Trends in Interventional Radiology

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If you look up the word “benefit” in the dictionary, you will see that it can be defined as “something that promotes well-being; a wonderful aid.”

Since its inception, the ACR has been focused on the well-being of its membership and, in turn, the well-being of the entire field of radiology. The ACR’s highly respected and proactive efforts with federal and state lawmakers and federal agencies on issues critical to the profession have enhanced radiologists’ professional standing and economic well-being. The College’s unparalleled array of educational materials boosts the professional well-being of practicing radiologists and residents alike. The progressive research being conducted by ACRIN® and RTOG® not only enhances radiologists’ practices but extends the benefit to improve the well-being of our patients.

Now, the ACR is prepared to introduce its latest benefit, another “wonderful aid” if you will, that will assist the membership both in their professional efforts and in their personal lives as well.

ACR Benefits Plus is a free, valuable, members-only lifestyles program that is specifically tailored to fit the needs of today’s on-the-go radiologists with services and assistance from many of the most prestigious names in business today. The College has partnered with these firms to offer you a diverse selection of benefits, including a bank card reward program that heralds your membership in the nation’s leading radiology organization, effectual payroll and purchasing services, and attractive discounts on hotel rates, car rentals, and auto insurance.

Of course, you’ve heard these marketing promotions before from any number of organizations and services, but no other benefits program meets the exacting demands and quality associated with the ACR. Whether it is booking a well-appointed room through the Starwoods hotel chain, planning for your future medical needs through the purchase of long-term care insurance, or augmenting your practice with efficient payroll and accounts-payable services or discounted shipping opportunities, this new program will make life easier for you.

The crowning appeal of the new program, however, is the new ACR credit card, thanks to the College’s partnership with Bank of America. In addition to no annual fee, the card offers you the chance to accrue valuable bonus points, the latest in fraud protection, and access to the advantageous MyConciergeSM service. Most important, the card is identified with the conspicuous ACR logo, further demonstrating your commitment to quality and to our profession.

There is much more to the latest ACR membership program than I have space to discuss in this column, and I have barely touched upon the numerous advantages afforded to you. To ensure that you are aware of the full benefits, you will soon be receiving a brochure that explains the program in complete detail with instructions on how you can begin benefiting your practice and enhancing your lifestyle.

I have already placed my name at the top of the list when the ACR Benefits Plus program is officially available and, to borrow a popular phrase, I wouldn’t even think of leaving home without it. I encourage you to take the time to read the information that is coming to you and join me in this important new program.

There is a Chinese proverb that says, “When a family builds a wall, two families benefit.” The ACR has built this notable wall, and it will serve as an important benefit to the more than 33,000 radiology professionals who are proud to be members of the ACR family and to the ACR itself as it continues to ensure its members have access to the tools and services they deserve.
Interventional Radiology: Evolution, Adaptation, and Survival

Radiology has come a long way from the days when the only tools of the trade were plain radiographs, intravenous contrast urography, and barium GI studies. Radiologists were clearly different from the “clinicians” who actually saw patients, diagnosed ailments, prescribed treatments, or performed curative surgeries and continued to follow patients through their clinical courses. Over the past quarter century, our imaging armamentarium has undergone revolutionary advances and diagnostic radiologists have moved to the forefront of medical diagnosis. However, we still did not become “clinicians.”

Within the field of radiology, a natural selection process also took place between those who enjoyed planning out and performing procedures (give a diehard interventional radiologist (IR) something to put a needle or guidewire and catheter into and we are happy) and those who did not. This was not unique to radiology in similarly affected fields such as cardiology and gastroenterology. As the number of different types and complexity of procedures evolved, this subset of radiologists felt they needed to be distinguished from the rest of the field, adopting the name “interventional radiologists.” By necessity, IRs had to actually see, and even touch patients, but still they were not considered clinicians.

It was not that radiologists were incapable of following patients from the beginning to end of their clinical course, but rather that for the five to six years of their training and umpteen years of practice, they were never asked to. It was much easier to dump a patient back to the clinician or referring M.D. What a simple way out! Realize that primary care physicians and even specialty physicians such as ophthalmologists or dermatologists largely love the idea that they are the patient’s M.D., while we radiologists (and IRs) predominantly do not. However, if interventional radiology is to survive and grow as a viable entity, it must adapt to the new reality that it must be a clinical specialty.

IRs now must treat patients and solve entire problems (from start to finish) to prove themselves as useful, if not more so, than those pesky interventional cardiologists, vascular surgeons, or interventional nephrologists. IRs must adapt and become functioning clinicians. To do so, IRs must embrace the corresponding clinical mindset and be given the tools and facilities with which they can function in this capacity, or it is unlikely that they will succeed in maintaining and growing their practices.

The reality is that for many radiology practices, unless IR procedures, or any procedures (GI, arthrogram, etc.) for that matter, happen to generate a disproportionately large revenue, they may frequently be seen as merely an annoyance. I have been on both sides of the fence now; I know what it is like to sit in front of a PACS station all day and peacefully grind out those RVUs. Despite the lure of the needle, I did not want to be interrupted with a procedure, any procedure — after all, you were cutting into my productivity and rhythm! Thus, I can understand why some of my diagnostic radiology associates have difficulty in seeing why we push for maintaining and expanding interventional radiology. However, it was not long ago that almost all radiology practices with an active interventional radiology section (I have been involved in both large and small group practices) generated considerably more in that section per FTE than in diagnostic radiology. I see no reason why this cannot still be the case.

To digress for a moment, I remember when, not too long ago, ultrasound, and then nuclear medicine, were felt to be subspecialties that were dying on the vine, especially with the advent of MRI. However, Doppler ultrasound, contrast-enhanced ultrasound, PET/CT scanning, and molecular imaging changed those dire predictions. Of course, interventional radiology has taken its hit with vascular turf battles, but vascular intervention (by radiologists), oncologic therapies (chemoembolization and RF ablation), pain management, chronic hemodialysis patient management, venous therapies, and uterine artery embolization are alive and well. We simply must continue to expand our range of services and adapt to newly developed technologies and procedures.

The world of medicine and radiology is changing rapidly and we must be willing to change with it. Diagnostic radiology and interventional radiology are at a crossroads, as Drs. Krol and Murphy eloquently explain in their article on “Clinical Practice, Ability to Compete Lead to Financial Health” in this issue of the ACR Bulletin. (Please see page 4.) This follows up on the 2003 ACR interventional radiology task force’s white paper, “Clinical Practice of Interventional Radiology and Neurointerventional Radiology” and the 2004 adoption of the ACR practice guideline for interventional clinical practice. If we passively accept that things are the way they are and we are doing so well financially that we should not change anything, then we run the chance that we will be blindsided. In nature, as in medicine, survival belongs to the fittest. ☉
ACR News

ACRIN, RTOG RECEIVE ASCO HONOR

The American College of Radiology Imaging Network (ACRIN) and the Radiation Therapy Oncology Group (RTOG), the ACR's prominent research divisions, were among the National Cancer Institute-designated cooperative groups to be honored with the American Society of Clinical Oncology's Distinguished Service Award for Scientific Leadership. The award, recognizing the groups for their leadership over the past 50 years, will be presented at ASCO's annual meeting in June in Chicago.

“It is a great privilege to receive this recognition in the company of the NCI therapeutic cooperative groups,” said ACRIN Chair Bruce J. Hillman, M.D. “The cooperative groups are the research engine primarily responsible for the major advances that we see emerging in today’s improved cancer care.”

For more information on the ACR’s critical research efforts, please visit the ACRIN Web site (www.acrin.org) and the RTOG Web site (www.rtog.org).

UPDATED VERSION OF THE ACR APPROPRIATENESS CRITERIA® NOW AVAILABLE

The ACR continues its update of the ACR Appropriateness Criteria® with the release of another 24 revised topics. Nearly all of the 160 topics included in the Appropriateness Criteria have been reviewed and updated since 2005.

For instant point-of-care access, you can download the updated version to your PDA. The PDA application features include compatibility with Palm and Pocket PC platforms, ability to search by condition or procedure, and e-mail notification when updates become available.

For information on the price of the PDA program and more about the ACR Appropriateness Criteria program in general, please call the ACR Quality & Safety Department at (800) 227-5463, ext. 4590.

AMCLC 2007 OFFERS PRACTICAL STRATEGIES FOR YOUR PRACTICE

Register now for the ACR’s 2007 Annual Meeting and Chapter Leadership Conference (AMCLC) in Washington, D.C., May 19-23. You’ll learn how to increase your practice’s fiscal strength and take away strategies that you can apply to your daily practice of radiology.

In the ACR Executive Series Course — Service, Quality, and Performance: What Patients Want from Us — you’ll learn why pay for performance counts. This all-day course is led by Frank Lexa, M.D., M.B.A., one of the ACR’s most popular speakers.

And, in the ACR Economics Update, a three-hour interactive session, you’ll receive practical guidance presented by a respected all-star faculty for the issues that today’s radiology practices face.

For more information on these courses, or to register for the 2007 AMCLC, please visit www.acr.org/07meeting or call (800) 373-2204.

MOOREFIELD ECONOMICS AND HEALTH POLICY FELLOWSHIP

The American College of Radiology’s Department of Economics and Health Policy is accepting applications from third- and fourth-year residents and fellows for its Moorefield fellowship. This fellowship will provide a radiology resident or fellow direct exposure to, and hands-on experience with, the functions of the ACR Department of Economics and Health Policy and the Commission on Economics within the ACR.

The two-week program is designed to better inform residents about reimbursement and medical policy issues, including development of new CPT® codes, the valuation process, Medicare national and local coverage of radiology and radiation oncology procedures, and coverage by third-party payers and managed care organizations. Three candidates will be selected for fellowships that will take place during separate time frames throughout the 2007-2008 academic years.

Recipients of the 2006 Moorefield Economics and Health Policy Fellowship are Bryan D. Berkey, M.D.; Michael H. Wittner, M.D.; and Joshua L. Rosebrook, M.D.

Deadline to apply is April 15, 2007. For more information, please contact the ACR’s Economics and Health Policy Department by e-mail at egilbert@acr.org.
Interventional radiology’s roots are in angiography, which was a hospital-based part of diagnostic radiology. The term “interventional radiology” was coined when therapeutic interventions became a fundamental part of “special procedures,” building on the basic catheter skills of angiography, but shifting the radiologist’s role from diagnostician to health care provider. In order to care appropriately for patients and compete for referrals for patient management rather than procedures, interventional radiologists (IRs) have adopted a more clinically oriented practice.

Clinical practice differs from procedural practice in that an IR accepts referrals for patients to assess, diagnose, and manage their diseases over time, rather than only accepting “orders” for a procedural or technical service. Recently, many IRs have opened independent offices and their practices have flourished. With that change, they have also become referring physicians themselves, admitting patients to the hospital, ordering diagnostic tests, determining the course of therapy, and requesting consultations from other doctors. To manage their patients, IRs typically refer patients for imaging tests.

