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SECTION I
ORGANIZATIONAL AND OPERATIONAL POLICIES
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 (Res. 57).

2. HONORING THE TEXAS RADIOLOGICAL SOCIETY ON THEIR CENTENNIAL MEETING

   The Council of the American College of Radiology commends the Texas Radiological Society for 100 years of imaging excellence. The Council of the American College of Radiology extends to the Texas Radiological Society best wishes for a hugely successful centennial meeting in 2013; adopted 2012 (Res. 10).

3. 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).

4. 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).

5. 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).

6. COUNCIL CONSULTATION REGARDING FINANCES


7. GREATER INVOLVEMENT OF YOUNG PHYSICIANS IN THE ACR

   The ACR will make available an additional alternate council seat earmarked for a young physician (aged 40 or younger or within eight years after completion of residency or fellowship) for all chapters.
The ACR will provide $1,000 per chapter to those chapters that designate an additional young physician Council member.

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 (Res. 43).

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 (Res. 30-k).

9. ACR ADVOCACY NETWORKS

The ACR encourages all chapters and practices to develop and support advocacy networks and coordinate their efforts through the Radiology Advocacy Group of the Government Relations Commission. The ACR encourages other radiology, radiation oncology, nuclear medicine, interventional radiology and medical physics societies to work with the ACR and the ACR Radiology Advocacy Group to optimize our collective advocacy efforts. The ACR encourages chapters to add an advocacy network position on their Executive Committees/Boards; adopted 2012 (Res. 20).

10. STRATEGIC PLAN

The American College of Radiology adopted the amended Strategic Plan (Appendix A) as policy; adopted 2003 (Res. 25).

11. 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 O).

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).

12. 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.

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. ACR/CHAPTER RELATIONSHIPS ON NATIONAL ISSUES

Chapters are urged to consult with the College prior to publication of material of potential national significance; adopted 1979, 1989, 1999, 2009 (Res. 30-c).

2. 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; 1987, amended 1997, 2007 (Res. 36-a).

3. CHAPTER’S POLITICAL INVOLVEMENT

Each state chapter should establish or maintain a state government relations program to meet the demands of increased legislative and regulatory activity. The American College of Radiology will continue to assist state chapters with their state government relations issues; 1992, amended 2002, 2012 (Res. 1-a).

4. 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; 1987, amended 1997, 2007 (Res. 36-b).

5. RESIDENT AND FELLOW SECTION

The American College of Radiology encourages chapter resident and fellow sections and will continue to assist in their formation; 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; 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; 1983, 1993, 2003, amended 2013 (Res. 23-a).

6. CREATION OF A YOUNG AND EARLY CAREER PHYSICIANS SECTION

The ACR shall create a Young and Early Career Physician Section to replace the current Young Physician Activities Committee. The members of the ACR Young and Early Career Physician Section shall be defined as ACR members who are age 40 or younger, or who are within the first 8 years of practice after residency and fellowship training.

The ACR Young and Early Career Physician Section shall be led by an executive committee elected by the Section. The elected Chair and Vice Chair (Chair-Elect) of the Young and Early Career Physician Section executive committee shall serve as councilors during their respective terms leading the Young and Early Career Physician Section, to represent the voice of young and early career members of the ACR.
The ACR encourages state chapters to facilitate greater young and early career member involvement. The ACR Young and Early Career Physician Section shall work in coordination with the Commission on Membership and Communications to increase young and early career physician membership and volunteerism in the ACR.

The ACR Young and Early Career Physician Section shall provide an annual report to the ACR Council regarding its activities, and provide biannual written reports regarding its progress to the Board of Chancellors, Council Steering Committee, and Commission on Membership and Communication; adopted 2012 (Res. 11).

7. RESOLUTION TO SUPPORT AND STRENGTHEN RADIOLOGY’S ACADEMIC INFRASTRUCTURE

The American College of Radiology will create a committee that will advance awareness throughout the radiology community of the critical importance of radiology service, education and research. The principal charge of the committee will be to coordinate a cooperative and noncompetitive effort to elicit real and tangible support of Academic Radiology. The committee will coordinate with the ACR state chapters to establish a “grass roots” development effort that will focus on the creation of regional alliances between academic radiology departments and local private practice groups. The committee will have the responsibility of reporting its activities to the Board of Chancellors of the ACR; adopted 2006 (Res. 33).

8. 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 (Res. 39-a).

2. REPRESENTATION OF RELATED ORGANIZATIONS

The ACR encourages inclusion of representatives of other radiological organizations as members on ACR commissions and committees; 1980, 1990, 2000, amended 2010 (Res. 39-b).

3. CODE OF ETHICS

The Code of Ethics of the American College of Radiology is intended to aid radiologists and radiation oncologists, 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, with the public, with colleagues, and with members of allied professions.
Section 1 – PRINCIPLES OF ETHICS

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

1. 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. Radiologists and radiation oncologists should merit the confidence of patients entrusted to their care, rendering to each a full measure of service and commitment.

2. Radiologists and radiation oncologists should strive continually to improve their medical knowledge and skill and make these improvements available to their patients and colleagues.

3. Radiologists and radiation oncologists 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.

4. 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. Radiologists and radiation oncologists 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.

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

6. Radiologists and radiation oncologists 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.

7. The decision to render a service by a radiologist or radiation oncologist is a matter of individual physician and patient choice governed by the best interest of the patient.

8. The traditional bond both between radiologists and radiation oncologists, 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.

Section 2 – RULES OF ETHICS

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

1. 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 images should reasonably participate in quality assurance, utilization review and other matters of policy which affect the quality of patient care.

2. 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 which affect the quality of patient care.

3. Prior to practicing in a hospital or other health care entity, a radiologist or radiation oncologist 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.

4. 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. When such an arrangement exists, radiologists and radiation oncologists may be in violation of these Rules of Ethics and should make efforts to restructure the ownership of the facility.

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

6. Radiologists and radiation oncologists 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.

7. Radiologists and radiation oncologists 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.

8. Radiologists and radiation oncologists 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 which misleads patients or third party payers concerning the fees charged by the radiologist. Radiologists shall not divide radiological fees either directly or by any subterfuge.

9. In providing expert medical testimony, radiologists and radiation oncologists should exercise extreme caution to ensure that the testimony provided is non-partisan, scientifically correct, and clinically accurate. The radiologist or radiation oncologist shall not accept compensation that is contingent upon the outcome of litigation.

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

11. Radiologists and radiation oncologists should not claim as their intellectual property that which is not theirs. Plagiarism or the use of others’ work without attribution is unethical.

12. Radiologists and radiation oncologists should not publicize themselves through any medium or forum of public communication in an untruthful, misleading, or deceptive manner.

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 (Res. 27-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. **DEMOGRAPHIC INFORMATION OF ACR LEADERSHIP**

   Each year the registration form for the annual ACR meeting shall include a portion in which the registrant would include demographics. This information is to include the registrant’s position(s), i.e., Board of Chancellors, Council Steering Committee, Commission member, Councilor, or Alternate Councilor. Demographic self-reported information is to 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 by the ACR Bulletin within six months of the meeting date; adopted 1998, 2008 (Res. 27-c).

4. **EDUCATIONAL TOPICS FOR ACR MEETINGS**

   The Commission on Education and the Council Steering Committee, when planning educational sessions at the Annual Meeting, shall consider inclusion of topics deemed relevant to practice leadership and management, along with quality and safety issues; 2000, amended 2010 (Res. 39-c).

5. **NON-SMOKING AT ACR MEETINGS**

   There will be no smoking at meetings of the American College of Radiology; adopted 1986, 1996, 2006 (Res. 52-a).

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 chairman 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 (Res. 41).

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.

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; 2004, amended 2014 (Res. 1-b).

b. Increased Council Representation for Resident and Fellow Section

Representation for the Resident and Fellow Section will be increased to 5 Councilors and 5 Alternate Councilors; adopted 2006 (Res. 57).

c. Society of Computed Body Tomography and Magnetic Resonance Representation on the ACR Council

The ACR will grant the Society of Computed Body Tomography one Councilor on the Council of the American College of Radiology, effective at the 2012 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 Computed Body Tomography and Magnetic Resonance; adopted 2011 (Res. 60).

d. 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).

e. Official Observer Representation on the ACR Council

The Council will grant Official Observer status to organizations that otherwise do not meet the criteria for a formal seat within the Council, but that do meet the following criteria:

• the organization and the ACR have established an informal relationship and have worked together for the mutual benefit of both, and

• the organization is national in scope and has similar goals and concerns about radiology-related issues.

The ACR Board of Chancellors or Council Steering Committee will make a recommendation to the Council concerning the application of an organization, with the ACR Council making the final
determination on the conferring of official observer status to an applicant. Organizations granted Official Observer status will be invited to send one representative to observe the actions of the ACR Council at all meetings of the Council. That representative will have the right to speak and debate on the floor of the Council, but will not have the right to introduce business, introduce an amendment, make a motion, or vote. The Council may, in its sole discretion, remove the Official Observer status of any organization. The Bylaws Committee will prepare an amendment to the ACR Bylaws to codify this action to grant Council representation to Official Observers; adopted 2006 (Res. 56).

f. 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; 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 based on directives of the previous minutes; adopted 1973, 1974, 1987, 1997, 2007 (Res. 36-c).

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).

d. Pre-Council Dissemination of Resolutions

The College will continue to provide a summary of proposed resolutions to the general membership prior to the annual meeting; adopted 1988, 1998, 2008 (Res. 27-d).

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 Guidelines 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 Guideline 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*; 2001, amended 2011 (Res. 18-a).

3. **SPEAKER AND VICE-SPEAKER AS ELECTED MEMBERS OF THE COUNCIL STEERING COMMITTEE**

The Bylaws Committee be directed to prepare for consideration at the 2012 Annual Meeting and Chapter Leadership Conference an amendment to the current bylaws to reflect that the Speaker and Vice-Speaker are elected members of the Council Steering Committee, and are thereby eligible to serve in positions open to elected members of the Council Steering Committee; adopted 2011 (Res. 30).

4. **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 6 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 (Res. 44).

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 (Res. 1-b).

   b. **Membership Dues Adjustment**

   The ACR dues will be as follows for the following years:

<table>
<thead>
<tr>
<th></th>
<th>2011</th>
<th>2012</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Members, Fellows and Associates</strong></td>
<td>$795</td>
<td>$850</td>
</tr>
<tr>
<td><strong>Active or Associate, Immediately out of Training:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>First Year</td>
<td>$65</td>
<td>$70</td>
</tr>
<tr>
<td>Second Year</td>
<td>$215</td>
<td>$230</td>
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<td>Third Year</td>
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<tr>
<td>Fourth Year</td>
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<td>$540</td>
</tr>
<tr>
<td><strong>Allied Health/MRI Scientists</strong></td>
<td>$215</td>
<td>$230</td>
</tr>
<tr>
<td><strong>International Member</strong></td>
<td>$315</td>
<td>$335</td>
</tr>
<tr>
<td><strong>International Member-in-Training</strong></td>
<td>$110</td>
<td>$115</td>
</tr>
<tr>
<td><strong>Medical Physicists</strong></td>
<td>$215</td>
<td>$230</td>
</tr>
</tbody>
</table>
Medical Physicists, Immediately out of Training:

<table>
<thead>
<tr>
<th>Year</th>
<th>First Year</th>
<th>Second Year</th>
<th>Third Year</th>
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<tr>
<td></td>
<td>$110</td>
<td>$115</td>
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<td></td>
<td>$125</td>
<td>$130</td>
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<tr>
<td></td>
<td>$160</td>
<td>$170</td>
<td></td>
</tr>
</tbody>
</table>

The Budget and Finance Committee will assess each year, beginning in 2012, whether a dues increase not to exceed 3% is warranted. When warranted by the assessment, dues will be increased beginning in 2013 by the amount recommended by the Budget and Finance Committee and approved by the Board of Chancellors and Council Steering Committee; 2010, amended 2011 (Res. 45).

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 (Res. 46).

1. Members, Fellows and Associate Members in the Military, Public Health Service and Veterans Administration receive a 50% discount on membership dues.

2. Canadian Members, Fellows and Associates receive a 50% discount on membership dues.

The ACR will provide to the membership specific examples of direct financial and other benefits that members have received as a result of ACR activities; 2001, amended 2011 (Res. 47-a).

**Note:** The dues schedule was changed by the ACR Council at its 2010 Annual Meeting and Chapter Leadership Conference.

d. **Encourage Funding of ACR Membership for Radiologists and Radiation Oncologists**

The leaders of all academic and private practice radiology and radiation oncology practice groups shall be encouraged to fund memberships in the ACR for all radiologists and radiation oncologists from their practice revenues; adopted 1999, 2009 (Res. 1-e).

G. **MEMBERSHIP**

1. **MEMBERS**

   a. **Addition of a Category of Fellowship for Long-Term Associate Members**

   The Council of the ACR authorizes the Fellowship Committee to develop a category of fellowship recognizing associate members with greater than 20 years of service to the ACR, and

   The Fellowship Committee will write criteria for this new category of fellowship, recognizing that a higher level of services will be required for these candidates than is required for a similar candidate who is an active board certified member of the ACR, and
The appropriate Bylaws changes will be brought to the 2011 AMCLC to ratify these changes and no candidates will be considered until the Bylaws are appropriately changed; adopted 2010 (Res. 9)

b. 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; 2003, amended 2013 (Res. 23-b).

c. 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).

d. Non-Members


e. 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).

f. Streamline Membership Process for Transitional Members

The College shall provide each chapter completed application forms, based on existing demographic information, for each new “transitional” member who has paid his/her national and chapter dues.

The ACR Council strongly encourages each chapter to accept this completed form and grant chapter membership without further requirement; adopted 2001, 2011 (Res. 47-c).

g. Transfers

The ACR will monitor and facilitate transfers of members and fellows from one chapter to another. The transferring ACR member shall remain a member unless the chapter challenges his/her right to membership in a due process hearing; adopted 1979, 1989, 1999, 2009 (Res. 30-o).
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 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 (Res. 47-d).
SECTION I

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 (Res. 1-c).

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 (Res. 27-e).

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 (Res. 36-d).

b. ABR Recertification

The College will continue its dialogue with the American Board of Radiology on Recertification and issues related to Board certification; adopted 1979, 1989, 1999, 2009 (Res. 30-a).

c. 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. **TIMING OF THE ORAL BOARDS IN DIAGNOSTIC RADIOLOGY**

The American College of Radiology will establish a Task Force to investigate the potential impact of changing the timing of the oral board examination inDiagnostic Radiology on resident physicians, recent residency graduates, private practices, academic practices, and the job market. The Task Force should report their findings and suggestions in a white paper to be presented to the council, submitted for publication, and shared with specialty societies. Representation on the Task Force should include resident physicians, private and academic practice members.

The American College of Radiology will encourage and facilitate open discussion between the ABR, ACR RFS, ACR Board of Chancellors, SCARD, APDR, private practice representatives, and other representative societies.

The American College of Radiology will consider the topic of timing of the oral board examination in Diagnostic Radiology for the Intersociety Conference Meeting for 2008.

