President’s Message

The last year has brought numerous changes to the AVIR as well. These changes would not have been possible without the extreme dedication by the current BOD, the Annual Program Committee, our new management organization and numerous tenured members seeking to raise the purpose and visibility of the association. As we draw close to the Annual Meeting in New Orleans, LA April 13-17th, a brief review and recognition for those efforts are truly due. Missy Post, Izzy Ramaswamy, Andrew Amorossa, Diane Koenigshofer, Rob Sheridan, David Douthett, Dana Bridges, Karen Finnegan, E&B Consulting and numerous others have spent hundreds of hours making this conference and all the events surrounding it possible.

As the Board left San Francisco last year, several goals were set to happen. The changes to the Association’s management needs were deemed necessary to both keep the Association solvent and fall within budgetary constraints. In the fall, after examining our options, the decision was made to change. Missy Post, Izzy Ramaswamy, Rob Sheridan, Andrew Amorossa, along with the staff at E&B Consultants worked diligently to make the transition a smooth process. Our new management organization has also allowed the AVIR to expand the website utilization and improve the opportunities available to our members.

And the new and improved website (avir.org) is truly an amazing thing! Within the last two years, and several website versions later, E&B consultants have taken us to a new level. There are numerous educational opportunities; member rewards options, the AVIR store, blogs, chapters and more. Encourage all your constituents to participate and join. Even join a local chapter. Look for a chapter event near you.

I would also like to look at the future of the Interventional Radiographer. I have a very personal view. I’ve been in the IR field for over 25 years, mostly at academic centers. Having been in several clinical and industry roles over the last three years, and seeking the best employment opportunities in my area, I have experienced a plethora of interventional services provided by a variety of disciplines in a variety of settings. There are settings where radiologic technologists, CV techs (RCIS/EMT-P) and RN’s basically perform the same functions, and some without any radiation/imaging trained personnel. A legislative requirement for necessitating adequately trained radiation workers is essential to ensure the protection of patients as well as the longevity of the Interventional RT profession. Almost 20% of the U.S does not require an RT certification for radiographic positions. Currently, the interventional RT is probably best served either in a university/academic IR setting, working with vascular surgery, or in a cardiology lab. Some smaller IR departments can often be relegated to lines, livers and others non-vascular procedures, losing
peripheral business to their surgical associates or even privatized radiology groups. The interventional radiologic technologist needs to be at the center of all of these services. I believe this is prevalent across the U.S., or it may only be localized. Blogs will be initiated on our website to discuss these issues that will definitely affect the future of the profession. How will we ensure our longevity?

Advanced Certification is one solution. CI and VI certifications are now being either required or mandated for maintaining employment. All IR technologists should achieve advanced certification. Push for it in your department, encourage your RT peers. If we are to work with or compete with non-radiation personnel in the workplace, then standardized training and specialized CE requirements should also be a requirement. I am interested in hearing your comments on the website.

In closing, I would like to thank the many people for all their support over the last two years, we have evolved in a very positive way, mostly due to the hard work and dedication of the current Board of Directors, as well as the associate and past members and the new management. It has been a very tough 24 months for me personally, and the Association would not be where it is without their influence, initiative, and dedication to our beloved profession. I am grateful for the opportunity the AVIR has afforded me, and to serve going forward as Past President and look forward to next year in San Diego.

Sincerely and With Warm Regards
Tony Walton RT (R) ARRT
President
Association of Vascular and Interventional Radiographers

Shari Ullman Gold Medal Award

This is the fourth year since the AVIR renamed the Gold Medal Lecture in honor of Shari Ullman. After Board approval, the AVIR presented this honor to Shari in 2008 and she had been really touched. In fact to quote Shari: “this means the world to me.” The first annual Shari Ullman Gold Medal Award was given at our 19th Annual Meeting in San Diego. Unfortunately, Shari past away before she could be presented with the first Gold Medal Award named in her honor. However, Shari’s family was able to attend the first awarding of the Shari Ullman Gold Medal Lecturer Award to Dr. John Aruny. A duplicate crystal was presented to her family, in remembrance of Shari Ullman.

This year it is being presented to Dr. Gary Siskin

Gary Siskin, MD
ALBANY MEDICAL CENTER, Albany, New York
Professor and Chairman, Department of Radiology
Medical Director, Vascular and Interventional Radiology
Society of Interventional Radiology
• 2013 Annual Meeting Chair
• JVIR Editorial Board
• Fellowship Award Recipient

AVIR has the privilege this year in receiving our Gold Medal Lecture from Dr. Gary Siskin, MD. Dr. Siskin is a dedicated interventional radiologist practicing at Albany Medical Center in upstate NY. Dr. Siskin has always been a strong advocate for furthering the education of the IR technologists in his department by providing local opportunities through lectures, angio clubs, and in-services. He has long supported the AVIR mission and has provided administrative backing along with funding for his technologists to attend the AVIR annual Meetings each year. We are not only honored to have him speak this year but also to have had him as the 2012-2013 Physician Liaison to our board. Through this role and his title as the SIR annual meeting chair, we are able to closely collaborate with the physician’s agenda and share some of the speakers and lectures. We appreciate his support and that of the SIR each year.
As our current president Tony Walton stated in his Address, it has truly been a year of transition for AVIR. We changed our management group, gave our website a user-friendly update, and have pulled together an amazing agenda for the 25th annual AVIR meeting in New Orleans. The AVIR board has been dedicated to revitalizing the association to support and adapt to the needs of this generation of IR techs, our technology, and its changing environment. Members of the AVIR gain immediate access to valuable education, community, and so much more. A great effort has been invested into bringing AVIR information and services into the ‘electronic’ age. Tell your peers membership has never been easier, just fill out your application online and hit submit! That’s it! Easy Right? Furthermore, there is no longer an end of the year deadline, rather an annual revolving deadline that gives our members an entire year from when they signed up or renewed. Inside the AVIR you will find many resources; see who is hiring in our career center, get AVIR gear in our all new AVIR store, or fill those CE requirements with our online education portal. AVIR really has it all! Becoming a member of the AVIR has many advantages; however, perhaps the most important part of becoming or being an AVIR member is our community. AVIR brings our community together, gives us a place to voice our thoughts, share our knowledge, and build a better future. This is our year to REACH OUT to our peers and colleagues.

Here is a look at what AVIR will bring to the table.

