regarding study appropriateness.

This presents unique challenges for teleradiologists when traditional nonstructured verbal and paper-based communication mechanisms are not available. The outside teleradiologist will not have met and therefore will not have established a relationship with the RT or sonographer, meaning that a barrier in communication may exist between these individuals. Reliable communication is particularly important for ultrasound technologists, with whom seamless bidirectional feedback may be necessary during the examination itself (ie, while the patient is in the examination room).

Communication by any means must be timely. Failure to implement a responsive communications system for addressing RTs' questions and concerns can lead to a number of adverse events, including failure to diagnose a condition because of an inappropriate examination and unnecessary radiation exposure from an unnecessary study. Failure to have an adequate communications system in place prevents RTs from fully complying with their obligation under principle 6 of the American Registry of Radiologic Technologists'

code of ethics, which requires RTs to “obtain pertinent information for the physician to aid in the diagnosis and treatment of the patient” [34].

Payment and Regulatory Considerations

In general, teleradiology services are paid under the same conditions as in-person physician services. However, the nature of teleradiology is such that the professional component (PC) of an examination is performed at a different physical address from where the technical component (TC) is performed. This difference in location affects billing, Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) [35] accreditation, medical directors' duties and supervision, and place of service as it relates to claims filing.

General Billing for Services

Earlier in this paper, the task force emphasized the importance of teleradiologist involvement from the time of ordering to well beyond the generation of the report. A teleradiologist who bills Medicare submits a CMS-1500 form, which certifies that the teleradiologist provided the entire service associated with any specific procedure [36, 37].

Accreditation for Offices (MIPPA)

MIPPA mandates the accreditation of suppliers of the TC of advanced diagnostic imaging. MIPPA defines advanced diagnostic imaging procedures as MR, CT, and nuclear medicine or PET but excludes x-ray, ultrasound, fluoroscopy, and mammography.

Medical Directors' Duties

MIPPA-accredited facilities must have medical directors whose roles are supervisory and who serve to fulfill a number of regulatory, professional, administrative, educational, and quality initiatives. Medical directorship is required for optimal imaging facility functionality, whether the facility is part of a hospital network, a physician-owned practice, or an independent diagnostic testing facility (IDTF) [38].⁴

If a teleradiologist is to act in the role of medical director for an imaging center or department, he or she must fulfill these roles to ensure that the facility meets its obligations to payers and patients. Ideally, at the outset of the relationship, the medical director should visit the facility to ensure that policies and procedures are established and followed within the department. If this is not possible, a conversation with the managers and review of policies and procedures is acceptable. After the initial visit or phone discussion, the medical director should be readily available to the staff to address any issues that arise. Annual review of the records, policies, and procedures with management is encouraged. If the facility is designated as an IDTF, the medical director must fulfill all CMS requirements, including but not limited to serving as medical director for no more than 3 IDTFs [38].

Place of Service

Teleradiologists, and facilities employing their services, must understand and comply with CMS place-of-service rules as they relate to reporting the correct location for where the teleradiologist's services were performed. There are 3 general issues related to place of service: (1) reporting the correct physical location on the claim forms, (2) submitting the professional or global claims to the correct carrier or insurance company, and (3) filing claims with the appropriate carrier or insurer as this relates to enrolment issues.

Adding to this complexity are the differing requirements between Medicare and commercial insurers and the practice of medicine across payment jurisdictions and state lines.

Since April 1, 2004, CMS has required that physicians specify where services were provided when submitting their claims. More recently, on October 11, 2012, CMS issued Transmittal 2613, clarifying certain aspects of the rule but leaving the general requirement intact. Essentially, CMS requires teleradiologists to submit the address where they were physically located when performing their interpretations as the work address, regardless of where the TC was performed. The only exception to this is when “the professional interpretation was furnished at an unusual and infrequent location for example, a hotel, the locality of the professional interpretation is determined based on the Medicare enrolled location where the interpreting physician most commonly practices.” In addition to identifying the teleradiologist's work location, CMS requires that claims for the teleradiologist's services be submitted to “the B/MAC [Part B Medicare carrier] which processes claims for the payment locality where the ... service was furnished” (ie, the Part B Medicare carrier that has jurisdiction over the teleradiologist's work address reported on the claim) [39].