COMPETITION IS THE NEW REALITY

In the days of “special procedures” and basic angiography service, radiology was the only game in town. All requests for angiographic procedures automatically went to radiologists. Today, many other specialists offer the techniques of percutaneous intervention, and most, if not all, of the disease states that IRs are trained to treat are treated by at least one other non-radiologic specialty. We firmly believe that our dedicated training and interventional radiology skills are superior to other specialists. However, referring physicians seem to expect that they’ll get “full-service management” for the patients they send to other specialists for evaluation and management.

Consequently, IRs must provide the same level of care that our competing clinical colleagues provide. Moreover, we believe that pay-for-performance criteria will dictate clinical management of patients, regardless of which specialty provides the care. We are ready to compete for the opportunity to care for patients, but we must have the necessary tools and support from our practice colleagues in order to change our practice patterns accordingly.

To successfully compete for patients and procedures, IRs must establish their own referral patterns and offer similar, if not better, care and service than the competition. Specifically, that entails providing clinical evaluation and consults, admitting patients to the hospital, rounding in the hospital to provide pre- and post-procedure care, and managing after-care issues. While these efforts appear time-intensive and under-reimbursed in the context of today’s radiology practice, they must be regarded as critical investments in the financial health of an entire radiology practice.

This practice pattern universally results in a financially viable interventional radiology practice that enhances the entire radiology group practice, and needs to be embraced by both
the interventional and diagnostic radiology (DR) partners. It influences the views of referring doctors to see radiologists as bona fide physicians rather than overpaid technicians.

The greatest successes are seen when adequate resources are provided to the interventional radiology section. A robust, well-rounded interventional radiology venture is a financial asset to a radiology practice. It is short-sighted to fail to plan and support a proficient clinical practice section by relegating interventional radiology to its historical state, by focusing on the need of the moment to read a stack of CTs, and ultimately accepting a significant loss of business to less-qualified competition.

**IS YOUR INTERVENTIONAL RADIOLOGY PRACTICE AT A CROSSROADS?**

Many IRs today have successfully evolved into clinical practice. Others, however, have not been as fortunate. Since all politics is local, some may be surprised to learn that radiologists not only remain involved in treating peripheral vascular disease but still perform the majority of noncoronary interventions in the United States. If this is not your local experience, consider how you can change that.

The practice model of a 1970s-style angiography service no longer works. However, by providing interventional radiology in the context of a clinical practice, interventional radiology is gaining a larger market share and scope of practice. Practices must decide between fully supporting a clinical practice of interventional radiology or not supporting this model. At a minimum, the following building blocks are needed:

1. **Dedicated clinical office space under the direction of the interventional radiologists** — IRs need office space to see patients for evaluation and management visits.Patients are referred for a specific problem, and the IR sees them for an office visit to evaluate them before proceeding with a patient plan. This office space must be set up like any clinical office, with a reception area, work area for staff, examination rooms, EMR/file room, transcription operation to generate letters to referring physicians, and billing services. The Society of Interventional Radiology maintains a list of “showcase” practices.

2. **Staff** — The office staff should include a receptionist, medical aides, office manager, scheduler, transcription employee, and physician extenders.

3. **Marketing** — Much of the practice marketing is done person-to-person and falls on the IRs’ shoulders. They must cultivate direct relationships with their referring doctors. Physicians typically send elective referrals to colleagues whom they know and trust, not simply to a practice, office, or hospital. These efforts require marketing staff and fiscal support. Roughly 5 percent of an interventional radiology operation’s gross revenue should be reinvested in marketing to support future growth.

**SPECIALTY TRENDS**

There are numerous positive trends and new growth areas in interventional radiology, such as interventional oncology, pain management, and the treatment of venous hypertension and varicose veins. Interventional radiology continues to perform large numbers of peripheral vascular therapies, perhaps drawing from “non-traditional” referral sources, such as primary care physicians. Building clinical practices is essential to success in all of these areas.

**HOW CAN RADIOLOGY HELP NURTURE INTERVENTIONAL RADIOLOGY?**

Organized radiology has done a good job of developing positions that are supportive of recent interventional radiology trends. However, the message of organized radiology has not led to widespread understanding and support at the grassroots level,
so radiology groups must consider the following ways to enhance their IR practices:

- Understand, encourage, and provide a culture of active support for interventional radiology to transition to a clinical practice. Diagnostic and interventional radiology can work together to create and execute a plan to adopt this necessary change.

- Recognize that we are valuable strategic members of the imaging team. Because of our interventional background, IRs are experts in many diverse disease states and therapies and offer increased accuracy and clinical applicability of interpretations, improved patient outcomes, and satisfaction and confidence to referring physicians. This can lead to direct interventional radiology conversations with referring physicians that result in increased patient referrals to interventional radiology (and potentially, additional imaging).

- Encourage IRs to develop direct referral patterns and relationships with referring physicians. Give your IRs office space and dedicated time to schedule clinical, pre-procedure, and post-procedure consults. View this as “productive” time.

- Consider using IRs to enhance a group’s expertise in cardiovascular imaging, including cardiac MRA and CTA. IRs are a radiology group’s cardiovascular specialists and can strategically give the group a competitive advantage in managing the gateway to the vascular market. If other specialties control this area, it will be a loss for all of radiology.

**WHAT DOES INTERVENTIONAL RADIOLOGY MEAN TO THE RADIOLOGY GROUP AS A WHOLE?**

All radiology groups can benefit from the reliance of referring physicians on a strong integrated IR component. Moreover, interventional radiology brings a frequently unrealized volume of diagnostic work and referrals to the group. Interventional radiology has significant growth potential, contributes to a practice’s bottom line, and creates substantial good will that reflects on the entire practice. It helps to diversify a radiology practice, a vital factor as reimbursement challenges increase and outside competition extends to all fronts. A big benefit is that interventional radiology responsibilities will never be outsourced to overseas markets.

Diagnostic and interventional radiology must work together to ensure that interventional radiology practices realize their full potential for growth in minimally invasive image-guided procedures. The stakes are becoming greater every year, and we cannot afford to not work together. Together, our marketplace potential and, more importantly, our contribution to patient care is almost limitless.

**PRE-AMCLC EDUCATIONAL SESSION**

**Oncologic Imaging and Image-Guided Interventions**

In conjunction with the Annual Meeting and Chapter Leadership Conference, the ACR is conducting a one-day session on May 19 on the current and emerging therapeutic modalities involved in interventional oncology.

Learn how diagnostic and interventional radiologists work together to enhance their patients’ well-being and experience.

Visit [www.acr.org/07meeting](http://www.acr.org/07meeting) for more information and to register for this session and for the AMCLC 2007 meeting.
Popular MRI Teaching File Increases Case Studies

When radiology residents responded to a nationwide survey with concerns about the lack of MRI teaching in their residency programs, the ACR’s Resident and Fellow Section (RFS) paid attention. The result is the MRI Teaching File Project. Supported by the ACR, the project was created by residents for residents. Its goal is to enrich the MRI learning experience by expanding the available number and variety of body, musculoskeletal, and cardiac MRI teaching cases. (Survey results show that residents found their exposure to neuroradiology MRI cases to be adequate.)

Currently, the MRI teaching database consists of 54 cases, with at least 24 additional cases under construction in the Body and MSK sections, and another 12 cases being added in Cardiac MRI, according to Gregg Miller, M.D. Miller is one of six topic-specific editors responsible for reviewing and approving cases for database entry. Managing Editor Don Mitchell, M.D., Department of Radiology, Thomas Jefferson University, is responsible for final editorial review of all cases. Each section has a resident or a fellow and a faculty editor.

Editors include:

- Cardiac Section Editor (Adult) — Eric Williamson, M.D., Mayo Clinic-Rochester
- Cardiac Assistant Section Editor (Adult) — Jacobo Kirsch, M.D., Mayo Clinic-Rochester
- Cardiac Section Editor (Pediatric) — Laureen Sena, M.D., Boston Children’s Hospital
- MSK Section Editor — Douglas Beall, M.D., Department of Orthopedics, University of Oklahoma
- MSK Assistant Section Editor — Amy Kirby, M.D., Department of Radiology, University of Oklahoma
- Body Section Editor — Jerry Tkacz, M.D., Boston Medical Center
- Body Section Editor — Avneesh Gupta, M.D., Boston Medical Center
- Body Assistant Section Editor — Gregg Miller, M.D., Boston Medical Center

Case material is reviewed at multiple levels. For example, in the Body section, Boston Medical Center resident, Meghan Blake, M.D., worked under the supervision of MR faculty to assemble nearly a dozen cases pertaining to body MRI. These cases were further reviewed and edited by Miller, Gupta, and Tkacz. The cases were sent for final review to Mitchell at Thomas Jefferson University.

GOAL OF 100 CASES BY AMCLC 2007

“Our goal is to accumulate a large number of interesting, peer-reviewed cases in the areas of body, musculoskeletal, and adult and pediatric cardiac MRI,” Miller explains. “We encourage residents to discuss the utility of MR as it applies to the particular clinical entity and to highlight any of the physical principles or MR-related artifacts demonstrated in the particular case.

“We hope to assemble and display as many as 100 cases by the AMCLC (in May), after which, cases will be available online for residents to review,” Miller says. “Eventually, we aim to disseminate cases by e-mail, much like Case in Point currently functions.” These MRI cases should complement the multimodality nature of Case in Point.

The RFS encourages residents to contribute cases. The ACR pays residents for each case accepted. Similar to the submission procedure for the popular Case in Point, each case requires a faculty or practicing radiologist co-author. Visit the RFS Web site at http://rfs.acr.org/mri/mri.htm for specifics on general submission instructions, case submission requirements, case examples, and reimbursement procedures.

The RFS demonstrated the MRI database at RSNA in November 2006; response was very positive among participating residents and several practicing radiologists. Even more important, according to Miller, is that those who submitted cases found the process very rewarding. “I have consistently received very positive feedback from case submitters who think that the time … putting together the cases was time well spent,” he says.

“None of this could have been accomplished without the groundwork laid by doctors Christoph Wald, Jesse Davila, and Sanjay Shetty, or without the ongoing financial and technical support from the ACR,” adds Miller. “Needless to say, those of us who have been involved with the project are grateful for this support.”

For case submission instructions or details on cash and iPod rewards, please visit the Web site: http://rfs.acr.org/mri/mri.htm.
FDG-PET/CT: An Early Look at Treatment Response

For most of the 175,000 Americans diagnosed with lung cancer each year, the prognosis is grim. Most patients present with advanced disease and undergo palliative chemotherapy — but only about one third respond to treatment. Currently, it is difficult for doctors to know which patients are good candidates for therapy, and it can take several cycles to detect a response.

Researchers hope that, in the future, more customized approaches to lung cancer treatment will allow doctors to determine earlier which treatment will work best for a particular patient. One way to customize treatment is to use biomarkers as indicators of whether treatment is effective. A new study — developed by the American College of Radiology Imaging Network (ACRIN)®, and the first trial ever supported by the Biomarkers Consortium — may validate positron emission tomography with fluorodeoxyglucose (FDG-PET) as a treatment monitor in patients with advanced non–small-cell lung cancer (NSCLC). “ACRIN 6678: FDG-PET/CT as a Predictive Marker of Tumor Response and Patient Outcome” is designed to show whether changes in tumor metabolism as measured by FDG-PET/CT provide an early predictor of the effectiveness of therapy for NSCLC.

