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I. PRESIDENT'S MESSAGE — Robert S. Pyatt, Jr., MD, FACR

The Annual Meeting of the ACR was recently held in Washington, DC. I would like to express my thanks to Senior Councilor, Dr. David Buck, for all his help in organizing our delegation and keeping everyone "on task." Our delegation was in the front row, close to center, and we probably commanded more visibility and attention than any other delegation. Indeed, Pennsylvania received many more accolades than any other state for the following very good reasons, with KUDOS!

- Drs. David Levin and Bob Campbell, both from Philadelphia, received the Gold Medal of the ACR for their many years of efforts and contributions on behalf of our profession. Both of these radiologists are International Icons and we are so proud to have them call Pennsylvania their home.
- Dr. Gordon Perlmutter, from Reading, received the Thorwarth Award in Economics. This is in honor of the many years of excellence Gordon has given as former Chair of the Coding and Nomenclature Committee, as well as for his many other contributions to the ACR Economics Section, CPT Panels, and other critical ACR efforts on behalf of our colleagues.
- We received the ACR Chapter Recognition Award for Excellence in Communications, which honors our work to disseminate information to our members. Special thanks to Drs. Tom Chang and Peter Arger and Mr. Bob Powell for their efforts.
- Our delegation achieved 100% participation in supporting RADPAC. This is a critical contribution level for us to meet in the future.

My thanks to Dr. Tim Farrell and Mr. Bob Powell for again organizing an excellent trip to Capitol Hill. Several radiologists visited our Senators and several Congressmen on Wednesday of ACR week.

The ACRIN Fund was also a meeting highlight. We must find ways to increase funding for Radiology research with ACRIN. This is one of the "seeds" for the future of our profession. Radiology will ultimately benefit as this funding "bears fruit." Also discussed was the increasing need for academic and private practice radiologists to come together and help each other. Private practice depends on the generation of quality residents, but the goal is not being met in a number of programs due to a variety of issues. Key research and publications are not being done. Film reading demands are causing a significant strain on the research and publication mission of residency programs.

Retaining radiology residents is another big issue. Ten years ago, 50% of residents who were trained in Pennsylvania stayed in Pennsylvania. We are now in the 5% or less range.

The Medicare Deficit Reduction Act (DRA) was another large topic of discussion and was a major focus for our congressional visits. The AMA has yet not taken a position on this issue. It will be an uphill battle to get the burdensome provisions of the bill overturned. The consequences are large and the implications for future cuts are worse.

Much time was spent discussing the Modular Accreditation of MRI, which would include small low-field extremity magnets. After much debate and discussion, including comments from our feisty delegation, the resolution to develop such an accreditation program passed.

We proudly celebrate our four new ACR Fellows, representing the top 5% of all radiologists, for their contributions to our profession: Drs. Chang, Ciotola, Lev-Toaff, and Strollo.

I would like to express my warmest wishes for continued success to Dr. Beverley Newman, who is leaving the Pittsburgh area for a new position on the faculty of Stanford University. Thank you, Bev, for your many years of contributions to the Pennsylvania Radiological Society.

On the state political scene, I am hopeful that we will finally pass the Teleradiology Bill this year. We have just received word at press time that the bill is now out of committee and headed to a vote soon! In terms of the State of Radiology in Pennsylvania, we have many serious challenges: the Medicare Deficit Reduction Act, the shortages of staff in both academia and private practice, malpractice insurance reforms (multiple aspects), reimbursements in general, continuing turf incursions, the lack of retention success for young radiologists, continuing emerging cardiovascular imaging issues, potential coding error/fraud issues, patient safety and quality issues, teleradiology issues, political action needs, PRS web site improvements, improving PRS membership and addressing the needs of our membership, Pay 4 Performance emerging issues, and declining mammographers, to name a few.

I hope that you and your colleagues will become more engaged as you read this Bulletin and become active in the PRS. Improving the future of Radiology will require the help of our members. Please call our Society office to offer your assistance.

I look forward to seeing you at our Annual Meeting, October 27-29, 2006, at the Four Seasons Hotel in historic Philadelphia!

