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- Managing Evolving Care Pathways
- Adapting to Shifting Reimbursement
- Optimizing Capital & Operating Budgets
- Competing for Patients & Physicians
- Improving Treatment Appropriateness & Clinical Outcomes
- Optimizing Operational Workflows & Assets
- Reducing Recall Rates
- Shortening Time-to-Diagnosis
- Evaluating and Cost Efficiently Integrating New Technologies
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MISSION STATEMENT
The ACR Bulletin supports the American College of Radiology’s Core Purpose by covering topics relevant to the practice of radiology and by connecting the College with members, the wider specialty, and others. By empowering members to advance the practice, science, and professions of radiological care, the ACR Bulletin aims to support high-quality patient-centered health care.
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Protecting Women’s Access to Screening Mammography

These members of Congress got it right.

I N AUGUST, SENATORS KELLY AYOTTE (R-NH) AND BARBARA MIKULSKI (D-MD) introduced the Protect Access to Lifesaving Screenings (PALS) Act (S. 1926) in the U.S. Senate. As its name says, this legislation aims to protect access to annual screening mammography for women ages 40 to 74. Congresswomen Renee Ellmers (R-NC) and Debbie Wasserman Schultz (D-FL) introduced similar legislation in the House of Representatives.

The legislation places a two-year moratorium on payers using the United States Preventive Services Task Force (USPSTF) draft breast cancer screening recommendations to deny coverage or require co-pays from patients undergoing mammographic screening. If passed, it will allow time for Congress and others to review the impact USPSTF recommendations will have on women seeking screening for breast cancer. For similar reasons, the Doctors Caucus (made up of physician members of Congress) in the House of Representatives sent a letter to Health and Human Services Secretary Sylvia M. Burwell asking that the USPSTF recommendations not be used to change women’s access to breast cancer screening.

The draft recommendations of the United States USPSTF released for public comment in April 2015 remain at odds with those of the ACR and many other specialty societies whose members have expertise in breast cancer care. The USPSTF maintains its previous “C” recommendation that, for women at average risk for breast cancer, the decision when to start screening mammography is an individual one. The USPSTF “C” recommendations are defined as follows: “the USPSTF recommends selectively offering or providing this service to individual patients based on professional judgment and patient preferences.” For screening mammography, the task force states that while beginning screening at age 40 reduces a woman’s risk of dying from breast cancer, the number of lives saved is much smaller in this age group than in older women.

USPSTF concluded that the benefit of screening mammography outweighs the harms in this age range, but only by a small amount. It [the “C” recommendation] is an acknowledgement that the balance of benefits and harms for any individual woman in this age group is a delicate one. Women ages 40 to 49 years must weigh a very important but infrequent benefit (small reduction in breast cancer deaths) against a group of meaningful and much more common harms (overdiagnosis and overtreatment; unnecessary and sometimes invasive followup testing and psychological harms associated with false-positive tests; and false reassurance from false-negative tests). Women who value the possible benefit of screening mammography more than they value avoiding its harms can make an informed decision to begin screening.

The lack of consensus on the number of lives saved by early diagnosis and the ambiguity around the true harms from breast cancer screening mean the USPSTF recommendations will continue to be controversial. As a radiologist, I am aware of the evidence that continues to demonstrate annual screening mammograms reduce breast cancer mortality, which in my opinion, outweighs the harms of a false-positive diagnosis. But I also recognize that others have differing opinions, and perhaps we have more work to do to understand the risks of DCIS and minimally invasive carcinoma in order to develop more appropriate treatment options. Despite the focus on the potential harms of screening for breast cancer, the task force acknowledged that more lives will be saved when screening begins at age 40. For this reason, I expect that many if not most women will continue to elect to begin screening at age 40.

However, this good-faith effort to place decision-making in the hands of patients is threatened by the task force’s “C” recommendation. It creates a

continued on page 21
You need to choose the best 3D mammography system for your patients. One that supports a more reliable diagnosis and reduces the need for callbacks.

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Answers for life.
**BI-RADS® Across the Globe**

**DO YOU HAVE A COPY** of the fifth edition of BI-RADS® yet? The BI-RADS Atlas provides standardized breast imaging findings, terminology, report organization, assessment structure, and a classification system for mammography, US, and MRI of the breast. The atlas aids radiologists in communicating findings to referring physicians in a clear and consistent manner — no matter what language you speak.

Recently, Joseph J. Crittenden, MD, FACR, embarked on a mission trip to Quito, Ecuador, where he was reading mammography reports in Spanish. He says, “It really hit me how much the ACR has influenced favorably breast imaging worldwide. In spite of the language barrier and because of BI-RADS lexicon and categories, the meaning of the reports in Spanish was crystal clear. It’s great to be a member of an organization that has done so much for health care.” Visit bit.ly/ACRBIRADS for more information.

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**New Mammography Saves Lives Materials Available**

**MAMMOGRAPHYSAVESLIVES.ORG OFFERS NEW RESOURCES** to help radiologists explain to referring providers and patients why women should continue to get annual mammograms starting at age 40. The site also clarifies differences between recent screening recommendations from the American Cancer Society, the U.S. Preventive Services Task Force, the ACR, and the Society of Breast Imaging.

New online materials include the following:

- A patient brochure explaining benefits and risks of screening mammography and detailing why women should seek annual mammograms starting at age 40.
- A brochure for medical professionals, outlining scientific support for starting screening at age 40 and explaining why they should continue to advise women to start at 40.
- A joint ACR–SBI press release and talking points for radiologists on new mammography recommendations from the American Cancer Society versus ACR and Society of Breast Imaging recommendations.