FDG-PET MEASURES EARLY RESPONSE

FDG-PET has the potential to improve patient management by signaling the need for early therapeutic changes in non-responders. Such changes can help patients avoid the side effects and costs of ineffective treatment. If FDG-PET is shown to be an early indicator of clinical benefit, it also may help promote the development of oncologic drugs by shortening Phase II trials and detecting clinical benefit earlier in Phase III trials.

“As different therapies are becoming available for treatment of NSCLC, it becomes more important to discover whether a treatment is working.”

—Wolfgang Weber, M.D.
Principal Investigator, UCLA

To determine whether the treatment is effective, researchers will use FDG-PET to examine tumors for a metabolic response — a decrease in the uptake of FDG. Says Wolfgang Weber, M.D., the trial’s principal investigator, “The basic idea of this trial is to evaluate whether one can use FDG-PET/CT in a multicenter setting to assess tumor response early in the course of therapy.” Weber previously conducted a single-center trial of PET for NSCLC in Germany. Now at UCLA, he looks to validate those findings prospectively across many sites.

Researchers hope that, in the future, more customized approaches to lung cancer treatment will allow doctors to determine earlier which treatment will work best for a particular patient.

ACRIN 6678, which opens this spring, will enroll 228 participants at 10 or more institutions. Participants, all of whom will receive three FDG-PET/CT scans, will be randomized into two groups. Group A will receive two FDG-PET/CT scans prior to chemotherapy and one scan after the first cycle. The two scans prior to therapy will be used to determine the reproducibility of quantitative measurement of tumor FDG uptake in a multicenter setting. Group B will receive one FDG-PET/CT scan prior to chemotherapy, one after the first cycle, and one after the second cycle. The two scans after start of treatment serve to establish the time course of metabolic changes during therapy in order to determine the optimal time point to assess treatment response by FDG-PET.

The trial is innovative in its quantitative analysis of PET. “The hope is that this trial will set some standards,” Weber says. “Quantitative assessment of FDG-PET is not complicated, but it needs to be done in a standardized way. Previous studies were too small to detect differences between the different approaches, but this trial has a much higher power to calculate differences.”

The primary endpoint is the correlation between a specific definition of response in PET and patient survival, but the
The trial’s use of CT scanning also will provide researchers with further valuable information. “This research is exciting because it has the potential to change how we assess the effectiveness of lung cancer treatment,” says Denise Aberle, M.D., one of the study’s co-investigators. “In the past, standard response assessment has been based on the measure of tumor diameters as a surrogate of tumor burden, using CT as the primary modality. However, rather than simple diameters, PET/CT-based tumor volumes may provide a more robust anatomic measure of treatment response, particularly for irregularly shaped lesions.

“Moreover, PET/CT has replaced stand-alone PET scanners at many institutions, providing the combination of both metabolic and high-quality anatomic measurements of tumor size. The use of PET/CT imaging in ACRIN 6678 will allow exploratory analysis of changes in tumor metabolic activity with changes in tumor volume.”

“The basic idea of this trial is to evaluate whether one can use FDG-PET/CT in a multicenter setting to assess tumor response early in the course of therapy.”

—Wolfgang Weber, M.D.
Principal Investigator, UCLA

A FIRST FOR BIOMARKERS CONSORTIUM
ACRIN 6678 has the distinction of being the first clinical trial supported by the Biomarkers Consortium, a public-private partnership launched in October 2006 whose membership includes the National Institutes of Health, the U.S. Food and Drug Administration, Centers for Medicare and Medicaid Services, as well as industry and patient advocacy groups. The consortium was created to develop promising biomarkers for research, medical, and regulatory uses and to improve understanding of the biology of health and disease. The consortium also will develop evidence to help guide the use and qualification of biomarkers for specific diseases and their treatment.

“It’s a great privilege for ACRIN to be associated with the Biomarkers Consortium and to be entrusted with the conduct of its initial trial of PET scanning to evaluate response to treatment for lung cancer,” says ACRIN Chair Bruce J. Hillman, M.D.

The trial will use the resources of ACRIN’s PET Core Lab. “ACRIN 6678 represents a significant investment by the National Cancer Institute and its Biomarkers Consortium partners to confirm, in a rigorous, multicenter setting, the validity of FDG-PET as a biomarker for tumor response,” says Barry A. Siegel, M.D., head of the PET Core Lab. “This study presents several challenges to the ACRIN Core Laboratory, but we are excited to have this opportunity to participate in this important trial.”

Weber emphasizes the impact ACRIN 6678 could have on lung cancer patients. “As different therapies are becoming available for treatment of NSCLC, it becomes more important to discover whether a treatment is working,” he maintains. “It’s especially important in non–small-cell lung cancer, where the survival of the patients is very poor, so you don’t have lots of time to determine whether treatment is effective. Our hope is that FDG-PET can help individualize cancer treatment and improve the prognosis for these patients.”

Axial images of CT above and PET below show a lung lesion pretreatment (left) and posttreatment (right).
Russian Radiologists and ACR Staff Meet at Summit

A good business opportunity to outsource the development of software applications — for a fraction of the cost if developed in the United States — could result in the ACR becoming more involved in international radiological education.

Currently, the ACR has contracted with CorePartners/Argusoft and its development team to build several important applications, including TRIAD-OA™, the National Radiology Data Registry, and ACRredit. Building on this successful working arrangement between the contractors and the ACR’s information technology team, Steve Giddens, the College’s chief information officer, envisioned a winning possibility: an untapped, skilled talent pool of radiologists in Russia and the mutually beneficial advantages of an electronic ACR membership. Giddens travels to Moscow every quarter to review the projects, and after a month of planning, his idea resulted in a top-level ACR/Russian summit in Moscow last fall, when ACR leadership and officials from the Russian radiology leadership met.

Arl Van Moore Jr., M.D., chair of the ACR’s Board of Chancellors, ACR Executive Director Harvey L. Neiman, M.D., and Giddens teamed up to present the status of radiology in the United States to a 10-member panel of senior-level Russian radiologists, scientists, and government officials. Several translators were on hand during the seven-hour presentation and subsequent social events to ensure a smooth exchange of information and ideas.

“It was a wonderful meeting with some of Russia’s leading radiologists,” Neiman says. “We discussed many topics, specifically, how both countries are striving for the highest quality of radiology practice.”

“The Russian radiologists are hungry for education,” Neiman explains. Although standard ACR membership benefits, such as advocacy and representation on Capitol Hill, would not apply in Russia, the Russians are very interested in the ACR’s many e-learning programs, such as Case in Point and the ACR Campus™.

One unexpected but beneficial outcome of the trip may result in involving Russian radiologists in the ACR’s international program. “We are hopeful that through the ACR International Service Program we will be able to offer some of the country’s lower-income radiologists used medical equipment for practicing radiologists and books for radiology residents,” Neiman says.
Challenging Your Skills

Challenge your skills, meet your educational requirements, and enhance your professional objectives, all from the convenience of your desktop, 24 hours a day. Whether you have just completed your residency or have been a practicing radiologist for years, the ACR Campus™ is the place for all your education needs, with world-class lectures and content on the latest topics in medical imaging.

NEW FOR RESIDENTS/PROGRAM DIRECTORS
International Pediatric Radiology Postgraduate Course
The Society for Pediatric Radiology is a professional medical organization dedicated to being the leader in advancing pediatric health care through medical imaging and image-related therapy.

The postgraduate course features a 26-lecture series of refresher lectures on topics such as head and neck imaging, musculoskeletal intervention, and emergency radiology. Additionally, there are special focus sessions on the important topics of radiation effects, fetal imaging, and the challenges of radiography in the digital age. This educational program is rounded out by four state-of-the-art sessions on CT radiation dosimetry, imaging in pediatric oncology, the cardiovascular and urogenital systems, and the dysplastic hip.

The 26-lecture series debuted on the ACR Campus Web site in February.

Visit http://campus.acr.org for pricing information on this exciting new course.

OB ULTRASOUND LECTURE SERIES
(for residents and practicing radiologists)
Women's health issues remain among the most influential and important topics in diagnostic imaging today. Obstetric Ultrasound: A Core Curriculum, a joint collaboration with the Society of Radiologists in Ultrasound, features interactive lectures that are designed to challenge radiologists and hone their skills in this critical area. Under the direction of Deborah Levine, M.D., the program features 22 lectures by some of the most recognized names in the field. Topics include first trimester sonography, ectopic pregnancy, the fetal heart, and fetal gastrointestinal tract imaging.

Key benefits include:
—Residents may purchase the lectures at institutional prices.
—Practicing radiologists may purchase the lectures as an entire series, a package of select lectures, or an individual lecture.
—Approved for 23.75 AMA/PRA Category 1 Credits™.

MAKE WAY FOR THE NEW IN 2007
Ultrasound Symposium covers a comprehensive series of ultrasound topics from imaging basics to gynecologic and obstetrics, from body parts and organs to musculoskeletal and vascular systems.

Musculoskeletal Systems comprises six lectures covering topics such as initial assessment, degenerative diseases, common disorders, and specifically targeted approaches.

Intermediate Cardiac Lecture Series builds on a basic understanding of cardiac diseases, with 22 lectures featuring coronary atherosclerotic heart disease and cardiac multidetector principles, roles, and catheterization imaging.

Visit the ACR Campus (http://campus.acr.org) each week to check out the new course offerings.
ACR Launches Contract Research Organization Subsidiary

The ACR recently launched the ACR Image Metrix™, a contract research organization (CRO) designed to accelerate advances in radiologic care and fund future research to benefit patients.

Headquartered in the ACR’s Philadelphia office, alongside the College’s clinical research division, ACR Image Metrix offers a complete menu of imaging CRO services, from study design to design of electronic data forms and image archiving, to image interpretation and measurement.

“ACR Image Metrix™ is another avenue to support one of the College’s key missions, which is to advance the science of radiologic care through large-scale clinical research.”

—Bruce J. Hillman, M.D.
Director of Scientific Affairs
ACR Image Metrix™

The ACR’s clinical research programs are among the largest recipients of federal medical research grants and have an established reputation for handling large-scale clinical trials involving up to 50,000 patients and some 50 million images at a time. ACR Image Metrix will leverage the same infrastructure and expertise but will provide support to pharmaceutical companies, biotechnology firms, and medical device manufacturers seeking FDA approval to bring new drugs, therapies, and medical devices to market. Revenue from the CRO’s various research projects will be used to help fund future American College of Radiology Imaging Network (ACRIN)®, Radiation Therapy Oncology Group®, and Quality Research in Radiation Oncology™ studies.

“ACR Image Metrix is another avenue to support one of the College’s key missions, which is to advance the science of radiologic care through large-scale clinical research,” says Bruce J. Hillman, M.D., director of scientific affairs for ACR Image Metrix. “The ACR, as a leader in clinical research, has the capacity and infrastructure to complete an increasing number of research projects simultaneously. ACR Image Metrix allows the College to enhance the ability of various imaging and radiation oncology stakeholders to bring lifesaving and life-enhancing advances to patients in a more timely and efficient manner.”