Pennsylvania's new ACR Fellows for 2006:
Drs. Ciotola, Lev-Toaff, Strollo, and Chang
(Photo by Joan I. Vondra, Ph.D.)

Dr. Pyatt, current President, with our
ACR Chapter Recognition Award
(Photo by Thomas S. Chang, M.D., FACR)

II. EDITOR'S COLUMN — Thomas S. Chang, MD

Here is a list of my personal highlights from the recent ACR Annual Meeting in Washington, D.C.:

1. **FACR** – Wow, what a neat ceremony the ACR put on to recognize the 69 new Fellows for 2006! It was just like a med school graduation, only much smaller – complete with cap, gown, and hood. We even got to keep our tassels. Pennsylvania did well by having four Fellows and it was an honor for me to represent our state in that way. I am indebted to my colleague and mentor, Dr. Marcela Böhm-Vélez, for encouraging me to get actively involved in the Pennsylvania Radiological Society, which undoubtedly played a large role in being selected as a Fellow at this stage of my career. The reception afterwards was quite nice too and allowed me to reconnect with a college friend I hadn't seen in 26 years.
2. **ACR Chapter Recognition Award** – As your Editor, I spearheaded our chapter's application for an award in the Communications category, which we ended up winning. It was indeed gratifying to see the efforts of all our contributing writers pay off, since we couldn't have done it without you. Many thanks also go to Dr. Peter Arger (Past President), Mr. Michael Beautyman (Legal Counsel), and Mr. Robert Powell (Executive Director) for their invaluable assistance toward this goal.
3. **Council Debates** – Every year, there is at least one resolution that fosters heated debate on the council floor. This year, that resolution was the one allowing development of a modular accreditation program for MRI (e.g. breast, head, extremity), as opposed to general accreditation. The concern by many was that this was a backhanded way for the ACR to accredit low-field extremity MRI units, which are used almost exclusively by non-radiologists who self-refer and which do not deserve a specific accreditation program. This led to a couple of counter-resolutions to weaken or kill the original resolution and to lots of well-reasoned and amazingly articulate arguments on both sides. This was much better than watching C-SPAN.
4. **Tuesday Lunch** – The featured speaker was Charles Cook, who is considered by many to be the best political handicapper in Washington. He gave a very entertaining talk about his predictions for the 2006 and 2008 elections. He made analyzing politics seem like loads of fun, if you can believe that.

A Little Humor (with apologies to our legal counsel)

If you ever testify in court, you might wish you could have been as sharp as this policeman. He was being cross-examined by a defense attorney during a felony trial. The lawyer was trying to undermine the policeman's credibility....

Q: "Officer, did you see my client fleeing the scene?
A: "No sir. But I subsequently observed a person matching the description of the offender, running several blocks away."
Q: "Officer, who provided this description?"
A: "The officer who responded to the scene."
Q: "A fellow officer provided the description of this so-called offender. Do you trust your fellow officers?"
A: "Yes, sir. With my life."
Q: "With your life? Let me ask you this then, Officer. Do you have a room where you change your clothes in preparation for your daily duties?"
A: "Yes sir, we do!"
Q: "And do you have a locker in the room?"
A: "Yes sir, I do."

Q: "And do you have a lock on your locker?"
A: "Yes sir."
Q: "Now why is it, Officer, if you trust your fellow officers with your life, you find it necessary to lock your locker in a room you share with these same officers?"
A: "You see, sir, we share the building with the court complex, and sometimes lawyers have been known to walk through that room."

Who knows if this is a true story, but it's funny nonetheless.

I hope all of you enjoy the rest of the summer. Before you know it, autumn, the new school year, and our Fall meeting in Philadelphia will be upon us.

III. CODING Q & A — Richard Duszak, Jr., MD, RCC

The "Quick Look" Doppler

Often, when evaluating an adnexal mass, we'll do a quick assessment of vascularity with color imaging, without performing a full spectral analysis. I've gotten mixed advice on whether this can be coded as a formal duplex study. Can you offer some guidance?