Visit MammographySavesLives.org to access these resources.
HERE'S WHAT YOU MISSED

The new Bulletin website is home to a wealth of content not featured in print. Check out blog posts, extra articles, and multimedia content at acrbulletin.org.

Transfiguring Medicine with CRISPR
Can diseases be cured by engineering DNA? Radiologists may need to be part of the team to find the answer. Read it at bit.ly/CRISPRBlog.

Modernizing the Radiology Residency Curricula
Are we training tomorrow’s radiologists to succeed in yesterday’s health systems? Read more at bit.ly/RadResCurricula.

A Resident’s Primer on Breast Density
Find out how to communicate with patients on this controversial topic at bit.ly/DenseBreastRFS.

SBI Seeks Abstracts

THE SOCIETY OF BREAST IMAGING (SBI) welcomes the submission of original scientific abstracts related to breast imaging for the SBI/ACR Breast Imaging Symposium. The symposium will be held April 7–10, 2016, in Austin, Texas. Authors must submit abstracts using the online system by Nov. 16, 2015. For more information and submission guidelines, visit bit.ly/SBIAbstracts.

Check Out the All-New Manual on Contrast Media

THE PREMIERE RESOURCE for using contrast media in diagnostic imaging just got even better.

The ACR Manual on Contrast Media, Version 10.1 is live on acr.org. The new version is loaded with updated chapters, tables, and references that make this revered online resource even more valuable. And it’s free.

So what’s new? Inside you’ll find information on the following topics:

• Post-contrast acute kidney injury and contrast-induced nephropathy in adults
• Adverse reactions to gadolinium-based contrast media
• Administration of contrast media to pregnant or potentially pregnant patients
• Contrast media in children
• And much, much more

The manual is available as a PDF, zip file, ePub (iOS), and Mobi (Kindle). To access the manual, visit bit.ly/Contrast10.

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THE COLLEGE IS PROUD TO WELCOME LIFELOCK, INC. identity protection to the Benefits Plus program. Since 2005, LifeLock has been a leading provider of proactive identity theft protection services for consumers and identity risk assessment and fraud protection services for enterprises. LifeLock now proudly offers transaction monitoring and data breach notifications.

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*At the end of the 30-day trial period, your card will be billed automatically ($8.99 per month or $98.90 per year for LifeLock Standard™ service or $17.99 per month or $197.90 per year for LifeLock Advantage™ service or $26.99 per month or $296.90 per year for LifeLock Ultimate Plus™ service. All pricing excludes applicable sales taxes.) unless you cancel within the 30-day trial period. You can cancel anytime without penalty by calling 1-800-LifeLock. Offer is for new LifeLock members only.
ACR Lung Cancer Screening Earns Top Honors

CONGRATULATIONS TO THE MEMBERS AND STAFF INVOLVED in creating the ACR Lung Cancer Screening Program, which has been honored by the American Society of Association Executives. ACR members and staff, including teams from Government Relations, Quality and Safety, Public Affairs, and Education, worked to secure reimbursement of screening for high-risk individuals and developed an entire suite of lung cancer screening resources, including standardized criteria for testing, reporting systems, physician training, and information for patients (available at bit.ly/LungImagingResources) to earn the Power of A gold award, the association industry’s highest honor, which recognizes the contributions of associations that positively impact society.

Who Will You Nominate?

IT’S TIME TO SUBMIT YOUR NOMINATIONS for next year’s ACR elected and selected positions. Among the open elected positions are president and vice president of the College; two positions on the BOC, one of which is held by an incumbent eligible to run for a second term; four positions on the Council Steering Committee; three positions on the College Nominating Committee (CNC); and two member-in-training representatives to the Intersociety Summer Conference (ISC). Additionally, the CNC will select a private-practice representative to the 2016 and 2017 ISC meetings.

Any ACR member may submit nominations to the CNC for elected or selected positions in care of the ACR Governance Office on or before December 15, 2015. Detailed information is available at bit.ly/NominationsACR or through the ACR Governance Office. All information can be sent to Katie Kuhn via email (cnc@acr.org) or to the ACR headquarters at 1891 Preston White Drive, Reston, VA 20191.

Medical records themselves are not the true picture of a person’s health. As long as patient portals are focused on those records, they’ll come up short as tools to improve health.

— Adam Baker, in “Who Are the Patient Portals Really For?” (Read more at bit.ly/PortalImprovement.)

Announcing the RLI Leadership Luminaries

CONGRATULATIONS TO Bruce J. Hillman, MD, FACR, and Leonard Berlin, MD, FACR, recipients of the 2015 Radiology Leadership Institute® (RLI) Leadership Luminary Awards. Each year, the RLI recognizes the imaging industry’s most respected leaders. Each recipient displays exceptional experience, performance, and leadership in organized radiology. Hillman and Berlin accepted their awards at the 2015 RLI Leadership Summit in August.
Cracking the Code

The ICD-10 switch presents many uncertainties, but practices don’t need a Rosetta Stone to streamline the transition.

Some People Had Doubts, but it happened. On Oct. 1, the U.S. Department of Health and Human Services (HHS) adopted the latest version of the International Classification of Diseases (ICD) diagnosis coding system, ICD-10.

