

SCANNER

THE OFFICIAL NEWSLETTER OF THE
AMERICAN COLLEGE OF NUCLEAR MEDICINE

ACNM Annual Meeting Topic & Research Roundup



We're sure we'll see many of you at the upcoming ACNM Annual Meeting held conjointly with the SNMMI Mid-Winter Meeting.

Many exciting topics are on the proposed schedule, and here is a preview:

- Appropriate Use Criteria – Where Are We Now, Where Are We Going, and Where Do We Fit In?
- The Year in Review – The Best Nuclear Medicine & Molecular Imaging of 2014
- Appropriate Use of Nuclear Medicine as Consultant and Colleague - How Nuclear Medicine Practitioners Can Give Clinicians the Best Information Every Time
- Appropriate Use of Radiation in Everyday Practice – Diagnostic and Therapeutic Considerations
- Personal Branding – Transitioning Your Learning Portfolio Into the Career You Want
- Challenging Cases in Pediatric Nuclear Medicine/RWE
- Appropriate Use of Nuclear Medicine and Imaging in Cancer Screening and Diagnosis
- Using Evidence-Based Medicine Appropriately in Imaging – Being Everyday Change Agents

(Continued on page 2. See *ACNM Annual Meeting*.)

Letter From the President



Twyla Bartel,
DO, MBA, FACNM

Dear Colleagues,

I trust you have all enjoyed the holiday season with a brand new year before us!

This is my last month as the ACNM President as this role is passed on to Dr. Rathan Subramaniam this month. I strongly encourage each of you to give him your full support in the same manner you have for me. The success of our College is not just based upon the board members, but is also strongly dependent upon ALL of our ACNM members. This includes your membership, your ideas, and your involvement whenever possible. We have just completed Strategic Planning meetings where we have been working on multiple items, and they just cannot all be included in this note.

There are three of these items, however, that I want to bring your attention to as follows:

- 1) **New fundraising effort for our young professionals in training.** If you have not seen this announced previously, please know that we have initiated the new ACNM Annual Fund in order to raise funds to continue to support and keep these items in place. They are invaluable to both our College and to our Nuclear Medicine community as we help train our future leaders. Our goal to try and raise \$10,000 per year in order to support our intern program, advocacy items for our young leaders, multiple educational items, and abstracts awards program, to name a few. Please consider making a donation to enable us to provide strong leadership and mentorship in these areas.
- 2) **I have established a new Government Relations/Advocacy Committee with Dr. Erica Cohen as the head of this.** One of the purposes is to strengthen our current ACNM-SNMMI GR committee ties and activities. Another is to provide better communication between our representation we have with other organizations such as ICANL, AMA, ARR, etc. Dr. Cohen and the committee are also working on some new items which will further strengthen the ACNM presence regarding patient advocacy and research, radiation training, and other GR items. Please keep a lookout for updates in these areas.

(Continued on page 2. See *Letter From the President*.)

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3) A new Educational Committee has also been established, and Dr. Amol Takalkar and I have taken the lead on several items related to this. In a prior survey, you spoke as our members and indicated desire for more items in this arena. We are working on MRI education, CME opportunities, and have already begun the new ACNM Webinar Series. We are working on several other items, also, including review type questions. If you didn't see the prior announcement in Spotlights, we have also a new IMAIOS-ACNM partnership which will help us display our newsletter cases in a professional format and accessible from our new updated ACNM website. This partnership also provides ACNM members with a 70% off discount for the IMAIOS e-anatomy program. If you are interested, you can call or sign up for this at the annual meeting.

I hope we will see many of you at the ACNM Program and Awards Banquet in just a few days!

Sincerely,
Twyla B Bartel, DO, MBA, FACNM
ACNM President

(ACNM Annual Meeting. Continued from page 1.)

Clinical and scientific abstracts will be presented on the following topics:

- Aspects of Clinical and Basic Science in Nuclear Medicine
- Correlative Imaging in Nuclear Medicine and Radiology
- Nuclear Pharmacy and Physics
- Nuclear Cardiology
- Radionuclide Therapy
- Quality and Safety in Nuclear Medicine

As you may remember, we will select 12 top abstract presenters to compete at the 3rd Sino-American Conference in Shanghai, China, in May 2015. We're excited to see who will be chosen.

IAC Update, Part II

Lorraine M. Fig, MD, MPH, FACNM and Leonie Gordon, MD, FACNM



Lorraine M. Fig,
MD, MPH, FACNM

In a previous issue of *Scanner*, an article on the Intersocietal Accreditation Commission (IAC) introduced the guiding principles underpinning the organization and discussed its value in advancing high-quality imaging services. In this article, we will briefly present some of the nuts and bolts of the accreditation process and examine the range of resources that IAC makes available to the general nuclear medicine community.