The appropriateness of coding Doppler studies in addition to a body-specific examination depends upon both 1) what was performed and 2) why it was performed. When medically necessary, a full and complete color duplex with waveform analysis may be coded separately, whereas a "quick look" color Doppler is included in the base ultrasound code. Doppler studies are indicated for only specific clinical indications and should never be billed routinely with every ultrasound performed. Medical necessity is most easily defended by a specific explicit order by the referring physician. However, if a Doppler study is performed and medically necessary based upon the clinical presentation and specific clinical question, then this procedure falls into the test design exception of the Ordering of Diagnostic Tests Rule. In such circumstances, a radiologist may include (and bill for) Doppler with the ordered examination, but the burden is on him to document in detail the reason this more extensive study was performed.

Note that the CPT code for the abdominal and pelvic adjunct Doppler imaging codes are written to require spectral "and/or" color Doppler. However, it is the consensus opinion of the American College of Radiology that this code should only be utilized when both spectral and color Doppler are performed, and the new edition of the *ACR Ultrasound Coding Users' Guide* reflects this recommendation. Similar changes in CPT instructions are anticipated in the near future.

For more information, refer to the Winter 2006 issue of the AMA/ACR *Clinical Examples in Radiology* and the 2006 edition of the *American College of Radiology Ultrasound Coding Users' Guide*.

MRI of the Internal Auditory Canals

We are often requested by our ENT physicians to perform MRI of the auditory canals, which we perform as a two-sequence brain MRI examination with a total of three additional sequences of the internal auditory canal region without and with contrast. We've heard that some experts advocate coding this as two studies. Can we do that?

Not in the situation you've described. The ACR has offered very specific advice on this issue:

> "If a complete MRI of the brain study is performed in conjunction with a complete study of the IACs, it is appropriate to code for two MRI of the brain studies; a "–59" modifier should be appended to the second MRI brain code to indicate that separate and distinct services were provided. On the other hand, if a complete MRI of the brain is done with just a few extra sequences focused on the IACs, the extra sequences would be considered part of the base study, and only one MRI of the brain study should be coded."

It is the opinion of the ACR that a typical radiology practice "rarely performs a full MR of the brain with a separate and distinct study of the IACs." Accordingly, when practices perform studies they consider separate and distinct (and such separate studies are medically necessary), radiologist documentation should be detailed and support such billing. Payer audits should be expected in such situations.

For more information, refer to March/April 2003 issue of the *ACR Radiology Coding Source*.

Fetal Nuchal Translucency Evaluation

Our obstetricians are now requesting that we perform detailed fetal nuchal translucency evaluation in some high-risk patients. Can this service be coded?

Yes. Dedicated new CPT® codes for fetal nuchal translucency evaluation are anticipated for 2007. In the meantime, the American College of Radiology, the American College of Obstetrics and Gynecology and the American Medical Association have all advised

that this service be reported with the unlisted procedure CPT® code 76999 (Unlisted ultrasound procedure [e.g., diagnostic, interventional]).

Occasionally, fetal nuchal translucency evaluation is performed as a stand-alone service (such as when the patient has already undergone a complete obstetrical ultrasound examination and is referred for dedicated high-risk genetic evaluation). In such circumstances, only the unlisted procedure code 76999 is reported. In other circumstances, this service is performed in conjunction with a full and complete first trimester examination, in which case both the obstetrical ultrasound code, 76801 (Ultrasound, pregnant uterus, real time with image documentation, fetal and maternal evaluation, first trimester (<14 weeks 0 days), transabdominal approach; single or first gestation), should be reported along with the unlisted procedure code 76999.

Remember that any such "add-on" services should never be performed as a matter of routine and can be performed only when medically necessary. Depending upon the site of service, such medical necessity demonstration may require a specific order from the referring physician or explicit documentation by the radiologist as to why this service was performed.

For more information, refer to the Winter 2006 issue of the AMA/ACR *Clinical Examples in Radiology* and Medicare Transmittal 1725.

The Coding Q&A column is a regular feature of the PRS Bulletin. *While space constraints preclude us from answering all coding questions, issues of greatest interest will receive the highest priority in future columns. E-mail questions to the author at rduszak@yahoo.com.*

IV. LEGAL NEWS HIGHLIGHTS — Michael J. Beautyman, Esq.

CMS Finalizes Rule on "Inherent Reasonableness" for Medicare Part B Services

CMS published in the December 13 Federal Register a final rule for establishing a realistic and equitable payment amount for Medicare Part B services when the existing payment amounts are inherently unreasonable because they are either grossly excessive or grossly deficient (70 Fed. Reg. 73623). Under the final rule, differences between current and proposed payment amounts of less than 15% will not be considered grossly excessive or grossly deficient and therefore will not be a sufficient basis for CMS to use its inherent reasonableness authority.