First, Education is your highest priority so we made it ours; therefore we are offering almost fifty ARRT approved CE credits this year. On the website, through the directed readings alone, our members can attain the 12 necessary annual credits required by ARRT each year. We will also provide quarterly and interactive webinars directly related to our field where we facilitate dialogue with our members and educate each other during these sessions. It is also our hope to bring a collaborative monthly case review online for discussion. Alongside the web accessible options are our local and annual live opportunities. AVIR will be working with our local chapters to provide better marketing and communication regarding what is going on in your own backyards. You should be able to access your chapter portals through the main site and if one doesn’t exist in your neighborhood, we will help you to create one. It is important that you, the members, participate in your places of work and community to get the word out that AVIR is here for you. Check out our resources page for information on educational programs and up to date information on advanced certification processes and study material.

http://avir.org/resources.php

Second, regarding access to our community and members AVIR has set up a multifaceted communication pathway. Upon our request, the Kourai Group, LLC has redesigned our website with state of the art HTML5 responsive code. This not only gives our site a fresh look, but it also automatically scales to size, fitting any device so our members always have the information they need/seek without having to scroll around. The new site works from anywhere on any device, all you need is an internet connection and AVIR information is at your fingertips. Included in the website redesign is the introduction of the AVIR blog, this addition gives us a landing page to add continuous information to our community and also links our social media outlets together i.e. Facebook, Twitter and LinkedIn. These additions provide us with a far reaching and centralized messaging engine that allows us to touch all members in the healthcare community. This will be a critical part of AVIR’s success moving forward, as we now have tools that allow us to not only engage our members, but more importantly, allow our members to easily engage us. We are all in this together, the board is selected by you and works for you, therefore, direction and opinions are not just appreciated, they are necessary for success.

Third, did you know that AVIR is now a nationally recognized provider of continuing education for technologists through its Approval of Continuing Education (ACE) system? Through ACE, the AVIR approves continuing education activities for credit and provides its members with a computerized transcript documenting participation in any of the E programs annually offered nationwide by the AVIR and other ARRT recognized continuing education evaluation
mechanisms (RCEEMs). If you are in need of getting your seminar, lecture, speaker, or case review session(s) approved for continuing education credit, our electronic application is the way to do it. Get your chapters running and provide the education to your community, we made it easy. Check out our website for more information: http://avir.org/ace.php

With regards to protecting our future, we appreciate that the ambiguous state of healthcare requires a close watch. Therefore, AVIR will monitor and report, to the best of our ability, the changes occurring in the political arena both nationally and locally to you and even take action when necessary. In conjunction with this, the board is working on a new engagement platform to focus in on the specific needs of our members and our community. In order to lead the charge in our field we will organize these ideas into five categories or Pillars. These Pillars will guide our priorities as we navigate through the ever-changing and unpredictable business of healthcare. Adapt or Die, right? It has never been more important to unify our voices in regards to the economic climate we are facing today. We are going to call this platform the AVIR Education and Awareness Pillars as they are defined below and they have already been taking effect helping to outline the 2013 Annual Meeting.

AVIR Education and Awareness Pillars:
• PRIDE (Personal Growth, Professionalism, Recognition, Integrity, Diversity, and Excellence)
• INNOVATION (Stay abreast of new technology and techniques, with our hands and minds directly involved in the modernization and growth of IR services world-wide)
• INTEGRATION (collaboration and cross training into the hybrid world and beyond)
• BUSINESS ACUMEN (Keeping abreast of the current economic climate to proactively adapt)
• QUALITY and SAFETY (Performance Standards and Regulatory Compliance; measurement tools and benchmarks to aid in achieving and maintaining the highest marks)

Moving forward, AVIR will look to you, our members for crosspollination of new ideas, benchmarks, and measurement tools that allow each of us to grow both personally and professionally. Please join us, get to know us, and most importantly, interact with us and each other. We at AVIR look forward to bringing this amazing community together in these interesting times; strengthening our profession nationally, and improving healthcare outcomes locally. AVIR is also Reaching Out this year.

The AVIR Pledge:
The AVIR is dedicated to you and is a powerful advocate for the special interests and concerns of health care professionals working in Vascular and Interventional Radiology. We acknowledge the importance of continuing education, establishing high standards of practice and care, certifying Vascular and Interventional Radiographers, and establishing a nationwide network for obtaining information and/or employment opportunities.

AVIR Members keep current of new licensing requirements, stay up-to-date on new and trending procedures, regulatory requirements, interventional innovations, and best of all gain access to a mature network interventional technologists around the world. What are you waiting for? Join today!
<table>
<thead>
<tr>
<th>MEETING</th>
<th>ACYRN</th>
<th>GET INFO</th>
<th>LOCATION</th>
<th>DATE</th>
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<tr>
<td>Hands-On Practicum on Hemodialysis Access</td>
<td>VASA</td>
<td>vasmnl.org</td>
<td>methodist hospital, Houston, TX</td>
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<td>SCAI 2013 Scientific Sessions</td>
<td>SCAI</td>
<td>scai.org/SCAI2013</td>
<td>Peabody Orlando; Orlando, FL</td>
<td>May 8-11, 2013</td>
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<td>Save a Leg, Save a Life Foundation 2013 Annual National Conference</td>
<td>savealegsavealife.org</td>
<td>Disney Yacht &amp; Beach, Lake Buena Vista, FL</td>
<td>May 9-11, 2013</td>
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<td>Society Vascular Surgery Annual Meeting 2013</td>
<td>SVS</td>
<td>vascularweb.org</td>
<td>Moscone Center, San Francisco, CA</td>
<td>May 30 - June 1</td>
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<td>New Cardiovascular Horizons 14th Annual</td>
<td>ncvh</td>
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<td>New Orleans</td>
<td>June 5-7, 2013</td>
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<td>MEET Congress/Multidisciplinary European Endovascular Therapy</td>
<td>MEET</td>
<td>meetcongress.com</td>
<td>Crowne Plaza St. Peter’s Hotel Rome, Italy</td>
<td>June 9-11, 2013</td>
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<td>SVM 24th Scientific Sessions</td>
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<td>Intercontinental Hotel, Cleveland, OH</td>
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<td>Complex Cardiovascular Catheter Therapeutic Conference (C3)</td>
<td>C3</td>
<td>c3conference.net</td>
<td>Rosen Shingle Creek; Orlando, FL</td>
<td>June 17-21, 2013</td>
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<td>Chicago EndoVascular Conference (CVC) 2013</td>
<td>cvcpvd.com</td>
<td>Swissotel; Chicago, IL</td>
<td>July 10-12, 2013</td>
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<td>SNIS 10th Annual Meeting</td>
<td>SNIS</td>
<td>snisonline.org</td>
<td>Loews Hotel, Miami, FL</td>
<td>July 29 - Aug 1, 2013</td>
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<td>AMP (Amputation Prevention Symposium)</td>
<td>AMP</td>
<td>AMPPhrCLmeeting.com</td>
<td>Chicago, IL</td>
<td>August 8-10, 2013</td>
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<td>Preceptorship in Carotid Ultrasound Interpretation</td>
<td>CCF</td>
<td><a href="http://www.ccfmse.org/carotid13">www.ccfmse.org/carotid13</a></td>
<td>Cleveland Clinic, Cleveland, Ohio</td>
<td>August 26-30, 2013</td>
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<td>Japan Endovascular 2013 Symposium</td>
<td>JES</td>
<td>japanendovascular.com</td>
<td>Tokyo, Japan</td>
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<td>The VEINS Chicago 2013</td>
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<td>Chicago, IL</td>
<td>September 20-22, 2013</td>
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<td>Cardiovascular and Interventional Radiological Society of Europe</td>
<td>CIRSE</td>
<td>cirse.org</td>
<td>Barcelona, Spain</td>
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<td>Lower Extremity Arterial Revascularization N</td>
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<td>Chicago, IL</td>
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<td>VIVA2013</td>
<td>VIVA</td>
<td>vivapvd.com</td>
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<td>Transcather Cardiovascular Therapeutics</td>
<td>TCT</td>
<td>ttcconference.com</td>
<td>Moscone Center, San Francisco, CA</td>
<td>October 27- Nov 12, 2013</td>
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<tr>
<td>Va Assoc. of Int. Radiographers 10th Annual Meeting</td>
<td>Va AVIR</td>
<td><a href="mailto:rhoward709@aol.com">rhoward709@aol.com</a></td>
<td>Great Wolf Lodge, Williamsburg, VA</td>
<td>November 8-9, 2013</td>
</tr>
<tr>
<td>Radiological Society of North America</td>
<td>RSNA</td>
<td>rsna.org</td>
<td>Chicago, IL</td>
<td>Nov 27 - Dec 2, 2013</td>
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**Newsletter Advertising rates:**