Building on years of experience collecting DICOM images to support ACRIN clinical trials, ACR Image Metrix will use a leading-edge, multitiered image management system, TRIAD-OA, to support external initiatives like the Biomedical Informatics Grid. The TRIAD-OA system includes image collection, transfer, anonymity, re-identification, archiving, and viewing.

“ACR Image Metrix will enhance the ACR’s already proven ability to provide leadership in developing new diagnostic and therapeutic measures that will benefit patients worldwide,” Hillman adds. “We are excited about the opportunity to further advance the science of radiology and radiation oncology — both through the research that ACR Image Metrix will be directly involved in, and the ACR research that will be funded as a result of the Image Metrix efforts.”

To learn more about ACR Image Metrix, please visit www.imagemetrix.acr.org, e-mail info@imagemetrix.acr.org, or call (888) 817-0817.
The Focus on Efficiency

In its never ending quest to ensure the highest quality care for its beneficiaries, the Centers for Medicare and Medicaid Services (CMS) has embarked on a process of developing imaging efficiency measures. In its “Request for Task Order Proposal” (RTOP), CMS indicated that its Quality Council “has adopted the vision of the right care for every person every time, where appropriate care corresponds to the Institute of Medicine report on improvements in six dimensions of health performance. In this context, CMS is interested in the promotion of efficient care — care which reduces waste and overuse.”

CMS further states that “imaging services have attracted attention, given their cost, rapid growth, and the belief that imaging services could be more efficiently utilized while maintaining the same level of quality.” Given CMS’ desire to reduce “over-use,” it is interesting to note that “in this contract, relative use, such as volume of imaging services ordered by a physician is not what is sought.”

CMS describes the purpose of this contract task order as developing a limited set of imaging efficiency measures that are focused on high-cost imaging services in order to “enable providers to compare themselves to others of similar size and patient-mix and potentially make process improvements in areas in which they score low.” These efficiency measures will be “based on clinical practice guidelines that promote cost-efficient care while maintaining high-quality patient care and that are feasible to implement.”

The process will involve development of 10 efficiency measures in the following domains:

- **Duplication** — studies that are duplicative within a short time of each other without identified clinical indication
- **Overlap** — studies using different modalities on the same body area that serve the same clinical purpose
- **Screening** — services that are solely for screening purposes without identified clinical indications
• Negative Studies — “imaging studies that are negative in a large percentage of the cases are a potential source of waste and inefficiency”

• Studies Without and With Contrast — “imaging studies repeated in a short period of time on the same body area differing only in whether contrast is used are a potential source of waste and inefficiency”

• Adjacent Body Areas — “imaging studies repeated in a short time on adjacent body areas are a potential source of waste and inefficiency”

In its “Request for Task Order Proposal,” CMS indicated that its Quality Council “has adopted the vision of the right care for every person every time, where appropriate care corresponds to the Institute of Medicine report on improvements in six dimensions of health performance.”

Congress Passes NIH Reauthorization

H.R. 6164, “The National Institutes of Health Reform Act of 2006,” surprised many Capitol Hill observers when it passed in the final hours of the congressional session after intense negotiations between the House and Senate. Among its components, the final legislation provides for:

• National Institutes of Health (NIH) funding levels authorized at $30,331 billion in FY 07; $32,831 billion for FY 08, and “such sums as may be necessary,” for FY 09. These amounts would allow for increases of approximately 7 percent in 2007 and 8 percent in 2008.

• A common fund for research to be established by the NIH director and funded by a reserve account from congressional appropriations.

• New authorities and responsibilities enhancing the NIH director’s ability to set an agenda for the NIH across the institutes.

• Program coordination across institutes and centers, overseen by the NIH director in consultation with institute directors, to review priorities, create balance, avoid duplication, and foster collaboration and cross-cutting research.

• Authority of the NIH director to transfer up to 1 percent of total NIH funding for trans-NIH research initiatives.

• A new electronic coding system for research grants and activities.

• Revised reporting requirements designed to foster interagency collaboration, prevent fraud and abuse, and monitor institutions receiving training awards for graduate students pursuing doctoral degrees, among other things.

The President signed the National Institutes of Health Reform Act of 2006 on Jan. 15, 2007, following bipartisan support in Congress. This is only the third omnibus reauthorization in the NIH’s history, and the first in 14 years.◆
The radiology profession faces tumultuous times in the political arena. In an effort to combat the misunderstanding of radiologists’ key role, the ACR has launched an important grassroots campaign. Why is a grassroots program important? As stated on the ACR Web site advocacy page, “Grassroots advocacy is the effective deployment of constituent-based political power to influence the legislative process and the way elected officials vote on issues of importance to your profession. If you are not active in public policy, then someone else is making extremely important decisions for you. Through involvement in the ACR’s new Grassroots Action Team program, ACR members will be armed with the necessary tools to effect real change on behalf of radiology.”

2006 Results
In keeping with this philosophy, the ACR’s Grassroots Advocacy Program took the following actions in 2006:

- Coordinated 21 visits to imaging facilities, including seven with congressional members of the House Energy and Commerce Committee and three with members of the House Ways and Means Committee
- Coordinated visits to Capitol Hill by 350 ACR members during the 2006 AMCLC, totaling more than 300 meetings with congressional members and staffs
- Increased participation in the grassroots program from 1,200 members in 2005 to 3,766 as of January 2007
- Identified a government relations contact in each state to serve as the political liaison between the ACR Government Relations staff and ACR members from the contact’s state
- Coordinated “calls to action” that have resulted in more than 4,500 letters sent to members of Congress and more than 5,000 calls from ACR members to their representatives on Capitol Hill asking for support of our imaging bills, H.R. 5704 and S. 3795

To better illustrate these accomplishments, the map below reflects the total number of grassroots advocates in each state compared to the total number of ACR members.

DRA Results
Despite the best efforts and long hours of work by the ACR membership, leadership, and staff, and our Access to Medical Imaging Coalition (AMIC) colleagues, Congress did not pass legislation to delay implementing the imaging cuts contained in the Deficit Reduction Act of 2005 (DRA) before it adjourned in December 2006. The cuts took effect January 1, 2007.

The ACR and its AMIC partners, a broad coalition representing manufacturers, patient advocacy groups, and physicians, lobbied extensively throughout the waning days of Congress to delay implementation of the DRA cuts. Although the ACR did not achieve its ultimate goal of delaying the cuts, the Grassroots Action Team made sure no additional unnecessary cuts to imaging occurred.

The team will continue its work to enact responsible imaging reimbursement policies that are based on quality and safety for patients. ✦
RADPAC enjoyed a record-breaking year in 2006 by raising more hard money and hard and soft money combined than in any other previous year, despite only 6 percent of ACRA™ members contributing to RADPAC — 1,700 contributors out of 27,000 ACRA members.

The RADPAC Board has set ambitious goals for the upcoming 2007-2008 election cycle, including raising $2 million and increasing support for RADPAC through practice participation. To date, more than 30 practices have 100 percent of their radiologists contributing to RADPAC.

It is my belief that radiologists need to take a more proactive and vested interest in protecting our profession. We have spent countless hours studying and working hard to perfect our craft. In order for us to maintain our status as the experts in imaging services, radiologists must have our collective political voice heard on Capitol Hill.

The result of the elections this past November is a drastic shift in political power with the Democrats now in control of both the House and the Senate. What everyone now wants to know is how this political shift in Congress will affect radiologists.

With these new political dynamics, health care priorities in Congress certainly will change.

The new Congress likely will focus on prescription drug safety issues, federal funding for stem cell research, efforts to cover the uninsured, and a variety of Medicare reforms.

One of the ways that we can keep the issue of imaging reimbursement at the legislative forefront is through the continued, aggressive efforts of RADPAC. In the most recent 2005-2006 election cycle, RADPAC was represented at more than 290 fund-raising events and contributed more than $1.1 million to federal candidates, political parties, and leadership committees. At these events, RADPAC educated members of Congress and their staffs about the flawed policy of the imaging cuts included in the 2005 Deficit Reduction Act (DRA).

RADPAC already has started working with the new congressional leadership and will continue to fight for legislative fixes for appropriate reimbursement for imaging services. I look forward to working with you as we face the challenges that lie ahead for our profession.

Thank you for your support. If you have any questions, please contact Ted Burnes, director of RADPAC, at (888) 295-8843 or via e-mail at tburnes@acr.org, or you may contact Heather Kaiser via e-mail at hkaiser@acr.org.
Call for 2008 Nominations: ACR Gold Medalists and Honorary Fellows

The Board of Chancellors awards the ACR gold medal to individuals who have contributed distinguished and extraordinary service to the ACR or to the discipline of radiology. Service to radiology can be in teaching, basic research, clinical investigation, or radiologic statesmanship, as well as outstanding contributions in working with other medical organizations, government agencies, and quasi-medical organizations. Since 1927, the award has been presented to 158 diagnostic radiologists, radiation oncologists, and physicists who have attained notable stature in the specialty of radiology. These awards are presented each year at the ACR Convocation.

The Board of Chancellors elects honorary fellows in recognition of pre-eminent contributions to the science or practice of radiology by individuals who are ineligible for admission as members of the College. Since 1947, this award has been presented to approximately 169 outstanding individuals from all over the world.

The ACR Committee on Awards and Honors is seeking nominations for the awards in 2008. The deadline for submitting nominations and supporting materials for candidates is July 1, 2007. The award will be presented at the ACR annual meeting scheduled for May 2008 in Washington, D.C. Any ACR member or fellow may submit a nomination for gold medalist; any ACR fellow may submit a nomination for honorary fellow.

Board rules stipulate that a College member or fellow may serve only once each year as either a primary nominator or a sponsor of a gold medalist nominee. For example, a College member or fellow cannot be the primary nominator for one nominee and a sponsor for another or act in either capacity for more than one candidate each year.

The rules also state that a fellow may serve only twice each year as the primary nominator or sponsor of nominees for honorary fellow (i.e., a fellow can serve as the primary nominator for one candidate and as the sponsor for another, or in either capacity, for no more than two candidates each year).

The rules further stipulate that reactivation of an individual’s nomination for gold medalist is permissible for one year only. If the individual is not chosen for the gold medal during the first year, the primary nominator will be given the opportunity to reactivate the candidate’s nomination for consideration the following year without submitting additional supporting letters. If the candidate is not recommended for the medal after being reactivated, he or she would then be ineligible for one year before a new nomination could be brought forward for consideration. All reactivation letters must be received by January 15 for consideration the second year.

A candidate for an honorary fellowship could be nominated one year, reactivated the second year, and, if not recommended for an award, would then be ineligible for one year before a new nomination could be brought forward for consideration.

Members of the Committee on Awards and Honors, current college officers and members of the Board of Chancellors, the executive director, and College staff are excluded from nominating or sponsoring candidates. Nominations must be submitted in writing. Accompanying materials must include detailed background information on the nominee’s qualifications for the award and comprehensive curriculum vitae of the nominee. In addition, each nominee must have at least two letters of recommendation from his or her sponsors.