The American College of Radiology will support the current timing of the oral board examination in Diagnostic Radiology in the fourth year of residency, until the ACR Task Force, established to examine this issue, can ensure that altering the timing of the oral board examination will have no adverse impact on the specialty; adopted 2007 (Res. 50).

3. **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; 1999, amended 2009 (Res. 1-b).

4. **SUPPORT FOR MARYLAND ANTI SELF-REFERRAL LEGISLATION**

The ACR continues to support efforts to defend the Maryland anti self-referral statute with both significant consultative input and strong financial support. The ACR will consider matching contributions from the individual states. The ACR will encourage all state chapters to make a contribution to the Maryland defense fund.

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 (Res. 17).

5. **AMERICAN REGISTRY OF RADIOLOGIC PATHOLOGY, CO-SPONSORSHIP**

The American College of Radiology agrees on a continuing basis to serve and function as the principal sponsor of the American Registry of Radiologic Pathology of the Armed Forces Institute of Pathology. The College on a continuing basis will serve as a co-sponsor of the position of distinguished scientist in radiology attached to the ARRP. The College will welcome the participation of other radiologic societies, as appropriate, in the activities of the ARRP; adopted 1988, 1998, 2008 (Res. 1-a).

6. **APPROPRIATE UTILIZATION OF IMAGING SERVICES IN HOSPITAL EMERGENCY ROOMS**

The ACR shall continue the dialogue with the American College of Emergency Physicians to review
and explore possible means to improve physician education and awareness of the proper utilization and costs of imaging services and optimal radiation dose; 2001, amended 2011 (Res. 47-e).

7. 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); 2001, amended 2011 (Res. 31-a).

8. 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 to effectively perform their duties for the benefit of patient care and the practice of radiology.

The ACR shall develop specific models, plans or examples to aid practices in their efforts to provide the time and resources to their colleagues for radiological and other medical societies service; adopted 1999, 2009 (Res. 30-i).

9. 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 (Res. 59).

10. RADIOLOGISTS VOLUNTEER SERVICES IN HEALTH ORGANIZATIONS

The American College of Radiology encourages radiation oncologists and diagnostic radiologists to volunteer to serve in voluntary health organizations (e.g. American Cancer Society) on a local, regional, and national basis; adopted 1999, 2009 (Res. 30-n).

11. 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 state chapter to identify such individuals and facilitate such activity; adopted 2005 (Res. 37).
12. 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).

13. 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
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. The Royal College of Physicians and Surgeons of Canada (RCPSC) and the College des Medecins du Quebec Residency Language in Practice Guidelines and Technical Standards for Diagnostic Radiology

The American College of Radiology will revise the language in the approved diagnostic radiology residency programs in all appropriate practice guidelines and technical standards to read:

Completion of an approved diagnostic radiology residency program by the Accreditation Council for Graduate Medical Education (ACGME), the Royal College of Physicians and Surgeons of Canada (RCPSC), the Collège des Médecins du Québec, or the American Osteopathic Association (AOA)…; adopted 2011 (Res. 29).

c. 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 (Res. 44).

The Dual Certification Proposal

<table>
<thead>
<tr>
<th>PGY Year</th>
<th>IR/DR Dual Certificate</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Internship</td>
</tr>
<tr>
<td>2</td>
<td>DR 12 / IR 1</td>
</tr>
<tr>
<td>3</td>
<td>DR 12 / IR 1</td>
</tr>
<tr>
<td>4</td>
<td>DR 12 / IR 1</td>
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<td>IR 10 / ICU / DR 2</td>
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<td>IR 13</td>
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<td>Total IR (min)</td>
<td>27 (includes ICU)</td>
</tr>
<tr>
<td>Total DR (max)</td>
<td>38</td>
</tr>
</tbody>
</table>

Legend:
IR = Interventional Radiology; DR = Diagnostic Radiology; ICU = Intensive Care Unit
SECTION II

d. Percutaneous Transluminal Angioplasty: Credentials Criteria


CREDENTIALS CRITERIA FOR PERIPHERAL, RENAL AND VISCERAL PERCUTANEOUS TRANSLUMINAL ANGIOPLASTY

Percutaneous transluminal angioplasty (PTA) 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 Society of Cardiovascular and Interventional Radiology proposes the following guidelines for physicians, hospital administrators and health planners who plan for and develop the optimal conditions under which these procedures should be performed.

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 femoral (retrograde and antegrade), auxiliary 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:

- Experience performing and interpreting peripheral arteriography and selective and subselective vascular procedures, or in lieu of residency training criteria, the performance of a substantial number of peripheral and selective angiographic procedures for at least five years with acceptable complication rates.

- Instruction in radiation physics, radiation effects and protection with successful completion of a formal examination on these subjects, and additional experience including one of the following:

  - 1 or 2 year post-residency training in percutaneous interventions, which includes participation in a substantial number of peripheral and renal angioplasty procedures, or

  - 200 peripheral and renal angiograms performed within the previous 3 years, with documented success and complication rates within accepted limits, and participation in a minimum of 25 peripheral and/or renal angioplasty procedures under the direct supervision of a physician who already meets these criteria, or

  - The performance of a substantial number of peripheral and renal angioplasties for a period of at least three years with documented success and complication rates within accepted limits.
The physician 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, including demonstration courses and visiting fellowships on an annual basis.

THE ANGIOGRAPHIC FACILITY

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

- A film changer capable of obtaining rapid serial films of at least 14 inches in diameter. Digital subtraction angiography is an adjunct to conventional filming which may reduce patient discomfort and provide increased safety in patients with reduced renal function.
- High-resolution image intensifier and television chain.
- Physiologic monitoring devices including ECG and intra-arterial pressures.
- Facilities to manage and resuscitate unstable patients.
- Personnel trained to provide proper patient care and operation of the equipment.

SURGICAL SUPPORT

The safe performance of peripheral and renal angioplasty requires a strong cooperative effort between the physician performing the procedure and a vascular surgery team. Although complications of peripheral and renal angioplasty only rarely require urgent surgery, these procedures should be performed in an environment where operative repair can be instituted promptly.

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

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 by utilization of the ACRI Physics Teaching File 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 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 (Res. 16-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 chairmen of radiology departments throughout the United States to implement these curriculum additions; adopted 1987, 1997, 2007 (Res. 12-a).

d. Radiation Oncology Residency Matching Program

The American College of Radiology supports the concept of a matching program for radiation oncology and encourages one hundred percent participation of all radiation oncology training programs. 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 (Res. 33-a).

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 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 (Res. 39-d).

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 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 (Res. 36-e).

f. Standards for Radiology Fellowship Programs

The American College of Radiology reaffirms its support of the requirements of the Accreditation Council for Graduate Medical Education (ACGME) for accredited radiology fellowship programs. The American College of Radiology strongly recommends that non-accredited radiology fellowship programs follow the requirements of the ACGME for accredited radiology fellowship programs; 1992, 2002, amended 2012 (Res.12-a).

g. Training Programs: Educational Material

The ACR shall continue to assist all training programs in radiology by providing educational materials; adopted 1976, 1987, 1997, 2007 (Res. 36-f).

h. 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).

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 (Res. 1-d).

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 the wide variety 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 (Res. 36-g).

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.

The 2012 Commission on Quality and Safety report include specific accreditation program changes that were made since the 2011 AMCLC; adopted 2011 (Res. 27).

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).
4. MISCELLANEOUS EDUCATION POLICIES

a. Chapter Officers—Annual Education Session

An educational session will be conducted annually for state chapter secretaries and presidents; adopted 1973, 1987, 1997, 2007 (Res. 36-h).

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 Guideline(s) and Technical Standard(s), and then only under the supervision of a licensed physician(s) who has the qualifications described in those Practice Guideline and Technical Standards; 2000, amended 2010 (Res. 1-b).

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:

“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).

Subspecialty certificates, if implemented, should be in addition to the radiology or diagnostic radiology certificate; 1973, 1987, amended 1997, 2007 (Res. 1-b).

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. DEVELOPING ULTRASOUND APPLICABILITY IN PACS

The ACR encourage PACS vendors to develop high quality standards in PACS archiving for all modalities including ultrasound; adopted 2010 (Res. 35).

3. GUIDELINES FOR MULTI-DETECTOR COMPUTERIZED TOMOGRAPHY SCANNERS

The ACR shall use its various publications to advise its members of dose estimates or indices of CT procedures commonly used with representative current CT scanners; in addition, the ACR will continue to encourage the use of the ALARA principle and promote techniques that reduce radiation dose without compromising the necessary diagnostic information; 2000, amended 2010 (Res. 10-a).

4. 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 (Res. 16-b).

5. PORTABLE IMAGE MEDIA (CDS AND DVDS)

The ACR strongly encourage the nation’s PACS vendors to adopt the IHE standards-based profiles; adopted 2010 (Res. 36).

6. RADIATION ONCOLOGY

a. External Beam Radiation Oncology Equipment


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 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 (Res. 12-c).

7. 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 (Res. 1-c).

8. STANDARDIZATION OF RELATIVE EXPOSURE UNIT OF MEASURE FOR DIGITAL DIAGNOSTIC RADIOLOGIC EQUIPMENT

The ACR encourage radiology equipment vendors to adopt the AAPM published exposure index standard (AAPM Report 116 An Exposure Index for Digital Radiography) as a standard for digital radiologic imaging equipment; adopted 2011 (Res. 15).
9. 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 (Res. 12-d).

10. UNIFORM TERMINOLOGY


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 establishment of the National Institute of Biomedical Imaging and Bioengineering at the National Institutes of Health; adopted 1997, 2007 (Res. 36-i).

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; 2002, amended 2012 (Res. 12-c).

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).

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 or courses accredited by the Accreditation Council for Continuing Medical Education; 1998, amended 2008 (Res. 8-a).

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 (Res. 27-f).
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 (Res. 36-j).

3. TORT 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;
- 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 (Res. 39e).

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 (Res. 36-k).

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

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. The ACR supports the adjustment of graduate medical education funding per specialty to rationally balance workforce supply and demand; adopted 1996, 2006 (Res. 52-d).
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 and radiation physicists; adopted 1986, 1996, 2006 (Res. 52-e).


The Board of Chancellors, through the appointed Committee on Radiologist 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 (Res. 1-c).

5. **SHORTAGE OF INVESTIGATORS**

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 (Res. 12-d).

6. **EVALUATION OF ACR PROFESSIONAL BUREAU SERVICES**

In the next year, a committee will be appointed consisting of interested academic, private practice radiologists and members-in-training. This committee will review the current status of the ACR Professional Bureau and offer suggestions on improving the Bureau and its relevance to the ACR members and members-in-training. Such suggestions should address the topics of enhancing the security of the website, expanding the website to include the addresses and contact information for academic departments and private practice groups according to geographic areas, and improving usage of the Bureau by members-in-training; amended 2006 (Res. 59).

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 (Res. 16-c).

2. **FOLLOW-UP EVALUATION OF RADIATION ONCOLOGY PATIENTS**

The American College of Radiology strongly supports the concept that radiation oncologists must have
SECTION II

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 B); adopted

4. INTEGRATED MULTIDISCIPLINARY CARE OF CANCER PATIENTS

The American College of Radiology strongly endorses the concept of integrated multidisciplinary care

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;

6. PRIMARY PATIENT ACCESS TO RADIATION ONCOLOGY AND INTERVENTIONAL
RADIOLOGY

Within the American College of Radiology any direction, guideline or limitation on “direct access” for
imaging procedures clearly excludes radiation oncology and interventional radiology, where “direct
access” is already the established practice; adopted 1986, 1996, 2006 (Res. 16-d).

7. RADIATION ONCOLOGIST DEFINED

A radiation oncologist shall be considered to be a physician either certified in radiation oncology or
therapeutic radiology by the American Board of Radiology or its equivalent or in the examination
process or who is certified in general radiology by the ABR and who confines his/her professional

8. 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 (Res. 52-f).

9. ELECTRONIC BRACHYTHERAPY

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 (Res. 44).

10. 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 (Res. 11).

11. 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


H. PUBLIC HEALTH AND RADIATION PROTECTION

1. ABDOMINAL RADIOLOGIC EXAMINATIONS OF WOMEN OF CHILDBEARING AGE AND POTENTIAL

The interruption of pregnancy is rarely justified because of radiation risk to the embryo or fetus from a radiologic examination, these examinations having been carefully planned with full consideration of the clinical status, including the possibility of pregnancy. The appropriateness and extent of the examination should be guided by the informational requirements predicated by the patient’s current illness; adopted 1988, 1998, 2008 (Res. 17-a).

2. 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; 1977, 1987, amended 1997, 2007 (Res. 12-k).

3. 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; 2001, amended 2011 (Res.1-a).

4. 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).
5. **DISPOSAL OF LOW-LEVEL RADIOACTIVE WASTE**

The American College of Radiology encourages its component 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; 1992, amended 2002, 2012 (Res. 33-b).

6. **GONADAL SHIELDS**


7. **MEDICAL RADIATION SHIELDING DESIGN LIMITS FOR THE GENERAL PUBLIC**

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

8. **TOBACCO CESSATION**

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

9. **OPPOSITION TO A GLOBAL TOBACCO SETTLEMENT**

The American College of Radiology expresses its opposition to any legal or legislative settlement which protects the tobacco industry from legal, legislative, or regulatory responsibility for its past and future impact on public health; adopted 1997, 2007 (Res. 36-l).

10. **NON-SMOKING HOSPITAL ENVIRONMENT**

The American College of Radiology supports the concept of a smoke-free hospital environment; adopted 1986, 1996, 2006 (Res. 52-b).

11. **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).

12. **PNEUMOCONIOSIS**


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 (Res. 1-g).
13. 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).

14. RADIATION EMERGENCIES: ACR/AMA ACTIVITY ON NON-MILITARY RADIATION EMERGENCIES

The ACR and its state chapters will provide leadership and work closely through the proper ACR Commissions or Committees to develop a pool of experts who possess the knowledge and expertise necessary to assist their local communities in a radiation emergency. The pool of expert radiologists and radiological physicists would also be available, working with state and county medical societies, to educate the media, civic organizations, and other groups on the health aspects of radiation exposure; 1986, amended 1997, 2007 (Res. 12-j).

15. RADIATION SAFETY OFFICER (RSO) TRAINING

The ACR, in collaboration with the AAPM and other stakeholders, provide models and educational materials for medical physicists, radiologists, radiation oncologists, and nuclear medicine physicians who provide RSO services; adopted 2012 (Res. 43).

16. REFER TO THE NORTH AMERICAN CONSENSUS GUIDELINES FOR ADMINISTRATION OF RADIOPHARMACEUTICAL ACTIVITIES IN CHILDREN AND ADOLESCENTS PAPER IN THE NUCLEAR MEDICINE GUIDELINES

The American College of Radiology will revise the paragraph on pediatric radionuclides dose currently included in the appropriate nuclear medicine practice guidelines as follows (new language shown in bold):

Administered activity for children should be determined based on body weight and should be as low as reasonably achievable for diagnostic image quality. For more specific guidance on pediatric dosing, please refer to the North American Consensus Guidelines for Administration of Radiopharmaceutical Activities in Children and Adolescents.