The combination of these 2 rules has significant implications for the billing of teleradiology services to Medicare:

1. It requires teleradiologists to report the physical location where they performed their work, not simply report the address where the TC was performed (unless that is where they performed the interpretation).
2. Each teleradiologist's work location must be separately and appropriately enrolled with the Medicare carrier that has jurisdiction over that geographic area.
3. It will frequently require teleradiologists to enroll with and submit claims to a carrier that is different from the carrier to which the TC was submitted.
4. Global billing is prohibited unless the billing entity is the same for both the PC and TC, and both components are performed within the same Medicare payment locality [39].

Requirements governing the submission of commercial insurance claims vary and are subject to numerous state laws, as well as the terms of the contract between insurer and provider, and are therefore too numerous to address here. However, the ACR believes that, absent state and contractual laws to the contrary, it is best practice to enroll each teleradiologist's work location with the insurer and report the teleradiologist's physical location when performing the interpretation as the service location on the claim form.

Antimarkup

Teleradiology services are frequently provided to IDTFs and physician practices performing services covered by the federal Stark self-referral law under its in-office ancillary services exception [40]. Because of the unique nature of these radiologic services and of teleradiology itself, many of these arrangements involve the reassignment of the PC from the teleradiologist to the facility performing the test, with the facility billing and collecting for the PC and paying the teleradiologist for his or her services at a prenegotiated fee. Through the antimarkup rule, CMS forbids the billing facility from “marking up” the claim for the professional services beyond what the providing physician would otherwise receive.^{5,6}

It is incumbent upon both the facility contracting with teleradiologists for the provision of PC services as well as the teleradiologists to understand and comply with the antimarkup limitation as it pertains to such arrangements.

Technology-Specific Considerations

The electronic practice of radiology imposes a variety of technology requirements, regardless of setting. Many of these are outlined in both the ACR Technical Standard for Electronic Practice of Medical Imaging and the forthcoming ACR IT Reference Guide for the Practicing Radiologist. Basic infrastructure demands include appropriate and auditable measures to ensure redundancy, reliability, recoverability, privacy, and security. Connectivity demands are particularly important because there must be sufficient and reliable network bandwidth to work efficiently and meet contractual requirements that serve patient interests. Local systems, where applicable, will need to conform to guidance in areas such as monitor display, clinical workflow, and systems integration designed to minimize error.

Systems integration challenges are particularly important, such as those that avoid manually entering patient identifiers. The Institute of Medicine [43] report on redesigning health care emphasizes that safety must be a property of the tools physicians use and must not rely purely upon vigilance to prevent harm. For example, the emerging practice today is to directly integrate between the PACS and the dictation reporting system.

Integration with the ordering process is important so that the report generated will be accessible to the referring physician. Manually associating the report to the order leads to a higher level of patient misidentification errors and can lead to an adverse event through omission [44, 45]. Detecting and repairing errors in these processes can take days, during which time fatalities have been reported [46].

PRACTICAL CONSIDERATIONS FOR RADIOLOGY PRACTICES

Contract Considerations

Because of the large variety of situations in which teleradiology services are used, it is not possible to provide highly prescriptive recommendations for all the various components of the relationship between a teleradiology provider and a hospital or a local radiology group. The following is meant to provide a list of issues that should be considered and addressed during negotiations or within a contract for services. This is not meant as legal advice, nor is it all-inclusive of the issues that should be considered.