Many radiology practices have been training and preparing their staffs for the ICD-10 switch for months, if not years. Still, transitioning from ICD-9’s 14,025 numeric codes to ICD-10’s 69,823 alphanumeric codes won’t be easy. “While many other countries implemented ICD-10 years ago, it has not yet been implemented in a health care system like ours, where the code will determine whether the provider is paid or not,” says Renée Engle, radiology certified coder (RCC), senior vice president of client services at MSN Healthcare Solutions, a billing and practice management company headquartered in Columbus, Ga.

Code Compliance

Before the Oct. 1 deadline, many radiology practices held workshops, obtained workbooks, and hired consultants to train their coders, radiologists, and other staff members on how to use ICD-10. Even so, coders will likely take longer to code and submit ICD-10 claims because the codes are completely different from ICD-9.

One way practices can ease the transition is by creating reference sheets that translate the most common ICD-9 codes into ICD-10. Pat Kinsley, RT, CPC, RCC, coding and compliance manager at Suburban Radiologic Consultants, says her group has outlined its top 200 codes in a quick-reference guide.

But a reference guide won’t help if coders don’t have enough patient information to code the claims to the level of specificity that ICD-10 requires. Ideally, referring physicians will order imaging exams through computerized order entry systems that require patient histories. If they don’t, radiologists and their staffs may need to retrieve the information from electronic medical records or contact referring physicians to obtain those details. “Unfortunately, we don’t have great ways of restricting or requiring certain information in imaging orders,” says Margaret Fleming, MD, breast imaging fellow at Emory University in Atlanta.

Radiologists must then include the patient information in their reports so the coders can assign appropriate ICD-10 codes. Kinsley recommends appointing a radiologist as an ICD-10 champion to promote the change throughout the practice. “It’s helpful to have that peer-to-peer encouragement rather than a business office person trying to convince them to do things differently,” she notes.

Cash on Hand

While ICD-10 definitely requires more specificity, it is unclear just how much specificity third-party payers will expect. “Payers could certainly use this as an opportunity not to pay claims, and that’s a big fear,” Engle says. Radiology practices should refer to payer coverage policies and determinations to identify appropriate ICD-10 codes and reduce the chances of rejected claims. To give practices time to acclimate to ICD-10, CMS announced that for the next year Medicare review contractors will not deny or audit claims based on specificity, as long as a valid code from the appropriate ICD-10 family is used. “The only problem with that is you might adopt bad habits in the process, and bad habits are hard to change,” Kinsley warns.

Since delayed payments are likely, practices should manage their cash flow diligently during the ICD-10 transition. Ronald V. Bucci, administrative director of radiology at MetroHealth, a system serving the Cleveland, Ohio, area, recommends postponing unnecessary purchases and expenses for the next few months. “Practices should hold off on purchases that do not impact their normal business operations until they know that they have money coming in,” he says.

Many resources are available to help practices resolve issues during the transition. The ACR and other professional groups regularly post news and references to their websites. Engle notes that the Radiology Business Management Association offers valuable resources, including a listserv, an ICD-10 toolkit, and members’ forum (available at bit.ly/ICD10Help), while CMS has appointed an ICD-10 ombudsman to address physician and provider issues. “The good thing is that radiologists are much more prepared for the ICD-10 switch than many other specialties,” Engle says. “The bad thing is that there are a lot of unknowns, so we have to be ready for whatever hits us and react appropriately.”

ENDNOTE

By Jenny Jones, freelance writer for the ACR Bulletin
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G70152R2
N THE LAST FIVE YEARS, we at the Society of Breast Imaging (SBI) have been fighting an uphill battle to carry out our mission: “to save lives through early detection, quality education, and trusted information provided to patients, physicians, and organizations worldwide.” Despite the obvious advantages of mammography as a key component of health care for women, many patients (and their referring physicians) are frustrated and confused by widespread variance in guidelines on when and how frequently women should get mammograms.

And we don’t blame women for being confused. On a regular basis, they are receiving mixed messages from respectable experts and organizations. In addition, the media do not always relay the information on mammography screening in a clear, understandable manner, choosing instead to stoke controversy and further muddy the waters. The two biggest points of contention are when to begin screening and how often to screen.

The confusion began to heat up in 2009, when the U.S. Preventive Services Task Force recommended that women ages 40 to 49 not receive screenings and, furthermore, that women ages 50 to 74 be screened every other year. This was followed by academic journal articles arguing that annual mammograms lead to overdiagnosis and overtreatment of breast cancer. Regardless of these studies’ flaws, the research has received a great deal of media attention. The resulting confusion has undermined women’s ability to take control of their health care decisions.

SBI strongly believes it is dangerous to let the confusion surrounding mammography continue. To cut through the noise and set the record straight on mammography, SBI created End the Confusion, a campaign to inform and engage providers, stakeholders, and the public about the benefits of breast cancer screening. End the Confusion arms women with clear and accurate information on mammography screening so they are prepared to make informed decisions in partnership with their health care providers.

On the End the Confusion website (endtheconfusion.org), patients, the media, and health care providers can access a host of resources, including multimedia presentations, fact sheets, and relevant articles. You can help spread the word by sharing the site with your physician colleagues (especially those outside of radiology), technologists and administrators at your practice, your patients, and other members of your network.

Breast cancer remains the second leading cause of deaths among women in the United States.1 In 2015, according to the National Cancer Institute, 231,840 women will be...
Women look to their physicians to provide appropriate, evidence-based recommendations. Here is a list of talking points to get the conversation started.