The ACR encourages radiology equipment vendors to develop a standardized unit of measure of radiation exposure from digital radiologic imaging equipment; adopted 2011 (Res. 14).
17. 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 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).

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 guidelines 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 guidelines and technical standards, and accreditation information. This information would include overviews, flow charts, applications and related instructions, guidance documents in regard to new facilities/new equipment and answers to frequently asked questions; adopted 1999, 2009 (Res. 1-a).

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 C) by any active or eligible participant. Any modification to a program, which includes the Certificate of Accreditation that is or will be issued, must be submitted for review to the Speaker and Vice Speaker, and if they deem material, shall be presented to the Council Steering Committee and approved by the Board of Chancellors, but in any event, the Board of Chancellors may require that any modification, material or immaterial, be submitted for such review and approval; 2000, amended 2010 (Res. 10-b).

c. Achievement of Accreditation Goals and Standards

The College shall develop, with specific involvement of all affected parties (such as the Commission on General, Small and Rural Practices, Committee on Pediatric Radiology, etc.) effective collaborative opportunities for all members to achieve the accreditation goals and standards created to maintain the required levels of excellence; 2000, amended 2010 (Res. 10-c).
d. **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).

e. **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 (Res. 12-k).

f. **Development of a Cardiac CT Accreditation Module**

The American College of Radiology shall approve development of a Cardiac CT Accreditation Module under the same general principles as other previously approved College accreditation programs; adopted 2006 (Res. 2).

g. **Development of a Cardiac MR Accreditation Module**

The American College of Radiology shall approve development of a Cardiac MR Accreditation Module under the same general principles as other previously approved College accreditation programs; adopted 2006 (Res. 3).

h. **Development of a Breast MR Accreditation Module**

The American College of Radiology shall approve development of a Breast MR Accreditation module or program under the same general principles as other previously approved College accreditation programs; adopted 2006 (Res. 19).

i. **Development of Modular Accreditation in MRI**

The American College of Radiology shall approve development of Modular Accreditation in MRI under the same general principles as other previously approved College accreditation programs; adopted 2006 (Res. 60).

2. **ACR POLICY ON DEVELOPMENT OF PRACTICE GUIDELINES AND TECHNICAL STANDARDS**

a. **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).

b. **ACR Radiation Oncology Practice Guidelines 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 (Res. 8).

c. 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:

a) ACR members will have an open comment period to allow them to participate in the expedited review process;

b) 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;

c) The CSC will inform the BOC of the approved Practice Parameters and Technical Standards;

d) Once received by the BOC, the Practice Parameters and Technical Standards will become effective immediately;

e) 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).

d. 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:

(a) ACR Practice Parameter for the Performance of Hysterosalpingography

(b) ACR Practice Parameter for the Performance of the Modified Barium Swallow

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

(d) ACR–SPR Practice Parameter for the Performance of Chest Radiography

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

(f) ACR–SPR–SRU Practice Parameter for Performing and Interpreting Diagnostic Ultrasound Examinations

(g) ACR Practice Parameter for the Performance of Total Body Irradiation

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

Based on the recommendation of the Joint Committee on Breast Imaging for Appropriateness Criteria and Practice Guidelines of the Commission on Breast Imaging, the ACR–ACS–CAP–SSO Practice Guideline for Breast Conservation Therapy in the Management of Invasive Breast Carcinoma is hereby recommended to be extended one year; 2011, adopted 2012 (Res. 31).


Based on the recommendation of the Joint Committee on Breast Imaging for Appropriateness Criteria and Practice Guidelines of the Commission on Breast Imaging, the ACR–ACS–CAP–SSO Practice Guideline for the Management of Ductal Carcinoma In-Situ of the Breast (DCIS) is hereby recommended to be extended one year; 2011, adopted 2012 (Res. 32).

g. **Extend the ACR Practice Guideline for the Performance of Computed Tomography for the Detection of Pulmonary Embolism in Adults and the ACR Practice Guideline for the Performance and Interpretation of Computed Tomography Angiography (CTA)**

Based on the consensus of the ACR Practice Guidelines and Technical Standards Committee of the Commission on Cardiovascular and Interventional Radiology, the ACR Practice Guideline for the Performance of Computed Tomography for the Detection of Pulmonary Embolism in Adults and the ACR Practice Guideline for the Performance and Interpretation of Computed Tomography Angiography (CTA) are hereby recommended to be extended until both practice guidelines can be sunset when the Practice Guideline for the Performance and Interpretation of Body Computed Tomography Angiography (CTA) is completed; adopted 2010 (Res. 23).

h. **Extend the ACR–ASNR Practice Guideline for the Performance of Magnetic Resonance Imaging (MRI) of the Spine**

Based on the recommendation of the ACR Neuroradiology Practice Guidelines and Technical Standards Committee of the Commission on Neuroradiology, the ACR–ASNR Practice Guideline for the Performance of MRI of the Spine is hereby extended until revised and presented for adoption at the 2012 AMCLC; adopted 2011 (Res. 28).

i. **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)**

Based on the recommendation of the ACR Practice Guidelines and Technical Standards Committee of the Commission on Body Imaging, the ACR Practice Guideline for the Performance of CT for the Detection of Pulmonary Embolism in Adults, and the ACR Practice Guideline for the Performance and Interpretation of Computed Tomography Angiography (CTA) are hereby sunset in the event that the ACR–NASCI–SIR–SPR Practice Guideline for the Performance and Interpretation of Body Computed Tomography Angiography (CTA) is adopted.

In the event that the ACR–NASCI–SIR–SPR Practice Guideline for the Performance and Interpretation of Body Computed Tomography Angiography (CTA) is not adopted or is referred at the 2011 AMCLC, both the ACR Practice Guideline for the Performance of CT for the Detection of Pulmonary Embolism in Adults and the ACR Practice Guideline for the Performance and Interpretation of Computed Tomography Angiography (CTA) will be extended to the 2012 AMCLC; adopted 2011 (Res. 37).
j. **Extend the ACR-SPR Practice Guideline 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).

k. **Extend the ACR-AIUM Practice Guideline 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).

l. **Sunset the ACR-ACS-CAP-SSO Practice Guideline 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 Guidelines, 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).

m. **Sunset the ACR–ACS–CAP–SSO Practice Guideline 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 Guidelines, 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).

n. **Extend the ACR–SIR Practice Guideline 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 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).

o. **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)
p. Maintenance of Competence in ACR Standards

In the absence of strong evidence requiring performance of numbers of procedures, the Commission on Quality and Safety will continue to review the “Maintenance of Competence” section in the practice guidelines and technical standards and work to develop methods other than number of procedures that assure competence; 2002, amended 2012 (Res. 12-e).

q. Name of ACR Practice Guidelines

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).

r. 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 Guidelines and Technical Standards (Appendix G); 2003, amended 2013 (Res. 4-b).*

s. 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.

11. ACR–SPR Practice Guideline for the Performance of Renal Scintigraphy (2008); adopted 2012 (Res. 8).

*In 2014 the Council adopted Late Resolution 39 Name of ACR Practice Guidelines that changed the name of Practice Guidelines to Practice Parameters.

1. Practice Guidelines 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 Guidelines and Technical Standards on Malpractice Litigation in radiology.


The following statement regarding pregnancy is to be included in all of the Practice Guidelines 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 Guidelines 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.”; 1995, 2005, amended 2015 (Res. 1-c).

v. 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 Standards Book and be referenced in each standard:

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 estimates of typical patient dose should be made by a qualified medical physicist as described in the appropriate ACR Technical Standard for Physics Equipment Performance Monitoring. 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 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 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 Technical Standard for Diagnostic Medical Physics Monitoring of Magnetic Resonance Imaging (MRI) Equipment.
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 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 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 (Res. 1-e).

w. Revision of Practice Guidelines and Technical Standards Review Cycle

ACR practice guidelines 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 (Res. 10-d).

x. Minor Modification of Standardized Language or Approved Policies/Resolutions Embedded in Practice Guidelines 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 Guidelines 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 guideline, technical standard or policy/resolution;
   and/or,

2. When new words or phrases have been approved by the Council and/or have developed since the adoption of the practice guideline, technical standard or policy/resolution that more accurately represent the meaning and intent of the practice guideline, technical standard or policy/resolution;
   and/or,

3. When a minor correction to specific language will improve understanding of the practice guideline, technical standard or policy/resolution so that it better addresses quality.

Procedure

• All existing Practice Guidelines 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 Guidelines and Technical Standards that contain the standardized language, to the Speaker, Vice-Speaker, Vice Chair of Quality and Safety for Guidelines 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 guideline and/or technical standard to be published in the ACR Practice Guidelines and Technical Standards CD and Book and 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 (Res. 38).

y. Standards: Implementation

The Commission on Quality and Safety (formerly the Commission on Standards and Accreditation) will submit Radiologic Practice Guidelines and Technical Standards, as they are developed, to the Council Steering Committee for review and recommendation to the ACR Council; 1989, amended 1999, 2009 (Res. 1-h).

z. Standards: Retirement/Sunset Process

The ACR Commission on Quality and Safety adopt the following procedure to sunset or retire existing guidelines and 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 technology or treatment:

• The revising committee will write a proposal with justification of why the procedure or therapy should be sunset, for review by the guidelines committee and the relevant commission.
• If the relevant committee and commission concur in the recommendation to sunset the
guideline or standard, the proposal and justification will be submitted for review to the Speaker,
Vice-Speaker, Vice Chair of Quality and Safety for Guidelines and Standards, and the Chair of
the Commission on Quality and Safety.

• If there is overall agreement to recommend sunsetting the guideline or standard, the sponsoring
guideline committee will draft a resolution for presentation to the Council that is sponsored by
the Council Steering Committee.

• If approved by the Council, the guideline will be removed from publication on the ACR
Website, and the ACR Practice Guidelines and Technical Standards CD and Book, but the title
of the guideline will remain in the list of guidelines with a notation that it was sunset and the
effective date; adopted 2007 (Res. 22).

aa. Practice Guidelines and Technical Standards: Written with Other Organizations

For practice guidelines and technical standards written with other medical specialty organizations
or societies, the ACR Council will follow the ACR Process for Amending Draft Collaborative

bb. Collaborative and Conflicting Society Guidelines

The ACR shall remove from a collaborative guideline 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 guideline or standard) that conflicts with
the ACR collaborative guideline or standard; adopted 2012 (Res. 21).

c. Practice Guidelines and Technical Standards: Uniform CME Statements

ACR practice guidelines 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 guideline or technical standard dealing with CME shall
state: “The physician should meet the ACR Practice Guidelines for Continuing Medical
Education.” The physician should include CME in whatever system or modality the practice
guideline or technical standard addresses as is appropriate to his or her needs; 1992, 2002,
amended 2012 (Res. 23-b).

dd. Revised Radiation Safety Language in Imaging Practice Guidelines

The ACR will use the following language regarding radiation safety in all appropriate X-ray,
fluoroscopy, interventional radiology, CT, and nuclear medicine ACR Practice Guidelines 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 Guidelines 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 Guidelines 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 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).

**bb. Radiologist Assistant Inclusion in Practice Guidelines**

The American College of Radiology will insert the following language describing the role of the Radiologist Assistant (RA) into the appropriate Practice Guidelines for the Performance and Interpretation of the various radiologic examinations in which a Radiologist Assistant might participate:

**Radiologist Assistant**

A radiologist assistant is an advanced level radiographer who is certified and registered as a radiologist assistant by the American Registry of Radiologic Technologists (ARRT) after having successfully completed an advanced academic program encompassing an ACR/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 Joint Policy Statement of the ACR and the ASRT 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 (Res. 34).
ff. “Request for Examination” Language in Practice Guidelines

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

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 (Res. 35).


The American College of Radiology will revise the alternative pathway language in all appropriate Practice Guidelines and Technical Standards to read:

Completion of an Accreditation Council for Graduate Medical Education (ACGME) approved diagnostic radiology residency program or an American Osteopathic Association approved diagnostic radiology residency program…; adopted 2006 (Res. 36).

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 (Res. 23-c).

b. Chest X-Rays/Examinations: Pre-Operative and General Hospital Admission

The American College of Radiology adopts the following position statement on pre-operative and general hospital admission chest x-rays:

1. Chest radiographs should not be required solely because of hospital admission. All “routine” diagnostic studies for the sake of “routine” should be avoided.

2. Pre-operative chest x-rays, are generally appropriate when ordered specifically by a physician prior to surgery involving, but not limited to, thoracic and abdominal contents, pelvis, and lower extremities. Patients who are prone to develop post-operative pulmonary complications should have a base-line study provided a similar recent study is not available. If post-operative monitoring by central lines (CVP, Swan-Ganz) may be anticipated, a base-line study is also appropriate.
3. Pre-anesthetic diagnostic studies (such as chest x-rays) are appropriate when the attending physician (anesthesiologist, surgeon, consulting internist/family physician) believe the results may influence decisions regarding risks and management of the anesthesia and surgery. Appropriate indications for ordering tests include the identifications of specific risk factors (e.g., age, pre-existing disease, magnitude of the surgical procedure).

4. Neither the hospital nor the radiologist can serve in a gatekeeper role for chest x-rays when complex historical and physical data are not immediately available at the time of the procedure.

5. The American College of Radiology, through appropriate committees at the national and local levels, pledges to work with insurance carriers in a joint effort of education and training, and to assist in the development of mutually agreeable guidelines. The carriers on their part should make every effort to protect their subscribers (the patients) from retroactive denial of coverage for appropriate diagnostic tests; adopted 1988, 1998, 2008 (Res. 27-g).

c. Chest X-Ray Examinations, Referral Criteria

1. Referral Criteria for Mandated Routine Screening Chest X-Ray Examinations

There are a variety of instances where freestanding screening chest x-ray examinations are performed in asymptomatic persons solely by administrative mandate or protocol. This practice is based on the assumption that significant disease can be detected in a silent phase when it is more amenable to successful medical treatment. The productivity of such mandated chest examinations in random populations is therefore dependent on the prevalence of existing disease in asymptomatic persons and whether its early detection does in fact effect a significant reduction in morbidity and mortality.

The yield of unsuspected disease (e.g. lung cancer, heart disease, and tuberculosis) found by routine mandated screening chest x-ray examinations of unselected populations, not based on history, physical examination, or specific diagnostic testing has been shown to be of insufficient clinical value to justify the monetary cost, added radiation exposure, and subject inconvenience of the examination.

It is therefore recommended that all such mandated routine screening examinations of unselected populations be discontinued, unless a significant yield can be shown. This statement does not preclude chest x-ray examinations based on individual history, physical examination, or specific diagnostic testing (e.g. sputum cytology, electrocardiography, and skin test); or in selected populations shown to have significant yields of previously undiagnosed disease.