- Definitions of examinations and interpretations: There should be a clear statement of what constitutes a study or examination. Interpretations may be preliminary reports, with subsequent final interpretations provided by the contracting local radiologists, who will ultimately bill for the service. Alternatively, the teleradiology provider may issue a final or official interpretation and directly bill the insurer or patient. There may be different performance expectations for reporting time, completeness of the interpretation, and comparison with historical examinations for preliminary versus final interpretations.
- Hours of coverage.
- Minimum and maximum volumes of examinations: Teleradiology companies may seek to negotiate additional fees if minimum volumes are not met.
- Response time: There should be a defined time for most reports to be available. There may be different times for emergency examinations and routine studies or for preliminary reports versus final reports. Care should be taken in defining what starts the clock and what determines the end point. There should be provisions for rapid evaluation and communication of findings in emergent life-threatening situations. Critical results reporting should meet established institutional policies.

- Modalities covered: The specific modalities to be covered should be specified. There may be agreement for different response times and qualifications of the interpreting physician for different modalities, especially for specialized examinations such as coronary CT angiography and CT colonography.
- Subspecialty interpretations: A clear definition of what constitutes a subspecialist should be agreed upon. The specific examinations requiring interpretation by subspecialists should be defined. It is important that all parties have a clear understanding of how examinations are assigned. For examinations that require special attention, there should be a defined process for informing the teleradiology provider and routing the examinations to appropriate interpreting radiologists.
- Credentialing: Processing credentialing applications for a teleradiology provider can be a lengthy and costly process because there are advantages to obtaining privileges for a large number of providers. How many teleradiologists will be granted privileges and who is responsible for any associated fees should be understood.
- Quality assurance: The teleradiology provider should have an established quality assurance program including formal peer review. There should be a defined process for resolving discrepancies between preliminary and final interpretations. The interpreting physician should be available for consultation with the ordering clinician and with local radiologists. A process should be in place to provide additional review upon presenting new historical images or clinical information, as well as for dictating appropriate addenda to the final report. There should be a means to request second opinions in cases in which clinicians or local radiologists have questions or concerns regarding the initial interpretations.
- Malpractice coverage: The teleradiology provider should meet all local requirements for malpractice coverage.
- Accreditation: The teleradiology provider should meet all requirements for the facility's accreditation processes, including ACR accreditation.
- Records: The contract should define who owns records and is responsible for storage and HIPPA compliance.
- IT requirements: Responsibility for network connections, how issues are reported and resolved, and hours of tech support should be defined. Emergency downtime processes should be understood.
- Standard contractual issues: There should be delineation of typical requirements for contracts, such as the term of the contract, termination, warranties and covenants, indemnification, and confidentiality. Many contracts will include clauses for exclusivity on behalf of one or both parties.

COMPETITIVE MARKET FORCES

Members of traditional group practices have expressed concern regarding what they perceive as unfair competition potentially disrupting contractual relationships. Examples of radiology groups recently displaced from long-standing hospital coverage have generated considerable discussion of “predatory” business practices by teleradiology providers and raised the notion that outsourcing to teleradiology firms facilitates such upheaval [5, 47, 48]. As discussed earlier in this paper, some teleradiology companies are aggressively seeking to replace incumbent radiology groups. The term disintermediation refers to the exclusion of the local radiology group when direct contract negotiations occur between hospitals and teleradiology companies [4].

There is no doubt that the evolution of technology allowing remote image interpretation has lowered the barriers to competition. However, it does not necessarily follow that such competition is “predatory,” which in business practice usually refers to pricing below cost to drive out competition. The activities of these companies are more confrontational and less collegial than radiology groups have experienced in the past. No longer are teleradiology companies passively waiting for groups to reach out to them; these companies are aggressively marketing themselves to hospital decision makers, a trend that shows little sign of slowing [4].