The final rule also sets forth eleven steps to be completed to ensure the use of valid and reliable data in making an inherent reasonableness determination, including developing written guidelines for data collection and analysis; ensuring that sampled prices fully represent the range of prices nationally; and considering the products generally used by beneficiaries and collecting prices of these products. Although the Medicare statute applies the inherent reasonableness to Part B items and services (except physicians' services), CMS opted not to apply the provisions to services paid under a prospective payment system such as outpatient hospital services or home health services.

Email is Evidence Mail

The Judicial Conference Committee on Rules of Practice and Procedure has proposed amendments to the Federal Rules of Civil Procedure to address discovery of electronically stored information (ESI). If the Supreme Court approves the amendments to the Rules, they will take effect no later than December 1, 2006.

The proposed amendments are meant to make discovery under the Rules relevant to the dynamic nature of ESI and the challenges associated with identifying, locating, preserving, and producing ESI. Discovery of ESI can involve burdensome disruptions and costs for parties' ongoing business operations. And, no matter how diligent parties are, the volume and complexity of ESI creates the very real potential for mistakes in discovery. Consonant with that recognition, the proposed amendments establish requirements and procedures to enable parties and courts to balance the burdens and costs of production of ESI against the need to discover such information; procedural mechanisms for resolving the unintended production of privileged information or trial preparation materials; and procedural mechanisms for handling failures to produce discoverable ESI.

Personal Financial Planning Strategies

Beginning in 2006:

- The top Federal estate and gift tax rates decreased from 47% to 46%
- The Federal estate and GST tax exemptions increased from $1.5 million to $2 million
- The Federal gift tax exemption remains at $1 million
- The annual gift tax exclusion increased from $11,000 to $12,000 ($24,000 in the case of a married couple)
- The annual gift tax exclusion increased from $117,000 to $120,000 for gifts made to a non-citizen spouse

Although the reduced Federal estate tax rate and higher exclusion amounts are good news, many states do not follow the Federal changes, resulting in higher combined estate taxes.

Malpractice Insurance Premiums

According to a study released by the American Medical Association, physicians paid less in malpractice premiums in 2000 then they did in 1986. This seems to contradict the popular belief that malpractice premiums have been driving physicians out of business.

The study, which was conducted from 1970 to 2000, showed that the average premium went from a low of $5,934 in 1970 (6 percent of total physicians' expenses) to a high of $20,106 in 1986 (11 percent of physicians' expenses). In 2000, the average malpractice premium was $18,400, or about 7 percent of their total expenses.

The authors of the study say these averages held up when applied to specific regions of the country and different types of practices, including high risk ones.

V. FELLOWSHIP COMMITTEE REPORT — Michael B. Love, M.D., FACR, Chair

The degree of Fellowship in the American College of Radiology was conferred upon the following Pennsylvanians at the May 2006 meeting of the ACR:

- Thomas S. Chang, M.D.
- Joseph G. Ciotola, M.D.
- Anna S. Lev-Toaff, M.D.
- Diane C. Strollo, M.D.

Congratulations to our newest Fellows.

VI. ANNUAL MEETING REPORT — Robert S. Pyatt, Jr., MD, FACR Chair

This past year's 90th Annual Meeting had a very successful educational program, judging from the program evaluations. As we work toward our 91st Annual Meeting at the Four Seasons Hotel in Philadelphia on October 28, 2006, we have had a number of topic suggestions. These include definite repeat performances for the ACR HOT National Issues Update, delivered this year by Arl Van Moore, MD, FACR, ACR Board Chairman, and Dr. Rich Duszak's very popular Coding and Avoiding Billing Fraud topic. In addition, the following topics/issues have been suggested for 2006:

- More programs with Patient Safety/Risk Management (PS/RM) credits to comply with the state licensing regulations… requested by many attendees
- The Radiologist Assistant (RA) and the Radiology Physician Assistant (RPA)… more practices are looking at this option
- Teleradiology panel discussion on a variety of issues. Speakers to include Doug Johnson from Nighthawk (and Dayhawk), Dr. Rich Taxin, and Dr. Tim Farrell.
- The State of Medicine and Radiology in Pennsylvania. This is a look at critical physician data from recently released Pennsylvania Medical Society Economics research. For example, ten years ago, 50% of residents stayed in Pennsylvania; now, only 5% stay in PA.
- Potential lunchtime program on Contrast-Induced Nephropathy (CIN) and strategies to better manage these patients.
- Afternoon session: Cardiac and Coronary Artery Imaging CME, both basic and advanced. Speakers are Dr. Charagundla from Penn and Dr. Bud Landry, from Louisiana.

We're going to have both morning and afternoon sessions, with CME credit also available for the Annual Oration in the evening. If you have any suggested topics for the speakers to address, please email me at bobpyatt@comcast.net.

VII. REPORT OF REFERENCE COMMITTEE I — Richard H. Daffner, M.D., FACR

Reference Committee I, for the first time in many years, did not have to deal with any controversial resolutions. In addition to approving a ten-year extension of the ACR policy on MR and CT reimbursement, the Reference Committee recommended for adoption the development of ACR Accreditation Modules for cardiac CT and for cardiac MRI; the adoption of six new Practice Guidelines; and the adoption of six revised Practice Guidelines.

The six new Practice Guidelines were for Performance and Interpretation of MRI of the Ankle and Hindfoot, the Elbow, and the Hip and Pelvis for Musculoskeletal Disorders. These were in collaboration with the Society of Skeletal Radiology. The Guideline for the Performance and Interpretation of Pediatric MRI was co-sponsored by the Society of Pediatric Radiology. Other new Guidelines were for Performance and Interpretation of Cardiac MRI and for Cardiac CT.

The revised Practice Guidelines were for Performance of MRI of the Adult Spine and of CT of the Spine, collaborative with the American Society of Neuroradiology (ASNR), as well as Guidelines for CT of the Extracranial Head and Neck, CT of the Abdomen and/or Pelvis, and Performing and Interpreting Diagnostic CT, and for MRI.

All the resolutions passed and the Guidelines were adopted.

REPORT OF REFERENCE COMMITTEE II **Nilima Dash, M.D., FACR**

Reference Committee II had 18 Resolutions. The topics were quite diverse, including breast imaging, medical physics, radiation safety, nuclear medicine, radiation oncology, interventional radiology, informed consent for image-guided procedures, and last, but not least, supporting and strengthening the academic infrastructure of radiology. Seven of the eighteen Resolutions were collaborative efforts with various societies.

Most noteworthy were Resolutions 18 and 19. **Resolution No. 18** was submitted by the West Virginia Radiological Society and stated, *". . . that the American College of Radiology make it a priority to advocate for a change to federal mammography law so that the three year requirement for 15 hours CME credit is based on the* ***calendar year instead of inspection dates,*** *and that the American College of Radiology also make it a priority to advocate for a change to the federal mammography regulations so that if a radiologist is found to be out of compliance on the CME requirements, he or she will have a minimum of* ***5 working days*** *to show proof of having fulfilled the requirements or to cure the problem before his or her privileges to read mammograms can be removed."*

Resolution No. 19 was submitted by the Board of Chancellors and stated, *". . . that the College approve development of a Breast MR Accreditation module or program under the same general principles as other previously approved College accreditation programs."* This was brought on since there is an increasing number of breast MR imaging exams being performed in an environment where technologists, physicists, and physicians have varying degrees of training and experience.

None of the resolutions under Reference Committee II was controversial and all resolutions passed, some with minor editorial changes.

REPORT OF REFERENCE COMMITTEE III **Eric N. Faerber, MD**

Prior to the meeting, resolutions and guidelines in this section were reviewed by Beverly Coleman, M.D., Thomas Chang, M.D., Marcela Böhm-Vélez , M.D., and Eric Faerber, M.D. Drs. Böhm-Vélez and Faerber served on the Reference Committee at the meeting.