2. Referral Criteria for Routine Pre-Natal Chest X-Ray Examinations

The yield of unsuspected disease found by routine chest x-ray examinations of unselected pregnant patients (i.e., by protocol or by mandate) has been shown to be of insufficient clinical value to justify the radiation exposure, inconvenience to the pregnant patient, and monetary cost.

It is therefore recommended that all such routine prenatal chest x-ray examinations be discontinued. This statement does not preclude prenatal chest x-ray examinations based on individual history, physical examination, or specific diagnostic testing, or in selected populations shown to have significant yields of previously undiagnosed disease.
3. Referral Criteria for Routine Hospital Admission Chest X-Ray Examinations

The rational for obtaining routine chest radiographs of patients admitted to hospitals is to discover unsuspected disease which might directly threaten the health of the patient and/or jeopardize the health of those coming in contact with the patient. However, available evidence suggests that the yield of clinically significant information (not available from history, physical examination, or previous diagnostic testing) from such routine screening chest radiographs is low. (References 1 and 2 below.)

It is therefore recommended that routine chest radiographs not be required solely because of hospital admission.

This recommendation should not be construed as precluding or advising against the ordering of chest x-ray examinations (1) on the basis of history, physical examination, or specific diagnostic testing, or (2) in selected patient populations in which a significant yield has been previously substantiated or is considered highly likely pending appropriate substantiation.

4. Chest X-Ray Examinations in Occupational Medicine

Preemployment/Preplacement Examinations for Appropriate Job Placement:

Preplacement chest x-ray examinations should be done selectively based on pertinent factors in the (1) occupational and medical history, (2) clinical examination, and (3) proposed work assignment.

1. Job Exposure Surveillance:

Chest x-ray surveillance of persons who work with or may be exposed to substances that adversely affect pulmonary function or cause pulmonary disease should be based on aperiodicity consistent with the current understanding of the disease process.

2. Periodic Examinations Unrelated to Job Exposure:

The yield of unsuspected disease (e.g. lung cancer, heart disease, and tuberculosis) found by periodic chest x-ray examinations of unselected populations, not based on history, physical examination, or specific diagnostic testing has been shown to be of insufficient clinical value to justify the monetary cost, added radiation exposure, and subject inconvenience of the examination. It is therefore recommended that such routine examinations be discontinued.

This statement does not preclude chest x-ray examinations based on individual history, physical examination, or specific diagnostic testing (e.g. sputum cytology, electrocardiography, and skin test); or in selected populations shown to have significant yields or previously undiagnosed disease.

5. Chest X-Ray Examinations for Tuberculosis Detection and Control

A chest x-ray examination should always be obtained whenever a specific medical indication exists (e.g. relevant history, symptoms and/or significant tuberculin skin test reaction). However, there are several situations where x-ray examinations have traditionally been performed solely because of administrative mandate, protocols, or by routine. The yield of tuberculosis cases found by screening or repeated chest x-ray examinations has not been shown to be of sufficient clinical value to justify the inconvenience to the subject, monetary costs, or added radiation exposure.

Chest X-Ray for Employment:

Mandated chest x-ray examinations as a condition of initial or continuing employment have not been shown to be of sufficient clinical value to justify their continued use for tuberculosis detection.
Chest X-Ray Examinations in Long-Term Care Facilities:

Because conventional tuberculin skin testing may not be a reliable screening method in older and/or chronically ill persons and because these individuals may be at high risk of having tuberculosis, the results of a recent chest x-ray examination should be obtained by the nursing home. Only if unavailable, a chest x-ray examination should be performed on admission. In the absence of clinical symptoms, repeated chest x-ray examinations have not shown to be of sufficient clinical value to justify their continued use.

Repeated Chest X-Ray Examinations of Tuberculin Reactors:

After an initial evaluation, which should include a chest x-ray examination, repeated chest x-ray examinations of individuals with significant tuberculin reactions (without current disease), whether or not they have been treated with isoniazid, have not been shown to be of sufficient clinical value to justify their continued use.

Routine Follow-Up of Tuberculosis Patients Who Have Completed Treatment:

Repeated chest x-ray examinations of asymptomatic tuberculosis patients who have completed treatment have been shown to be of insufficient clinical value to justify their continued use.

Routine Periodic Chest X-Ray Examinations During Tuberculosis Treatment:

Radiographic stability does not indicate success or failure of chemotherapy as reliably as the results of sputum smear and culture, and assessment of symptoms and clinical status. However, an occasional x-ray examination may have value in confirming bacteriologic and clinical findings and enhancing patient compliance; 1982, 1992, 2002, amended 2012 (Res. 1-e).

d. Colorectal Cancer Screening


e. 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 (Res. 12-a).

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

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.

f. 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).

g. 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; 1992, amended 2002, 2012 (Res. 23-d).

h. Multidisciplinary Evaluation of Prostate Cancer

If a diagnosis of 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 treatment; adopted 2001, 2011 (Res. 1-c).

i. 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 (Res. 33-c).

j. Portable X-Ray Services Guidelines

In order to achieve maximum patient benefit and diagnostic quality radiographs, portable 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.

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 portable examination. 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; 1977, 1987, amended 1997, 2007 (Res. 12-l).
k. **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 JCAHO 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 JCAHO for the same services provided in an accredited hospital; adopted 1973, 1987, 1997, 2007 (Res. 36-m).

l. **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 (Res. 1-d).

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

m. **Radiological Practice, Principles**

Clinically unproductive examinations should be eliminated. Optimal techniques should be used when examinations are performed. Appropriate imaging equipment should be employed; 1979, 1989, amended 1999, 2009 (Res. 30-m).

n. **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; 2003, amended 2013 (Res. 4-c).

**o. 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 (Res. 23-e).

**p. 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 F); 2003, amended 2013 (Res. 4-d).

**q. 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.

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).

**r. 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; 2001, amended 2011 (Res. 1-b).

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; 2004, amended 2014 (Res. 21-c).

s. Whole Body MRI Screening Exams

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

t. 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 (Res. 18).

4. RADIOLOGY BY RADIOLOGISTS

a. Diagnostic Radiology

The fields of ultrasound, computed tomography, magnetic resonance imaging, and positron emission tomography shall be considered as technology to be incorporated in the existing areas of radiology; adopted 1976, 1987, 1997, 2007 (Res. 36-n).

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 (Res. 36-o).

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 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 (Res. 52-c).

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).

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 (Res. 48).

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™”); 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; 1991, 2001, amended 2011 (Res. 47-g).

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 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 (Res. 36-p).

e. Clinical Data

In order to afford optimal care to the patient, and to enhance the cost-effectiveness of each diagnostic examination, radiological consultations ought to be provided and radiographs interpreted within a known clinical setting. The ACR supports radiologists who insist on clinical data with each consultation request; adopted 1979, 1989, 1999, 2009 (Res. 30-d).

f. Direct Patient Communication

Radiologists are encouraged to increase direct communication with their patients in a manner appropriate to the clinical circumstances; adopted 2000, 2010 (Res. 10-e).

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 Guideline 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.

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 work 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 create a Task Force to define and prioritize the business needs of IR and INR clinical practices, and develop implementation and marketing tactics with respect to optimizing clinical practices in radiology. The task force should have appropriate representation from the ACR, SIR, SNIS, and other stakeholders.

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, and health care organization leaders; including but not limited to web-based information, printed materials, audio/visual media, and targeted conferences.

The ACR work 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 (Res. 9).

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. To the extent allowed by law, the ACR will actively assist state and local societies in opposing clinical pathways that are in conflict with current ACR Practice Guidelines and Technical Standards, policies, and ACR Appropriateness Criteria; 2002, amended 2012 (Res. 12-f).

k. **Radiologist Admitting Privileges**

Radiologists should have access to admitting privileges in hospitals where they practice; adopted 2002, 2012 (Res. 1-f).

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.

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 (Res. 22-a).

m. Conflicts of Interest

The ACR adopts as policy the following statement on conflicts of interest; 1991, amended 2001, 2011 (Res. 47-h).

CONFLICTS OF INTEREST

The American College of Radiology depends to a great extent on the knowledge, expertise, and efforts of members who volunteer their services, and it is desirable that as many members as possible participate in its activities. The confidence that members of the profession and the public have in radiology and radiologists, radiation oncologists and medical physicists depends on the integrity of those who represent the College.

Chancellors, officers, committee or commission members, staff, volunteers, and all others representing or acting on behalf of the American College of Radiology should avoid conflicts of interest or the appearance of conflicts of interest. All decisions and actions considered or made by such individuals should be based solely on the best interests of the College and in accordance with applicable federal, state, and local laws and regulations. Personal considerations should not be a factor in any action or decision made on behalf of the American College of Radiology.

WHAT IS A CONFLICT OF INTEREST?

A conflict of interest occurs whenever an individual or a member of his or her immediate family has a direct or indirect interest or relationship, financial or otherwise, that may conflict or be inconsistent with the individual’s duties, responsibilities, or exercise of independent judgment in any transaction or matter involving the College.

A conflict of interest does not necessarily imply that an individual is ineligible to serve on a College committee, commission, or task force or cannot represent the College in a specific situation, but it may indicate that participation in some matters should be avoided or limited. Questions relating to whether a conflict might arise should be referred to the chair of the Board of Chancellors or the College’s executive director.

REPORTING CONFLICTS OF INTEREST

If an individual has an actual or potential conflict of interest relating to business or transactions before the College, he or she should immediately notify the chair of his or her commission, committee, or task force or the chair of the Board of Chancellors and the executive director of the College. Members of the College’s staff should disclose potential or actual conflicts of interests to
the executive director. The executive director should disclose his own conflicts of interest to the chair of the Board of Chancellors. In making the disclosure, the individual should reveal all material facts about the conflict of interest and explain his or her relationship to the transaction or matter at issue. In some circumstances, full disclosure of the conflict may in itself be sufficient to ensure the integrity of College operations.

If a conflict of interest arises in connection with the activities of a deliberative body, such as a commission, committee, or the Board of Chancellors, the conflict should be disclosed to the other members of the body and the individual should not participate in the consideration of the matter at issue. Any withdrawal by a member of a commission, committee, or task force and the reasons for it should be recorded in the minutes of the meeting. Councilors and alternate councilors with a conflict of interest relating to a policy matter before the Council may participate in debate on that issue after disclosing the conflict to the Council but should refrain from voting.

When a conflict arises from an individual’s presentation or participation in a seminar, workshop, or other such event, or in connection with an individual’s contributions to a College publication, the facts giving rise to the conflict should be disclosed to other participants, attendees, or readers and the individual should clearly identify his or her statements or contributions as personal opinions.

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 (Res. 53-a).

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 D) to ACR members as a resource document; adopted 1986, 1996, 2006 (Res. 16-e).

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:

• 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.

q. Efficacy

1. Efficacy Studies

The ACR will continue to sponsor efficacy studies; adopted 1979, 1989, 1999, 2009 (Res. 30-h).
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 (Res. 1-d).

r. Family Leave Policy

The ACR supports the development of family leave policies in radiology facilities consistent with federal and state laws; 2001, amended 2011 (Res. 47-i).

s. 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 (Res. 36-q).

t. 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, and not the hospital, bills and receives a professional fee for services from patients or agencies responsible for paying physicians.

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 (Res. 36-r).

u. 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 (Res. 36-s).

v. 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.

w. **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 provide guidance to radiologists on the legal implications of such
contracts. The American College of Radiology will continue to gather data regarding radiologists’

x. **Medical Staff Privileges, Exclusive Contracts, and Economic Credentialing**

**QUALITY IN HOSPITAL CLINICAL PRIVILEGES**

The American College of Radiology reaffirms its current policies on medical staff privileges,
exclusive contracts, and economic credentialing (Appendix D); 1986, amended 1996 (Res. 20-a).

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 (Res. 16-f).

**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; 1992, amended 2002,
2012 (Res.1-i).

**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 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 as an appropriate and mutually beneficial method in ensuring high quality 24-hour care for hospital patients.

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, amended 2011 (Res. 47-j).

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.”
• 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 (Res. 52-g).

Ownership, Retention and Patient Access to Medical Records


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, or the American Board of Medical Physics (ABMP).

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

The subfields of medical physics are*:

• 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 radions 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.

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

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 (Res. 42).

aa. 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 (Res. 27-h).

bb. Diagnostic Radiologic Consultation (see also Referral Practice of Radiology)

THE CONSULTATIVE PRACTICE DIAGNOSTIC OF RADIOLOGY

Diagnostic radiology practice is a consultative physician service rendered by qualified specialists who have completed an accredited residency program in diagnostic radiology or one of its branches, which include the utilization of all modalities for the imaging portrayal of human morphology and physiologic processes, in medical diagnosis and treatment.

Elements of a Diagnostic Radiologic Consultation

The public interest of patients and their referring physicians are well served when the following elements of a diagnostic radiologic consultation are complete, in all practice settings:

- A pre-examination evaluation by the referring physician or other allied healthcare professional for whom this activity is within the scope of practice.
- A written request for diagnostic radiologic consultation that includes pertinent clinical findings and a working diagnosis. The diagnostic radiologist should “under pertinent clinical circumstances” recommend the sequencing of diagnostic radiologic procedures which will yield the maximum information of the patient’s condition.
- A safe patient environment in which the diagnostic radiologist supervises a qualified staff whose efforts are directed at producing a radiologic examination yielding the maximum diagnostic information consistent with the least possible exposure to radiation.
• A comprehensive consultative report rendered in writing and directly, if necessary, to referring physicians to effectively communicate and to record informed judgments on the radiologic findings. The reporting includes timely delivery, authentication, and careful filing and storage.

Applicability of These Elements

The modern practice of diagnostic radiology includes an evolutionary approach to new medical technology and imaging techniques. These are adopted into daily practice and are subject to the elements of a consultation described above. These elements, furthermore, have uniform applicability to practice in the hospital, in the office setting, in clinics, and in every other practice site; 1980, 1990, 2000, amended 2010 (Res. 39-g).

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 film records available in each community can be made accessible to this nationwide effort of gathering data on missing children; adopted 1985, 1997, 2007 (Res. 36-t).

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 (Res. 36-u).

ee. Referral Practice of Radiology

The ACR adopts as policy the following statement on the referral practice of radiology; 1991, 2001, amended 2011 (Res. 47-k).

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.

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 regularly practice telemedicine; adopted 1996, 2006 (Res. 52-h).
SECTION II

gg. Teleradiology

ACR POSITION STATEMENT ON REMOTE INTERPRETATION OF RADIOLOGIC IMAGES

The American College of Radiology, through its Board of Chancellors or appropriate College committee shall continue to monitor the issue of the remote interpretation of radiologic images, addressing the relevant legal, regulatory, ethical, quality-of-care, quality-of-service, and reimbursement issues, such that radiologists may be better able to guide themselves, referring physicians, managed care directors, and hospital administrators regarding these issues, including the consummation of contracts for radiological services; adopted 1996, 2006 (Res. 52-i).

hh. 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 K); 2004, updated 2006 (Res. 58).

ii. 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 N); 1993, 2003, amended 2014 (Res. 10-d)

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 (Res. 49).