If not predatory, do these examples violate some business ethic, or are they simply examples of successful competition? In a recent ACR Chair's Memo, Patti [49] wrote of the ACR's “moral and legal obligation to objectively represent its entire membership” and therefore its “inability to take sides in business conflicts between competing members, even if that competition exceeds the boundaries of what once was a collegial process.” However, Patti noted, the ACR can develop and advocate quality and performance guidelines, or best practices. These operational and regulatory guidelines for teleradiology are discussed elsewhere in this document. From the perspective of business practice, the burden of protecting existing contractual relationships between radiology groups and hospitals or imaging centers falls on the contracted radiology group.

First and foremost, radiology groups must understand that they create opportunity for competitors when they fail to satisfy the legitimate demands and expectations of their hospitals. Failure to provide rapid turnaround, subspecialty interpretations, or adequate coverage can force hospitals to consider alternatives. Hospitals may resent the competition of radiologist-owned imaging centers or the lack of flexibility in solving turf battles. Cost may be a reason as well, but it is harder for a hospital to displace a high-quality group that provides top-level service to the medical staff and community over disagreement on price alone [5]. It is important for radiology groups to remain aligned with the hospital system's strategic goals. Even better, radiologists would be well served to involve themselves in the planning process. Understanding the needs of the hospital, maintaining focus on quality and service, and aligning the incentives of the group with those of the hospital are important steps to preserve longevity in hospital relationships.

What precautions should be taken by radiology groups considering contracting with teleradiology providers? A simple step would be to include a noncompete clause in any contract with a teleradiology provider that the teleradiology company and any of its subsidiaries or successors will not seek business directly with the hospital or with any of the radiology group's existing customers. An additional consideration would be a notification clause requiring that the teleradiology provider disclose any communication that occurs directly between the hospital and teleradiology company, regardless of whether that communication was initiated by the provider or the hospital.

Radiology groups should explore the business focus of the teleradiology provider in advance of any consideration of a contract. Does the provider focus on contracts with other radiology groups, or does it also seek direct contracts with hospitals, imaging centers, and other entities? What public information is available about the company on its website or in public documents? What is the mission statement of the company? Have others experienced unreasonable competition or changes in a relationship? Are there references?

What about the radiology group's professional services contract with the hospital? Is there any language in the contract that describes circumstances under which the group can be displaced? Is it required that the current service levels and staffing be maintained or improved should displacement of the group occur? Can a hospital switch radiology providers without cause? Does the group contract include noncompete language

for its own members so that the hospital cannot “cherry-pick” individual radiologists directly from the group to cover certain subspecialty areas and then substitute a teleradiology provider for the remainder of the group? The group's contract with the hospital should require the hospital to immediately disclose any communication with a teleradiology company, whether that company directly contracts with the group or not.

What obligations does a teleradiology provider have in this regard? At a minimum, there should be full disclosure of business strategy to potential customers; that is, companies should be willing to share and discuss whether and how they intend to market their services in the same market as any radiology group for which they provide services. Teleradiology providers should honor any noncompete contracts.

RECOMMENDATIONS TO THE ACR

1. The task force acknowledges the benefits teleradiology services can bring to patient care, including improved access to radiologic services and subspecialty expertise in settings in which it otherwise may not be available. Therefore, the ACR should continue to refine the guidelines and standards for teleradiology practice and work to develop protocols and software to better enable the bidirectional communication between physicians, technologists, imaging managers, and the like. Similarly, better protocols for electronic medical record integration, peer review interfaces, and nonmanual communications with dictation systems should be developed.
2. The task force is concerned that the emerging model of full-service teleradiology companies' assuming the professional contracts for facilities may be evolving faster than the development of appropriate safeguards and acceptable work processes. Specifically, the evolving nature of teleradiology and the potential shortcomings described in this document could increase the possibility of communication errors, incomplete and nonactionable reports, and harm to patients ranging from increased radiation to major lapses in treatment. The ACR should continue monitoring the practice of teleradiology and work with its providers to ensure the use of teleradiology achieves the same high standards we expect from the more traditional practice model. The ACR should also remain watchful that incumbent radiology providers strive to maintain practices that are at least of the same quality as teleradiology providers.
3. Although the task force understands and appreciates the benefits teleradiology brings to the profession and the communities we serve, we also believe the traditional practice model of having on-site, local radiology groups may better serve the overall interests of most communities. The task force recommends that the ACR educate and inform its members as to how they should be changing to enhance their provision of noninterpretive services that may become critical to maintaining a presence at their respective facilities. This includes training for leadership roles within the hospital system, particularly as such roles relate to broader strategic planning. More important, every radiologist practicing within a group should strive to participate as fully as possible in the best quality patient care. Radiology groups that do not engage in such activities may find themselves more easily replaced by a corporate entity.