**Size Options:**
- **Full Page**
  - Full Page (bleed): 8.75”x11.25” $2,000.00
  - Full Page (no bleed): 7.5”x10” $2,000.00

**Fractional (Black and white only):**
- Classified Ad: 1 column inch $125.00
- 1/2 Page Vertical: 3.5”x10” $800.00
- 1/2 Page Horizontal: 7.5”x4.75” $800.00
- 1/4 Page Vertical: 3.75”x4.75” $425.00
- 1/8 page black/white ad: 2¼ x 3¼ $225.00

**Mechanical Specifications**
- **Dimensions:** Trim Size: 8.5”x11”
- Live Area should be kept 1/4” from trim on all sides including gutter. Bleed extends 1/8” beyond trim on all sides.

**File Submission**
- Digital files should be provided in high resolution PDF format, including crop marks and bleed if applicable. Although not recommended, we will accept the following formats: .eps, .tiff, or Adobe InDesign native files with all support links and fonts. The following file formats are not accepted: Corel, Microsoft Word, PowerPoint or Publisher documents.
- All images must be 300dpi and in CMYK or Grayscale color format. All fonts should be embedded or in outlines where applicable. Artwork should be submitted at 100% scale.
- Please contact AVIR for ad submission due dates. Full payment must accompany ad order.
Spring has sprung and it’s time to let in the sunshine (act, that is)!! What do I mean by “Sunshine Act?” Unless you’ve been hibernating for the last several years, you know that the world of medical devices has changed dramatically. Extra taxes, more restrictions, and full disclosure of financial relationships (otherwise known as the “Sunshine Act”) have altered the way hospitals and device companies do business. If any of your reps are like me, they like to give back to the departments who support them but how can we do that nowadays? One suggestion is for reps to provide CE presentations onsite.

Asking your reps to provide continuing education credits may sound daunting unless the company is a multi-billion dollar entity with tons of support staff because the process to get credits HAS to be difficult, right? Not true!! It’s a lot easier than you might think. You may have seen us advertise that AVIR is a RCEEM but what does that mean to you, your department or sales reps? RCEEM stands for “Recognized Continuing Education Evaluation Mechanism” which allows us to certify Category A credits for continuing education for any organization. Jeff Kins, one of AVIR’s past presidents, has made sure this process is as streamlined as possible. The application is readily available to be downloaded from the AVIR website. Ultimately, if someone puts together an educational presentation that meets certain criteria and goes through the process, then members attending the events (whether they are local or even facility-based learning sessions like grand rounds) can get CE credits. As an organization, it has been one of our goals for device companies to take advantage of this opportunity but it may be up to you to give them this suggestion.

One final comment … in sales, I’ve always heard if you’re not networking, you’re not working and the same applies to our meeting. Attending our meeting really is an amazing opportunity to meet and interact with people from all over the country (which is truly one of my favorite parts of being at the annual conference). You may think you’re the only department dealing with “problem A” but talk to others and you’ll find that they experience the same issues and concerns that you do. Networking with other techs provides invaluable insight into different ways to handle similar problems or difficult procedures.

Some techs are lucky that they get to attend the annual meeting with several other people in their departments. However, if you’re like many hospitals, only one tech and one nurse get to attend which means as the lone tech from your department, you’re sitting by yourself all day in a sea of people who all seem to know each other. If this describes you, SPEAK UP!!! Please come talk to one of the board members and we’ll introduce you to other people. It can be intimidating to be the “new kid” but techs, in general, are more than welcome to bring you into their “circle of friends and family” and make sure you enjoy your time at the meeting. And finally, all of your board members want to make sure you get the most out of attending AVIR’s annual meeting so please let us know what we can do to help you!!!
What a ride.
I have completely enjoyed and loved my time working on the board for the AVIR and it is sad to step away. The folks one meets and the networking that is secured is invaluable.
Like I have mentioned before, each new board member has so much to offer this association, I am fortunate to have been involved at such a time.
The three year president commitment is a commitment—not to scare anyone off! But it is so worth it. The board as a whole has a great way of working together, picking up the slack any one may be experiencing at any one given time due to other commitments. This collaboration has been a God send—many hands make for light work, right?
This past year has been no different.
President (Tony) has tackled the challenge of changing up our management company for the best of our association. Our incoming President (Izzy) has been doing a lot of the heavy lifting positioning our association in a direction for growth. He has worked with a new website designer (Jared) and pampered our new website to a functioning tool—actually designed for this era!
Our Program Chair (Andrew) has been making contacts around the country to make this annual meeting a success, but again this is not without the efforts of the entire team reaching out, making deals.
Speaking of deals, our usual fund raising efforts (Diane) have been difficult. The various vendor partnerships are still good (Dana), but this isn’t necessarily being reflected in the amount of funds donated.
As you will note from our treasurer’s (Rob) article the country has taken on the ACA in various forms. This has challenged us to work smart and slash expenses in other ways.
Our new management company needs to be mentioned here (E&B), their contacts with various convention vendors afforded us some steep discounts with the audio/visual equipment thus allowing us to continue with the fun aspects of our annual program (Gala). The AVIR is celebrating our 25th Anniversary this year too which promises to be a fun celebration. 25 years is a mile marker, indeed. The profession has been around for a while and has had to adapt to the various external influences (turf wars). If anything this has made us stronger as an association, as a technologist, as an employee, as a peer. Leaning on each other and finding best practices is one of the easiest ways to impact your day. I encourage each of you to consider being apart of something like the AVIR (board). It will give you lasting memories and relationships. Thank you for my experiences. I will not forget them.
Let me introduce the incoming board for 2013 (to assist with your networking).
This line up is so exciting. I feel much better stepping aside knowing that I am not just finished but the AVIR has finished ahead…Keep up the good work everyone!