IAC Nuclear/PET (formerly known as "ICANL") is one of 8 current divisions of IAC (other modalities are echocardiography, CT, MRI, vascular testing, and so on). More than 3600 nuclear/PET sites are currently IAC accredited. Accreditation is a multi-step process that begins with a detailed self-evaluation of one's laboratory through review and comparison to the published IAC Standards and Guidelines. Completion of the

(Continued on page 4. See *IAC Update*.)

MITA PET Group Educational Efforts



Terri Wilson

The Medical Imaging & Technology Alliance (MITA), a division of the National Electrical Manufacturers Association, is the leading organization and collective voice of medical imaging equipment, radiation therapy, and radiopharmaceutical manufacturers, innovators, and product developers. The MITA PET Group, representing those companies involved with PET imaging, focuses on activities related to policy, coverage, advocacy, and education.

One area of great importance to the MITA PET Group is advocacy and education, and MITA works to influence both in a number of ways. First, the MITA PET Advocacy and Education Committee contracts with expert PET imaging physicians who submit evidence-based requests to the National Comprehensive Cancer Network (NCCN) Guidelines Panels for consideration when updating guidelines. These requests summarize the literature for integrating appropriate PET imaging into patient management for certain types of cancer. Our [DETAIL](#)® kits are another resource for education on the appropriate uses of PET imaging. Each kit contains indication-specific education on Medicare coverage, appropriate utilization, and supporting clinical data that may be used with patients, technologists, marketers, and referring physicians. Finally, in 2014, MITA provided an educational grant to Medscape Oncology to create a CME-certified medical education video collection titled "Is There a Limit? FDG PET and Cancer." The goals of this activity are to (1) help learners understand and explain the Centers for Medicare & Medicaid Services ruling for the use of FDG PET and its implications regarding initial and subsequent treatments in patients with cancer and (2) identify methods and strategies to improve communication among care team members regarding the appropriate use of FDG PET imaging in patients with cancer.

The robust educational offerings from the MITA PET Group are continually evolving. If you would like to lend your support to these important initiatives, please contact Terri Wilson at twilson@medicalimaging.org.

Government Relations and Advocacy Corner

Erica J. Cohen, DO, MPH – Committee Chair



Erica Cohen, DO, MPH

ACNM representatives once again attended the 2014 AMA Interim Meeting in early November in Dallas, Texas. ACNM was voted on and approved to retain representation in the House of Delegates for 5 more years. Some of the major topics and goals identified by the AMA included repeal of the Sustainable Growth Rate (SGR); delaying implementation of International Classification of Diseases and Related Health Problems, 10th Revision (ICD-10); working with the Centers for Medicare & Medicaid Services (CMS) to ensure that the Sunshine Act not only encourages transparency but also contains accurate information; supporting domestic and global efforts to fight the Ebola epidemic; scaling back the Value-Based Payment Modifier (VBM), Physician Quality Reporting System (PQRS), and meaningful use penalties; facilitating multiple state licensure for telemedicine; and maintaining separation of Maintenance of Certification (MOC) from Maintenance of Licensure (MOL). The ACNM Government Relations and Advocacy Committee (GRAC) is working to identify potential resolutions to bring before the House of Delegates to strengthen our voice in the organization.

It was recently announced that CMS will extend no-cost coverage for lung screening CTs to Medicare beneficiaries who have a 30

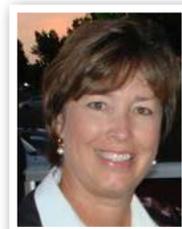
pack-year smoking history, even if they quit smoking as long as 15 years ago. This applies to asymptomatic beneficiaries between 55 and 74 years of age and requires a written order, lung cancer screening counseling, and a shared decision-making visit. It is estimated that this coverage could save 20,000 lives per year. Current requirements for interpretation of lung screening CTs include current American Board of Radiology or equivalent certification, documented training in diagnostic radiology and radiation safety, involvement in/supervision of and interpretation of at least 300 chest CTs in the past 3 years, and documented participation in continuing medical education in accordance with American College of Radiology standards. Radiology imaging centers must also meet certain eligibility requirements to perform lung screening CTs. This proposal is expected to be finalized in February 2015.

The GRAC currently has representation in several organizations outside of the College, including the American College of Radiology, American Board of Science in Nuclear Medicine, Academy of Radiology Research, Intersocietal Accreditation Commission, and Accreditation Council for Graduate Medical Education. We have many exciting projects currently under way and look forward to updating you in the coming months.

Thank you to Dr. Hadyn Williams, ACNM Delegate to the AMA, for his contributions to this article.