J. TECHNOLOGISTS AND ALLIED HEALTH PROFESSIONS

1. 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 (Res. 23-a).
2. 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 (Res. 1-b).

3. BUSINESS MANAGEMENT ASSOCIATION

The ACR urges all radiologists and radiation oncologists to encourage their business managers 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 (Res. 1-j).

4. 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 certifying agency for evaluation and review prior to initiation; adopted 1980, 1990, 2012 (Res. 12-g).

5. 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 (Res. 12-m).

*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.

6. 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

The language below replaces the language currently in the ACR Technical Standard for Management of the Use of Radiation in Fluoroscopic Procedures under Section III, E – Other Ancillary Personnel.

“Other ancillary personnel who are qualified and duly licensed or certified under applicable state law may, under supervision by a radiologist or other qualified physician, perform fluoroscopic examinations or fluoroscopically guided imaging procedures. Supervision by a radiologist or other qualified physician must be direct or personal, and must comply with local, state and federal regulations.

All ancillary personnel using fluoroscopy should be credentialed for those fluoroscopic examinations or procedures and should have completed 40 hours of didactic education or its equivalent in digital image acquisition and display, contrast media, fluoroscopic unit operation and safety, image analysis, radiation biology, radiation production and characteristics, and radiation protection; and 40 hours of clinical experience supervised by a radiologist or medical physicist. Required CME for other ancillary personnel performing fluoroscopy should include education in radiation dosimetry, radiation protection, and equipment performance related to the use of fluoroscopy”; adopted 2011 (Res. 58).
7. OTHER ANCILLARY PERSONNEL PERFORMING FLUOROSCOPIC PROCEDURES

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

All ancillary personnel using fluoroscopy should be credentialed for those fluoroscopic examinations or procedures and should have completed 40 hours of didactic education or its equivalent in digital image acquisition and display, contrast media, fluoroscopic unit operation and safety, image analysis, radiation biology, radiation production and characteristics, and radiation protection; and 40 hours of clinical experience supervised by a radiologist or medical physicist. Required CME for other ancillary personnel performing fluoroscopy should include education in radiation dosimetry, radiation protection, and equipment performance related to the use of fluoroscopy; adopted 2010 (Res. 52).

8. WORKFORCE IN RADIOLOGIC TECHNOLOGY

The American College of Radiology supports and will continue to support the collaborative efforts of the participating organizations of the Summit on Radiological Sciences and Sonography in identifying current and long-term technology workforce needs and in developing and implementing strategies for addressing the identified needs; 1988, amended 1998, 2008 (Res. 1-c).

9. 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).

10. NUCLEAR MEDICINE ADVANCED ASSOCIATE (NMxAA)

The American College of Radiology accepts and endorses the statement “Nuclear Medicine Advanced Associate – Roles and Responsibilities”; adopted 2011 (Res. 13). Refer to Appendix M.

11. 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 H); adopted 2003, 2013 (Res. 41-e).

12. 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 under radiologist supervision be well-defined and documented; and the RA will not interpret imaging studies.

The ACR will create a process enabling the expeditious ongoing review of the roles and responsibilities of the Radiologist Assistant. This process will incorporate an expert panel, including a member of the ACR Commission on Quality and Safety, to review and make initial recommendations for any changes in the roles and responsibilities of the RA.

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

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 RA; adopted 2008 (Res. 39).

13. 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 masters degree as the minimum educational requirement for the Program Director of an accredited educational program in radiography/radiation therapy; 1988, 1998, amended 2008 (Res. 1-d).

14. RADIOLOGIC TECHNOLOGISTS AND RADIATION THERAPISTS

The Radiologic Technologist 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. 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 and radiation therapist as professional members of the health care team; 1980, 1990, 2000, amended 2010 (Res. 1-e).

15. 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).

16. 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 (Res. 1-k).

17. STATE LICENSURE OF MEDICAL RADIOLOGICAL PHYSICISTS

18. 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 (Res. 52-j).

19. 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 (Res. 12-n).

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 (Res. 36-v).

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 ACR Ethics Committee will present this Expert Witness Affirmation at the 2009 annual meeting for consideration and adoption; adopted 2008 (Res. 42).

The ACR adopts the attached voluntary Expert Witness Affirmation (Appendix L) for implementation by the Board of Chancellors by January 1, 2010.
L. THIRD PARTY CARRIERS AND COMPENSATION

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 (Res. 30-b).

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-IV 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 (Res. 39-h).

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 (Res. 39-i).

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 (Res. 1-d).

6. COGNITIVE SKILLS IN RADIOLOGY

The American College of Radiology will continue to emphasize that radiology is a cognitive as well as a procedural specialty; 1989, amended 1999, 2009 (Res. 30-e).

7. 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; adopted 1973, 1987, 1997, 2007 (Res. 1-e).
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 (Res. 30-f).

8. 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).

9. 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 (Res. 1-i).

10. 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 (Res. 30-g).

11. 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 (Res. 27-i).

12. 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).

13. 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).

14. INDEMNITY SYSTEM OF PHYSICIAN PAYMENT

Of the several methods of third party payment of physician services, including customary, prevailing and reasonable (CPR), indemnity, capitation (such as HMO’s) and diagnosis-related groups (DRG’s), the indemnity system for the development of an equitable physician payment schedule is the most desirable for the private sector; adopted 1990, 2000, 2010 (Res. 39-j).
15. INDEPENDENT PRACTICE

The basic tenets of the independent practice of radiology (diagnostic radiology, radiation oncology, 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 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 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; 1983, 1993, 2003, amended 2013 (Res. 41-f).

16. **MAMMOGRAPHY SCREENING: INSURANCE COVERAGE**

The ACR urges all insurance carriers to cover screening mammography studies at the time schedule recommended by the ACR/ACS and to reimburse for the procedure at a fair and equitable level; adopted 1990, 2000, 2010 (Res. 39-k).

17. **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 (Res. 30-j).

18. **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 (Res. 1-f).

19. **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 (Res. 1-g).

20. **MR AND CT REIMBURSEMENT**

The American College of Radiology opposes the categorical limitation of reimbursement by third-party payers and Medicare to one procedure in cases where CT and MR procedures are both medically necessary; adopted 1986, 1996, 2006 (Res. 1-a).
21. 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 (Res. 1-h).

22. PAYMENT FOR THE PRIVILEGE OF SERVING PATIENTS IN HOSPITALS (ANTI-KICKBACK LAW VIOLATIONS)

Payment arrangements knowingly demanded by certain hospitals in return for the right of physicians to provide patient services may violate the anti-kickback law. The College shall take action to effect the regulatory and legislative changes necessary to stop such hospital kickback demands; adopted 1990, 2000, 2010 (Res. 39-l).

23. 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).

24. 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.


25. 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 (Res. 12-o).

26. 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.

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 (Res. 33-d).
27. 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 Guidelines 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).

28. COMMITTEE ON IMAGING POLICY

The American College of Radiology, in lieu of the previously created Committee on Imaging Policy, charges the newly formed Government Relations Commission (GRC) with, among its other responsibilities, producing a plan of action to promote cost-effective, high-quality, and ethical medical imaging, including addressing the adverse effects of self-referral to patients and to the health care system, and methods for payors to eliminate or limit the practice. The GRC should meet no less frequently than quarterly. It should issue reports to the Council Steering Committee and the Board of Chancellors at their October meetings, to the Board of Chancellors at their January meeting, and present specific recommendations to the council at the Annual meeting in 2008; adopted 2007 (Res. 46).

29. 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).

30. 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 dispute; adopted 2000, 2010 (Res. 39-m).

31. 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 (Res. 36-w).
SECTION III
CHRONOLOGICAL LISTING OF APPROVED COUNCIL ACTIONS:
2006–2015
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
ACR Action on the CMS Professional Component (PC) Multiple Procedural Payment Reduction (MPPR)
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–SPR–SRU Practice Parameter for the Performance of Diagnostic and Screening Ultrasound of the Abdominal Aorta in Adults
ACR–AIUM–SPR–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–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
ACR Patient Advocacy Liaison Program
ACR Practice Parameter for the Performance of Therapy with Unsealed Radiopharmaceutical Sources
ACR–SAR Practice Parameter for the Performance of Adult Cystography and Urethrogram
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
ACR–STR Practice Parameter for the Performance of High-Resolution Computed Tomography (HRCT) of the Lungs in Adults
AMA Liaison Role for the Council Steering Committee
Bylaws Proposal
Coordination of National Board Examinations and Fellowship Interviewing
Deaths and Injuries Related to Firearms as a Major Public Health Concern
Diversity is Central to Our Mission
Election of Member-in-Training Representatives to the Intersociety Summer Conference
Eliminate the Resident Conference Registration Fee
Expedited Review of ACR Practice Parameters and Technical Standards
Extension of Review Cycle for Eight Practice Parameters
Honoring the Massachusetts Radiological Society on Their Golden Anniversary
Lead Chapter Contact for CSC Outreach
Review of Evidence Concerning the Patient Care Impact of ABR MOC/CC Participation, Costs of Participation, and Optimization of Member Participation
Supporting Diagnostic Imaging Interpretations by Physicians
Ten Year Extension of Policies

-2014-

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 Medical Physics Performance Monitoring of Image-Guided Radiation Therapy (IGRT)
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 Practice Parameter for Communication of Diagnostic Imaging Findings
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 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
Lung Cancer Screening Programs
Name of ACR Practice Guidelines
SNMMI Council Representation
Ten Year Extension of Policies
The National Medical Association (NMA) Official Observer Representation to the ACR Council
Tobacco Cessation

-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–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–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 Radiography of the Extremities
ACR–SPR–SSR Practice Guideline for the Performance of Quantitative Computed Tomography (QCT) Bone Densitometry
Distribution of Imaging Reports
Electronic Health Record Interoperability
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
Point of Care Ultrasound
Policy Progress Reporting Resolution
Proposed Bylaws Changes (Editorial)
Proposed Bylaws Changes (Format)
Proposed Bylaws Changes (Substantive)
Radiation Safety Language in Practice Guidelines
Ten Year Extension of Policies

-2012-

ACR Advocacy Networks
ACR Practice Guideline on Informed Consent – Radiation Oncology
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
Creation of a Young and Early Career Physicians Section
Definition of a Qualified Medical Physicist
Distribution of Imaging Reports
Honoring the Texas Radiological Society on their Centennial Meeting
Implementation of the Clinical Practice of Interventional Radiology (IR) and Interventional Neuroradiology (INR)
Late Resolution-Electronic Brachytherapy
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
ACR–ASNR–SPR Practice Guideline for the Performance of Functional Magnetic Resonance Imaging (MRI) of the Brain
ACR–NASC1–SPR Practice Guideline for the Performance of Quantification of Cardiovascular Computed Tomography (CT) and Magnetic Resonance Imaging (MRI)
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–AIUM–SPR–SRU Practice Guideline for the Performance of the Musculoskeletal Ultrasound Examination
ACR–AIUM–SPR–SRU Practice Guideline for the Use of Intravascular Contrast Media
Radiation Safety Office (RSO) Training
Sunset: ACR Practice Guideline for the Performance of Coronary Vascular Brachytherapy (CVBT)
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
Ten Year Extension of Policies
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 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
Interventional Radiology Pathway
Leadership in Radiology and Radiation Oncology Membership Discounting
Nuclear Medicine Advanced Associate
ACR–SIR Practice Guideline for Endovascular Management of Thrombosed or Dysfunctional Dialysis Access
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 Endovascular Management of Thrombosed or Dysfunctional Dialysis Access
ACR–NASCI–SPR Practice Guideline for Performing and Interpreting Diagnostic Ultrasound Examinations
ACR–NASCI–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)
ACR–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) 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
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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–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
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–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
ACR Practice Guideline for Communication of Diagnostic Imaging Findings
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)
Membership Dues Adjustment
Naming Convention for Collaborative Practice Guidelines and Technical Standards
Nuclear Medicine Advanced Associate (NMAA)
Other Ancillary Personnel Performing Fluoroscopic Procedures
Portable Image Media (CDs and DVDs)
ACR–SIR Practice Guideline for Sedation/Analgesia
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 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
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ACR Standard for the Diagnostic Medical Physics Performance Monitoring of Real Time B-Mode Ultrasound Equipment
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The Society of Gastrointestinal Radiologists Representation on the ACR Council
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ACR Annual Meeting Site 2003 – Denver, Colorado
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ACR Council Meeting Site 2001 – San Francisco, California
ACR Position Statement on Criteria for the Intravascular Use of Water Soluble Iodinated Contrast Media
ACR Standard for 3-D External Beam Radiation Planning and Conformal Therapy
ACR Standard for Diagnosis and Management for Invasive Breast Carcinoma
ACR Standard for Diagnosis and Management of Ductal Carcinoma In-Situ of the Breast (DCIS)
ACR Standard for Diagnostic Medical Physics Performance Monitoring of Radiographic and Fluoroscopic Equipment
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ACR Standard for Performance of Abdominal, Renal, or Retroperitoneal Ultrasound
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ACR Standard for Performance of the Peripheral Arterial Ultrasound Examination
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ACR Standard for Skeletal Surveys in Children
ACR Standard for the Performance of Computed Tomography of the Abdomen or Pelvis
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Radiation Emergencies: ACR Activity on Non-Military Radiation Emergencies
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Radiologic Identification of Unidentified and Missing Children
Radiology as Practice of Medicine
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Safe Equipment and User Training
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ACR Accreditation Program for Facilities Where Imaging-Guided Invasive Vascular and Interventional Procedures are Performed
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ACR Position Statement on Spinal/Paraspinal Ultrasound
ACR Position Statement on the Remote Interpretation of Radiologic Images
ACR Standard for Adult Cystography and Urethrography
ACR Standard for Continuing Medical Education
ACR Standard for Gastrointestinal Scintigraphy
ACR Standard for General (Plain) Radiography
ACR Standard for High-Dose-Rate Brachytherapy
ACR Standard for Liver/Spleen Scintigraphy
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ACR Standard for Magnetic Resonance Imaging (MRI)
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ACR Standard for the Performance of Ultrasound-Guided Percutaneous Breast Interventional Procedures
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ACR Standard for Tumor Scintigraphy (With Gamma Cameras)
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1991 ACR Standard for Communication
1991 ACR Standard for Continuing Medical Education (CME) Revised
1991 ACR Standard for Excretory Urography
1991 ACR Standard for Performance of the Pediatric Neurosonology Examination
1991 ACR Standard for Performance of Ultrasound Examination of the Female Pelvis
1993 Standard for Diagnostic Arteriography in Adults (for revision)
Accreditation of Stereotactic Breast Biopsy Units