2013-2014 AVIR Board of Directors
Past-President – Tony Walton
Anxiously waits to pass this busy president baton on. As you know our association is under new management. This breath of fresh air has been realized with Tony’s acumen.
President – Izzy Ramaswamy
Is a force to be reckoned with. Izzy is a leader in his field by working with leading peers in Miami. Not only that, Izzy is also in tuned with the social needs of our association. He has invested many hours working with our marketing chair and web design chair to offer the latest and best to our members via the internet.
Vice-President – Robert Sheridan, RT(R)
Mr. Sheridan is the Director of Clinical Operations for Interventional Radiology at the Massachusetts General Hospital (MGH), a 900 bed academic medical center located in Boston. Rob has 18 years experience in Interventional Radiology and is responsible for the overall strategic planning and operations for 15,000 image guided procedures for 6 IR divisions, and 4 clinical units.

continued on next page
As a board member; Rob's aim is to ensure the AVIR continues to grow and diversify with offerings such as: enhanced educational offerings through new platforms, continuous improvements to our newly renovated webpage and social media sites and bring a larger sense of community to AVIR.

As treasure; Rob’s my aim is to ensure the long-term solvency of the AVIR through new diverse revenue streams so that future members of the AVIR have a flourishing society they can be proud to be a part of.

**Secretary/Treasurer - Andrew Amorosso, RT(R)**

Andrew is located in New York Presbyterian/ Weill-Cornell Medical Center where he is a technologist fostering the development and utilization of IT technology in IR.

As the AVIR Program Chair, Andrew is truly grateful to be in a position of service to our profession.

**Director at Large - Crystal Hanson, RT(R)(CT)**

At the UW Hospital in Madison, Crystal strives to put patient care first. She works first hand with physicians and RNs making sure their procedures go smoothly. Whether it’s positioning or prepping patients, getting the physicians the correct wires and catheters, running equipment such as ultrasound, CT and fluoro, she uses her anatomy background for good filming techniques.

Interventional Radiology is constantly evolving and the ability to adapt to change is important. Being a young employee in Interventional Radiology, Crystal feels that growing with the current technologies she can provide good leadership and mentor new technologists.

**Associates Representative Chair – Dana Bridges RN**

Currently, Dana works as a VP of Client Development for SurgPro, a southern medical device distributor. SurgPro offers a wide array of vascular and interventional products and strive to deliver tomorrow’s technology today.

It is an honor for Dana to serve on the AVIR board because vascular and interventional radiographers have played such an important role in her professional growth. Over the years, many techs have taken her “under their wings” and really shown her the bigger picture of IR as well as how to be a good rep (versus being one of those annoying reps ... I’m sure you know what I mean!). Dana is proud to have the opportunity to give back by serving on the board with the AVIR.

**Web Chair – Jared Friends**

Jared recently assisted us with the re-launching of our website. During this process we found Jared to be loyal and honest and extremely intelligent and engaged. His talent of finding the needs of his clients has earned him this newly appointed role in the AVIR. While not working for the AVIR he is polishing his skills in:

- LEAN in Healthcare
- Six Sigma
- Patient Satisfaction
- Patient Flow
- Eliminating Wasteful Motion
- Increasing Staff Utilization/Productivity Rates
- Real-time RFID (Radio-Frequency Identification) Standards.

**Program Chair - David Nicholson RT R CV**

David is the Interventional Technologists for a progressive Interventional Radiology Department at the University of Virginia Health System (UVA), a 750 bed academic medical center located in Charlottesville, VA. David has 13 yrs experience in Interventional Medicine and is responsible for the planning and clinical training of over 1200 endovascular interventional procedures for 4 IR Angio Labs.

It will be so nice to have David with his wealth of clinical knowledge and contact relationships to mastermind our next year’s annual meeting. He is full of energy and excited to be with this board as we move the AVIR forward.

**Publication Chair - David S Douthett RT R CV**

Currently, Dave works as a FSA with the Endovascular Division of W.L. Gore & Associates. Focusing on the EVAR and TEVAR end of Aortic disease.

Dave has been working with the board for over 15 years and is honored to be with the AVIR and to continue to work, now with this board to help with the Publications and focus on the newsletter, Interventional Informer.

So as you can read, the board for this year is energized and ready to take this awesome association to the next level. If you are interested in committing more to this association think about becoming a board member this upcoming year. Here is an outline what each position involves.
What are the responsibilities and commitments to be on the AVIR Board of Directors?

Our Board of Directors consists of President-Elect, Secretary/ Treasurer, Director at Large, and Associate Representative. A requirement to be nominated for a Board position consists of being a current AVIR member and must have served on an AVIR committee for at least one (1) year. The following are a brief explanation of some of the responsibilities and commitments.

**President-Elect**: Three (3) year commitment.

**Vice President** — this is a voting position. Your first year responsibilities would include being the Chair of the Education Committee, Chair of the Fellowship Committee, and a member of the Finance Committee. You also shall attend all Board Meetings and conference calls, write newsletter articles, work closely with President for a smooth transition, and stand in for President whenever needed.

**President** — this position is a non-voting position (unless there is a tie). Your second year responsibilities would include being the Chair of the Ethics and Judicial Committee, a member of the Finance Committee, a correspondent with all external organizations, and presidential correspondence. You are responsible for writing the “Presidents Message” for the newsletter, work with Immediate Past President on projects thus enabling a smooth transition. You conduct the Annual Business Meeting and are responsible for the agenda for all of the Board of Director meetings and conference calls.

**Past President** — this is a voting position. Your third and last year of commitment include being the Chair of the Nominating Committee, a member of the Finance Committee, and are responsible for the AVIR External Liaisons. You will write newsletter articles, work with President on projects from previous years, and attend all Board Meetings and conference calls.

**Secretary/Treasurer**: One (1) year commitment. This is a voting position. Your responsibilities include chairing the Finance Committee and the Membership Committee. You will work closely with the home office on all Financial Reports, write newsletter articles, present a Finance report at Annual Business Meeting, and attend all Board Meetings and conference calls.

**Director at Large**: One (1) year commitment. This is a voting position. Your responsibilities include being the Chair of Chapters Committee, a member of the Education Committee and the Finance Committee, assist with local chapter committees by answering questions and corresponding with local chapter members. You will write newsletter articles, present the Director-at-Large report at Annual Business Meeting, and attend all Board Meetings and conference calls.

**Associate Representative**: One (1) year commitment. This is a non-voting position and your responsibilities would include Chairing the Associate Representative Committee and attend all Board Meetings and conference calls. This position represents non-RT members.

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**2013 AVIR Award of Excellence**  
**Roberto Telleria RT R CV CT**

We are honored to recognize Roberto Telleria RT, R CV, CT as our 2013 Excellence Award Recipient. Mr. Telleria is Technical Educator at Baptist Cardiac & Vascular Institute in Miami FL. He has been an interventional technologist for more than 30 years. In that time, Mr. Telleria has exemplified our profession by being a mentor for his peers and educating the by providing lectures at the ISET symposium on various advanced procedures and techniques. Mr. Telleria is dedicated and passionate about his role in interventional services and therefore it is our privilege to acknowledge him this year.
One thing about having been the president of the AVIR, you kind of know what’s going on. Well, at least more so than when I started!

My role this next year as one of the Past President is to keep others informed and be a liaison for the board. This will be an exciting role as we get moving in tandem with our ARIN partners, SIR colleagues and vendor supporters.

After reading all the comments from our last annual meeting in San Francisco, we received great feedback on ways to improve on an already awesome meeting.

Besides keeping the quality and appropriateness of topics, we are going to take your suggestion and try to combine/streamline the 3 conferences thus providing additional tech credits for more venues.