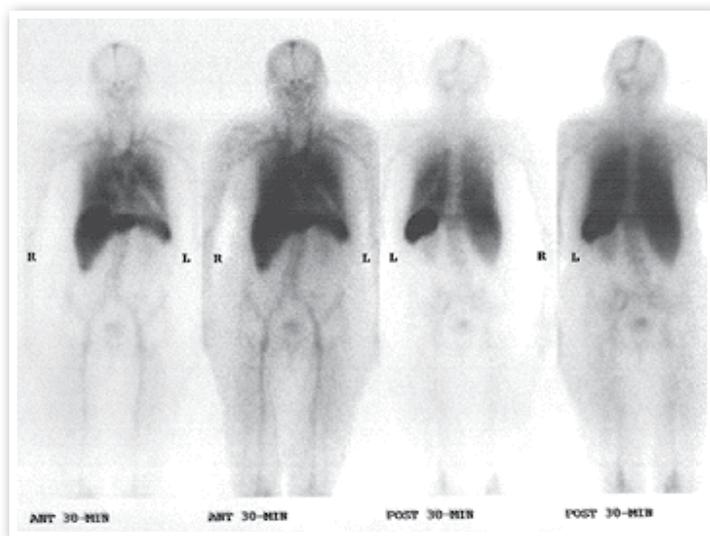
Indium-111 vs Tc-99m HMPAO labeled WBCs Selecting the right isotope for the patient

Nicki Hilliard, PharmD, BCNP, FAPhA



Nicki Hilliard,
PharmD, BCNP, FAPhA

Continuity in patient imaging is often important to compare patients to the norm, i.e. making sure each gastric emptying patient eats the same meal and using the same myocardial perfusion imaging agent. There are other times that you should change the radiopharmaceutical based on the patient conditions. One prime example is labeled WBCs for infectious imaging. As a nuclear pharmacist, I often see hospitals always using the same isotope for imaging no matter the patient variables. I just want to review some of the patient conditions that should be taken into account when choosing between Indium-111 and Tc-99m HMPAO for autologous leukocyte labeling.



Transient lung uptake and blood pool seen in Tc-99m HMPAO labeled leukocytes imaging.

Isotope Info:

	Indium-111 WBCs	Tc-99m HMPAO WBCs
Activity	0.5 mCi	20 mCi
Half-life	2.8 days	6 hours
Imaging times	4 and 24 hours	30 min and 3 hours
Normal distribution	Liver, spleen, & bone marrow	Liver, spleen, bone marrow, bowel, gallbladder, kidney & bladder

• early imaging times depending on condition

Patient condition variables to take into consideration:

- Pelvic infection – consider In-111 WBCs because there is no bladder activity that might interfere with imaging.
- Abscess localization – it may take time for WBCs to penetrate a walled off infection in an abscess, Indium would allow for delayed imaging at 24 hours.
- Extremities – Tc-99m HMPAO labeled WBCs have 40 times more activity than Indium labeled WBCs and improve imaging

(Continued on page 5. See WBCs.)

application process requires submission of information about the laboratory's personnel and practice as well as a crucial aspect, clinical case studies (images and reports), for peer review. Two nuclear medicine practitioners (generally a technologist and a physician) independently review the application by using a standardized review form to evaluate for compliance with the standards as well as the quality of the case studies. The reviewers' comments and preliminary recommendations are then presented to the IAC Nuclear/PET Board for a decision regarding accreditation. The vast majority of decisions fall into 2 categories: "granted" (ie, accreditation is awarded) or "delayed." In the latter case, the laboratory is generally required to submit additional and/or revised evidence of compliance with the standards. An overriding philosophy of IAC is that their application review should be educational and provide specific feedback to the laboratory to help improve quality. After initial accreditation, an audit (ie, a request to provide documentation for items such as personnel licenses, patient reports, case studies, quality improvement [QI] data) or a laboratory site visit will occur during the 3-year accreditation period to substantiate continued compliance. An audit versus a site visit is randomly assigned.

The specific IAC Nuclear/PET standards have been selected for their importance in promoting safety and fostering high-quality practice. These standards are published at http://www.intersocietal.org/nuclear/main/about_standards.htm and are available to both IAC subscribers and nonsubscribers. Even if you do not participate in accreditation, these comprehensive documents are extremely useful to compare your own laboratory's practice with contemporary, peer-authored standards and to use as a road map for achieving high-quality care. The standards are developed with reference to previously published guidelines and protocols from major professional societies. The standards are revised on a defined cycle to reflect evolving practice patterns and protocols. The public has a 60-day comment period to provide input into the accreditation process. In fact, the most recent standards review has recently been completed and the document is currently being readied for public comment. A new feature of the revised standards is a clearly formatted distinction between definite accreditation requirements and those that are simply recommendations.

IAC is a forward-looking organization that embraces technological developments. Gone are the days of the copious paperwork required for accreditation applications; the application process is now simplified and fully electronic, and data may be submitted online at any time to reflect changes in staffing and equipment. Images and reports for the accreditation application are also submitted electronically to a platform that accepts nearly all image formats. IAC is moving toward a goal of continuous accreditation to replace the current 3-year periodic reaccreditation.

IAC Nuclear/PET provides a variety of education programs and resources to clinicians, technologists, and trainees. These offerings, found under the Helpful Resources tab at http://www.intersocietal.org/nuclear/main/about_iac_nuclear.htm, include the following:

- On-demand webcasts, produced by IAC, highlighting the accreditation and reaccreditation processes, with information on useful topics such as standards for interpretation and report-

ing, documenting quality, and explanations about Appropriate Use Criteria.