Send nominations for 2008 awards, including all attached materials, to Lee F. Rogers, M.D., chair of the Committee on Awards and Honors, 1891 Preston White Drive, Reston, VA 20191, Attention Harvey L. Neiman, M.D. Or, you can e-mail the information to mjdonahue@acr.org.
Life is the result of a series of decisions — some of them trivial, others more significant. However, it is fateful when faced with a decision like the one that challenged ACR member Julie M. Miller, M.D., nearly three years ago.

Miller, a breast imaging specialist at Central Baptist Hospital in Lexington, Ky., is all too aware of the physical and psychological effects of breast cancer. Her mother developed breast cancer at the age of 45 and several other close relatives also battled the disease — a family history that cast an emotive shadow over Miller’s professional and, more importantly, personal life as she had children of her own.

While most instances of breast cancer are not hereditary, studies have suggested that hereditary breast cancer is responsible for about 10 percent of all cases and the prospects of such an occurrence should be strongly considered if a woman has two or more close relatives who developed the disease before the age of 50. So, facing the risk of developing breast cancer herself at some point, Miller chose to undergo a preventive mastectomy with the aim of sparing herself and her family the anxiety of breast cancer.

“It’s something that’s been a shadow over my entire life,” Miller recalls, her warm and welcoming Southern accent offering no evidence of lingering regrets about her decision. “I kept looking at myself and thinking about my family history and wondering ‘how does this affect me and how will it affect my family?’”

Moreover, as a breast imaging specialist, Miller has seen more than her share of women who were diagnosed with breast cancer at an early age. She also realized the possibility of having someone have to break the news to her.

“I’ve seen women with young children and newlyweds who were told they had breast cancer,” Miller says compassionately. “I knew I could not be that person, especially with my knowledge that I could have potentially prevented it by being proactive.”

Miller says her two young children, now ages 5 and 3, were a crucial factor in her decision to undergo the procedure. “I had a toddler and a young baby at the time;” she points out. “I wanted to be there for them as they grew up.”

She also recounts an earlier breast biopsy that took a mental toll on her. “I had the biopsy on a Friday, and before the weekend was over, I was convinced I had full-blown breast cancer,” she remembers. “I remade my will and considered every possible scenario. You naturally fear the worst and then your imagination just runs with it.”

Fortunately, the biopsy showed nothing serious, but the experience had a lingering effect on Miller’s outlook on her life and the future prospects of developing breast cancer. Knowing that studies have demonstrated that preventive mastectomies have been shown to reduce the chance of breast cancer by as much as 90 percent, Miller decided to undergo the procedure and have her healthy breasts removed.

“I felt like I was waiting my turn,” Miller recounted in an Oct. 24 article in the Lexington Herald-Leader. “I needed to get that weight off my shoulders. I needed peace of mind and as close to an assurance as I could get.”

While not a new procedure several years ago, preventive mastectomies were not often requested or performed. The procedure is, for the most part, the same surgery as a bilateral mastectomy, with some minor differences. Now, however, the procedure is much more common. Miller underscores that the entire process was made easier with the support of her husband and “a great team of medical professionals” who counseled her through the process.

And today, nearly three years since the procedure, Miller is confident “it is the best thing I ever did.”
THE CHOICE OF GENETIC TESTING

For the last decade, women who think they may be at risk for hereditary cancer have had the option of a genetic test to serve as another key indicator. The tests can confirm the presence of two genes — BRCA 1 and BRCA 2 — which put women at a significantly higher risk of developing breast or ovarian cancer. According to studies, women who present either gene have between a 60 percent and 85 percent chance of developing breast cancer before the age of 90.

More recently, women have had the option of preventive mastectomies as a way to try and avoid the trauma associated with cancer. The procedure has gained popularity in recent years as more women opt for the genetic testing, and now as many as 70 percent of the women who test positive for one of the marker genes choose the procedure.

However, Miller chose not to undergo the genetic tests. “I was not planning on having the testing prior to the procedure because of the timing and certain job constraints,” she says. “However, a negative result would not have changed my plans to have the mastectomies performed.”

“I always thought that I would do it once my children were grown and then I could go into it with my eyes wide open,” she adds, noting that she is a believer in the testing. “It was always something on my ‘to do list’ and it still is.”

A NEW PERSPECTIVE

While the procedure has lifted a tremendous emotional burden from Miller’s mind, the experience also left her with a new perspective on her career as a radiologist. Her memory of “the little things that made a difference” in her case has made her more empathetic and compassionate for her own patients.

“No I love my job even more,” she explains. “I feel that, in a unique way, this has made me a better radiologist.

“I can speak to my patients as a person who has been there. I can share my own personal experience with them and help them understand the road ahead of them.”

Miller says that, when possible, she steps out of the “doctor role” and tries to speak to a patient as a friend and mentor, allowing her to feel closer to the patient. She explains that she tries to relate to her patients as if each one was her own mother.

“I feel as if I’m doing a real favor for my patients when they ask, ‘What did you feel?’” Miller says. “I can advise them on the pros and cons of the procedure that many patients don’t have access to. I advocate a very proactive approach to the process and let them know that they are not a victim of circumstances.”

From a technical perspective, Miller says that her own experience has influenced how she practices medicine. She adds that she now views images with a “different view of things.”

“My life and my experiences have made me a more cautious breast imager than before,” she explains. “I am more liberal with breast biopsies, for instance, because I know how stressful it can be to be told to follow up in six months.”

From her experience, Miller says that women are more interested in immediate results, even if it means an invasive biopsy, just to ensure their peace of mind. “I think I understand that thinking better now than when I began my radiology career,” she adds. “It is always surprising to get back a positive cancer result from a biopsy that you thought was most likely benign on an image.”

“IT FELT LIKE HOME”

A native of Alabama, Miller did not start out planning on a career in radiology. In fact, after earning her undergraduate degree from Birmingham-Southern College with a major in chemistry and a minor in art and completing medical school at the University of Alabama-Birmingham, she originally was attracted to a career in pediatrics and family practice.

However, while completing her radiology residency breast rotation at Emory University in Atlanta, Miller recognized an instinctive bond with breast imaging, the memories of her mother’s battle with breast cancer in the back of her mind.

“It just triggered an interest and it felt like a good fit,” Miller recalls. “Breast imaging is not where I thought I’d end up, but it just felt like home.”

Professionally and personally, this home is no longer affected by the lingering fear of an all-too-familiar menace, but rather an outlook that is based on optimism instead of worry.
Dealing With the Federal False Claims Act

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

We reported in a previous column that as the legal spotlight keeps shining brightly on medicine, radiology has had its share of “law and order” moments (see the “RADLAW” column in the September 2006 issue of the ACR Bulletin). For example, some recent radiology cases in Florida and Indiana started because a former practice member or office manager visited the local authorities and alleged that practice leaders had failed to comply with laws and regulations. Typically, such “whistleblowers” have used the federal civil False Claims Act (FCA) to target corporate wrongdoing and, in many instances, obtain significant monetary settlements. This article will answer key questions about the FCA law and a new related challenge that ACR members should watch carefully.

WHAT IS THE FALSE CLAIMS ACT?

Originally enacted by Congress during the Civil War, the False Claims Act prohibits individuals or entities from submitting, causing to be submitted, or conspiring to submit a false, fictitious, or fraudulent claim to a federal employee or officer (e.g., a contractor). The law permits individuals, or relators, to bring *qui tam* lawsuits themselves and on behalf of the government if they are the “first to file.” If the government decides not to intervene or take over prosecuting the case, then the relator must be an “original source” of the information pleaded, or the information must not have been previously “publicly disclosed.”

WHAT IS A “FALSE” CLAIM?

A false claim may include data contained within a document, such as services provided, codes used, or a patient’s eligibility for Medicare or Medicaid. Services performed that are not medically necessary also may be deemed a false claim. Another, more controversial basis for a false claim accusation falls under the “implied certification” provision — when, for example, a provider certifies in submitting a claim and seeking payment that the services met applicable law, such as the federal antikickback law, when, in fact, they did not.

Unlike the “beyond a reasonable doubt” criminal standard, the government only has to prove that one knows or should have known that a claim was false. Nevertheless, some courts have rejected the government’s efforts to bring quality-of-care actions based on this theory.

Originally enacted by Congress during the Civil War, the False Claims Act prohibits individuals or entities from submitting, causing to be submitted, or conspiring to submit a false, fictitious, or fraudulent claim to a federal employee or officer (e.g., a contractor).

HOW COULD THE FCA AFFECT MY PRACTICE?

A false claim investigation can devastate a practice. Not only can the government seize and examine any records pertinent to the complaint, but once investigators are in the door, all of your business practices are also fair game. The financial consequences of facing an FCA lawsuit are dire: civil penalties range from $5,500 to $11,000 per “claim” plus triple damages and exclusion from participation in all federal programs (except for the Federal Employees Health Benefits Program). Even if you successfully defend the case, you’ll likely incur major legal and accounting costs. Perhaps even more worrisome is the potential effect on your practice’s clinical or financial relationship with a multispecialty clinic or hospital system. The government can decide to look into your interactions with such clinics or systems and seek to review their records as well. In the event that your practice is excluded from federal programs, those clinics and systems will not be able to refer any Medicare, VA, or TRICARE patients to your practice and may choose not to do business with you at all.

HOW CAN I PREVENT OR REDUCE POTENTIAL LEGAL LIABILITY?

Polish up your compliance plan or start one immediately. Law enforcers continue to maintain that an ongoing plan can help you avoid major penalties and, more importantly, keep patient care in your practice running smoothly. The
compliance stakes are now higher than ever. As of January 1, 2007, the Deficit Reduction Act (DRA) of 2006 mandates a compliance program for any entity that receives or pays $5 million or more annually in Medicaid funds. The entity must educate its employees (including managers), agents, and contractors about the federal FCA and any state equivalent, how the entity will stop fraud and abuse, and employees’ rights as whistleblowers. Since the DRA may boost states’ Medicaid funding by 10 percent if they enact their own false claims statute with whistleblower provisions, you should communicate more frequently with your coding and billing staff regarding your practice’s compliance efforts. By committing to follow the law and instilling a culture of compliance, you can minimize a potential whistleblower’s grievances.

Unlike the “beyond a reasonable doubt” criminal standard, the government only has to prove that one knows or should have known that a claim was false.

The DRA provisions could affect large radiology practices, especially those that serve several hospitals within a health system. Consult with a qualified health care attorney in the state(s) where you practice.

NOTICE: The ACR Legal Office exists to represent the College and to provide legal advice to the College leadership and the executive director, as well as to handle the day-to-day legal activities of the College. The attorneys are not licensed in all 50 states, the District of Columbia, Puerto Rico, Guam, and Canada, and therefore, cannot give direct legal advice to members or represent chapters, practices, or individual members. The office can provide general information of interest to members as well as general guidance on a variety of legal topics. All information is provided with the express understanding that no attorney-client relationship exists and that members, practices, and chapters should always consult their personal or corporate counsel on matters of concern.

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

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

ACR Boosts Presence at 2007 ECR

The annual meeting of the European Congress of Radiology (ECR) is the international imaging event of the year, drawing radiologists and imaging specialists from around the world for several days of groundbreaking information sessions and a variety of industry-related exhibits.