ACKNOWLEDGMENTS

We wish to acknowledge the work and effort of the entire Task Force on Teleradiology Practice for the research, insight, and analysis they contributed to this project. Task force members include Robert M. Barr, MD (chair, Business Standards of Practice Workgroup), Paul Berger, MD, Giles W. L. Boland, MD, Michael Bohl, RT (chair, Regulatory Issues Workgroup), Jonathan Breslau, MD, Lawrence A. Liebscher, MD, Woojin Kim, MD, (chair, Technology Workgroup), Paul Nagy, PhD, Samir S. Shah, MD, MMM, Cynthia Sherry, MD (chair, End User and Standards Workgroup) and James Tierney. We also acknowledge the contributions of Brent Savoie, MD, JD. In addition, we are deeply indebted to ACR staff members Tom Hoffman, JD, CAE, Mike Tilkin, and Shavouna Farmerie for their ongoing support, guidance, and diligence. Lastly, we thank the many peripheral consultants to whom we turned for guidance on specific matters within their respective fields of expertise.

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1 Most states require a full and unrestricted license to practice telemedicine. Many states have adopted formal telemedicine policies, but in the states that have remained silent, it is implied that telemedicine is no different from any practice of medicine requiring licensure [18].

2 There is no specific language, however, from the Federation of State Medical Boards or the individual state medical boards to support the requirement for licensure in a state other than that in which the patient resides, nor is there a clear legal basis for states to have authority over actions affecting only citizens of another state. The AMA has adopted language supporting full and unrestricted licensure for out-of-state physicians practicing medicine via telemedicine, but it does not require that a teleradiologist who interprets studies that occur in another state maintain a license in the state in which the interpretation is provided (ie,

the receiving site) [19]. Furthermore, the ACR Task Force on International Teleradiology limited its recommendation to requiring licensure in the transmitting state [2].

3 The 2012 ACR Technical Standard for Electronic Practice of Medical Imaging states, “When interpreting images from a hospital, physicians should be credentialed and obtain appropriate privileges at that institution. Physicians providing domestic and international teleradiology services should consult with their professional liability carrier to ensure coverage in both the sending and receiving sites (state or jurisdiction). The malpractice insurance coverage and claims jurisdiction should be determined by those contracting to receive teleradiology services” [3]. Therefore, teleradiologists should have malpractice insurance coverage at the transmitting and receiving sites. The amount of coverage should meet all local requirements for coverage, satisfy contractual obligations with facilities, originate from a rated carrier, and be verifiable upon request.

4 The medical director collaborates with the administrative director of the facility to devise the policies and procedures for the facility and to review them at least annually. They are responsible for ensuring that all professional and technical staff members meet the obligations set by the policies and procedures. The medical director may at times also have disciplinary responsibilities if professional or technical staff members fail to meet these obligations [38].