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ACR Annual Meeting Site: 2001 Indianapolis, IN  
ACR Annual Meeting Site: 2002 Charlotte, NC  
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   Radionuclide Sources  
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ACR-NEMA Digital Imaging and Communications Standard(s)
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ACR Information and Speakers on Benefit-Risk of Medical Radiation
ACR Offices in Washington, D.C. Area
Annual Meeting Site - 1986
Bylaws Revision Council Structure
Cardiovascular Nuclear Radiology
Categorical Course at ACR Annual Meeting
Centralized Membership
Chapter Dues
Chest X-Ray Referral Criteria
Committee for Radiation Oncology Studies
Councilor Representation D.C. Chapter
Digital Imaging Information Network Study
Federated Council of Nuclear Medicine Organizations
Intersociety Commission
Mammography, Guidelines for
Mobile Diagnostic Ultrasound
Model QA Programs
Model State Legislation
Nuclear Magnetic Resonance Supervision and Interpretation by Diagnostic Radiologists
Radiologists’ Business Managers Association
Repeal of the 1976 Consent Order

-1981-

Accreditation Funding
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American Society of Radiologic Technologists Membership
Applications
Chiropractors, Use of Radiation
Commission on Administrative Affairs
Commission on Nuclear Medicine
Continued Involvement by the Medical Community
Encourage Individual Research
Equipment Purchasing Program
Essentials of an Accredited Educational Program in Radiation Therapy Technology
Expression of Gratitude
Federated Council of Nuclear Medicine Organizations Bylaws
HSA, PSRO and Federally Funded HMO’s
Medicare Reimbursement Inequity
Nuclear Cardiology Guidelines
Repeal “Misadministration”
Residency Training in Ultrasound
Solicitation/Recruitment by College Members
Subspecialty Certification
Informational:
  - Centralized Membership Intro.
  - First Annual ACR Annual Report
  - Images of Life Motion Picture
Membership Survey Report by Professional Management Research, Inc.
Reports of Special Work Groups on:
  - College Organization and Governance
Extra-Radiological Societal and Government Relations
  - Educational Delivery Systems
  - Staff and Executive Director
Workforce Studies

-1980-

Appropriateness Review
Bylaws Changes
Certification of Need Opposition
Commissions and Committees Membership
Computed Tomography Statement
CT – Head and Body
Definition of Diagnostic Radiology Practice
Deletions and Additions to Digest
Directors of Residency Programs
Efficacy
Elements of Radiologic Consultation
Elimination of Section A, Item #23 in Digest
Final Diagnosis Exemption
Future Annual Meetings (1983-84)
Government Agencies Restriction Re: Postgraduate Training
Health Care Financing
International Congress – 1985
National Health Insurance
National Plan of Radiology
Non-Members Serving on Commissions

Notification of Product Changes
Opposition of National Health Insurance
Peer Review and PSRO
Physician Assistants
Quality Assurance Program with AHA
Quality Standards by Medical Boards
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
SUMMARY OF PAST COUNCIL
ANNUAL MEETINGS
AND COUNCIL SPEAKERS
(1972–Present)
## PAST COUNCIL ANNUAL MEETINGS
AND COUNCIL SPEAKERS

<table>
<thead>
<tr>
<th>Year</th>
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<td>San Francisco, CA at the St. Francis</td>
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<td>1975</td>
<td>Portland, OR at the Hilton</td>
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<tr>
<td>1977</td>
<td>Houston, TX at the Shamrock</td>
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<td>1979 (Fall)</td>
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<td>1983</td>
<td>Denver, CO at the Marriott</td>
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<td>1985</td>
<td>Montreal, Canada at the Queen Elizabeth</td>
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<td>1987</td>
<td>San Diego, CA at the InterContinental Hotel</td>
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<td>1989</td>
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<td>2007</td>
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<tr>
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SECTION VI
APPENDICES
APPENDIX A

Strategic plan
(As of January 2011)

MISSION

To serve patients, society and the membership by optimizing the delivery of diagnostic and therapeutic radiological care.

VISION

To be the recognized leader for safe and effective radiological patient care through advocacy, economics, education, quality and safety, and research.

PLAN PRIORITIES

• Advocacy: Positively influence the socio-economics and health care policy of the practice of radiology
• Economics: Be the leader in facilitating radiological practice transformation
• Education: Provide primary and continuing education for radiology
• Quality and Safety: Improve the quality and safety of patient care
• Research: Advance the science of radiology through research in diagnostic and therapeutic patient care

ACTION PLANS

Advocacy and Health Policy

Government Relations

Be the leader in influencing legislation and regulations

Economics and Health Policy

• Help radiology, radiation oncology, interventional radiology, nuclear medicine and medical physics adapt to a competitive and changing health care environment
• Be the most effective and influential medical specialty advocacy organization
• Through the American College of Radiology Association, sponsor the most influential health care political action committee
• Assist chapters with state legislative and regulatory issues
• Influence payers and key federal agencies to make fair and evidence based policy decisions
• Identify and address the changing economic and health policy challenges
• Provide information to members on health policy and practice management issues
• Use health policy research efforts to assess the value of diagnostic and interventional imaging and its contributions to the enhancement of patient care.
Quality & Safety

Be the leader in quality and safety in the practice of radiology, radiation oncology, interventional radiology, nuclear medicine and medical physics

- Market and promote ACR quality and safety measures to public and private payers as the preeminent products in their markets
- Make the accreditation process more efficient by utilizing innovative ACR technology
- Implement the Diagnostic Imaging Centers of Excellence program
- Develop and maintain clinically effective Practice Guidelines and Technical Standards
- Improve the effective delivery of medical care through the appropriate use of imaging
- Develop and implement data registries
- Expand opportunities for members to fulfill ABR mandated Practice Quality Improvement (PQI) requirements
- Develop strong working relationships with leading national and international quality and safety organizations
- Through participation in multi-stakeholder, scientifically valid processes such as the National Quality Forum and the AMA Physician Consortium for Performance Improvement promote the use of a consistent set of ACR-endorsed quality measures across payment plans and credentialing organizations

Education

Be a leader in ongoing radiology training, life-long-learning activities and maintenance of certification

- Promote the ACR Education Center as the preeminent state of the art, hands on training facility providing engaging, interactive, high quality programs
- Develop and promote the American Institute for Radiologic Pathology (AIRP) as a key component of radiology education
- Be a leader in web-based education
- Develop educational products that address the needs of ACR members including maintenance of certification and certificates of proficiency
- Produce educational services to support accreditation programs
- Develop radiology leadership, innovation, and management education programs

Publications

Be a leader in the field of association and scholarly publishing to meet the needs of ACR members

- Maintain the JACR as an integral resource in the practice of radiology and a leader in scholarly publishing
- Be a leading source of radiological news and information for ACR members
Membership

Assure a productive and growing membership base committed to the needs of the ACR

- Develop and implement an effective plan to recruit and retain members
- Explore potential expansion into new categories of membership and new markets
- Enhance and maintain the Practice of Radiology Environment Database.
- Provide ongoing surveys of the membership
- Encourage active participation of residents, fellows, associate members and young physician and physicist members in chapter and ACR activities
- Strengthen chapters and enhance the relationship of each to the ACR
- Develop, promote, strengthen and recognize the importance of volunteers to the ACR and its chapters.

Information Technology

Be a leader in technology development assessment, and application.

- Achieve recognition of the ACR as a premier healthcare information technology organization
- Continue to develop world class solutions to support activities of the College
- Identify commercial opportunities for imaging technology
- Leverage technology expertise for business opportunities
- Provide leading solutions to promote knowledge sharing, foster collaboration, and create an increasingly integrated ACR membership community

Marketing and Communications

Be a leader in effective communication with members, decision makers and the general public

- Maintain a coordinated approach to brand and market the ACR
- Maintain the ACR as a key resource for national and local media on radiological issues
- Continuously improve interactive communication with the membership
- Position the ACR as the leader in electronic interactions in radiology
- Promote the humanitarian benefit of radiology.

Clinical Research

Be the leader in clinical research as the basis for tomorrow’s practice

- Expand clinical research activities
- Promote membership awareness, recognition and participation in the ACR Clinical Research Center activities
- Leverage clinical research capabilities to increase the scope of ACR activities in both the grant and commercial sectors
• Develop industry partnerships to further expand the translational scope of clinical research

• Incorporate efforts of the Commission on Clinical Research and Information Technology to address clinical research needs

• Seek opportunities to perform comparative effectiveness research to demonstrate impact of imaging and treatment research on patient care and outcomes

**Finance**

*Keep the ACR financially sound*

• Ensure fiscal responsibility by prioritizing all expenditures in accordance with this plan and within the ACR’s resources

• Diversify revenue sources and effectuate cost savings and cost containment

• Ensure that an adequate system of internal control exists and operates as designed

• Ensure transparency and accountability in all ACR financial transactions

**Talent Management**

*Attract, retain and develop resources necessary to achieve ACR’s goals*

• Acquire and/or develop the human resources necessary to fulfill the ACR’s goals

• Provide employees with the highest level of support and guidance

• Ensure compliance with all regulations and human resources best practices

• Develop and maintain a staff succession plan.

**Other business activities**

*Ensure additional funding and support for ACR members and programs*

• Consider investments that leverage the College’s core competencies as alternative revenue sources

• Work with the ACR Foundation on recommended fundraising opportunities

• Explore opportunities to collaborate with other professional organizations

• Seek international partners to further the ACR mission
APPENDIX B

HYPERTERMIA GUIDELINES


BACKGROUND

For more than ten years, hypertermia 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 hypertermia 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 hypertermic 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 hypertermia 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 hypertermia.

These steps were taken in anticipation of progressively increasing numbers of patients being treated by practitioners with local, regional or systemic hypertermia 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 hypertermia as follows:

“Whereas, no guidelines exist for technicians who administer hypertermia 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 hypertermia 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 hypertermia.”

The Quality Assessment Committee, chaired by Dr. Gerald Hanks, who charged by the College to develop a document concerning physician qualifications to conduct hypertermia. 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 Hypertermia Society, Hypertermia 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 C

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 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 D

Delineation of Privileges in Diagnostic Radiology and Nuclear Medicine

INTRODUCTION


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 radiology residency program which may be further substantiated by certification by the American Board of Radiology or the American Board of Nuclear Medicine. 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 also have in common the use of multi-dimensional display of three-dimensional body structures and organs, presenting the potential for artifacts that may be mistaken for pathology, requiring great expertise to recognize. Radiologists are aware of the potential for 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 and may be preceded by one or more years of postgraduate training in another clinical specialty. Those radiologists certified in radiology have supplemented the previously shorter residence period 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 and 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 spreading and its appearance in other imaging techniques. An understanding of the requirements of an imaging technology necessitates learning the fundamental physical principles of the technique, how varying the parameters of this technique affect the image, how to vary the parameters to maximize information content, how the appearance of the image relates to the disease process, the potential complications and how they are avoided or prevented, the indications and contraindications for the procedure and the role of this particular technique in the diagnostic armamentarium. 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 skill required for the new modalities as they develop. As such technologies and procedures are introduced they are routinely absorbed into residency programs. Radiologists who previously completed training programs master new imaging more quickly than other medical specialists because of 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 lead 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 application of the specialty may be required before clinical privileges are approved, depending upon the variance of the technology from their 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 radiotracers. 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 indicators. Competency in the practice of nuclear radiology is acquired in the standard diagnostic radiology training program but for radiologists specializing in the field of nuclear radiology, completion of an approved training program in nuclear radiology or nuclear medicine and 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, depending 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 depending on the training and experience of the nuclear radiologist.

Model Application for Privileges

On the basis of training, experience and expertise, I hereby request the specific privileges in the Department of Radiology as identified below. These privileges are to include the performance of any interventional techniques that are a natural extension of the designated procedure.
### DIAGNOSTIC RADIOLOGY
- Routine radiography (including intravenous injection of contrast media)
- Fluoroscopy
- Mammography
- Myelography (including discography)
- Arthrography
- Lymphangiography
- Arteriography
- Venography
- Angioplasty
- Percutaneous aspirations, biopsies and drainage procedures
- Other: ________________________________________

(please specify)

### SPECIAL IMAGING
- Ultrasonography
- Computed Tomography
- Magnetic Resonance

### NUCLEAR MEDICINE
- In vivo diagnostic procedure
- In vitro diagnostic procedure
- In vivo therapeutic procedure
- Other: ________________________________________

(please specify)

### BOARD CERTIFICATION:

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### SIGNATURES
- SIGNATURE OF APPLICANT
- SIGNATURE OF DEPARTMENT CHAIRMAN
- SIGNATURE OF HOSPITAL CREDENTIALS COMMITTEE CHAIRMAN
APPENDIX E

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 F

ACR Remains Committed to Mammography and Supports Study of Screening Modality Options


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 G

ACR Practice Guidelines and Technical Standards Purpose and Intended Use

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 Guidelines and Technical Standards; 2003 (Res. 30).

ACR Practice Guidelines 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 Guidelines 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 Guidelines 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 Guidelines 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 Guidelines 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 GUIDELINES 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 H

ACR ASRT Joint Statement on Radiologist Assistant
Roles and Responsibilities

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

A radiologist assistant is an advanced-level radiologic technologist who works under the supervision of a radiologist to enhance patient care by assisting the radiologist in the diagnostic imaging environment. The radiologist assistant is an ARRT-certified radiographer who has successfully completed an advanced academic program** encompassing a nationally recognized radiologist assistant curriculum and a radiologist-directed clinical preceptorship. Under radiologist supervision, the radiologist assistant performs patient assessment, patient management and selected exams (as outlined below).

- Obtaining consent for and injecting agents that facilitate and/or enable diagnostic imaging
- 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 with the radiologist providing direct\textsuperscript{1} supervision of the service
- Monitoring and tailoring selected exams under direct\textsuperscript{2} supervision (e.g. IVU, CT urogram, GI studies, VCUG, and retrograde urethrogram)
- Communicating the reports of radiologist’s findings to the referring physician or an appropriate representative with appropriate documentation
- Providing naso-enteric and oro-enteric feeding tube placement in uncomplicated patients
- Performing selected peripheral venous diagnostic procedures

The radiologist assistant will not perform interpretations (preliminary, final or otherwise) of any radiological examination, nor will he or she transmit observations other than to the supervising radiologist. The radiologist assistant may make initial observations of diagnostic images and forward them to the supervising radiologist.

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

The radiologist assistant should actively participate in a facility quality assurance program.

Any formal national or state certification 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.

\textsuperscript{1, 2}The Centers for Medicare and Medicaid Services (CMS) direct supervision requirement states that the “physician is required on site and immediately available.”

** Note: “advanced academic program” means a baccalaureate or post-baccalaureate program.
APPENDIX I

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.
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 K

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 L

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 M

Nuclear Medicine Advanced Associate (NMAA) Roles and Responsibilities

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 SNMTS leadership will work with the SNM Leadership, the ACR and other appropriate stakeholders to assess new procedures that the NMAA may perform.
Appendix N
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 protocoting 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 intra-departmental 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].

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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A profession demands unconditional acceptance of the inalienable responsibilities to those it serves. Such obligations to patients, colleagues, and society infuse the specialty of radiology with meaning that elevates it to a profession and distinguishes radiologists’ efforts from a simple occupation. The recognition and fulfillment of these duties are also how the ACR differentiates itself from an ordinary trade association. Professional insight provides a platform for analysis of and response to the issues confronting our specialty from the perspective of our founding principles and ethics. Judged by its history and recent leadership, the ACR has served and continues to serve this critical function by providing commitment, direction, and voice for our profession’s core values.