This May, a couple of us traveled to New Orleans and approach this topic head on. As some of you know, ARIN provides Nurses with credits and AVIR provides Techs and Radiology Assistants with A+ Credits, however it appears each conference has great speakers which deem to be accredited for both nurse and tech credits—we just needed to come up with a format to entertain everyone’s needs. To me, this sounds like working smart—not hard. We were able to meet this request, as we should see shortly how it goes.

Other comments from our meeting range from the awesomeness of the CIT review (thanks Deb!) and the desire to have a more hands-on approach to new products, maybe add workshops, additional but shorter lectures or possibly live cases. All of these are great suggestions and provide opportunity to network with SIR and ARIN so we will see what we can do.

One comment, which I loved, was to have an area demonstrating posters or ways and ideas other techs/sites are doing things. This sounds like an awesome educational and networking opportunity. Are you interested? We would love to have your involvement in next year’s meeting—a poster is a great way to start!

Besides posters, we have a Members Committee which provides the AVIR with themes and ideas for speakers not to mention new thoughts and ideas on how to improve our association. From this past meeting we received requests to join the Member Committee from: David Baires, Anne Oteham, Ashely Hester, Anastasia Peckeral, Karen Finnegan, John Mancera, Carol Risley, Ed Clunies-Ross, Kelly Kincaid, Sultan Albugami, Sean Keating, Lacey Woolery, Cristy Daniels, Leann Osadchuk, Afif Aoun, Maryann Wilson, and Nick Adams.

And these folks join our Current Member Committee: Marilou Cicero, Crystal Brihahn, Heidi Apfel, Anita Bell, Schlena Dowell-Jones, Julie Malkowski, David Nicholson, Jaime Hiott, Louis Cassar, Jean Rhoten, Heeralall Hohabir, Shay Bevard, Patti Payne, Jodi Hinckley, Darlene Crockett, Jaime Nodolf and Lora Cheek.

All these folks are dear friends, I am so proud of everyone’s commitment and involvement.

I hope you are catching the vibe I am sending. I want you, our dear AVIR Member, to feel like we are here for you. AVIR is supposed to bring value to your career. To quote an evaluation comment: “Complacency is the Enemy!”

Take charge of your association, tell us what you want. I will see about getting exactly what you are asking for. That is what a liaison is supposed to do.
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www.mobileaspects.com
Goof Flavors
by Melissa Post MBA, CRA, RT(MR)(CV)(CT), FAVIR

I love coffee—almost as much as I love wine. Recently, I took some instant espresso and sea salt and added it to the double boiler loaded with chocolate chips. It’s amazing how just adding a little flavor to an already known good substance can open a new appreciation for something else.

This year, my excitement for the AVIR doesn’t stem from the fact that I am no longer the President; well most of it anyway comes from our latest additions to the board. Adding new leaders within our profession to lead our association is like adding spice—a delicious flavor to an already great dish.

Andrew, Izzy and Rob are our spices to the AVIR. Each one of them represents a well known, highly regarded institution within our profession and each one of them has awesome ideas and beliefs that will continue to broaden our profession and provide depth to our association.

Did I say I was excited??
I am way excited.

I will continue to keep you abreast of all the latest thoughts and endeavors this board is cooking up. We are planning on a delicious 2013 annual meeting.

This article is to get each one of you in the kitchen and invested in our association.

Think of ways to broaden your scope of knowledge.

Just being a part of the Member’s committee may provide depth to your knowledge, or maybe lending a hand at the annual meeting in New Orleans (talk about flavor!) will tempt you to throw your hat in the ring and run for a board position. Either way, think about it. I promise it’s worth trying.

Taking applications for nominees of the 2014-15 positions of:

- VP
- Director @ Large
- Treasure
- Program Director

The application may be found on our newly created website: AVIR.ORG under the Board Resources.

2013 AVIR Continuing Education Now Available…!!!

AVIR has approved and posted TWELVE (12) Directed Readings for 1 CE credit each for 2013. Members can go to the Resources page and click on Directed Readings, read the Article online or print it and read it at your leisure. Then return to the same spot, take the quiz and you will receive 1 CE for each of them. The articles have been carefully selected by the board members. We appreciate feedback and thoughts on this process. We are also offering a Webinar in February and will continue to schedule them quarterly, your input is welcome and appreciated on new topics for discussion. Let’s get smarter together. Enjoy!
Certification is the initial recognition of an individual who satisfies certain standards within a profession. Employers, state licensing agencies, and federal regulators look at the ARRT credential as an indication that a person has met a recognized national standard for medical imaging, interventional procedures, and radiation therapy professionals.

As outlined in ARRT’s “Equation for Excellence,” candidates for ARRT’s Vascular-Interventional (VI) Radiography certification must meet basic education, ethics, and examination requirements to become eligible. The following sections outline the eligibility requirements for all three areas. Note that there is no such thing as “registry-eligible” as far as the ARRT is concerned. Additional eligibility details can be found in the Vascular-Interventional (VI) Radiography Certification Handbook.

Education Requirements for Vascular-Interventional (VI) Radiography Certification

Candidates pursuing certification in vascular-interventional (VI) radiography must be registered with the ARRT in Radiography and must document completion of the Vascular-Interventional (VI) Radiography Clinical Experience Requirements (effective 2008, effective 2012). Learn more about ARRT’s education requirements.

Ethics Requirements for Vascular-Interventional (VI) Radiography Certification

Every candidate for certification must, according to ARRT governing documents, “be a person of good moral character and must not have engaged in conduct that is inconsistent with the ARRT Rules of Ethics,” and they must “agree to comply with the ARRT Rules and Regulations and the ARRT Standards of Ethics.” ARRT investigates all potential violations in order to determine eligibility.

Issues addressed by the Rules of Ethics include convictions, criminal procedures, or military court martials as described below:

- Felony;
- Misdemeanor;
- Criminal procedures resulting in a plea of guilty or nolo contendere (no contest), a verdict of guilty, withheld or deferred adjudication, suspended or stay of sentence, or pre-trial diversion.

Juvenile convictions processed in juvenile court and minor traffic citations not involving drugs or alcohol do not need to be reported.

Additionally, candidates for certification are required to disclose whether they have ever had any license, registration, or certification subjected to discipline by a regulatory authority or certification board (other than ARRT). Read all about ARRT’s ethics requirements.

Examination Requirements for Vascular-Interventional (VI) Radiography Certification

After having met the education and ethics requirements, candidates for Vascular-Interventional (VI) Radiography certification must pass ARRT’s Vascular-Interventional (VI) Radiography examination, which assesses the knowledge and cognitive skills underlying the intelligent performance of the tasks typically required of staff technologists practicing at entry-level within the discipline. Applications may be submitted online by logging into My ARRT Info. If you don’t have access to My ARRT Info, are not using ARRT certification as a supporting category or would prefer to submit a paper application by mail, please contact the Initial Certification Department at (651) 687-0048, ext. 8560.

When completing their applications, candidates should keep a few things in mind:

- All photos, signatures, and/or dates of signatures on an application form must occur within the six months before the date the application is received at the ARRT office.
- Be sure to include the correct application fee.