Given the extraordinary success of the ACR’s presence at the two previous ECR gatherings, featuring an eye-catching booth and ACR leaders and staff ready to discuss the latest in educational and professional programs and services, the College will boost its presence at this year’s ECR meeting, scheduled for March 9 through March 13 in Vienna, Austria, the crown jewel of European culture.

“With the advent of the easy sharing of information and diagnostic images around the world, it is important for the ACR to have a strong, visible presence at the ECR meeting,” says Arl Van Moore Jr., M.D., chair of the ACR Board of Chancellors and one of the ACR representatives at this year’s meeting. “As radiology continues to transcend international borders, it is important for the ACR to lead the way in establishing worldwide standards of quality and safety and promote its excellent array of educational products.”

This year, the ACR will feature several key quality and safety programs, including e-RADPEER™, BI-RADS®, and the ACR Appropriateness Criteria®. The College also will spotlight several of its more popular education programs, such as the Professional Self-Evaluation syllabi series, the ACR Campus™, and the ACR Learning Files®.

Look for more details on the ACR’s presence at the 2007 ECR in a future issue of the ACR Bulletin.
Plan to Attend the 2007 Chapter Leaders’ Workshop and Breakfast

The ACR’s Office of Chapter and Volunteer Development invites you to the Chapter Leaders’ Workshop to be held May 19 during the 2007 Annual Meeting and Chapter Leadership Conference. The workshop will provide chapter leaders with the opportunity to learn from and interact with their colleagues from other chapters. ACR staff will be on hand to answer questions and provide information on key ACR resources and programs.

We also invite you to attend the Chapter Leaders’ Breakfast on May 21, which will focus on grassroots organizing and RADPAC®.

For more information on the workshop and breakfast, please visit the chapter section of the ACR Web site (www.acr.org) or contact Trina Zeberlein at tzeberlein@acr.org.

RESIDENT AND FELLOW SECTION ANNUAL MEETING

This year marks the 15th anniversary meeting of the ACR Resident and Fellow Section (RFS). This meeting will be held in conjunction with the ACR Annual Meeting and Chapter Leadership Conference in Washington, D.C., on May 19-23.

Since its inception, the ACR RFS has served radiologists-in-training by:

- Introducing them to the important role the ACR Council plays in policymaking for the organization
- Catalyzing the development of the future leaders in radiology
- Providing a national forum for residents and fellows to discuss issues of mutual concern

All of the ACR’s members-in-training are welcome to attend the meeting. For more information, please visit the RFS Web site at http://rfs.acr.org or contact Trina Zeberlein at tzeberlein@acr.org.

UPCOMING CHAPTER MEETINGS

Massachusetts Radiological Society
March 14, 2007
Westin Hotel
Waltham, Mass.
Contact: Ginny DuLong
Phone: (781) 434-7313
E-mail: vdlulong@mms.org

Illinois Radiological Society – Joint Meeting
March 16-17, 2007
Feinberg Pavilion Conference Center at Northwestern Memorial Hospital
Chicago, Ill.
Contact: Merle Hedland
Phone: (630) 323-5344
E-mail: mhedland@bacon-hedland.com

DC Metro Radiological Society – Dinner Lecture
March 22, 2007
Topic: MRI of Articular Cartilage: Trauma Degeneration and Repair
Cosmos Club
Washington, D.C.
Contact: Barbara Zweig
Phone: (301) 406-0412
E-mail: DCMSRS@planitnow.com

North Carolina Radiological Society
March 24-25, 2007
Carolina Hill Hotel
Chapel Hill, N.C.
Contact: Dixie Harris
Phone: (704) 873-2583
E-mail: dixnie@roadrunner.com

Indiana Radiological Society
March 31, 2007
University Place Conference Center and Hotel
Indianapolis, Ind.
Contact: Sally Pierson
Phone: (317) 261-2060, ext. 262
E-mail: spierson@ismanet.org

New Hampshire Radiological Society
March 31-April 1, 2007
The Mount Washington Resort
Bretton Woods, N.H.
Contact: Mark D. Luedke, M.D.
Phone: (603) 487-3323
E-mail: mlduedkemd@msn.com

Texas Radiological Society
April 13-15, 2007
The Woodlands
Houston, Texas
Contact: Renita Fonseca
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New York State Radiological Society
April 15, 2007
LaGuardia Marriott
Queens, N.Y.
Contact: Dawn Muniz
Phone: (212) 448-1866
E-mail: nysrad@aoi.com

Illinois Radiological Society
April 19, 2007
Rush University Medical Center
Chicago, Ill.
Contact: Grace Pascual
Phone: (918) 906-5455
E-mail: goruiz@remham.com

Oklahoma State Radiological Society
April 21, 2007
Perdido Beach Resort
Orange Beach, Ala.
Contact: Natalie Munroe
Phone: (334) 514-8407
E-mail: nsmunroe@hiwaay.net

South Carolina Radiological Society and Georgia Radiological Society—Joint Meeting
June 22-23, 2007
Charleston Harbor Hilton Hotel
Patriots Point in Mt. Pleasant, S.C.
Contact: Clydie de Brux
Phone: (843) 883-9516 or (843) 345-7052
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Magnetic Resonance Update


This comprehensive document has been retitled ACR Guidance Document for Safe MR Practices: 2007. Each section of the white paper’s MR Safe Practice Guidelines has been re-evaluated and either updated or entirely rewritten. Several new sections and appendices also have been added. The paper is scheduled for publication in the American Journal of Roentgenology (www.ajronline.org) in mid-2007.

WHAT’S NEW?

Significant revisions and modifications include the following:

• The FDA Public Health Notification on MRI-related incidents or “near incidents” mandates reporting MR accidents via the FDA MedWatch program; the ACR supports this requirement (A.4).

• How the three-dimensional qualities of a magnetic field affect safety assessment of the static fringe field is explained (B.1.c).

• As an adjunct to the MR screening process, it is recommended that the newly available ferromagnetic detectors (which can differentiate between ferromagnetic and nonferromagnetic materials) be used (B.3.c).

• The updated document stresses the limitations of relying on interpretation of the ECG complex for monitoring patients while a patient is lying within the magnetic field in the MR scanner (B.3.j.2).

• The advised waiting periods for certain implants have been revised. This update explains how to manage ferromagnetic foreign bodies, objects, or implants that are unexpectedly discovered within a patient during an MR imaging examination. It also describes several potentially acceptable courses of action (B.3.k).

• The American Society of Testing and Materials created (and the FDA has since adopted) a new standard, F2503-05 Standard Practice for Marking Medical Devices and Other Items for Safety in the Magnetic Resonance Environment, that defines proper identification and labeling of various devices. This new terminology is addressed and incorporated throughout the updated ACR document (B.5.d).

• An overview of Lenz’s forces for nonferrous metallic items, their possible interactions with the static magnetic field gradients of MR imaging, and the clinical implications thereof, has been added (B.5.f).

• Detailed explanations are provided as to why wires, electrodes, and leads in MR scanning environments should be treated as special MR safety topics and considerations. The white paper introduces the concept of resonant circuitry’s potential and explains why all thermal safety claims are field-specific to the exact magnetic field-strength conditions tested (H.2).

• An extensive new section has been added to provide state-of-the-art information and guidance on administering gadolinium-based MR contrast agents (especially Omniscan) to patients with renal failure and the recent discovery that some patients develop nephrogenic systemic fibrosis. This topic was recently addressed in an updated FDA public health advisory (L.3). Additionally, the white paper revisits and elaborates on the topic of administering gadolinium-based MR contrast agents to pregnant patients.

• The section on cardiac pacemakers has been completely rewritten. It contains the latest information available, along with clinical recommendations and guidelines for patients with cardiac pacemakers and implantable cardiofibrillators.

• For the first time, the document now discusses MR safety issues to be considered during the initial planning and siting phases for design and installation of MR sites. This exhaustive new section provides relatively detailed analysis of various factors to consider, including the safety of patient and health care practitioners as well as throughput issues. The focus includes consideration for accommodating the ACR-defined 4-zone construct, patient screening and changing/holding areas, restricting access to sites, and discussions of the safety of magnetic fields and cryogen, among other topics.

• A newly added section introduces disaster preparedness for MRI facilities and covers identification of the greatest risk-threats for facilities as well as preparations to mitigate damage and threats to safety and equipment operations. Recommendations highlight how to prevent or minimize damage from flooding and power outage, and how to establish effective coordination among MR staff, code teams, and other emergency response personnel.

This is the most comprehensive and detailed version of these MR Safe Practice Guidelines that the ACR’s MR Safety Committee has ever produced. Significantly, the entire contents of this document represent complete and unanimous consensus on the part of each and every committee member as opposed to a majority opinion. Substantial efforts were made to ensure that this guidance document is not only accurate and up-to-date, but also readily implementable by sites that wish to follow its recommendations.
Should gadolinium be reported in the office setting, and will it be reimbursed by Medicare in 2007?

Yes, the paramagnetic contrast agent gadolinium should be reported, when used in any setting (e.g., office, IDTF, hospital). As of Jan. 1, 2007, Medicare no longer bundles payment for gadolinium into the MRI or MRA procedure codes. The corrections document to the Medicare Physician Fee Schedule (Federal Register, Dec. 8, 2006, Vol. 71, No. 236, p.71066, #4) notes the separate reporting and payment of contrast as follows: On page 69646, in the 2nd column, the 4th full paragraph, the response “We will implement these changes for CY 2007” is corrected to read as follows: ‘We are implementing these changes for CY 2007. Because we are implementing the bottom-up methodology, which utilizes the direct inputs to determine the PE [practice expense] RVUs [relative value units] for CY 2007, a separate payment for the contrast media used in various imaging procedures will be available. In addition to the CPT® code representing the imaging procedure, providers are instructed to use the appropriate HCPCS Q-code, Q9942 through Q9964, to separately bill for the contrast medium utilized in performing the service.’”

As published in the November/December 2005 ACR Radiology Coding Source™ Q&A, codes Q9952-Q9954 should be used to report the use of gadolinium in all settings. While the Centers for Medicare & Medicaid Services (CMS) has established this new payment policy, the manuals (MCM 15022(B)(6), IOM Chapter 13, 40) currently contain the old nonpayment verbiage. Therefore, the CMS national office has notified the ACR that it will issue a change request to reflect this change in CMS payment policy for gadolinium.

When 3-D angiography is performed, is it coded in addition to the base angiography procedure code?

Yes, 3-D angiography reconstruction images are coded in addition to the base angiography procedure code. Newer equipment allows for independent 3-D reconstruction that requires additional work, skill, and time to create diagnostic images. These images provide additional diagnostic information that would not otherwise be obtainable with another modality. Therefore, it is appropriate to report either 76376, when performed on the console (extremely rare for angiography), or 76377, when performed on an independent workstation (the norm for this service), in addition to the base angiography procedure code.

As long as all of the criteria for concurrent supervision are met (e.g., design the anatomic region that is going to be reconstructed, determine the images or cine loops to be archived, and monitor and adjust the 3-D work product), it is appropriate to code for the 3-D reconstructions. The rationale for the use of these codes with angiography is that this procedure meets the definition of “other tomographic modality,” as listed in the descriptor of the 3-D rendering codes (76376, 76377). Three-dimensional angiography is a tomographic modality wherein an X-ray tube rotates about an isocenter collecting data at various reference points. Typically, the data is sent to an independent workstation for postprocessing. Because this is performed on an independent workstation, 76377 is the appropriate code to report for this procedure.