**Key Words:** ACR, history, profession, quality, value, pay for performance, self-referral, inappropriate utilization, ethics


Every great institution should revere its genesis. The discipline of radiology and the ACR are no exceptions. Unique among the branches of medicine, the specialty of radiology can trace its origin with remarkable precision to a single scientific discovery made on a specific day in history. On November 8, 1895, an obscure university physicist working in his laboratory observed what he called a “new kind of light.” And on that afternoon, he could not have fathomed how brightly this light would shine. The evolution of the x-ray from a basic science discovery to the profession of radiology has been extraordinary, in large part because of the dedication of a cadre of physicians who have believed in its potential. However, in the very tumultuous times following Wilhelm Conrad Roentgen’s discovery, the discipline of radiology was quite tenuous. During this period, a wide spectrum of souls wrestled for primacy of the x-ray in a marketplace of unrestrained entrepreneurism. It was the task of early organized radiology to establish qualifications and standards for those seeking to pursue the x-ray as a medical discipline. To its credit, the fledgling American Roentgen Ray Society in the invitation for its first meeting insisted that “no quacks or fakes, of whatever sort need apply” [1]. Not an entirely reassuring exclusion, but it was a beginning.

**LESSONS FROM TRADITION**

In 1910, Russell Carman, MD, of St. Louis, in a paper titled “Medical Roentgenology as a Specialty,” posited this simple concept: “The right of a specialty to existence has only this test,” he said, “that it employ the specialist’s entire time and attention, with increased benefit to himself, to the profession, and to the public. Judged by this test, roentgenology is, and of right, ought to be a legitimate specialty” [2]. As more physicians accepted this full-time commitment, others were realizing that they could not master radiology as a part-time vocation. One surgeon, Reginald Sayre, MD, of New York, explained why many physicians who had previously used x-rays themselves had now abandoned this practice and were sending their patients to x-ray specialists such as Dr Carman. Dr Sayre confessed, “I found, before the lapse of many years, that if I was to do as good x-ray work as was being done by others, I could not practice surgery...the demands of my surgical practice were too exacting to permit me to do justice to the x-ray work” [2]. Drs Carman and Sayre were but the first of many to recognize the need for dedicated physician imagers. It was in this nursery that the medical specialty of radiology was born, delivered by practitioners who were no longer just part-time, piecemeal dabblers but were completely devoted to
the endeavors of imaging, performed safely and appropriately. However, the journey from an occupation to a full-fledged profession required something more palpable.

Every successful endeavor requires a coalition of like minds to carry it to its next stratum. In June 1923, 21 radiologists duly formed a fellowship embracing the lofty ambitions to develop, exemplify, and enforce the highest traditions of the calling of roentgenology. They pronounced it the American College of Radiology. This defining moment changed the destiny of American radiology forever. At the first ACR convocation, in June 1924, a newly adopted oath was administered to the candidates for membership. Each new member pledged to live in strict compliance with these principles: to avoid “dishonest money seeking and commercialism”; to “refuse all money trades with consultants, practitioners or others”; and to place the welfare of patients “above all else.” But giving simple lip service to this oath was not enough. The newly sworn were also required to sign their oaths, and sign them they did. It was actually expected that their actions throughout their careers as radiologists would reflect the principles in the vows they had just taken. This was no Kabuki theater. As is typical of founding fathers, they were dead serious. Their intent was to establish a profession, and they understood that a stable, successful profession demands a strong, active, and principled professional organization. This solid foundation provided by the inception of the ACR has been reinforced stone by stone, year by year, by a continuum of councils and leadership consistently upholding radiology’s traditional values, up unto this very meeting. And, now that it is our turn, we may rightly ask, for what purpose? What exactly is this thing that has been entrusted to us—this concept, this duty to those with whom we serve, our colleagues and\n
REDISCOVERING PROFESSION

Quite a few years ago, as a much younger radiologist, I was traveling to our annual ACR meeting. During my journey, I engaged in conversation a distinguished elderly gentleman who asked me the reason for my travel. I replied that I was attending a meeting of a professional organization. “Tell me,” he continued, “what is it that your organization professes?” I replied, “Radiology.” Unsatisfied, and being more than a bit cantankerous, he persisted. “No,” he said, “radiology is what you do! What do you profess?” Well, it was a good question, and I wasn’t ready for it. After all, the word profession is derived from a Latin word meaning “to openly avow.” Indeed, what do radiologists profess? Have you ever contemplated what distinguishes a profession from a mere occupation? What do we believe makes what you and I do different from a trade, a craft, a business, or, for that matter, a racket?

One definition holds that a profession consists of men and women of a common vocation who possess a shared mastery of specialized knowledge. But is that all there is to a profession? A job that takes a lot of study and a long, intensive apprenticeship? Not an entirely satisfactory answer. However, if we scour tradition, including our own, we are obligated to add to expertise, a subscription to common principles of practice, values, and ethics. And if we are feeling a bit medieval, we can include an oath of fiduciary duty, sworn to those served by the profession. Finally, there is one additional aspiration that demands inclusion. It is a responsibility to the broader constituency of the public, a duty so frequently abridged in the past that George Bernard Shaw was moved to slur professions as conspiracies against the common man (words his crusty alter ego Professor Henry Higgins might have spoken). However, in today’s world, a duty to society is essential if we are to be pertinent beyond this silo we call “radiology”—and, more specifically, if we are to be relevant to our overall system of health care.

The bottom line seems to be that a profession demands many things that a simple job does not. And from what I have been able to learn, this so-called job with conscience exacts from us 3 cardinal responsibilities:

- 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.

Together, these duties infuse our specialty with the meaning that elevates it to a profession. And recognition and fulfillment of these obligations is how we, the ACR, distinguish ourselves from an ordinary trade association, or any other group of purveyors of goods and services. These defining responsibilities do indeed require commitment. However, in our time, with the increasing scrutiny and demands on professions by government, the public, and the marketplace, are we up to these tasks? In our council and leadership deliberations, we commonly address the issues confronting us from the point of view of our medical specialty, our occupation. But profession demands that we also view these same issues from the perspective of our sworn responsibilities. This distinction is not merely semantic or academic. In my experience, such a view often reveals very different imperatives to guide the endeavors of the ACR.
SERVING OUR PROFESSION

The duty to those with whom we serve encompasses our many responsibilities to our profession, chief among them for the profession of radiology to prosper. By any mundane definition, a profession is in part an occupation that entails the expectation of fair compensation for services rendered. It is understood that there would be no professions if those devoted to them could not sustain themselves or their families. Thus, it is, and always has been, an important part of ACR activities to champion equitable reimbursement for our clinical efforts. However, the ACR is where profession and livelihood intersect. To narrowly characterize the ACR as simply an economic organization shortchanges both the ACR and our profession.

For the profession of radiology to truly flourish, a primary goal must be to define, quantify, and expound the value both of radiologists to imaging and of imaging to health care. We are fond of touting our perception that radiologists add value. And there is much circumstantial evidence that we do. But let’s not confuse value with superficial operational behavior such as timely reports, availability, collegiality, and service with personality. Surely, our value is much more fundamental. In many settings, radiologists have rapidly become medicine’s primary diagnosticians. Nowhere is this more apparent than in the emergency rooms of our nation. Still, too often, our profession is doggedly defined by the technology we use rather than by those who use it. I am sometimes asked by referring physicians, “What does the x-ray, CT, or PET scan show?” Or “What does it tell us?” Well, these procedures don’t do show and tell. We do! Medical images in themselves have no value until they are interpreted by qualified and experienced imagers. The intrinsic value in imaging is infused by radiologists, who derive diagnostic information from images, synthesize it with patients’ clinical findings, and then communicate the results to the patients’ physicians, who use them to manage the patients’ health. Ladies and gentlemen, in a very real way, we don’t just add value; we are an essential value in imaging. And we should not be shy in this acknowledgment, especially now. Amid all our technologic sophistication, the obfuscation of the considerable human effort and expertise in our specialty is a real danger. With electronic communication of images and reports increasing our detachment, it is more important than ever for our efforts to be clearly recognized. Our referring physicians, our patients and the public must be consistently aware that there is still a radiologist, a real person with hard-learned, expert skills behind the lead curtains in Oz; a radiologist who transforms inert technology into valuable, patient-specific, health care information that can measurably contribute to patient care. However, although it is obvious to us that radiologists are inextricable and indispensable at every step of the imaging process, it is no longer good enough to simply contend that we bring value to imaging. We must prove it. And just as important, we must substantiate that the imaging we provide brings value to health care. The word value itself begs 2 questions: “What is value?” and “How much is that value worth?” To be relevant beyond our own specialty, we must answer these questions. First, we must define the elusive concept of value as it applies to us. And second, we must demonstrate and measure this value in the currency of patient care.

In the world of the public and of the marketplace, the implication of imaging for patient outcomes is fast becoming the ultimate measure of our worth. In this paradigm, radiologists can invest as much as we choose into the process of high-quality imaging, but this will not change the fundamental value of a procedure if there is no measurable clinical benefit to patients. Quality and value are related, but they are not synonymous. In this model, we are called upon to select and perform the procedure that has been documented to produce the best diagnostic or therapeutic result for a particular clinical setting. But we cannot do what we do not know. Critical to this endeavor is unbiased research defining and quantifying our impact on patient care, research with genuine economic consequences. And some of the answers may well reside within our own practices. By participating in ACR-mediated research and by enlisting radiologists in the National Radiology Data Registry, we can mine a rich resource, converting it to benchmarks for imaging practice, to measures of impact on patient care, and to platforms for fair reimbursement. Our support of and participation in these research efforts are essential investments in our profession. We must not allow others to take this helm. The responsibility is ours, and it must be recognized and addressed now, or there will be very real consequences. We will not prevail in any meaningful discussion of the value of radiologists to imaging, or of imaging to health care, unless we have the proof. These tasks will not be simple ones for radiology, a specialty that typically plays a small but pivotal role in each episode of care, but we will learn as we proceed. We must become masters of the metrics of our profession.

In 1890, Professor Arthur Goodspeed of Philadelphia placed aside a curious image to gather dust. He had inadvertently produced the image while experimenting with a Crooke’s tube almost 6 years before Roentgen’s discovery of x-rays [3]. In doing so, he joined the ranks of those who might have discovered x-rays, had he only been prepared to recognize the significance of this image. The future of radiology depends on a culture that values research and development in defining and expanding our landscape. We must not, like Goodspeed, observe these
indispensable efforts yet fail to appreciate their very direct significance for our profession. As imaging moves inexorably from the anatomic to encompass the biometric, we must do whatever it takes to ensure the vitality of fundamental and clinical research in our specialty, so that our profession will continue to endure and to prosper.

RESPONSIBILITY TO THE PUBLIC

Although duty to our profession is easily grasped, a societal duty is more difficult. However, nowhere have our efforts to the public good been more persistent than in our concern for quality imaging. From our beginnings, the ACR has consistently valued its independence and primacy as the profession best suited to determine the qualifications and standards of imaging physicians. As pioneers of imaging, we hold a genuine responsibility to provide broad guidance at a time when other physician groups seek to narrowly define parameters for focused imaging within their clinical practices.

Just as high-tech devices, once the exclusive tools of astronauts and cold war spies, have found their way into our daily lives, sophisticated imaging devices have rapidly become commonplace. As these advanced radiology procedures have become indispensable to patient care, they have been thrust to the forefront of medicine in every setting. But this success comes with mixed blessings for the public. As complex imaging technology has become more automated and the images produced more refined, there has emerged the curious perception that it can be popped into any office, by almost anyone, to churn out diagnostic information as an unregulated commodity. This is often accomplished with little expertise or supervision on the part of physician owner-operators and with scant oversight by regulatory or accrediting bodies. And ubiquity has given the false impression to patients that how, where, and by whom these procedures are performed and interpreted is immaterial. Recently, one subspecialty journal editorial addressing computed tomography opined, “Imaging is now considered fundamental to daily treatment by many cardiovascular specialists, on par with blood pressure cuffs and stethoscopes, albeit much higher tech” [4]. Computed tomography, some blood pressure cuff. Magnetic resonance imaging, some stethoscope. Although acknowledging the increasing clinical value of these “high-tech” modalities, declarations such as this reveal an incredible naiveté regarding their true underlying complexity, as well as nonchalance for the underlying economics. Although it would be unrealistic for us to believe that the number of nonradiologist imagers will cease to grow, it is entirely reasonable for us to advocate that they should be held to well-founded training and performance standards. But it appears that lessons learned in the last century must now be learned anew at the beginning of this one. Once again, it is the task of the ACR to communicate effectively to patients, primary care physicians, payers, regulators, and Congress that imaging with computed tomography, magnetic resonance imaging, and PET/CT is still a complex, quality-driven, full-time technologic enterprise best performed by expert physicians devoted to imaging.

Even as other physician groups have become dismissive of quality standards, it has also been the mission of the ACR to translate these standards into tools and processes that promote quality as a hallmark of our profession. At the same time, I do realize that our own members often perceive these initiatives with mixed emotions. In my conversations with some of them this year, quality efforts have been variously viewed as a defense against growing incursions by those simply dabbling in imaging, as a necessary inconvenience, and, to a few, as simply an unnecessary validation of a level of service that radiologists already provide. If we are expecting quality initiatives to be a magic shield or a panacea for forays into imaging by others, we will likely be disappointed. However, in a very practical manner, interest in quality has recently been given a considerable boost by those with direct financial interests in our health care system. This is embodied in the mellifluous alliterative phrase “pay for performance.” It is no speculation that growing payer, governmental, and regulatory initiatives are demanding quality in physician services [5]. What final form these programs will ultimately assume for radiologists is still uncertain; however, how they are now perceived is clear. Payers seek optimum care for their beneficiaries, and providers hope that quality care will at last be valued. Both are laudable results.

But let’s also be realistic. The subtext of these efforts is principally economic. Everyone is hoping that there is an underlying secondary financial benefit for all involved: increased reimbursement for quality providers, cost savings for payers. To be certain, this perceived marriage of principle and pragmatism, quality and economics, is philosophically satisfying. However, we are working within a sometimes fickle and capricious system. Thus, it remains to be seen whether the promises of this approach will be fully realized, especially given the recent failures of lawmakers and regulators to consistently embrace the concept of quality in imaging when given the opportunity. But to find out, we will have to participate in the paradigm. And in a larger sense, from the perspective of professional duty, we have no choice; we must embrace quality. Yes, it requires extra time and effort in our already full days at work. But like it or not, for radiologists, the pursuit and measurement of quality are professionally inherited traits. Quality is an ethical imperative. It is who we are. Quality is as important today as it was in the
entrepreneurial free-for-all after Roentgen’s discovery, when all manner of men sought to provide services with minimal training and inadequate performance standards. Organized radiology served our profession well in those early years, and the ACR must continue to be the leader, not a follower, in defining and demanding quality and safety today, even if others shy away. We cannot leave a quality vacuum for others to fill for us. It is simply the right thing to do.