There were no contentions resolutions or guidelines. They were all passed unanimously with the exceptions of Resolutions 35, 37, and 49, which were extracted for discussion and then passed.

RESOLUTION

34. Radiologist Assistant Inclusion in Practice Guidelines
35. "Request for Examination" Language in Practice Guidelines
36. American Osteopathic Association (AOA) Residency Equivalency language in Practice Guidelines and Technical Standards for Diagnostic Radiology
37. ACR Practice Guideline for Performing and Interpreting Diagnostic Ultrasound Examinations
38. ACR Practice Guideline for the Performance of Ultrasound Vascular Mapping for Preoperative Planning of Dialysis Access (Collaborative)
39. ACR Practice Guideline for the Performance of an Ultrasound Examination of the Abdomen and/or Retroperitoneum (Collaborative)
40. ACR Practice Guideline for the Performance of Peripheral Venous Ultrasound Examination (Collaborative)
41. ACR Practice Guideline for the Performance of Peripheral Arterial Ultrasound Using Color and Pulsed Doppler (Collaborative)
42. ACR Practice Guideline for the Performance of Scrotal Ultrasound Examinations (Collaborative)
43. ACR Practice Guideline for the Performance of Pediatric Contrast Examinations of the Upper GI Tract
44. ACR Practice Guideline for the Performance of Pediatric Fluoroscopic Contrast Enema Examinations
45. ACR Practice Guideline for the Performance of Pediatric and Adult Portable (Mobile Unit) Chest Radiography
46. ACR Practice Guideline for the Performance of Pediatric and Adult Chest Radiography
47. ACR Practice Guideline for Skeletal Surveys in Children
48. ACR Practice Guideline for the Performance of Abdominal Radiography

49. ACR Practice Guideline for the Performance of Hysterosalpingography
50. ACR Practice Guideline for the Performance of Modified Barium Swallow in Adults
51. ACR Practice Guideline for the Use of Intravascular Contrast Media

REPORT OF REFERENCE COMMITTEE IV **Richard N. Taxin, MD, FACR**

Reference Committee IV turned out to be the committee of most interest, especially with regard to the development of an MRI Extremity Accreditation Module. The following resolutions were passed:

- There was a 10-year extension of policies, ranging from no smoking rules to teleradiology
- Membership dues increase for international members (with the proviso that the College reevaluates what it means to be an international member)
- Bylaws revisions
- Membership dues for International Members in Training and Allied Health Members
- Official Observer Representation on the ACR Council
- Increased Council Representation for the Resident and Fellow Section
- ACR Revised Statement on the Interpretation of Radiology Images Outside the U.S.
- Development of Modular Accreditation in MRI (this would include development of an MRI extremity module)
- Evaluation of ACR Professional Bureau Services

VIII. RESIDENTS' REPORT — Michael F. Goldberg, MD, MPH

It's been a busy year for the Resident and Fellow Section (RFS) of the Pennsylvania Radiological Society, and much has happened since my last column several months ago.

First, in April, I had the honor and pleasure of speaking at the Philadelphia Roentgen Ray Society (PRRS) Meeting at the Philadelphia College of Physicians. The RFS would like to thank Dr. Beverly Coleman, President of the PRRS, for allowing us to continue to share our message at the PRRS monthly meeting. In my talk, I outlined the mission, goals, and activities of the RFS.

Among these activities were the recent PRS-sponsored dinner symposia held in several locations throughout the state. At the Philadelphia dinner on May 18th, 24 residents representing six (out of eight) Philadelphia training programs were in attendance. Al Riviezzo, a partner at the law firm of Fox-Rothschild, discussed both the general principles as well as the smaller, yet equally important, details that should guide residents in evaluating a job offer and contract from a potential employer.

Dr. David Levin, former chairman of Radiology at Jefferson, recent ACR Gold medal recipient, and a leading expert on the topic of over-utilization and self-referral spoke on the topic of "turf battles," an issue which, based on the recent annual ACR meeting, is one of the most pressing dilemmas facing radiology. Focusing his comments on cardiac imaging, Dr Levin outlined his thoughts about why Radiology can and should have a major role in cardiac imaging.