It is important that documentation of the 3-D work is noted in the report to ensure that it is not confused with 2-D rotational angiography, which is not reported separately.
The Neuroform stent is a Humanitarian Device Exemption (HDE) device approved for use in stenting wide-neck aneurysms and subsequent coiling. Some radiologists place the stent and do not coil the aneurysm at the same setting. Since the stent placement is inherent in the coiling and usually not reported separately, should the Neuroform stent be coded, if placed during a different session?

When a combined stent placement and embolization procedure is performed on the same day, only the appropriate embolization code should be reported. The stent is placed to aid in the embolization procedure. It is considered a part of the embolization procedure and should not be coded separately.

When a staged procedure is performed, stent placement on Day One should be reported with code 61635 \textit{[Transcatheter placement of intravascular stent(s), intracranial (e.g., atherosclerotic stenosis), including balloon angioplasty, if performed]}. As noted in the \textit{CPT} code book, following code 61635, “It includes all selective vascular catheterization of the target vascular family, all diagnostic imaging for arteriography of the target vascular family, and all related radiological supervision and interpretation. When diagnostic arteriogram (including imaging and selective catheterization) confirms the need for angioplasty or stent placement, codes 61630 and 61635 include these services. If angioplasty or stenting are not indicated, then the appropriate codes for selective catheterization and imaging should be reported in lieu of 61630 and 61635.”

The embolization performed on Day Two should be reported with code 61624 \textit{[Transcatheter permanent occlusion of embolization (e.g., for tumor destruction, to achieve hemostasis, to occlude a vascular malformation), percutaneous, any method; central nervous system (intracranial, spinal cord)]}, as well as with all of the appropriate catheterization and radiological supervision and interpretation (RS&I) codes. In addition, a separate postembolization angiogram code 75898 should be reported, if performed and documented. Modifier 58 should be applied to the surgery codes (e.g., 36216, 36217, 61624) to indicate that this part of the procedure was staged.

\textbf{ACR Collaborates, Increases Its Reimbursement Efforts}

As radiologists continue replacing the traditional catheter-based coronary angiography with cardiac computed tomography (CT), the ACR increases its efforts to ensure that members are reimbursed appropriately for their training and expertise. New cardiac \textit{CPT\textsuperscript{®}} codes (category III) went into effect in January 2006. Since then, the College has worked closely with the American College of Cardiology (ACC) to develop a new package of cardiac MRI \textit{CPT} codes (category I) that reflect the complexity of services currently being performed. “If our efforts before the \textit{CPT} Editorial Panel are successful,” Richard Duszak Jr., M.D., says, “we anticipate these new codes for 2008 and coronary CT angiography (CCTA) codes in 2009.

“The College continues its work on multiple fronts to facilitate appropriate reimbursement, as CT and MR technology mature and as radiologists continue to take a clinical leadership role in these arenas.” Duszak, in private practice with Mid-South Imaging and Therapeutics in Memphis, Tenn., and the ACR \textit{CPT} advisor to the American Medical Association’s \textit{CPT} Editorial Panel, has been instrumental in developing the cardiac CT and coronary CT angiography (CTA) coding.

Although the current category III service codes describe most cardiac CT services and cover emerging technology, they are not nationally valued. Subsequently, often they are not reimbursed for cardiac CT. Once they are replaced with category I \textit{CPT} status, radiologists can expect uniform and universal payment for services rendered.

“Cardiac CT has kept the various economics teams quite busy,” Duszak explains. After the ACR and the ACC successfully co-sponsored an application for Category III \textit{CPT} codes in 2006, they have collaborated to educate Medicare contractors and private payers about these services to ensure appropriate reimbursement.

Currently, a combined ACR-ACC \textit{CPT} work group is working to advance cardiac CT and coronary CT angiography codes to Category I \textit{CPT} status. “Although the burden to approve Category I codes has evolved over the years,” Duszak adds, “this group of clinical experts and economics volunteers is committed to seeing these services appropriately recognized by \textit{CPT}.”

The ACR’s accomplishments in other economic arenas, such as valuation and coverage (for Medicare and private payers), will be highlighted in upcoming \textit{ACR Bulletin} issues.
**Job Listings**

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

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

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

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

Job listings are in order of state.

**ALABAMA - Anniston** - BC/BE General or Fellowship-Trained Radiologist - BC/BE diagnostic radiologist to join seven-member group located between Birmingham, Ala., and Atlanta. Group covers two hospitals plus outpatient center; 150,000 procedures annually. **Contact:** Gary H. Morgan, M.D., by phone at (256) 237-9729; via e-mail at annrad@bellsouth.net; or mail CV to 425 E. 10th St., Suite B, Anniston, AL 36207.

**CALIFORNIA - Arcadia** - Radiologist - Busy Southern California private practice is recruiting a board-certified radiologist for a partnership-track position. We seek a radiologist with broad clinical skills in the full range of general radiology, including CT with cardiac applications, ultrasound, MRI, nuclear medicine, and breast imaging. Competitive compensation and benefits offered. **Contact:** Michael Smith by phone at (626) 445-4850.

**CALIFORNIA - Los Angeles** - Interventionalist/Body Imager Radiologist - We are a stable, medium-sized radiology group in the Los Angeles area interested in expanding our practice. We serve three hospitals with PACS. We are looking for one interventionalist and one body imager. These are partnership-track positions with a nice benefit package. **Contact:** Tony Nahas by fax at (626) 795-0751.

**CALIFORNIA - Los Angeles** - Radiologist - Radiologist needed for medium-sized hospital. Broad clinical skills in the full range of general radiology, including CT, ultrasound, MRI, nuclear medicine, breast imaging, fluoroscopy, and limited interventional procedures needed. Diagnostic night call covered by teleradiology service. Competitive high salary and superior benefit package included. **Contact:** Paul Kash by phone at (818) 710-6011.

**CALIFORNIA - Sacramento** - Interventional Radiologist - Radiological Associates of Sacramento is seeking a board-certified, fellowship-trained interventional radiologist to fill a partnership-track position, to start 2007 or sooner. **Contact:** John de la Vega, M.D., by phone at (916) 646-8427; fax (916) 920-4434; via e-mail at recruit@radiological.com; or mail CV to Radiological Associates of Sacramento, 1500 Expo Pkwy., Sacramento, CA 95815.

**CALIFORNIA - Tustin** - Radiologist - Located in Southern California, near the Tustin Marketplace, Healthview is an outpatient radiology center pioneering preventive medicine. Its founder is the inventor of full-body scanning. The majority of our procedures are body scans utilizing 3-D reconstruction of CT imagery. Check out our Web site at www.healthview.com. **Contact:** Terri Eisenberg by phone at (949) 306-1253.

**COLORADO - Denver** - Full-Time Academic Neuroradiology Position - University of Colorado at Denver and Health Sciences Center Neuroradiology Division has opening for full-time or part-time associate or assistant professor. New outpatient center and moving into a state-of-the-art inpatient facility July 1. Looking for an exceptional fellowship-trained neuroradiologist for this clinical-track position. **Contact:** Robert Bert, M.D., Ph.D., via e-mail at robert.bert@uchsc.edu.

**CONNECTICUT - New Haven** - Assistant or Associate Professor, Neuroradiology - Yale Diagnostic Radiology is seeking a translational neuroscience researcher to collaborate with programs in MR imaging, MR spectroscopy, CT, MR physics, image analysis, brain physiology, and metabolism. Candidates should be board certified, possess an M.D., and eligible for licensure. Equal opportunity/affirmative action employer. **Contact:** Gordon Sze via e-mail at gordon.sze@yale.edu.

**FLORIDA - Hollywood** - General/Interventional Radiologist - Seeking a general/interventional radiologist to perform basic interventional procedures and general radiology. **Contact:** Jill Avendano by phone at (954) 437-4800, ext. 2148; or mail CV to Jill Avendano, Radiology Associates of Hollywood, 9050 Pines Blvd., Suite 200, Pembroke Pines, FL 33024.

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

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

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

**FLORIDA - Titusville** - Radiologist - Five-member group seeking personable BC radiologist for stable practice near Orlando. Fellowship preferred. Should be skilled in all aspects of radiology, including interventional. Excellent equipment in new hospital with PACS. Call 1:5 with nighthawk. Early partnership with excellent vacation time (12-14 weeks). **Contact:** Richard Mayer via e-mail at mayer5e@gmail.com.

**GEORGIA - Atlanta Area** - Mammographer - Large multispeciality group, with radiologists fellowship-trained in all areas, seeking an associate for full partnership position in mammography. Flexible working structure and schedule. Recent acquisition of PACS, MRI with CAD, and MRI Bx capability. **Contact:** Terry Ward by phone at (678) 581-3830.

**GEORGIA - Savannah** - Vascular/Interventional - Ten-member group looking for a fellow or recently trained interventional radiologist for a private practice, hospital-based setting covering two hospitals with ~550 beds. Broad spectrum of IR cases, with 50 percent to 60 percent IR. Nighthawk. **Contact:** Robert Myers, M.D., by phone at (912) 658-1470, fax (912) 355-1361, or via e-mail at rmyers001@gmail.com.
HAWAI'I - Honolulu - Neurointerventional Radiologist - Private-practice group in Honolulu seeking CAQ neurointerventional radiologist to work with two other neuroradiologists at a 540-bed JCAHO stroke center hospital. 1.5 & 3T MRI, multiple 64-slice CT. New neurovascular angio suite to be installed this year. Contact: Send CV via e-mail to jcieply@rahawaii.com.


MAINE - Brunswick - General Radiologist - Six full-time/one part-time general radiologist for a community-based practice, including subspecialties, servicing beautiful coastal Maine. All modalities, PACS, nighthawk. One position available. Equal call; vacation; great compensation/benefits; great lifestyle. Exciting new growth. Fellowship in MSK or body imaging a plus. Contact: Robert Finegold by phone at (207) 846-0040 or via e-mail at rfinegold@rsmaine.com.

MASSACHUSETTS - Ayer - Mammography Coordinator - Days: 8 a.m.–4:30 p.m. Seeking positive, high-energy professional. NVHC has a recent addition of a hologic digital mammography machine with CAD. Two years of supervisory experience, state, and AART certification required. EOE. Contact: Grace Richards by phone at (978) 784-9215; via e-mail at jobs@nashobamed.com; or mail CV to Nashoba Valley Medical Center, 200 Groton Rd., Ayer, MA 01432.

MASSACHUSETTS - Ayer - Private-Practice Partnership - Growth-oriented radiologist sought for three-person hospital-based group. Growing practice that, at present, performs 45,000 cases per year. New hospital to be built in 2008 to meet growing demographic demand. Excellent equipment. Nighthawk in place. Excellent income and lifestyle. Contact: Matthew Foley by e-mail at mfoley@massmed.org.