- Mammography screening is not perfect. It does not find all cancers and does not find all cancers early enough to cure. But when used by women beginning at the age of 40, screening has been shown to markedly reduce the number of women who die from breast cancer and brings a greater chance that treatment will be successful.

  For every 1,000 women who have a screening mammogram, we see the following:
  - 100 are recalled to get more mammography or ultrasound images.
  - 80 are advised to return for follow-up in 6 months.
  - 20 are recommended for a needle biopsy.
  - 5 are diagnosed with breast cancer.

- Research shows that nearly all women who experienced a false-positive exam still support screening.

- The decision whether or not to undergo mammography lies with the patient. However, experts on breast cancer believe mammography can detect cancer early, when it’s most treatable and can be treated less invasively — which not only saves lives but also helps preserve quality of life.

ENDNOTES

What should you tell your patients about mammography screening?

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ENDNOTES
EVERY PERSON HAS SEVERAL PIVOTAL MOMENTS IN THEIR LIFE, ones that you look back on and judge your life before and after. One of my most key moments began with the best $400 I’ve ever spent. We had an extended weekend and decided — on a whim — to spend money we didn’t have and go to a water park. I was playing in the water with my two daughters, Penny and Lucy, when they decided they wanted to “rumble” (on a normal day, this consists of wrestling with whatever family member is closest and slamming them to the floor). When Penny hit the left side of my chest, it hurt, far more than the right.

I was so concerned about it that I made an appointment with my primary care physician immediately. Breast cancer was the farthest thing from my mind. I was 38, I’d never performed a self-breast exam, and, to be honest, I wasn’t concerned about breast cancer because I had no family history of the disease. I was much more afraid of developing Alzheimer’s than I ever was of breast cancer. Yet, when I visited my doctor, she advised that I get a mammogram.

I’m an engineer. I don’t have time for hedging, and I like to get straight to the facts. So I asked her, “What do you think it is?” And she replied, “I think you have breast cancer.” Needless to say, I went through with the biopsy. Again I received bad news. I had cancer, and I needed to have a mastectomy. That was it. There would be no chemotherapy for me, I was reassured.

But when the pathologist’s report came back, it turned out my cancer was more advanced than they’d realized. And it was HER-2 positive, which tends to be fast and aggressive. All of this, plus my relative youth, meant I needed more treatment, and a lot of it.

I remember sitting on the phone crying with my parents. I was so young. My daughters were so young. They were only three and six. What would happen if they had to go through their lives without their mother? I didn’t want to be the tragically dying parent that left them letters on my deathbed.

What would have happened if my physician hadn’t been aware of the radiologist-recommended age for screening and had sent me on my way, telling me it was only a bruise? What would have happened if I had listened to the recommendations to start screening at 50 and canceled my mammogram? I almost did.

While I consider myself an informed consumer of health care, I’m not a physician and I don’t know the intricacies of breast imaging and evaluating the research around when to begin screening. I didn’t think I was even remotely a candidate for breast cancer. And the anti-mammography data swirling in the media made sense to me. The flaws in the data were not explained to me — the media discusses the data surrounding how harmful radiation can be, but it never mentions that the studies used out-of-date equipment and the USPSTF panel does not include any breast imaging experts.

The media writes about the health care costs of mammography but never mentions how little reimbursement breast imagers actually receive from it. And they talk about the anguish that false-positives can bring, but they fail to mention the much greater, more lasting anguish when you do not catch the cancer. Nor do they talk about the flood of relief that comes once you’re declared cancer-free, whether it’s after a biopsy or after months of radiation therapy.

I haven’t had that talk yet — I’m still undergoing treatment. But because of a mammogram we caught the cancer early. With luck, I’ll be having that conversation soon.

By Chelsey Fischer and Meghan Edwards, copywriter for the ACR Bulletin
ANY OBSERVATIONAL STUDIES have demonstrated the efficacy of women beginning mammography screenings at the age of 40. In addition, organizations such as the ACR and the Society of Breast Imaging have contended that the so-called “downsides” to starting screening at age 40 are overstated. Most instances in which patients may be recalled due to inconclusive findings result in nothing more than another mammogram or ultrasound being performed. Published studies show that anxiety from this process is short lived, has no lasting effects, and pales in comparison to the enormous benefits of catching breast cancer early to reduce mortality.

Despite these benefits, however, in April of this year the U.S. Preventive Services Task Force (USPSTF) released draft recommendations assigning a “C” grade for women ages 40 to 49 receiving biennial mammograms, reserving the “B” grade for biennial mammograms for women ages 50 to 74. Because the Affordable Care Act does not require private insurers to cover screening tests with a USPSTF grade of “C” or lower, many insurers could drop coverage for women in their 40s and limit coverage to every other year for those 50 to 74. This would create a financial barrier to care for many women of screening age and likely result in thousands of unnecessary breast cancer deaths each year.

To counter the recommendations, the ACR took action. In a comment letter submitted during the task force’s open comment period, the ACR outlined several problems with the recommendations, including the total exclusion of breast imagers from the task force’s panel of experts. “The USPSTF panel did not include a single expert in breast cancer diagnosis or care,” reads the comment letter. “This is unreasonable for a guideline with such important implications.” Added to this was a lack of transparency about the decision-making process. Further, it is unclear whether comments from external reviewers were taken into account by the panel and, if they were, which comments were incorporated and which were discounted.