- CME resources: As a service to the nuclear medicine community, IAC maintains a limited listing of upcoming educational meetings at various sites in the United States and provides details on recurring educational courses and self-study resources that offer CE/CME credits.

One of the important IAC accreditation requirements is participation in QI. This requires facilities to perform measures in 3 quality areas: administrative, technical, and interpretative. Study appropriateness (eg, the published 2009 Appropriateness Use Criteria for Cardiac Radionuclide Imaging) must be periodically measured, and QI staff meetings must be held to discuss the results of the measures and formulate plans for improvement. Many laboratories have found the QI exercises useful in assessing and strengthening their internal processes. Although these requirements may sound daunting, IAC greatly facilitates the process by posting sample QI plans for all required QI measures, suggestions for appropriate QI monitors, and even a sample QI Meeting Minutes Template on their website (http://www.intersocietal.org/nuclear/seeking/sample_qualitycontrol.htm). In fact, there is a wealth of information on the Nuclear/PET site (under the Helpful Resources tab) that is heavily accessed by laboratories participating in the IAC accreditation program but is also available to the nuclear medicine community at large. Useful items such as sample protocols for quality control, administration, clinical procedures, competency documentation, radiation safety, checklists, and many more useful documents may be downloaded and customized for individual laboratories. There is also a section called "Links and References" that contains a list of useful reference documents and/or information, organized by professional society. An interesting aspect of the IAC Nuclear/PET QI initiative is that sites have the option of utilizing the SNMMI Quality Assurance Patient Simulator (Phantom) program to meet the annual QI requirement for both the technical and physician performance measurements. Details about this program are available on the SNMMI website.

IAC has identified research as a vital strategy toward collecting and analyzing data to improve accreditation. In 2012, a major research effort was launched to objectively assess the relationship between accreditation and improvement of patient care. The formation of a research committee and the more recent appointment of Mary Beth Farrell (the former Nuclear/PET Director of Accreditation) as Director of Research was a big step forward in promoting the importance of this initiative. You may be interested in applying for one of the annual research awards, which support innovative and meritorious research through 1-year grants up to a maximum of \$75,000. Complete details are available on the IAC website (<http://www.intersocietal.org/iac/research.htm>). To date, 2 peer-reviewed research manuscripts and nearly 20 abstracts have been published. Of special interest to nuclear medicine practitioners are articles dealing with various aspects of radiation dose and dosing strategies associated with scintigraphic studies, and links to these articles are available on the research webpage.

(WBCs. Continued from page 3.)

resolution especially if there is poor blood flow as in diabetic foot infections.

- Low WBC count – The greater activity of Tc-99m HMPAO WBCs allows for imaging with lower patient WBC counts. Infectious imaging with In-111 WBCs is more reliable above a 4000/mm³ WBC count while Tc-99m HMPAO WBCs can be performed down to 2000/mm³. If the WBC count is too low, it is possible to use a blood donor to label WBCs for the patient. The final preparation should be suspended in saline rather than plasma.

Facts to remember:

1. Both Indium-111 oxine and Tc-99m HMPAO are lipophilic and allow passage across the WBC membrane. In-111 oxine binds to the cytoplasmic proteins and stays fixed inside the WBC while HMPAO will diffuse back out of the cell. With Tc-99m HMPAO WBCs it is important to image the abdomen before 4 hours because the Tc-99m HMPAO labeled WBCs will be excreted into the intestine and may interfere with differentiating between normal excretion and infection.
2. Transient lung uptake is seen in both In-111 and Tc-99m labeled cells, but the earlier imaging times with Tc-99m HMPAO might interfere with imaging.
3. False positive may result from imaging swallowed WBCs from phlegm as it moves through the GI tract. May want to image the head for identifying sinus infections.
4. External radiation exposure and healing surgical wounds may cause a positive uptake of WBCs.
5. Acute infections have a great imaging sensitivity than chronic infections.
6. Sickle cell patients are difficult to obtain an adequate plasma and WBC sample for labeling.
7. You can use the WBC count to help determine how much blood would be adequate for a pediatric patient. Tc-99m HMPAO WBCs would have a much lower radiation burden to the patient.
8. It is normal to see more blood pool activity with Tc-99m HMPAO labeled cells because of the increased activity.
9. F-18 FDG is a good infectious imaging agent, but it is not reimbursable.



Normal In-111 WBC scan. Absence of bladder activity is advantageous for pelvic imaging but low activity and count rates make it difficult for good extremity images.

ICD-10 Cometh

Erin Grady, MD



Erin Grady, MD

Implementation of the International Classification of Diseases and Related Health Problems, 10th Revision (ICD-10) is coming. Although change is difficult for every health care organization in the United States, ICD-10 is being implemented by the World Health Organization member states for coding of national morbidity and mortality statistics. Approximately 25 countries

already use ICD-10...one even dating back to the 1990s!