MINNESOTA - Bemidji - Radiologist - MeritCare Clinic is seeking a BC/BE radiologist to step into an existing practice. All modalities performed. State-of-the-art equipment, including PACS and teleradiology. Practice in both clinic and hospital settings. Join a 57-physician multispecialty group practice. Contact: Dick Reis by phone at (701) 280-4887 or via e-mail at Dick.Reis@meritcare.com.

MINNESOTA - Minneapolis - Radiation Oncologist - Private-practice group in Minneapolis is seeking a motivated candidate to join two experienced physicians in their hospital-based practice. Department is well-staffed and equipped with a Novalis (Brain Lab) System, Varian 2100EX, 2100 MLC, Pinnacle TPS, Varian HDR, Philips CT/Sim. Board eligibility required. No post-residency experience required. Contact: Send CV via e-mail to RCarpenter@mrpa.org.

MISSOURI - Columbia - Neuroradiologist - The University of Missouri Health Care System Department of Radiology seeks fellowship-trained neuroradiologist to join department of 17 radiologists (two neuroradiologists). Contact: Robert Churchill, M.D., by phone at (573) 882-1026; fax (573) 884-3052; via e-mail at churchillr@health.missouri.edu; or mail to Department of Radiology DC069.10, University of Missouri Healthcare, One Hospital Drive, Columbia, MO 65212.

NEBRASKA - Omaha - Neuroradiologist - The neuroradiology section at the University of Nebraska Medical Center seeks faculty member who has completed a formal neuroradiology fellowship and is fully ABR certified. Contact: The University of Nebraska Medical Center by phone at (402) 559-1010; fax (402) 559-1011; via e-mail at matthewwhite@unmc.edu; or mail to The University of Nebraska Medical Center, Omaha, NE 68198-1045.

NEW YORK - Nassau and Suffolk County - Radiologist - Fifty-person radiology group at multiple hospitals needs mammography, MRI, and interventional radiologists for Nassau, Suffolk County, and Long Island locations. Contact: Kenneth Schwartz by phone at (914) 666-2220, fax (914) 666-2987, or via e-mail at kschwartz@nighthawk.com.

NEW YORK - Queens - Breast Imager - Columbus Medical Institute seeks radiologist proficient in breast imaging for lead mammographer position. Division PACS integrated with GE Senograph 2000D Digital Mammography with CAD. Siemens 1.5 Tesla MRI with breast coil, Siemens Biograph 16 PET/CT, Siemens e-cam nuclear medicine, multiple SonoCT units, etc. Contact: Leonid Futerman by phone at (718) 261-9100 or via e-mail at leo.futerman@columbusmedical.org.

NORTH CAROLINA - Gastonia - Nighthawk Radiologist - One nighthawk position available for Charlotte Metro area to work at 400+ bed hospital. Competitive salary with full benefits. Contact: Rick Keener by phone at (704) 671-7734 or (704) 852-9759; fax (704) 864-4606; via e-mail at keenerr@gastondiagnostic.com; or mail to Rick Keener, Administrator, P.O. Box 1495, Gastonia, NC 28053.

NORTH DAKOTA - Fargo - Radiologist - MeritCare - Seeking BC/BE radiologist to join 20-physician dept. All modalities performed. State-of-the-art equipment - PACS, teleradiology, NightHawk. Practice in clinic & hospital. UNDSONMHS faculty position available. Join 411-physician multispecialty group practice. Contact: Dick Reis by phone at (701) 280-4887 or via e-mail at Dick.Reis@meritcare.com.

OREGON - Portland - Radiologist - The Portland Clinic is an independent, full-service medical clinic that was established in 1921. Our four branches house over 50 physicians representing multiple specialties. Visit our Web site at www.theportlandclinic.com. Contact: Jan Reid by fax at (503) 221-4451; via e-mail at jreid@tpcllp.com; or mail CV to Jan Reid, 800 S.W. 13th Ave., Portland, OR 97205.

PENNSYLVANIA - Philadelphia - Diagnostic & Interventional Neuroradiology - One- and two-year fellowship positions available in diagnostic and interventional neuroradiology. Visit our Web site: http://www.temple.edu/medicine/departments/centers/clinical_departments/radiology.htm. Contact: Jeffrey P. Kochan, M.D., by phone at (215) 707-2525; fax (215) 707-8154; via e-mail at jkochan@temple.edu; or send CV to Jeffrey P. Kochan, M.D., Temple University Hospital, Department of Diagnostic Imaging, 3401 N. Broad St., Philadelphia, PA 19140.

PENNSYLVANIA - Western Suburbs of Philadelphia - Neuroradiologist - Excellent opportunities. Seeking fellowship-trained neuroradiologists to provide interpretations for patients and their physicians at Paoli, Bryn Mawr, Lankenau Hospitals, and related outpatient centers using state-of-the-art equipment and PACS. Full-time partnership track and part-time opportunities available. Reasonable call with nighthawks. Competitive package. Contact: Send CV by e-mail to Campagnab@msn.com.

PENNSYLVANIA - Western Suburbs of Philadelphia - Women's Imaging/Breast Imaging - Suburban Philadelphia practice seeks breast imagers for three women’s imaging centers with state-of-the-art equipment, including digital mammography and systemwide PACS. Full-time partnership track and part-time positions avail-
able. (Director position available.) Reasonable call with nighthawks. Competitive salary, vacation, and benefits. Contact: Send CV by e-mail to Campagnab@mson.com.

SOUTH CAROLINA - Charleston - Fellowship-Trained Radiologist
- Partnership-track, private practice opportunity available for fellowship-trained, board-certified/eligible radiologist interested in joining a progressive 19-member subspecialized group. The ideal candidate would be subspecialized in neuroradiology, musculoskeletal imaging, or body imaging. Comprehensive benefit package includes generous time off, CME stipend, and relocation assistance. Contact: Michael Garovich by phone at (843) 824-0606.

SOUTH DAKOTA - Sioux Falls - Interventional Radiology Position
- MXC is recruiting a board-certified, fellowship-trained, interventional radiologist to begin ASAP. The successful candidate will become part of a four-member interventional team providing invasive services to two tertiary-care hospitals. Some general radiology is required. Contact: Pat Tripp by mail at 1417 S. Minnesota Ave., Sioux Falls, SD 57105.

TEXAS - Houston - General/Body Imaging Radiologist - The Michael E. DeBakey VA Medical Center has an immediate opening for a full-time, board-certified/board-eligible radiologist. EOE. Please send current CV, a statement of interest, and names of three references. Contact: Meena S. Viji, M.D., via e-mail at viji.meenas@med.va.gov; or mail to Meena S. Viji, M.D., MEDVAMC, 2002 Holcombe Blvd. (114), Houston, TX 77030.

TEXAS - Houston - General Diagnostic Radiologist - The Department of Diagnostic and Interventional Imaging at The University of Texas HSC at Houston, seeks a general diagnostic radiologist to practice in an outpatient imaging center. Broad imaging skills desirable. Academic rank and salary are based upon experience. Contact: Susan John by phone at (713) 506-7626, or via e-mail at Susan.D.John@suth.tmc.edu.

TEXAS - Houston - Interventional Radiologist - Michael E. DeBakey VA Medical Center seeks full-time interventional radiologist — board-certified or board-eligible with a minimum one-year fellowship in IR. EOE. Please send current CV, a statement of interest, and names of three references. Contact: Meena S. Viji, M.D., via e-mail at viji.meenas@med.va.gov; or mail to Meena S. Viji, M.D., MEDVAMC, 2002 Holcombe Blvd. (114), Houston, TX 77030.

TEXAS - Tyler - Radiologist - Tyler Radiology Associates seeks board-certified radiologists to replace retiring partners. Hospital-based private practice. Fellowship training in neuroradiology, musculoskeletal, or interventional radiology. Heavy cross-sectional imaging load with high volume of CT, CTA, neuro, and musculoskeletal MRI. No mammography. Basic interventional skills required. Contact: Buddy Powell by phone at (903) 593-2539.

VIRGINIA - Alexandria - Mammography/Women’s Imaging - Private practice group covering two hospitals and five outpatient offices is seeking BE/BC radiologist with fellowship training in mammography/women’s imaging. Opportunity to practice in high-quality environment with the latest imaging technology. Highly competitive package in partnership-track position. Contact: Meghan Clinton (H.R. Manager) by phone at (703) 824-3216 or via e-mail at mclinton@alexandriaradiology.com.

VIRGINIA - Bluefield - General Radiologist - Radiology Solutions is a growing practice in need of a general radiologist. Full-time associate position. Private practice. Multiple modalities: MR, PET, CT/Cardiac CT, plain film, US, mammo, fluoro. Board certified or eligible. Virginia license. Contact: Kay Binis, M.S.N., N.P., by phone at (716) 608-2003 or via e-mail at kay@radiologysolutions.us – subject: RAD CV.

VIRGINIA - Roanoke - Radiologists - Carilion Clinic in Roanoke is accepting CVs for ABMS/AOA-BC radiologists in all subspecialty areas for its 835-bed teaching/tertiary referral hospital with Level I Trauma Center, serving 1 million people throughout Southwest Virginia. AA/EEO Contact: Rhonda Creger via e-mail at rhondac@carilion.com; or mail to Rhonda Creger, Senior Physician Recruiter, Carilion Clinic, P.O. Box 40032, Roanoke, VA 24022-0032.

WASHINGTON - Moses Lake - BC Radiologist - Wenatchee Valley Medical Center offers an excellent opportunity for a BC radiologist. Join department of two radiologists. Interpret plain film, ultrasound, CT, mammography, nuclear medicine, and MRI. Contact: David Weber, M.D., by fax at (509) 664-3404; via e-mail at MDRRecruit@wvmcmedical.com; or mail to David Weber, M.D., 820 N. Chelan Ave., Wenatchee, WA 98807-0489.

WASHINGTON - Vancouver - Body Imager/General Radiologist - Vancouver Radiologists P.C. is seeking an experienced radiologist with strong body imaging abilities, including image-guided procedures and body MRI/CT. Experience in other modalities preferred. We offer competitive salary/paid benefits, with partnership-track opportunities. Qualified candidates please send resume and salary requirements. Contact: Send e-mail to HR@vanrad.com.

WEST VIRGINIA - Morgantown - Teleradiologist - Amerirad, a full-service teleradiology company is seeking two radiologists to provide tele-reads. The positions are to be located at the main office in Morgantown, W.V. The starting salary is $400K, with full benefits and eight weeks vacation. Contact: John Mazzetti by phone at (304) 654-8789.
ACR
Calendar of Events

Oncologic Imaging and Image-Guided Interventions
May 19, 2007
Hilton Washington, Washington, D.C.
At this one-day session, you’ll focus on the current and emerging therapeutic modalities involved in interventional oncology. You’ll also learn how diagnostic and interventional radiologists work together to enhance their patients’ well-being and experience.

Cardiac MR: Supervised Case Review
May 19, 2007
Hilton Washington, Washington, D.C.
Document 50 cases in cardiac MRI and learn from an acclaimed faculty. You’ll review the principles of cardiac MRI (CMR), including appropriateness of imaging modality, pulse sequences, ECG-gating, imaging planes, and injection techniques. This course is open to ACR members only.

Service, Quality, and Performance: What Patients Want from Us
May 19, 2007
Hilton Washington, Washington, D.C.
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