“We don’t think the task force is doing a service to women by putting out recommendations like these,” says Debra L. Monticciolo, MD, FACR, chair of ACR’s Commission on Breast Imaging. Monticciolo is critical of the task force’s process, which she calls opaque. “We’ve asked them to engage us and to listen to some of our concerns,” she notes. “We’re not asking them to accept everything because we know that nothing is perfect. But we thought they’d at least seek the input of people who are knowledgeable in breast cancer care.”

In addition to the comment letter, the ACR took other measures to express its disapproval: the College issued a letter2 directly to President Obama and Secretary of the Department of Health and Human Services Sylvia Burwell. The ACR also worked with Members of Congress and their staff in facilitating a letter3 signed by several high-ranking members of Congress addressed to Secretary Burwell. A separate a letter4 signed by members of the GOP Doctors Caucus to Secretary Burwell expresses similar concerns. The ACR supplemented these efforts by making the recommendations a major talking point during ACR 2015®, when over 600 College members advocated on Capitol Hill. In particular, members raised concerns with the 2009 and 2015 USPSTF process and recommendations related to breast cancer screening. They urged their Congressional representatives to support USPSTF transparency legislation that is currently making its way through Congress.

If the draft USPSTF recommendations are adopted in their current form, the effect will be to limit women’s access to life-saving technology, reverse the decline in breast cancer morbidity and mortality, and cause undue suffering to women and their families facing breast cancer. The ACR has asked the task force to follow sound scientific reasoning and protect women’s access to this vital screening tool.

By Chris Hobson, Imaging 3.0™ senior communications manager
Breast cancer’s history is rife with empowered patients willing to fight for the cause. How can breast imagers continue that effort?

Breast Cancer Awareness is Everywhere.
Once October hits, the varied pinks of breast cancer awareness ribbons and products are just as common as the red and oranges of falling leaves. It’s hard to believe that decades ago even mentioning breast cancer was frowned upon.

In 1913, the year the American Cancer Society was founded, any type of cancer was considered an unspeakable death sentence, appropriate to discuss only in hushed tones and medical circles.1 And no cancer was more taboo than breast cancer. So how did the disease go from “the unspoken affliction” to one of the most well-known public health causes in America?

The answer lies in its proponents. “Breast cancer awareness is so pervasive because women came together around it,” says Allyson N. Parnes, MD, breast imager at Women’s Breast Center of Stamford Hospital in Stamford, Conn., and breast cancer advocate and survivor. “Patients and their friends and families have rallied behind women fighting breast cancer, making them feel like heroes. Their advocacy efforts have had a major influence on Congress and big business, increasing funding for awareness efforts, access to care, and research.”

Continuing Battles
Despite the success of the breast cancer awareness movement, one of the keys to fighting the disease is again under attack. With the USPSTF recommending mammography for most women starting at age 50, empowered patients and physicians must again take up the mantle and fight for their care. And it’s up to breast imagers to help make that happen — by using some of the same tools that brought breast cancer to the forefront of the public’s mind in the first place.

Powerful Allies
The history of breast cancer features a host of women who battled the disease and fought to ensure better care for those who came after them. One of the earliest proponents for better breast health was Terese Lasser, whose breast cancer was treated with a radical mastectomy. Frustrated by a host of unanswered questions about post-cancer care, Lasser founded the Reach to Recovery program in 1954. Reach to Recovery still provides women with social support and encourages them to participate in their own health care today.1

The movement also gained important and powerful advocates: In the early 1970s, First Lady Betty Ford revealed her breast cancer diagnosis and subsequent mastectomy, as did former child star and diplomat Shirley Temple Black. Women began writing publically about their experiences with breast cancer. “A lot of women realized that this disease was not uncommon. They thought, ‘If the wife of the president, someone who has the greatest access to health care, can develop breast cancer, then so can I.’ And the result was that they began demanding better care and education for women,” says Parnes.

Education Station
Just as empowered women who felt strongly about the breast cancer movement were key to its success, engaging patients today is imperative, notes Parnes. You can begin by educating your patients and helping them understand why mammography is so vital, says Debra L. Monticciolo, MD, FACR, chair of the ACR Commission on Breast Imaging. “It’s hard because the lay media is more interested in controversy — medicine is boring to them when it saves lives like it’s supposed to,” says Monticciolo. “It’s up to us as radiologists to lead the way, look at the data, and explain it in a cogent way. We need to explain to patients the inaccuracies they’ve been reading about and how the facts presented in the lay media are not necessarily based on credible science.”

One way to do that is to make use of the information on the ACR Breast Imaging Resource page (at bit.ly/BreastHealthResource) and on the website for the Society of Breast Imaging (at sbi-online.org). Advocacy sites such as mammographysaveslives.org and RadiologyInfo.org contain patient-friendly information, talking points, and brochures that can help explain why mammography is vital for women over 40.

You can continue to empower patients by educating your colleagues as well. “Their help is invaluable in encouraging patients to get screened. Most patients trust their doctors more than they trust the lay press,” says Monticciolo. Talk to your referring physicians about mammography and explain why the USPSTF ruling may be incorrect, she says. Monticciolo plans on speaking to the OB/GYN department in her hospital, going through the data piece by piece to demonstrate that mammography does in fact save lives.
Facial Recognition

Another way to help educate and empower your peers is to put a face on the breast cancer movement. "A huge part of breast cancer's success is that women were able to share their stories and the public could empathize with their struggles," says Parnes. She notes that it’s important to share personal stories and accounts with your patients and those you’re educating. “When I meet with patients, especially those who are long overdue for their annual exam, I tell them that finding this disease early can make it a whole different ballgame. I tell some patients that I know this because mammography saved my life. It becomes a little more motivating than ‘See you next year.’”