5 In 2008, CMS imposed an antimarkup limitation on the PC of diagnostic tests provided to IDTFs [41]. The antimarkup limitation is triggered when the facility bills and collects for the PC on behalf of the physician providing the PC service and then pays the physician for having performed the service. For services subject to the antimarkup limitation, “the payment from the facility to the physician who provided the PC may not exceed the lowest of the following amounts: [1] The performing supplier's net charge to the physician or other supplier; [2] The billing physician or other supplier's actual charge; or (3) The fee schedule amount for the test that would be allowed if the performing supplier billed directly.” In 2009, CMS extended the antimarkup payment limitation on the PC of diagnostic tests to those that are performed under the in-office ancillary services exception of the Stark law [40, 42]. This rule applies to the PC of diagnostic tests that are ordered by the billing physician or other supplier if the PC is outright purchased or if the PC is not performed in the office of the billing physician or other supplier.

6 Although there are exceptions to the antimarkup rule, they are generally reserved for situations involving a direct employer-employee relationship between the physician office performing services under the in-office ancillary service exception and the teleradiologist. (The employment exception does not apply to IDTFs.) Because few teleradiologists are direct employees of transmitting sites, most teleradiologists' compensation arrangements will be subject to the antimarkup rule [40].

SECTION VI

Appendix N

APPENDIX N

**ACR Commitment to Professionalism
(JACR article)**

APPENDIX O

Core Privileging for Image-Guided Procedures**PREFACE**

The American College of Radiology® (ACR®) Interventional Credentials Overview Committee was established on June 1, 2017, to address the need for core privileging for image-guided procedures. This led to the passage of Resolution 23 at the ACR Annual Meeting in 2019, to advocate for and support core privileging for image-guided procedures. A key component to the resolution was the creation of a library to assist members in their establishment of image-guided core privileges.

Members of the ACR Interventional Credentials Overview Committee who participated in this important project deserve our heartfelt thanks:

Chair: Dr. Philip Cook

Members: Drs. James Benenati, Kenneth Chin, Timothy Crummy, Laura Findeiss, Scott Goodwin, Neil Halin, Sanjeeva Kalva, John Kaufman, Robert Lewandowski, Alan Matsumoto, Mary Marx, Timothy Murphy, Parag Patel, Robert Pyatt and Charles Ray

We would also like to thank our collaborating partners for participating on this important project. Without the support of the Society of Interventional Radiology, Society for Pediatric Radiology, and the state radiology societies of Florida, California, Virginia, and Wisconsin, this would not have been possible.

INTRODUCTION

The ACR supports and encourages the use of core privileging methodology for physician privileging and re-privileging in the performance of image-guided procedures by diagnostic and interventional radiologists.

SUMMARY

A Library of Core Privileging Templates for Image-Guided Procedures has been collected and will be periodically updated to serve as references for those who wish to use core privileging for image-guided procedures. Different institutions have been successful in the use of core privileging and these are included. Examples are provided from several large urban university practices, a multispecialty clinic and a small community/rural referral hospital.

BACKGROUND

Privileges to practice medicine within particular areas of specialization are granted by hospitals or healthcare systems to physicians who are appropriately credentialed. Regulation of the credentialing process varies from state to state. Medical education and training and board certification are often used for both credentialing and privileging.

At a given hospital or other healthcare facility, a physician may be credentialed but not privileged. If not

privileged, then a physician may NOT perform the procedures for which they may have credentials. A key component of the process is patient safety. Healthcare institutions have the responsibility to have properly licensed and competent healthcare providers and verifiable processes to grant initial and ongoing credentials and privileges.

The two most common approaches to the requesting and granting of procedural privileges involve either individually listed procedures or grouped core privileges. Individually listed procedures — sometimes referred to as “salad bar procedure lists” — frequently require experience documentation for both initial and re-credentialing for each separate procedure. The other common type of procedural privileging involves the granting of core privileges, which combines all present and potential procedures within a specialty into a single set or groups of privileges.

Individually listed procedural privileging has several challenges. These challenges may present issues with primary source verification of the number of procedures performed (typically within the past two years) and with limitations of information systems to document continued procedural volume (often used as a measure of competency).