The date for implementation of ICD-10 in the United States has been pushed back a couple of times, but some are saying that October 1, 2015, may well be the date that we should be ready for this change. The AMA and many other organizations continue to lobby to once again delay implementation (to 2017); however, according to many sources, the delay proposal seems to be “dead on arrival” in the lame duck Congress. Others worry that physicians haven’t been included in the discussion of how to implement the ICD-10.

Because use of ICD-10 will affect vendors of electronic health record systems, practice management systems, hospital and out-patient billing departments/practices, insurance companies, and

so on, it behooves us to be ready for the possibility of a change-over in October 2015. There is a lot of misinformation about ICD-10, but here are some reliable resources:

ICD-10 CMS Myths & Facts:

<http://www.cms.gov/Medicare/Coding/ICD10/downloads/ICD-10MythsandFacts.pdf>

The CMS website dedicated to ICD-10:

<http://www.cms.gov/Medicare/Coding/ICD10/Index.html>
(includes a tool for small practices)

The AAMC Introduction:

<https://www.aamc.org/download/270020/data/icd10implementationguide.pdf>

The Pulse:

<http://www.pulseinc.com/icd-10-mu2/pulse-systems-icd-10-readiness>

Modern Healthcare:

Several interesting articles, including <http://www.modernhealthcare.com/article/20141211/NEWS/312119999>

AMA Report to ACNM

Haydn T. Williams, MD, FACNM



Haydn T. Williams,
MD, FACNM

Medicare covers CT lung cancer screening – November 10, 2014

Under the Affordable Care Act, private insurers must cover CT lung cancer screenings, but the law was silent on whether Medicare had to do so. The Centers for Medicare & Medicaid Services (CMS) will now extend no-cost coverage for low-dose CT (LDCT) to Medicare beneficiaries who smoked at least one pack of cigarettes a day for 30 years or the equivalent, even if they quit smoking as long as 15 years ago. This applies to asymptomatic beneficiaries between 55 and 74 years of age and requires a written order as well as counseling for lung cancer screening and a shared decision-making visit. This coverage will affect 4 million people at greatest risk and has the potential to save 20,000 lives a year.

Eligibility criteria for radiologists include current American Board of Radiology or equivalent certification, documented training in diagnostic radiology and radiation safety, involvement in supervision and interpretation of at least 300 chest CTs in the past 3 years, and documented participation in continuing medical education in accordance with current American College of Radiology standards.

Eligibility criteria for radiology imaging centers for the purpose of Medicare coverage of LCDT lung cancer screening include participation in past lung cancer screening trials, such as the National Lung Screening Trial, or an accredited advanced diagnostic imaging center with training and experience in LDCT lung cancer screening; LDCT with an effective radiation dose <1.5 mSv; and collection and submission of data to a CMS-approved national registry for each LDCT lung cancer screening performed.

The proposal is open for public comment for 30 days and will not become final until February 2015, but such draft decisions are rarely reversed.

2014 AMA Interim Meeting – Dallas, Texas, November 8-11, 2014

Ebola: The AMA strongly supports US and global efforts to fight the Ebola epidemic and support health care workers and volunteers who are treating patients with Ebola worldwide, supports the use of quarantine and isolation when it is based on science, and is asked to make emergency recommendations on Ebola for the medical community and the general public.

Adequate Networks for Patient Access, Choice: The AMA adopted a policy that calls for health insurers to update their provider networks before the open enrollment period begins each year to avoid patient confusion and reiterates the need for health insurers to provide patients with an accurate, complete directory of participating physicians and to identify physicians who are not accepting new patients.

Medicaid Enhanced Rates: The AMA advocates for the Affordable Care Act's Medicaid primary care payment increases to continue past 2014 in a manner that does not negatively affect payment for

any other physicians.

AMA Promotion of Improved Electronic Records: The AMA continues to advocate with CMS for a halt to meaningful use penalties.

Facilitating Multiple State Licensure: The AMA supports the Federation of State Medical Boards compact designed to facilitate a speedier medical licensure process with fewer administrative burdens for physicians seeking licensure in multiple states.

Cannabis: The AMA encourages model legislation to put a warning on all cannabis products not approved by the US Food and Drug Administration that says, "Marijuana has a high potential for abuse. It has no scientifically proven, currently accepted medical use for preventing or treating any disease process in the United States." The resolution also urges legislatures to delay full legalization of any cannabis product until further research is completed on the public health, medical, economic, and social consequences of long-term use of cannabis.

Maintenance of Certification: An adopted policy outlines principles that emphasize the need for an evidence-based process that is evaluated regularly to ensure physician needs are being met and activities are relevant to clinical practice.

Expanded access to Medicaid: The AMA supports expansion of Medicaid and encourages lawmakers to identify realistic coverage options for adults currently in the coverage gap, even if states choose not to adopt the Medicaid expansion outlined in the Affordable Care Act.