This openness around breast cancer explains in part why interest in mammography grew after women like Betty Ford spoke up. “I'm sure it became more real to some women. And it became permissible to have a dialogue about it,” adds Parnes.

You can also do a lot of good by putting a face on the physicians behind the movement, says Monticciolo. Visit health care fairs and patient groups to explain the logic and science behind mammography screening, she says. Parnes’ hospital creates a huge breast imaging event each year, complete with a fashion show, golf tournament, lunch-and-learn events, and more. She says, “Women enjoy the fashion, but also want to learn the latest recommendations from the medical community. We also talk to the media and are able to reach even more women with their coverage.”

The Search for Funding

Breast cancer awareness also owes its success to its long partnership with advocates on Capitol Hill. During the 1980s, breast cancer advocates noted the success of HIV/AIDS patients who were advocating for increased research funding.1 With this example in place, several breast advocacy groups joined together in the early 1990s to create a petition aimed at convincing Congress to fund breast cancer research. After gathering over 2.6 million signatures, they were successful — President Clinton signed the National Action Plan on Breast Cancer into law, which brought policymakers, scientists, providers, and patients together to search for a cure for breast cancer.

Today, with mammography under attack, advocacy from patients and physicians is still imperative. “More than 50 percent of Congress is new since 2010, and only 7 percent of the current members have a health care background. So radiologists have a lot of educating to do on important issues like mammography. And congressmen and women are more than willing to learn, especially about mammography. It’s seen as a patient-oriented issue, and often it’s a personal issue to these members,” says Ted Burnes, director of RADPAC and political education at the College.

Getting involved in advocacy can mean any number of things. You can support RADPAC, host a member of Congress for a facility visit (read about one member’s experience at bit.ly/PracticeVisit), or participate in the College’s Capitol Hill Day, adds Burnes.

Breast cancer’s success in drawing the public eye cannot be disputed, largely in part because of the actions of patients and physicians who were willing to share their stories and empower others to fight for the cause. By continuing their efforts and empowering allies, radiologists may be able to make history repeat itself.

By Meghan Edwards, copywriter for the ACR Bulletin

ENDNOTE

A CONTROVERSY CONTINUES TO SWIRL around mammography, patients and referring physicians often struggle to make sense of the conflicting information about this life-saving screening. To combat this confusion and train radiologists to educate their patients and colleagues about the value of breast cancer screening, the ACR Commissions on Quality and Safety, Breast Imaging, and Economics joined together. Their goal: launch the Leadership Course in Breast Screening, a nine-week webinar series that arms imagers with the skills to clearly and effectively communicate the value of breast cancer screening.

“This course was conceived as a way to pass on the knowledge and experience gained by our leaders in breast imaging over the previous three decades. Those leaders bring a perspective that we thought would be useful to those newer to the field,” says Debra L. Monticciolo, MD, FACR, current chair of the Commission on Breast Imaging and chair of the ACR Commission on Quality and Safety at the time the course was created. Monticciolo, along with Barbara S. Monsees, MD, FACR, former chair of the ACR Commission on Breast Imaging, and Geraldine B. McGinty, MD, MBA, FACR, chair of the Commission on Economics, chose topics ranging from evidence of mammography’s benefits to the economics of breast imaging.

One of the challenges that radiologists will have to overcome in advocating for breast cancer screening is the U.S. Preventive Services Task Force 2015 draft guidelines for screening mammography. Participants learned to clearly present information about the structure and methodology of trials, while explaining how these factors can impact the results. McGinty adds, “We have to be vigilant because we’re seeing people publishing nonsense not only in scientific journals, but also in mainstream outlets like the LA Times and the New York Times.”

In addition to giving radiologists a strong basis of information to share, faculty also stressed the need for patience and persistence when advocating for breast screening. “You have to get a clear, crisp message across, but you also have to maintain the energy to keep responding and not give up,” McGinty says.

“Women’s lives are at stake. Breast cancer is a major killer, and mammography is the only method that allows for early detection. Cancers are easier to treat and more likely to be cured when they are found early,” Monticciolo says. “Mammography has been proven to significantly decrease deaths from breast cancer. We need to make sure that women understand that.”

By Abby Short, freelance writer for the ACR Bulletin

7 Facts About Breast Cancer Screening

Debra L. Monticciolo, MD, FACR, provides her takeaways from the course. Consider sharing the list with patients, colleagues, family, and friends.

1. The most lives are saved with annual mammography beginning at age 40. Women in their 40s account for about 40 percent of the years of life lost to breast cancer.¹
2. Screening saves more years of life for women who get screened every year rather than every other year.²
3. The reduction in breast cancer mortality from mammography is significant and has been proven in multiple studies involving millions of women,³ yet it is routinely understated in the press.
4. When presenting research results, being invited to screening is different from being screened. Not all women who are invited to screening actually go through with it. Population-based studies show that breast cancer death decreases by 25–31 percent among women invited to screening, but women who are screened will reduce their chances of dying of breast cancer by 36–48 percent.⁴,⁵
5. Entities like the U.S. Preventive Services Task Force underestimate the benefits of mammography and overstate the risks. Radiologists are interested in saving the most lives.
6. Most false positives from mammography are resolved with only additional imaging. Less than 2 percent of women will be recommended to have minimally invasive needle biopsy as a result of screening.⁶,⁷
7. Overdiagnosis has been overstated. Studies that properly account for lead time and underlying incidence trends show that the overdiagnosis rate is 1–10 percent, nearly all of which is ductal carcinoma in situ (the presence of abnormal cells inside a milk duct in the breast).⁸,⁹,¹².¹¹ The risk of overdiagnosis is small and is outweighed by the mortality benefits of screening.