The Vascular-Interventional (VI) Radiography Content Specifications provide an outline of the topics covered in the exam. Since ARRT uses many references to build its exams, it does not provide specific lists of study materials or textbooks, nor does it recommend or endorse any review programs, mock registries, or study guides.

continued on next page
Individuals who are determined eligible by ARRT will receive, via the USPS, a Candidate Status Report (CSR) that details eligibility status and provides information on scheduling an exam appointment within the 90-day window. The CSR also addresses how to change an exam window or appointment, and how to prove identity at the test center.

Find out more about ARRT’s exams, including details about exam format and exam length, test centers, and how to request testing accommodations.

Candidates are allowed three attempts to pass an exam, and they must complete the three attempts within a three-year period that begins with the initial ARRT examination window start date.
AVIR Fellow Award

The honor of AVIR Fellowship could be yours in 2014. Interventional Technologists that have dedicated themselves to personal and professional growth are on the right track. The AVIR has an established fellowship status for members who have made significant strides in our field and organization. AVIR fellows include individuals who have dedicated themselves to striving for quality and improvement in interventional radiology as leaders, educators, authors, and committee members.

The AVIR Fellowship recognizes Interventional Radiographers who demonstrate a continuing pursuit of excellence in the IR profession. The commitment begins at the hospital level, moves on to the local AVIR chapter and escalates to your commitment at the national level. The application employs a point system to evaluate the contributions of the candidate in three areas: Personal qualifications (education, experience), contributions to the AVIR (national and local chapters), and contributions to the profession (other than AVIR). Once the minimum amount of points is reached, an application may be submitted to the Fellowship Committee for review.

The Fellows Award is presented at the annual meeting, with next year’s being held in San Diego March 2014. Do you think you have the qualifications to become an AVIR Fellow? If so, go to www.avir.org resources page and download the application from the governance section. If you have any questions, email me at izzyavir@gmail.com and I would be happy to assist you.

AVIR Webinar: There’s no “I” in team, but there is an “I” in “improvement”

AVIR Will be hosted it’s first webinar of 2013 on Tuesday, March 19, at 1:00 pm ET. Webinar attendance was good with lots of IR professionals. 1 ARRT CE Credit was awarded for attendance. ONLY Active AVIR members were eligible to receive credit other attendees are welcome to enjoy the education.

If you need to renew your AVIR membership to the next webinar go to AVIR.org
If you have any questions about the next webinar or registration, please contact Jared Friends at 877-833-7570 x 302.

Webinar Abstract:

Odds are this is not the first time you are going to be clued in on how ‘healthcare is changing.’ In fact, we’re willing to bet you would be just fine in never having to read or listen to these words in this sequence again! On a daily basis we get a pep talk, email or blog reference about LEAN this, change management that, or our personal favorite, ‘if we improve the quality over here, that will make people smile over there…’ Seems logical, right? Well hopefully you comply because the changes taking place in our health community are finding themselves on your task list.

“I felt pushed beyond my limits,” recalled a surgeon, who accidentally broke a technician’s finger after she slammed an incorrectly loaded device down on a table. This surgeon, who was suspended for two weeks and ordered to attend anger management, represents a common outlier all too often forgotten about, the limitations of our medical staff. Health systems have become so focused on the process of change and often forget what drives change in the first place, people. When we feel we have been ‘pushed beyond our limits,’ we break, the process fails.

We invite you to tag along with us as we take a look at why we, the people, not the process, need improvement. Join the eWB™ team for a workshop on how we can better manage our own expectations inside the IR lab in an effort to improve our attitudes towards our ever changing work environment and responsibilities.

Well if you missed this one and are looking for some information about this topic. Reach out to the office to get more information. We will be continuing to do these and Webinars and look forward to you be on these as we move on.
Interventional radiology gets specialty status

September 13, 2012

The Society of Interventional Radiology (SIR) is lauding the decision by the American Board of Medical Specialties (ABMS) to make interventional radiology a primary medical specialty.

The ABMS has approved an application by the American Board of Radiology (ABR) for a new dual primary certificate in interventional and diagnostic radiology. The approval confirms interventional radiology’s benefit to patients, according to the society.

The new dual certificate in interventional and diagnostic radiology will be the fourth primary certificate for ABR and the 37th overall in the U.S. A primary certificate differs from a subspecialty certificate, as it designates a distinct area of medicine, rather than an area of focus within an existing specialty, SIR said.

Defining Interventional Radiology

In each country and region, IR practice varies according to local factors. Furthermore, in some countries, IR is formally recognized as a unique subspecialty of diagnostic radiology, whereas in other countries IR is formally recognized as a distinct radiologic specialty.

The following features are common to IR both as a subspecialty or specialty:

1. Expertise in diagnostic imaging and radiation safety.
2. Expertise in image-guided minimally invasive procedures and techniques as applied to multiple diseases and organs.
3. Expertise in the evaluation and management of patients suitable for the image-guided interventions included in the scope of IR practice.
4. Continual invention and innovation of new techniques, devices, and procedures. Based on these features, IR is unique and distinct from all other surgical, radiologic, and medical subspecialties and specialties.

D. ELEMENTS OF IR

The following elements define IR:

1. Clinical Scope

   a. Evaluation and management of patients with diseases or conditions amenable to image-guided interventions.
   b. Invasive diagnostic imaging with the exception of invasive cardiac imaging.
   c. Minimally invasive image-guided and related procedures of vascular, gastrointestinal, hepatobiliary, genitourinary, pulmonary, musculoskeletal, and, in some countries, neurologic conditions amenable to these procedures.
   d. Diagnostic imaging as relevant to local practice.

2. Training

   a. Dedicated, standardized, and regulated IR training programs that include:
      i. Formal training and testing in diagnostic imaging.
      ii. Formal training and testing in radiation physics and safety.
      iii. Formal training and testing in image-guided minimally invasive and related procedures and techniques.
iv. Formal training and testing in longitudinal outpatient and inpatient care relevant to patients undergoing IR procedures.

v. Training in research.

b. Support for trainees by hospital, medical school, or other mechanisms used to support residents and fellows.

3. Certification

a. Completion of standardized IR and imaging training programs.
   i. Examination by a generally accepted and recognized medical certifying body.
   ii. Maintenance of certification as required by national and local medical certifying bodies.
   iii. Formal acknowledgment by board-certifying organizations (or their equivalent) of IR as a unique specialty or subspecialty of radiology.

4. Clinical Practice

a. Patient care
   i. Outpatient clinical facilities and staff for patient consultations, treatment planning, and follow-up.
   ii. Admitting privileges to an IR service.
   iii. Inpatient rounds on admitted IR patients.
   iv. Documentation in permanent medical records of above interactions with patients.

b. Dedicated and adequate imaging equipment, facilities, and tools for performing image-guided interventional procedures.
   i. Adherence to radiation safety practices for patients and staff.
   ii. Adherence to local standards of patient monitoring.

b. Dedicated IR clerical, technical, nursing, midlevel practitioners, and radiation safety staff.

d. IR practice combined with or exclusive of diagnostic radiology.