VA Secretary Robert A. McDonald: The US Department of Veterans Affairs is working to right wrongs, reframe perceptions, and enhance care for veterans, and it needs the help of physicians.

2015 Medicare Physician Fee Schedule Final Rule: The Final Rule was released on October 31, 2014, and published on November 6, 2014, in the *Federal Register*.

The Sustainable Growth Rate (SGR) formula calls for a 21.2% decrease in physician payments, effective April 1, 2015. Although this is a steep reduction, it is a considerable drop from the nearly 30% reduction projected just a few years ago. The reduction is thanks to nearly flat growth in utilization of physician services over the past several years. The AMA continues to press Congress to repeal the SGR formula to eliminate the perennial threats of payment cuts and temporary legislative patches.

Continuing medical education will not be reported under the Physician Payments Sunshine Act. CMS proposed including continuing medical education activities in reports of physicians' financial interactions with medical device and drug manufacturers in the new Open Payments public database. The AMA led dozens of other medical associations in calling on the agency to eliminate this requirement because it would affect physician participation in independent (continuing education) programs.

Proposed penalties under the Value-Based Payment Modifier (VBM) will be scaled back. CMS intended to increase payment penalties under the modifier from 2% to 4%, beginning in 2017.

(Continued on page 7. See *AMA Report*.)

(AMA Report. Continued from page 6.)

Some physicians would be vulnerable to payment cuts totaling more than 11% as a result of the VBM and other Medicare reporting programs, which means some of Medicare's sickest patients could lose access to their physicians. Although the Final Rule still maintains a potential pay cut of 4% for larger medical groups, practices with fewer than 10 physicians will not be subject to more than a 2% VBM penalty.

The Physician Quality Reporting System (PQRS) becomes a penalty-only program in 2015. To avoid PQRS and VBM penalties in 2017, physicians must successfully report in 2015 on at least 9 quality measures that cover 3 domains on at least one of the 18 new cross-cutting measures. There were plans to shorten the period during which physicians can review their feedback reports to 30 days. However, after lobbying from the AMA, CMS decided to leave the review period at 60 days.

The Physician Compare website will continue to expand, but not as much as planned. Continued pressure from the AMA led CMS to commit to better prevention and correction of errors on this website, which has been riddled with problems. The agency also will notify physicians when they can preview their reports. Although the agency's plans to post benchmarks to the site have been put aside for now, the website will show physicians' performance under PQRS, the electronic health record meaningful use program, and Medicare accountable care organizations.

350 CPT codes have been identified as new, revised, or potentially misvalued, and 318 of these changes were based on physician input. These changes represent 86% of those recommended by the RUC, a group of more than 300 participants that includes physician advisers from every medical specialty and a dozen other health care professionals. The group provides input on values based on their highly technical expertise.

The timeline for submitting new codes and revaluations of services will shift. The deadline for receiving all code and value recommendations for the following year's payment policies will be in February to allow more time for public comment. This change will take place for the 2017 Medicare Physician Fee Schedule. CPT and RUC timelines will be modified to accommodate the new process, thereby ensuring that physicians continue to have strong input on appropriate values for services.

The CMS Final Rule issued in November 2014 allows multi-hospital systems to have a unified, system-wide medical staff rather than a medical staff at each hospital. A medical staff may become part of a unified multi-hospital medical staff only if the medical staff affirmatively votes to do so; medical staffs incorporated into a unified structure may opt out by vote at any time and reestablish a separate, hospital-specific staff. A new requirement for the hospital governing body is consultation with an individual assigned responsibility for the medical staff at least 2 times per year.

NMRO Update

Alexander Antoniou, MD, MA



Alexander Antoniou,
MD, MA

The Nuclear Medicine Resident Organization (NMRO) has been productive in the winter months. Dr. Tatianie Jackson recently represented the NMRO at the 2014 AMA Interim Meeting of the House of Delegates. Additionally, the ACNM-NMRO Educational Committee, chaired by Dr. Twyla B. Bartel, announced the IMAIOS-ACNM partnership. This partnership will allow us to showcase educational content to our residents and young professionals. If you (or a resident you know) would like to contribute an interesting case, please send an e-mail to acnm@acnmonline.org.

The NMRO is pleased to have prepared the Virtual Journal Club on ⁶⁸Ga-PSMA PET/CT for prostate cancer presented by Christos Sachpekidis, MD, and Christos Liolios, MSc, PhD. This is our first international virtual journal club to be streamed live from Germany. We hope to have many more virtual journal clubs and continue to foster cross-Atlantic (and cross-Pacific) collaborations.

Several members of the NMRO Board of Directors will attend the 2015 ACNM Annual Meeting in San Antonio, Texas. Residents and young professionals in training will have the chance to compete for different trainee awards, and 12 abstract presenters will win a paid trip to participate in the 3rd Sino-American Exchange Program from May 4 to 9, 2015.