OUR DUTY TO PATIENTS

I have saved perhaps the most important duty of profession for last. From its first breath, the ACR has considered responsibility to the patients we serve as an inviolable priority. It is the measure by which we have judged ourselves and all others who seek to minister to the sick through the specialty of imaging. Although of late, we have focused on the persistent issue of self-referral primarily in terms of imaging utilization and economics, we should not forget that there is still a profound professional perspective that is central to our concerns [6]. Traditionally, all physicians have served as fiduciaries for their patients, obtaining for them the best and most appropriate services offered by the health care system. However, this tradition is undermined as physicians seek to replace eroding income by acquiring imaging devices that they have been led to believe are effortless, income-producing adjuncts to their busy practices. These urges are made virtually irresistible by promised prospects of financial rewards limited only by a physician’s capacity to self-refer. This economically motivated self-referral places the physician in a critical conflict of interest with the welfare of patients. And, in any setting, conflict of interest is the common predicament underlying breach of fiduciary duty. When the ethic of patient care is confronted by the prospect of financial gain, very few can resist the temptation of additional income. It is human nature. It should be clear, however, that no matter how seductive the attempts to paint the practice of self-referral in a benign light, regardless of the name we call it, a conflict is a conflict is a conflict. Not sympathy to motivation, not convenient lapses in codes of ethics, nor complicit collegial silence can alter the fundamental absoluteness of duty to patients.

I suspect there are more who agree with us than admit to it. In an article in the Journal of the American Medical Association this past January, a multi-institutional panel of prestigious researchers lamented that physicians’ commitment to putting the interests of patients first “now regularly comes up against financial conflicts of interest” [7]. They further concluded that the current influence of market incentives in the United States is posing extraordinary challenges to the principles of profession. And to be certain, these challenges are not just confronting individual physicians making all too human but ill-advised choices. Professional organizations are also struggling with this issue, even to the verge of ethical capitulation. How can physicians be expected to do the right thing when even their professional organizations are having difficulty reading their moral compasses?

Because the US Congress believed that professional organizations could no longer effectively enforce their ethical codes to protect patients from self-referral, it was motivated to pass the Ethics in Patient Referral Act, commonly known as the Stark law. Although only partially effective in curing one problem, this law has had serious unintended ethical consequences. It has encouraged physicians to confuse legality with ethics. Thus, the large loopholes in the law, which still permit self-referral under specific circumstances, have been seen by many physicians as a green light to flout their moral obligations under the physician-patient relationship. However, when this practice has been challenged by organized radiology, the principal defenses from those blatantly exploiting the sick and vulnerable have ironically been retorts of “self-interest.” But this misleading rebuke is no need for us to cower, or to cut and run. From the perspective of professional duty, the issue of self-referral is not about turf. It is first and foremost about duty to patients. In truth, there is enough ever expanding turf to accommodate well-trained, appropriately qualified physicians who honestly seek to embrace quality imaging as a full-time profession outside the arena of economically motivated self-referral. As our specialty hurls toward new horizons of perfection in anatomic imaging and biomolecular revelation, bringing with it enhanced diagnostic and therapeutic capability, there will inevitably be more imaging, not less. But to afford it, this imaging must be stringently appropriate. Our already financially challenged health care system cannot and will not afford the wasteful and expensive practice of economically motivated self-referral. As our specialty mortgages the future of all imaging. And we dare not risk foreclosure on the brilliant future of our profession.

To keep that future bright, for our patients’ sake, we must advocate against self-referral as effectively and as appropriately as we can. I am aware that some may have differing stances on how to approach self-referral. Which approach is best has yet to be determined. Recent but admittedly modest successes with state laws, with payers, and with regulators suggest that a variety of approaches are needed. We know that Congress understands the financial consequences of the unfettered growth in imaging stoked by self-referral. However, instead of embracing quality and competency standards, their recent solution has been to punish the sins of some with indiscriminate cuts in reimbursement to all imagers. Although
we should continue to articulate the need for quality standards and the concept of dedicated physician imagers, we must do a better job of differentiating radiologists from those who self-refer. And we must not limit our options. Our responses to the issue must remain flexible, and our commitment to eradicating or mollifying the insidious effects of self-referral on the practice of medicine must remain firm. I must also be frank. If we truly believe in what we profess, radiologists must be united in our conviction that self-referral is bad medicine. And, if so united, we must not hedge our bets. We must be careful of arrangements with the potential to slide us through the same loopholes along with our nonradiologist colleagues. We cannot wag a finger at self-referral with one hand while patting it on the back with the other. True collaboration can be desirable, but not if it comes with professional or ethical compromise. Nothing less than our credibility and our profession are at risk.

Certainly, there is no doubt, the issue is complex. I have been asked, “Why should we care?” Are we treading on ground that is not our concern? Are we merely being priggish or puritanical and out of touch with marketplace values? I can only answer that if the concept of profession is to have any significance in our society, we must hold our ethical obligations in earnest. When the first fellows of our society took their oaths, the vow to serve patients’ interests first was woven into the fabric of our profession. When our newest fellows take their oaths, this pledge to our patients will be once again renewed. The ACR has stood steadfastly by this ethic, even as it has set us apart from others. However, we should never be made by anyone to feel disloyal for protecting the vulnerable or for elevating the physician-patient relationship to the priority it deserves. As the line of duty to those we serve is drawn, we must cross to the side on which our patients stand; and we invite all others to come with us. I am proud to be a member of an organization that believes that patients are our most meaningful commitment.

THINGS TO COME

There are those who contend that professions are in decline; that organizations such as ours are becoming irrelevant [8]; that our functions are being replaced by the ethics of the market place and by the regulatory edicts of government; and that as our defining principles are eroded away, what remains are simply associations of tradesmen, peddling commodities. But judging from the responses of the ACR to just a few of the challenges facing our profession, it is clear that we are determined to resist this scenario. As the stresses on all professions have become more acute, few have experienced a more challenging environment than our own. With each new wave of technologic innovation transforming our specialty into an almost limitless terrain of possibilities, the sheer effort required to manage our occupations has had the capacity to overwhelm the additional demands placed on us by profession. Yet in this trying time, when many succumb to the temptation to preserve privilege at the expense of principle, the ACR council and leadership have maintained an unshakable dedication to our traditional goals. And in a very real way, it is principle that has given us the freedom, conviction, and motivation to act proactively in our own best interests, as well as those of our patients, without regret, without apology. We will not win every skirmish, but with our professional affairs in order, we will be ready and unafraid. If leadership is a process of keeping our vision at the forefront and aligning our course and our actions accordingly, then the ACR is in excellent hands. If the health of a profession can be measured by the credibility of the organizations which embody its principles, such as the ACR, then our profession will be secure.

In 1895, this once astounding and now rather prosaic image of a hand was taken (Figure 1). It is perhaps the most famous radiograph ever produced. To be certain, it is one of the first. And it isn’t just any hand; it is traditionally held to be the hand of Bertha, the wife of Wilhelm Conrad Roentgen. For personal reasons, this image has special meaning for me, and I have pondered it over the years. Although taken as part of her husband’s research, as one might take a photograph, really, its significance in demonstrating the miraculous ability to penetrate human flesh, and thus to reveal the secrets of the living body, epitomizes our specialty, even today. But there is something else of interest here. This image is intensely personalized by the presence of Frau Roentgen’s ring on her fourth finger. This ring and all it may have symbolized to Bertha Roentgen, her vows, her re-
sponsibilities, her fidelity, are here forever fused with the image of her anatomy, producing an intriguing portrait. The radiograph alone does not reveal her; the ring in the radiograph does. In a similar way, our occupation does not define us. But that occupation, instilled with our inherited wisdom, our obligations, our principles, gives rise to the profession of radiology, which does define and distinguish us. Without the ring, this radiograph is just a hand. Without our values and obligations, we just have jobs.

We must ensure that this never happens. As practitioners of the “new kind of light” and the many new lights to come, we have gathered together, yet again, to chart the course of our profession, because we hold in common the vision of our founders. Today, it is our vision. And whatever tomorrow may hold, we will be armed with the unshakable confidence in the course we have set, as a bright future unfolds. Together, we will carry our profession forward, with the same courage and determination that has shaped our destiny since the discovery of the x-ray.

For we are the eyes of medicine. We are the vision in imaging. We are the stewards of our profession. We are the ring in the radiograph. We are the American College of Radiology.

REFERENCES


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46. Smith, J.J. and Berlin L. **Picture archiving and communication systems (PACS) and the loss of patient examination records**. *AJR Am J Roentgenol*. 2001; 176: 1381–1384


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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 VII
LIST OF PRACTICE PARAMETERS*
AND TECHNICAL STANDARDS

*In 2014 the Council adopted Late Resolution 39 Name of ACR Practice Guidelines that changed the name of Practice Guidelines to Practice Parameters.
## Documentation and Reporting

| 1. | ACR Practice Parameter for Communication of Diagnostic Imaging Findings | Res. 11 – 2014 |
| 2. | ACR–ASTRO Practice Parameter for Communication: Radiation Oncology | CSC/BOC – 2014 |
| 4. | ACR Practice Parameter for Continuing Medical Education (CME) | Res. 53 – 2011 Amended 2014 (Res. 39) |
| 6. | ACR Practice Parameter on the Physician Expert Witness in Radiology and Radiation Oncology | Res. 38 – 2012 Amended 2014 (Res. 39) |
| 8. | ACR Practice Parameter for Radiologist Coverage of Imaging Performed in Hospital Emergency Departments | Res. 24 – 2013 Amended 2014 (Res. 39) |
| 10. | ACR–AAPM–SIIM Technical Standard for Electronic Practice of Medical Imaging | Res. 35 – 2012 |

## Diagnostic Radiology

### General

| 1. | ACR Practice Parameter for Continuing Medical Education (CME) | Res. 53 – 2011 Amended 2014 (Res. 39) |
| 2. | ACR Practice Parameter for Communication of Diagnostic Imaging Findings | Res. 11 – 2014 |
| 4. | ACR Practice Parameter on the Physician Expert Witness in Radiology and Radiation Oncology | Res. 38 – 2012 Amended 2014 (Res. 39) |
| 5. | ACR–AAPM Practice Parameter on the Expert Witness in Medical Physics | Res. 43 – 2013 Amended 2014 (Res. 39) |
| 6. | ACR–SPR Practice Parameter for General Radiography | Res. 30 – 2013 Amended 2014 (Res. 39) |
| 7. | ACR–SIR Practice Parameter for Sedation/Analgesia | Res. 23 – 2015 |
| 8. | ACR Practice Parameter for Radiologist Coverage of Imaging Performed in Hospital Emergency Departments | Res. 24 – 2013 Amended 2014 (Res. 39) |
| 9. | ACR–SPR Practice Parameter for the Use of Intravascular Contrast Media | Res. 3 – 2012 Amended 2014 (Res. 39) |
### DIAGNOSTIC RADIOLOGY

#### GENERAL

10. **ACR–SPR Practice Parameter for Imaging Pregnant or Potentially Pregnant Adolescents and Women with Ionizing Radiation**
   - Res. 48 – 2013
   - Amended 2014 (Res. 39)

11. **ACR–AAPM Practice Parameter for Diagnostic Reference Levels and Achievable Doses in Medical X-Ray Imaging**
   - Res. 53 – 2015

12. **ACR–AAPM–SIIM Practice Parameter for Electronic Medical Information Privacy and Security**
   - Res. 37 – 2014

#### RADIOGRAPHY

1. **ACR–SPR Practice Parameter for General Radiography**
   - Res. 30 – 2013
   - Amended 2014 (Res. 39)

2. **ACR–SPR Practice Parameter for the Performance of Abdominal Radiography**
   - Res. 52 – 2011
   - Amended 2014 (Res. 39)

3. **ACR–AAPM–SIIM Practice Parameter for Digital Radiography**
   - Res. 37 – 2012
   - Amended 2014 (Res. 39)

4. **ACR–SAR Practice Parameter for the Performance of Adult Cystography and Urethrography**
   - Res. 31 – 2015

5. **ACR–SAR Practice Parameter for the Performance of Excretory Urography**
   - Res. 14 – 2014

6. **ACR Practice Parameter for the Performance of Hysterosalpingography**
   - Res. 50 – 2011
   - Amended 2014 (Res. 39)

7. **ACR–SPR Practice Parameter for the Performance of Voiding Cystourethrography in Children**
   - Res. 13 – 2014

   - Res. 2 – 2012
   - Amended 2014 (Res. 39)

9. **ACR–SIR Practice Parameter for the Performance of Diagnostic Infusion Venography**
   - Res. 33 – 2013
   - Amended 2014 (Res. 39)

    - Res. 31 – 2013
    - Amended 2014 (Res. 39)

    - Res. 28 – 2013
    - Amended 2014 (Res. 39)

    - Res. 15 – 2014

13. **ACR–SPR Practice Parameter for Skeletal Surveys in Children**
    - Res. 54 – 2011
    - Amended 2014 (Res. 39)

    - Res. 56 – 2011
    - Amended 2014 (Res. 39)

15. **ACR–SPR Practice Parameter for the Performance of Portable (Mobile Unit) Chest Radiography**
    - Res. 55 – 2011
    - Amended 2014 (Res. 39)

16. **ACR–ASNR–SPR Practice Parameter for the Performance of Myelography and Cisternography**
    - Res. 9 – 2013
    - Amended 2014 (Res. 39)
### DIAGNOSTIC RADIOLOGY

#### RADIOGRAPHY


#### COMPUTED TOMOGRAPHY (CT)

| 1. | **ACR Practice Parameter for Performing and Interpreting Diagnostic Computed Tomography (CT)** | Res. 35 – 2011 Amended 2014 (Res. 39) |
| 3. | **ACR–SPR Practice Parameter for the Performance of Computed Tomography (CT) of the Abdomen and Computed Tomography (CT) of the Pelvis** | Res. 32 – 2011 Amended 2014 (Res. 39) |
| 5. | **ACR–NASCI–SPR Practice Parameter for the Performance and Interpretation of Cardiac Computed Tomography (CT)** | Res. 38 – 2011 Amended 2014 (Res. 39) |
| 6. | **ACR–NASCI–SPR Practice Parameter for the Performance of Quantification of Cardiovascular Computed Tomography (CT) and Magnetic Resonance Imaging (MRI)** | Res. 14 – 2012 Amended 2014 (Res. 39) |
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ACR Diagnostic Radiology Practice Parameters contain recommendations for performing and interpreting radiology procedures for both adult and pediatric patients unless otherwise noted.

The PEDIATRIC RADIOLOGY Practice Parameters pertain specifically to performing procedures on pediatric patients.

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| 2. | ACR–ASTRO Practice Parameter for Communication: Radiation Oncology | CSC/BOC – 2014 |
| 4. | ACR Practice Parameter on the Physician Expert Witness in Radiology and Radiation Oncology | Res. 38 – 2012 Amended 2014 (Res. 39) |
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The following Practice Parameters / Technical Standards were Sunset according to ACR Policy.

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