To view the endnotes for this article, visit bit.ly.com/ACRSpreadingTheWord.
Informatics Meets Patient Care

A new video series traces the patient experience and aligns informatics tools along each step of the way.

John is somewhere over the Midwest, trying to read an inane magazine from his seatback pocket, when his head begins to spin and he’s hit with a wave of fatigue. But by the time the plane lands, John is experiencing chest pain, calf swelling, and a high heart rate. He hasn’t officially finished his trip and he is headed to the nearest emergency department.

John’s last name is Doe, and (as you might have guessed) he’s not a real patient. His story is the focus of a video series hosted by the JACR Informatics Resource Center (bit.ly/JACRseries). Throughout John’s journey, the videos discuss the role of informatics and demonstrate how physicians can use the ACR’s latest IT tools to care for their patients more efficiently.

In the ED, the physician assesses John’s symptoms and pulls up ACR Select® to order the most appropriate imaging procedure for John. The verdict is chest CTA.

“The videos really cover the full spectrum of the imaging care process, from the time imaging is being considered until the time the results are delivered to the referring clinician and the patient,” explains Geraldine B. McGinty, MD, MBA, FACR, chair of the ACR Commission on Economics. “We’re hoping the radiologists who view these videos will understand how critical their input is to that care process and how the technology solutions that ACR is preparing will help them be part of that care process.”

Radiology became involved in John’s care as soon as the ED physician accessed ACR Select, which uses ACR Appropriateness Criteria® to recommend imaging studies. The radiologist confirms pulmonary embolism and initiates the critical-finding pathway, which electronically documents when the finding was reported back to the ED. While reading the exam, she also notices a small liver lesion. Because her dictation system is equipped with ACR Assist®, the radiologist has immediate access to the ACR’s Liver Imaging Reporting and Data System (LI-RADS®), which helps categorize liver findings. ACR Assist categorizes the lesion as benign, requiring no follow-up (and thereby avoiding additional imaging and radiation for John).

“Radiologists have to cover the entire waterfront of health care and have to be facile across many areas of medicine,” states McGinty. “ACR Assist will help radiologists in all specialty areas and aid even general radiologists to be more proficient in the delivery of critical information in the radiology report.”

After his condition stabilizes, John is discharged and finally able to head home. His primary care physician receives his images and radiology report via ACR Connect. The report was created using ACR Common™ (a lexicon of standardized imaging exam names designed to help both the patient and referring physician understand the terminology used within radiology). “Not everyone knows this kind of jargon, and it’s rampant in not just radiology but throughout health care,” McGinty comments. “We are excited about the potential to standardize terminology and ensure that there isn’t a disconnect in the information that the radiologist is providing.”

With technology playing an increasingly central role in health care, it’s never been more important for stakeholders to understand informatics within the full spectrum of the imaging care process. “I would strongly encourage you to begin building the infrastructure for the department of the future,” says Christoph Wald, MD, PhD, FACR, author of the video series and vice chair of the ACR Commission on Informatics. “As far as I’m concerned, that means facilitating patient-centered imaging care, where radiologists create noticeable value to health care delivery, to their referring colleagues, and to their patients.”

By Amena Hassan, freelance writer for the ACR Bulletin
The OIG Work Plan Update

Find out which sections affect radiology and the potential impact on your practice.


The OIG has published a mid-year update to its 2015 Work Plan. The update continues to list two key projects that could impact medical imaging or radiation oncology.

The first ongoing interest area is titled, “Diagnostic radiology – Medical necessity of high cost tests.” It reads as follows:

While this audit focus may initially seem somewhat benign, in fact, ACR staff has received member calls regarding fiscal intermediaries that are asking to see the medical record information the radiologist reviewed to make his or her independent determination of medical necessity. In our view, this approach is not required under law and regulation and is tantamount to an additional preauthorization — a practice that is clearly designed to hinder or prevent patient treatment and to deny payment after treatment is rendered.

Electronic medical records combined with simple and rapid access for all physicians may ultimately make it possible for radiologists to review sufficient patient information to make medical necessity determinations. But today, and for the foreseeable future, radiologists do not and cannot make such determinations. The treating or referring physician has always been responsible for medical necessity determinations. The increasing use of imaging appropriateness criteria such as ACR Select™ is designed to help those physicians make appropriate choices.

The next interest area is titled, “Imaging services – Payments for practice expenses” and includes the following:

We will review Medicare Part B payments for imaging services to determine whether they reflect the expenses incurred and whether the utilization rates reflect industry practices. For selected imaging services, we will focus on the practice expense components, including the equipment utilization rate. Practice expenses may include office rent, wages, and equipment. Physicians are paid for services pursuant to the Medicare physician fee schedule, which covers the major categories of costs, including the physician professional cost component, malpractice insurance costs, and practice expenses. (Social Security Act, § 1848(c)(1)(B).) (OAS; W-00-13-35219; W-00-14-35219; various reviews; expected issue date: FY 2015)

This clearly is a ramp-up for another attack on the technical component of imaging. After years of reductions in the percentage of actual costs the government will reimburse, the OIG now wants to target the baseline costs themselves. If that baseline is reduced while the payment percentage is retained, the government may effectively make significant further cuts in technical component reimbursement. CMS retains the final decision on payment policy but will have to address any OIG audit findings that advocate for lower technical component imaging payments.