In addition, there may be a wide variety of different image-guided procedures for which privileges are requested and performed by any qualified physician with significantly varying degrees of frequency. Medical advancements and changes in practice patterns may also alter procedural volumes over time. Core privileging has many advantages. It streamlines the credentialing process for both the healthcare practitioner and the medical staff offices. It also recognizes that a given specialty has many procedures that constitute core skill sets (both knowledge and technical) and that these skill sets are translatable to other related applications and procedural developments within the specialty.

Initial and re-credentialing may take into account residency and/or fellowship training as well as board certification. Lifetime procedural experience may also be used. If procedural numbers are used, the numbers should be inclusive of a global compilation of an individual radiologist’s image-guided procedural experience. This methodology recognizes the translation of fundamentals related to image-guided procedures and our specialty.

The ACR now joins the American College of Obstetricians and Gynecologists, American College of Emergency Physicians and Society for Vascular Surgery in advocating for and supporting the core privileging process. Several well-respected radiology departments and hospitals across the country have relied upon the granting of core privileges for image-guided procedures for the past several years.

PROCESS

Establishment of image-guided core privileging requires several steps. ACR policy addresses the process of privileging radiologists. Privileging of physicians in other medical specialties who perform similar image-guided procedures is determined by those specialties and departments. If a hospital institutes a multispecialty privileging process, the ACR Core Privileging Policy should be used by the radiologists under that umbrella of core privileging.

Two or more core privilege procedural sets may need to be created and used at a given institution (e.g., stroke intervention and general image-guided core privileging documents). The core privileging

documents of the American College of Emergency Physicians recognize different levels of expertise that may be needed (e.g., a level one trauma center versus a non-trauma community hospital). These documents also include distinct core privilege sets prepared for different practice needs.

Core privileges should be tailored to meet the procedural needs of a given healthcare institution and the skill sets of the proceduralist. A large urban university hospital, by its nature, would have different core privileges than a smaller community or rural practice or pediatric hospital.

This approach to privileging recognizes and hopes to facilitate the ongoing contributions of radiologists who are often necessary for patient access to procedural care in many different types of practices. Appropriately written core privileging documents may facilitate, as opposed to creating barriers to, recruitment and retention of diagnostic and interventional radiologists across the spectrum of national healthcare settings.

Federal and individual state regulations may have separate privileging criteria that must be included for some procedures. Some examples of this situation are Y90 embolization, breast procedures and use of lasers.

A broad spectrum of procedures is typically included in core privileging. When a given radiologist does not possess the skills or experience for all procedures in a set of core privileges, he or she may opt out of being privileged for those specific image-guided procedures. The ethics of each individual physician and availability of mentoring, CME and additional post-graduate training could address best practices and staffing needs as determined locally, now and in the future.

Once a set of image-guided core procedural privileges is identified as meeting local institutional needs, these privileges will need to be presented and reviewed by the respective medical staff office and the hospital's board of directors. Once instituted, the process of core privileging will be administered by the medical staff office and ultimately met with scrutiny by regulatory agencies such as The Joint Commission. The Joint Commission does not require one particular standard, but rather mandates that local institutions follow reasonably established internal policies and procedures with appropriate documentation.

Documents included in the Library:

1. Examples for Core Privileging of Image-Guided Procedures
2. Core Privileging Resolution
3. Current ACR Practice Parameters for Which Core Privileging May Apply

This list should not be interpreted as all-inclusive for procedures that would qualify for core privileging. For example, some diagnostic procedures such as CTA, MRA and vascular ultrasound may be included in image-guided interventional radiology core privileges.

The ACR Commission on Interventional and Cardiovascular Imaging hopes that you find this Library and introductory guide helpful in your endeavor to move toward implementation of an image-guided core privileging process in your respective institutions.

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SECTION VII

ACR [PRACTICE PARAMETERS AND
TECHNICAL STANDARDS](#) Documents