The NMRO Board of Directors will meet at the annual ACNM event to discuss our future educational events, announce the new ACNM intern, and plan for our annual event and resident social in Baltimore, Maryland, this year. We hope you enjoyed the holidays and hope to see you at the annual conference!

2015 Fundraising

ACNM has Launched the ACNM Annual Fund to Benefit Nuclear Medicine Residents and our Other Young Professionals in Training

ACNM is very excited about this new fundraising program! We strongly believe in our Nuclear Medicine young professionals! We will dedicate these funds primarily for their use in the areas of education, research, leadership, and professional development, and also support of our own ACNM internship. This is an awesome way to support our Nuclear Medicine community and develop our future leaders! For donations, please contact us via acnm@acnmonline.org or donate when you renew your membership either online, or by calling us. Your donations are tax-deductible

DONATE



International Nuclear Medicine Interview: Dr. Zvi Bar-Sever, President of the Israeli SNM and Israeli Delegate to the EANM

Erica Cohen, DO, MPH, CCD



Dr. Zvi Bar-Sever



Erica Cohen, DO, MPH, CCD

What is the makeup of your organization: physicians, technologists, scientists, industry, students, etc.?

The Israeli Society of Nuclear Medicine (ISNM) is part of the Israeli Medical Association and is governed by its rules. As such, only physicians are full members of the society. Recognizing that nuclear medicine is a multidisciplinary field we encouraged technologists, physicists, radio-chemists to join our society as “associate members”. They participate in our meetings and contribute to the activities of the society but cannot vote or get elected for positions within the society.

How often do you have national meetings? Regional meetings? What is the attendance like?

Our national meeting occurs once a year on a regular basis. It is the largest nuclear medicine event in the country that attracts all professionals involved in NM as well as most of the NM industry. Our meeting takes place over a weekend in a hotel typically in the North or the South of the country. It is rich in scientific content including presentations by distinguished guest speakers from all over the world. This all adds up to 150-200 participants (we are a small country...). We do not have regional meetings.

What are some of the biggest accomplishments of your organization?

Working in harmony with the ministry of health and the IAEA to enhance quality assurance in nuclear medicine practice

Maintaining the autonomy of nuclear medicine as a separate medical specialty with its own residency program despite on going attempts to merge nuclear medicine with radiology.

Recognition of nuclear medicine as a “special” medical field. This means that the basic salary of nuclear medicine physicians is higher than the basic salary of radiologists and of some other medical specialties. This is part of the agreement between the Israeli Medical Association and the government intended to encourage physicians to move to this field.

What are some of the biggest challenges for the members of your organization in their practice of nuclear medicine? What does your organization do to support these efforts?

There is considerable variability in the equipment and staffing between nuclear medicine departments in the country. Some have it all while others are limited in staff and do not hold positions for physicists nurses or radiochemists. More than half of the nuclear medicine departments do not have PET/CT. Our organization is negotiating the need for additional PET/CT licenses with the ministry of health (who regulates the number of cameras in the country). We also participated in a project, lead by the Israeli Medical Associa-

tion, that defined the required number of NM physicians required for each department based on scientific measurements of the workloads. A major threat to nuclear medicine practice in Israel is the low number of residents attracted to this field. We launched a campaign with an external PR company to enhance the visibility of nuclear medicine among the general population and specifically among medical students and interns. Our Facebook page is a result of this initiative.

What kind of relationship does your organization have with other specialty healthcare organizations, such as those belonging to radiology, cardiology, endocrinology, radiation oncology, etc.?

We do our best to maintain friendly working relationships with other healthcare organization for the benefit of our patients. Some years ago we worked jointly with the Israeli Society of Cardiology and created a fellowship in nuclear cardiology.

We are currently working with the Israeli Society of Radiology to streamline the reporting of PET/CT and SPECT/CT (e.g. when is a radiologist required to sign a joint report?).

What kind of relationship does your organization have with other nuclear medicine organizations, such as ACNM, SNMMI, EANM, etc.? How would you like to see these relationships grow or change in the future?

Israeli Nuclear Medicine physicians are often members of international nuclear medicine societies on a personal basis, including the ones you mentioned. The ISNM has formal relations with the EANM, since Israel is a full member of the EANM. I am the national delegate of Israel at the EANM.

How do you envision the future of nuclear medicine?

Prior to entering nuclear medicine I specialized in pediatrics. I love both fields but I noted that the rate of change and innovation in nuclear medicine is much higher. This keeps me optimistic regarding the future of nuclear medicine. It is important, in my opinion, to preserve nuclear medicine as an autonomous field. There is obviously overlap with radiology in the era of hybrid imaging but it's not the CT or MR components of our hybrid cameras that make nuclear medicine shine. It is the basic tracer principle and the functional and molecular information that can be obtained. This information can then be used selectively for targeted radionuclide therapy.

Innovations and developments in the field of PET are overwhelming. I would like to see a similar trend in the so-called “conventional nuclear medicine” with development of advanced gamma cameras and new SPECT tracers.