Finally, speaking about "how to choose a career in academic or private practice radiology," Drs. Ronit Devon (Mainline Health Imaging), Irene Woo (Crozer-Chester Medical Center), and Levon Nazarian (Jefferson) each gave their perspectives on the career path they had chosen.

In Pittsburgh, there was well-attended dinner with talks about different types of job opportunities. At Geisinger Hospital, Mr. Robert Powell, the PRS Executive Director, talked about contracts and pitfalls of private practice; special thanks to Dr. Anne Dunne for helping to organize this.

Dr. Javier Quintana, a resident at Geisinger Hospital, and I attended the ACR Annual Meeting in Washington, D.C., in late May. As resident representatives of the PRS, we joined over 140 residents at the meetings of the ACR's Resident and Fellow Section. It was a great opportunity to meet residents from around the country and to compare and contrast our experiences. Some of the most hotly debated issues in the RFS sessions were the future of AFIP and improved training in cardiac imaging.

As we review this past academic year, we are very excited by much of what the RFS has accomplished and by the tremendous support we have received from the PRS. We will build on this momentum as we strive to achieve our mission of raising resident awareness of the many challenges and exciting opportunities that face the field of radiology.

IX. NATIONAL ONCOLOGIC PET REGISTRY — Randall S. Winn, M.D.

The National Oncologic PET Registry (NOPR) was developed in response to the Centers for Medicare and Medicaid Services' (CMS) proposal to expand coverage for positron emission tomography (PET) with F-18 fluorodeoxyglucose to include cancers and

indications not presently eligible for Medicare reimbursement. The NOPR is managed by the ACR through the ACR Imaging Network (ACRIN). The NOPR is also supported by the Academy of Molecular Imaging, the Society for Nuclear Medicine, and the American Society for Clinical Oncology.

This program is important for the radiology and nuclear medicine communities, as it is a new way to collect quickly a large volume of data on new imaging procedures and new indications for existing imaging procedures. Patients who were not previously covered can now have a PET scan to help diagnose and manage their cancer. The process was simplified to encourage participation, particularly by referring physicians.

The NOPR is now open for registration of PET facilities and patients. More information may be obtained at the NOPR website, www.cancerpetregistry.org.

X. ANNOUNCEMENTS

August 3-6, 2006: 24th Annual Pittsburgh Breast Imaging Seminar to be held at the Pittsburgh Convention Center, with all events on one floor, Pittsburgh, PA. Featured speakers to include Farhad Contractor, MD, FACR, Debra Deibel, RTR(M), Stephen Feig, MD, FACR, Terri Gizienski, MD, Ronald Johnson, MD, Thomas Julian, MD, Kathy Lang, RTR(M), Elsie Levin, MD, FACR, Michael Linver, MD, FACR, Ingrid Naugle, MD, FACR, Jay Parikh, MD, Jules Sumkin, DO, FACR, William Poller, MD, FACR. Course Director: William R. Poller, MD, FACR. For further information and to receive a brochure, please call 412-359-4952, e-mail Cheri Jackel at cjackel@wpahs.org, or visit www.aghcme.org.

Breast Imaging - Body Imaging Fellowship (Funded)
The Department of Human Oncology at Allegheny General Hospital has a Breast Imaging Fellowship position available July 1, 2006. Enjoy the comforts of a 10,000 square foot breast center that is fully digital. In addition, there are two stereotactic units, state-of-the-art ultrasound units, the hand-held Mammotome, the Intact biopsy device, MRI and CAD. Twenty-four thousand (24,000) total breast imaging studies are performed yearly. Flexible year to include dedicated time with surgery, pathology, **and body imaging**, if desired. Research opportunities are also available, either with the NSABP (National Surgical Adjuvant Breast Project) or the ACRIN (American College of Radiology Imaging Network) trials associated with breast imaging. There is direct interaction with dedicated breast surgeons who are associated with the NSABP.

For further information, please contact and send a resume and two letters of reference to William R. Poller, MD, FACR, Allegheny Cancer Center, 5th Floor, Allegheny General Hospital, 320 East North Avenue, Pittsburgh, PA 15212-4772. Telephone: 412-359-8366, FAX: 412-359-8685, Pager: 412-359-8220 ID 4544, e-mail: wpoller@wpahs.org.