5. Quality

a. Lifelong dedication to continuous quality improvement.

b. Lifelong continuing education through organized programs.

c. Adoption of best practices when applicable.

b. Adherence to official IR societal practice standards whenever feasible.

e. Formal collection, recording, and analysis of complications and outcomes.

6. Research

a. Basic, laboratory, and clinical research performed according to the internationally accepted principles of ethical research practices and standards of quality.

b. Investigations into diseases and conditions treated with image guided techniques.

c. Development of new image guided interventional techniques and devices.

d. Outcomes investigations including comparative effectiveness to non-IR treatments.

e. Randomized, prospective clinical trials whenever feasible.

f. Investment by IR organizations in research training.

7. Professionalism

a. The best interests of the patient first in all clinical interactions.

b. Collaboration with other specialists to optimize patient outcomes.

c. Open disclosure of conflicts of interest (especially financial) to patients, referring physicians, hospital administrators, audiences, and journal referees.

d. Formal recognition of IR at all levels as a distinct subspecialty or specialty of radiology.

e. Promotion of the specialty or subspecialty of IR.

f. Promotion of IR procedures as first treatment options for patients whenever appropriate.
Angiography (Angio) Certificate Program

http://www.csun.edu/~vchsc02t/AngCert.htm

Program Objectives

- Provide continuing education for licensed Radiologic Technology Professionals (AA, RTs and ARRTs) at the university level.
- Provide access for professionals to use their mandated continuing education requirements to complete a certificate program.
- Provide advanced Radiologic Technology imaging education to promote excellence in the health care environment.
- Provide advanced imaging course work in computer applications, angiographic imaging, physics and cross-sectional anatomy.
- Provide advanced clinical internships through placements at the Radiologic Sciences program's affiliate medical centers.
- Prepare and qualify the student to sit for the national advanced imaging angiography certification examination.
- Prepare the student for new employment in the angiographic imaging field or adds these responsibilities to current employment.
- Prepare for the student to sit for the national advanced imaging angiography certification examination.

Criteria for Admission

1. Overall GPA of 2.5 or greater in all previous college coursework. The applicant must have graduated from an accredited program approved by the JRCERT and have passed the ARRT certificate exam.
2. Radiologic Technologists must obtain from the Department of Health Sciences an application for the advanced imaging certificates. Upon submission and review of the application and processing fee per certificate program, the applicant may be accepted into the program.
3. Accepted Radiologic Technologists will enroll in courses as advised through the College of Extended Learning and/or Open University.
4. Prerequisite coursework for advanced imaging may be taken at a community or other college but must be approved by the Program Director to ensure that credit will be given.
5. To continue in the program, students must earn no less than a grade of C in each course in the program. (Note: A grade of C- is not acceptable)
6. To continue in the program, students must be accepted for clinical internships by at least two clinical affiliate medical centers, where they must spend a minimum of 24 hours per week during a clinical internship in order to achieve specified competencies for each clinical placement. (Note: Clinical placement is not guaranteed on admission to the program. Clinical placements require acceptance by the affiliated medical center after an interview, criminal background check and review of applicant qualifications by each medical center affiliate.)

Completion of the Angiography Certificate Program

1. All angiography certificate didactic course work and clinical internships must be completed with no less than a grade of C in each course. (Note: A grade of C- is not acceptable)
2. The student must be accepted for clinical internship by at least two clinical affiliate medical facilities, where they must spend a minimum of 24 hours per week, in order to satisfactorily pass all clinical competencies identified for each assigned internship. (Note: Clinical placement is not guaranteed on admission to the program. Clinical placements require acceptance by the affiliated medical center after an interview, criminal background check and review of applicant qualifications by each medical center affiliate.)
3. If the Radiologic Technologist is accepted for clinical placement, actual clinical rotations will be scheduled after completion of the academic course work in that specialty. There is no guarantee of placement, location or time schedule.

Faculty Members

Anita Slechta, Program Director, M.S., BSRT, CRT, ARRT(R)(M), Professor, Health Sciences Department, CSUN
Jennifer Little, Clinical Coordinator, BS, RT, ARRT (R)(MR), CRT
Edmundo Quezada , BS, RT, ARRT(R)(VI), CRT

New PRESERVE Study Takes Shape With SIR Lead

Representatives from SIR, the Society for Vascular Surgery (SVS) and the U.S. Food and Drug Administration (FDA) have been collaborating to launch PRESERVE, a new large-scale, multispecialty prospective study to evaluate inferior vena cava (IVC) filter use and follow-up protocols to improve patient care. The effort is a direct result of an August 2010 FDA medical alert detailing the possibility that retrievable IVC filters could move or break, perhaps causing significant health risks for patients. SIR and SVS are in the process of forming a joint foundation to oversee the Predicting the safety and effectiveness of Inferior Vena Cava Filters Study. With the goal of obtaining a functional view of all filters placed in the United States, the study will evaluate the overall safety and efficacy of filters placed by vascular specialists and intends to enroll about 2,500 patients at approximately 50 centers in the United States. The specifics of the study must first be approved by FDA through an investigational device exemption (IDE) study with HIPAA compliance. The societies are also in the process of making a final decision for a contract research organization (CRO). Filter manufacturers are participating in study discussions. SIR will announce more information about the study’s start as details become available.

FDA clears Vital Images CT TAVR planning app

Mar 07, 2013

Vital Images, part of the Toshiba Medical Systems Group, has received 510(k) clearance from the
FDA for its CT TAVR (transcatheter aortic valve replacement) planning application. The company will showcase its TAVR planning application at the American College of Cardiology (ACC) annual scientific session, March 9-11 in San Francisco.

TAVR procedures are used to replace faulty aortic valves with artificial valves using endovascular techniques on patients who cannot withstand invasive surgeries. Vital’s CT TAVR planning application is used in the planning process to visualize and measure vascular anatomy for the evaluation, treatment and follow-up of aortic vascular disorders.

A Couple Items on Reimbursement

What are the Appropriate codes to use when Microwave Ablation is the energy source used for liver, lung or renal lesions?

Answer: The existing Current Procedural Terminology (CPT) codes for tumor ablation are defined for radiofrequency ablation. This definition has led to some confusion, resulting in the use of unlisted procedure codes for Microwave Ablation. SIR does not recommend the use of unlisted procedure codes for Microwave Ablation of kidney, lung or liver tumors. Microwave is part of the radiofrequency spectrum and simply uses a different part of the radiofrequency spectrum to generate heat energy to destroy abnormal soft tissue. Microwave Ablation equipment is substantially comparable to operate in practice, which is also reflected in the U.S. Food and Drug Administration (FDA) approval of microwave devices under the 510(k) clearance process as equivalent to radiofrequency.

As such, SIR recommends that CPT codes 47382, 32998 and 50592 be used for both microwave and radiofrequency ablation in their respective anatomic locations, in conjunction with the appropriate imaging guidance code: 47382

Ablation, one or more liver tumor(s), percutaneous, radiofrequency; with appropriate image guidance code: 77013 (CT), 76940 (US), 77022 (MRI)

50592

Ablation, one or more renal tumor(s), percutaneous, unilateral, radiofrequency; with appropriate image guidance code: 77013 (CT), 76940 (US), 77022 (MRI)

Nephrostomy tube exchange

When is it Appropriate to code for a nephrostogram during a tube change?