When it announced the audit last fall, OIG also identified radiology systems as one area in which patient privacy and security may be at risk. In its update, OIG lists this project as part of an initiative to address hacker groups that have infiltrated government systems and either released sensitive data or leveraged it to perpetrate fraud. Thus, OIG plans to conduct network penetration testing to gauge whether HHS network security needs an upgrade.

Notably, OIG’s mid-year update also includes a new project regarding intensity modulated radiation therapy (IMRT). OIG will audit whether Medicare outpatient payments for IMRT comply with federal regulations. Prior OIG reviews have found that some hospitals have inaccurately billed for IMRT. It believes that certain other services should not be billed when performed as part of developing an IMRT plan. Those services include CPT® codes 77014, 77280–77295, 77305–77321, 77331, 77336, and 77370. This audit should emerge some time in FY 2016. OIG may focus on claims that were submitted several years ago and compare those with more recent claims, which had to account for IMRT coding revisions.
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Georgia – Georgia Regents University at the Medical College of Georgia has an opening for a one-year ACGME-accredited vascular and interventional radiology fellowship to start July 1, 2016. Contact: If you would like to join our team, please send your CV to Frances M. M. Wolff at franw@gru.edu.

Indiana – X-Ray Consultants (XRC) is a 15-member subspecialty private practice seeking a fellowship-trained, board-certified/eligible diagnostic radiologist. Fellowship training in pediatrics, mammography, and/or body imaging a plus. XRC serves South Bend/Mishawaka, Plymouth, and Bremen, Ind. XRC has close proximity to Chicago, Lake Michigan, and local Notre Dame athletic, social, and academic/cultural activities. Contact: Dale Huffman by email at dhuffman@xrcmi.com.

Montana – Kalispell – Progressive, growing private-practice group of 13 radiologists and two RPAs in northwest Montana seeks partnership-track body imager who is fellowship-trained in body, chest, or MSK. Must be comfortable in all modalities and basic interventional work. Contact: Ty Weber (chief administrative officer) by phone (406) 751-7519 or email tweber@hcnwmt.com.

Montana – Kalispell – Progressive, growing private-practice group of 13 radiologists and two RPAs in northwest Montana seeks mammographer who is fellowship-trained in breast imaging. Must be comfortable in all modalities and basic interventional work (thoracentesis, paracentesis, and myelograms). Call required. Contact: Ty Weber (chief administrative officer) by phone at (406) 751-7519 or email tweber@hcnwmt.com.

New York – Buffalo – The Division of Nuclear Medicine of the Department of Diagnostic Imaging at the Roswell Park Cancer Institute, in Buffalo, N.Y., seeks a full-time, fellowship-trained specialist in nuclear medicine to fill an unexpected vacancy. Practice is limited to oncology with heavy emphasis on PET/CT. Contact: Zachary Grossman by email at Zachary.Grossman@roswellpark.org.

New York – Mount Sinai Beth Israel is looking for a breast-imaging attending physician to join a group of six breast imagers at four Manhattan locations. We are a busy, dynamic practice with increasing demand. Contact: Barbara Zeifer by email at bzeifer@chpnet.org.

Protecting Women’s Access to Screening Mammography
continued from page 5

significant dilemma and perhaps an unintended consequence for payers, patients, and physicians.

The Affordable Care Act has a provision that requires third-party payers to cover preventive services that receive USPSTF “A” or “B” recommendations without any co-pay. If insurers follow the provisions of the ACA, they may require a co-pay for screening mammography for patients in their 40s or, worse, may not provide coverage at all. In that case, patients may be making their decision on when to begin screening based on financial considerations rather than by weighing the benefits versus the harms the USPSTF suggests.

A woman’s decision on when to begin screening can be truly informed by a shared decision-making process with her doctor only if out-of-pocket costs for mammography are not a consideration. Senators Ayotte and Mikulski and Congresswomen Ellmers and Wasserman Schultz recognized the impact of the ACA on the USPSTF recommendation to place more decision-making power in the hands of women and their physicians. These members of Congress are taking measures to ensure access to mammography for women in their 40s. I applaud them for their effort to make sure that a woman’s decision on when to begin screening is informed by the data and not by the costs.

ENDNOTES
What has helped you get through residency?

**Q:** What has helped you get through residency?

**A:** I distinctly remember one of my most nerve-racking days early in residency. My co-resident Crystal and I were left by ourselves without a senior backup for the first time. We were only first-year residents and were holding down the fort. It was a stressful day and we had a long worklist, endless STAT exams, and residents from every specialty coming in to ask questions. Crystal and I were trying our best to stay afloat and to avoid being the weakest link in the reading room. We quickly found ourselves working efficiently by alternating STAT cases, answering the phone, protocoling studies, and keeping up with the worklist. Neither of us wanted to let the other down, and neither of us wanted to be defeated by the day or, truthfully, each other.

Since that time, Crystal and I have joked that our competitiveness with each other has driven us to become the best version of ourselves. Typically competition in the workplace has been frowned upon, but I think it can be inspirational. Crystal has inspired me tremendously by pushing me and challenging me. We have worked together many times since that first day, and we still find ourselves working harder when we are with each other.

Residency is a challenging time in a young physician’s life. Fortunately for me, I have a colleague who continually inspires me and pushes me to be the best radiologist by being my toughest competition.
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