Understanding the Approval Process for PET/CT Studies for Private Payers

Edgar O. Alvarez, MPH

More than 1 year ago, Siemens Molecular Imaging, a business unit of Siemens Medical Solutions USA, Inc., conducted market research to better understand levers that could help patients obtain more access to PET/CT studies in the United States. A key finding identified by this research was the need for simplification of the approval process for referring physicians, especially with private insurance companies (private payers).

In early 2014, Siemens Molecular Imaging conducted a follow-up study to gain better understanding of the specific challenges faced by referring physicians in the preapproval process among private payers, specifically interacting with Radiology Benefit Managers (RBMs). With the support of our imaging center customers, Siemens identified referring physicians willing to participate in the study to uncover the root cause of challenges in obtaining preapprovals for PET/CT scans.

As expected, the criteria used by all RBMs for authorization of PET/CT studies were medical necessity, active disease, signs and symptoms, and monitoring of treatment response. The most prevalent issue identified among all referring physicians in the study was the amount of time and effort required to obtain authorization. The average turnaround time was more than 3 business days.

Three recommendations to improve the PET/CT approval process for referring physicians with private payers resulted from this study:

(1) Educational resources for referring physicians

- Development of payer-specific coverage guidelines for referring physicians that detail plan-specific coverage, plan requirements for authorization, guidelines for submitting requests (including the required documentation), link to updated forms, and include contact information, such as the e-mail address/fax number for submission of requests
- Development of coverage descriptions outlining the differences between preventative, surveillance, and rule-out scans

(2) Direct support services for referring physicians

- A hotline/website to support referring physicians with prior authorization requests
- Support for telephone authorizations, when required, especially for emergency requests

(3) Engagement with private payers and RBMs to educate and simplify the approval process and ease the burden of approvals for PET imaging studies, not only for referring physicians but also for private payers. Specifically,

- PET education for private payers and RBMs
- Development of a patient criteria document that can be used by case managers at the RBMs and private payers to more easily identify and approve patient cases who meet specific criteria
- Development of a recommended authorization request form for referring physicians to answer clinical questions to support the request in a simple check-off format. This would ease the case manager's approval process and enable a more expeditious review of the request.

These recommendations were reviewed by the referring physicians who participated in this study, and they agreed that these actions would assist in a faster, more appropriate, and acceptable approval process for PET imaging studies with RBMs and private payers. As a first step, Siemens developed an interactive payer/RBM resource map that explains the PET coverage criteria by payer and by state ([click here to download](#)) that can be used by both imaging and referring physicians to help simplify the complexity of working with multiple RBMs and payers.

Although providing physicians with payer resources helps address many of the recommendations obtained from the study, the true catalyst of change can only come from the industry, the medical community, and SNMMI continuing to work together. We all share a common goal to facilitate the approval process for referring physicians to provide patients with greater access to PET studies.

Let us know your opinion!



As part of the "new and improved" ACNM, we would like to make this newsletter a useful resource for you. We hope to keep you abreast of the news that matters to you. This includes things like upcoming events and items available for public comment that could affect the future of our specialty. We welcome ideas for topics you would like to see in the newsletter. Likewise, if you have any clinical questions you would like us to forward to an expert or letters to the editor of the ACNM Scanner Newsletter, please send us your inquiries.

Additionally, if you're a member and have an exciting accomplishment to highlight or share with the rest of the nuclear medicine community, please send us your announcement.

Please send your inquiries or announcements to Erin Grady, MD, the ACNM Scanner Newsletter editor, at egrady@christianacare.org. We will do our best to be a valuable resource for you.

Upcoming Events

January 2015

- **January 22 – 25, 2015** : SNMMI 2015 Mid-Winter Meeting
- **January 23 – 25, 2015**: Advances in Nuclear Cardiology and Cardiac CT: 30th Annual Case Review with the Experts with 101 Evidence-based Cases

February 2015

- **February 11 – 14, 2015**: AACR-SNMMI Joint Conference on State-of-the-Art Molecular Imaging in Cancer Biology and Therapy
- **February 14 – 18, 2015**: 92nd Annual ABNM Board Meeting
- **February 21 – 26, 2015**: SPIE Medical Imaging 2015
- **February 23 – 27, 2015**: 4th Tübingen PET/MR Workshop
- February 26, 2015 : The 2015 Northern California Annual Chapter Meeting
- **February 26 – March 1, 2015**: Dartmouth Radiology 8th Annual PET/CT Symposium
- **February 28 – March 4, 2015**: The 36th Annual High Country Nuclear Medicine Conference

March 2015

- **March 5, 2015**: ACR Annual PET/CT Symposium
- **March 11 – 14, 2015**: 3rd Theranostics World Congress (3TWC) on Ga-68 and PRRT
- **March 14 – 15, 2015**: 2015 PNWSNMMI Spring Meeting
- **March 18 – 20, 2015**: 10th EMIM European Molecular Imaging Meeting



See you in **San Antonio, Texas!**

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