Answer: There is much confusion about the use of CPT codes 50398 and 50394: 50398 Change of nephrostomy or pyelostomy tube 50394 Injection procedure for pyelography—as nephrostogram, pyelogram, antegrade pyeloureterograms—through nephrostomy or pyelostomy tube or indwelling ureteral catheter

The position of SIR is that contrast injection used for basic anatomy during nephrostomy tube exchange is part of the procedure, is therefore included in CPT code 50398, and should NOT also be coded as a diagnostic nephrostogram. Coding for both under this circumstance is an area of potential misuse of the codes. There are occasions when a diagnostic study is performed at the same time as a tube change. Under that circumstance, it is appropriate to include CPT code 50394 with the -59 modifier. The use of modifier -59 with CPT code 50394 indicates that a true diagnostic study was performed. CMS does allow the use of National Correct Coding Initiative (NCCI)-associated modifiers for clinical scenarios where the patient having a tube change also presents with new symptoms related to the tube.

For example:

-A patient presents with pain and leakage in the area surrounding his nephrostomy tube.

-Contrast is injected, a diagnostic nephrostogram is performed, and it is determined, on the basis of the diagnostic study, that the tube must be changed.

Codes 50398 and 50394-59 are reported.
Healthcare value is in the eye of the beholder
By Evan Godt Mar 12, 2013

In chasing “value” as the ultimate goal of healthcare reform, providers may misunderstand that patients and physicians see value in different ways, creating barriers to true reform, according to an article published March 7 in the New England Journal of Medicine.

Comparing the concept of searching for value in healthcare to the notion of inattentional blindness — discussed previously in Health Imaging — author Lisa Rosenbaum, MD, of the University of Pennsylvania in Philadelphia, explains that value depends on who is looking and what they expect to see.

“The value narrative effectively splits patients and physicians into separate teams,” wrote Rosenbaum. “When we focus on physicians, creating value means mitigating overuse, increasing efficiency, and providing incentives to deliver evidence-based care. When we focus on patients, creating value means enhancing patients’ experience, honoring patient-centeredness, and catering to outcomes that matter to patients.”

For example, patients may ask physicians for tests to achieve peace of mind about an illness even if no evidence exists that these tests produce better outcomes. A physician-centric view of value would see little value in administering a costly test in such a situation, but a patient-centered view acknowledges the psychological benefit patients experience from undergoing such a test, explained Rosenbaum.

“Rewarding value when it comes to physician behavior is easy when we are talking about measures, such as prescribing aspirin after a myocardial infarction, that clearly confer better health,” she wrote. “But as we move away from a robust database into the area where most of medicine is practiced, the line between objectively necessary health measures and the type of care patients expect and value becomes blurred.”

This is particularly true in imaging, noted Rosenbaum, since imaging tests can often be adopted in practice without a robust demonstration of clinical efficacy. As a result, imaging technology can outpace an understanding of how best to use it. She praised efforts of the Choosing Wisely campaign in identifying tests that do not need to be performed routinely, but acknowledged that for many tests and indications, detailed data are lacking.

Rosenbaum suggested reframing value in such a way that decisions incorporate patients’ values to improve overall care, even if evidence-based decision making may seem to be undermined and imaging increases. For instance, showing a patient an image of his or her coronary plaque may not have any direct diagnostic benefit, but may motivate them to reduce risk factors. Head CTs and repeat mammograms may not be warranted based on evidence, but if they ease the minds of patients and lead to happier, more productive lives, they may become necessary.

“If we want to simultaneously improve quality and cut costs, we must first stop creating incentives that effectively split patients and physicians onto different teams,” wrote Rosenbaum. “We must acknowledge that shared decision making is just that: shared.”

10 steps to a healthy future for radiology
By Lisa Fratt Mar 14, 2013

The crisis facing radiology is no secret. However, crisis need not turn into catastrophe, according to an online opinion piece in the March issue of Journal of the American College of Radiology. The expert authors offered 10 strategies for radiology practices to consider and to ensure a vibrant and profitable future.

Each of the 10 steps is important, according to authors David C. Levin, MD, and Vijay M. Rao, MD, both from the Center for Research on Utilization of Imaging Services at Thomas Jefferson University in Philadelphia, and Jonathan Berlin, MD, MBA, from North Shore University Health System in Chicago.
The first five steps are:

Refute the notion that radiology is a commodity by acting as true consulting physicians. Radiologists often abdicate responsibility for three key elements of clinical service: pre-exam of the imaging request for necessity and appropriateness, monitoring of exam quality and consultation with referring physicians. Focusing solely on image interpretation and failing to perform these duties crosses the line into commoditization, according to the authors.

Take back the night. Outsourcing night and weekend call coverage is problematic from multiple perspectives. Radiologists appear to care more about personal convenience than the patient. Teleradiology providers may operate at bargain-basement prices, which devalue imaging. And opening the door to teleradiology also provides an ‘in’ for encroachment by other specialties.

Create more job openings for young radiologists. When radiologists commit the time to consultation and bypass teleradiology, job opportunities for young physicians will follow, according to the authors. This brings two benefits. Younger rads can handle duties such as night call and supervision of advanced studies, and it leaves fewer physicians in the teleradiology hiring pool.

Consolidate into larger groups. Larger groups are better positioned to handle expanded duties and night and weekend coverage, and they may be able to leverage economies of scales in operational processes, such as billing and malpractice insurance. Finally, “a larger group may have more market power in dealing with payers and hospital administrations.”

Build bridges to your hospital administration and primary care physicians (PCP). Hospital administrators and primary care physicians will play essential roles in new payment models, while radiologists are expected to have less influence in these models. By participating in hospital committees, strategic planning and marketing, radiologists can seize an opportunity to educate these stakeholders about the value of imaging. “Radiologists might consider promulgating what could be termed ‘the 90 percent rule’: that a PCP working closely with a clinical laboratory and a radiologist can solve 90 percent of the diagnostic problems in that physician’s practice without referring the patient to a specialist,” the authors wrote.

The second five steps are:

6. Consider becoming affiliated with or employed by a hospital. “[T]he model of the totally independent radiology group may no longer be viable,” cautioned the authors, who advised radiologists to ponder employment. Employed radiologists or those affiliated with accountable care organizations are more likely to receive referrals than those who remain independent.

7. Support and participate actively in utilization management. A host of stakeholders have taken note of the plethora of potentially unnecessary imaging, and diagnostic imaging secured a prominent place on the American Board of Internal Medicine Foundation’s Choosing Wisely list of commonly overused tests. “Now it is up to individual radiologists and their groups to follow through,” wrote the authors. They suggested use of the American College of Radiology (ACR) Appropriateness Criteria, radiology benefits management and computerized order entry with decision support.

8. Do more to publicize the ACR Appropriateness Criteria. Not enough physicians know about or use ACR Appropriateness Criteria, according to the authors, who focused on professional specialty journals as the primary avenue for promulgation.

9. Prepare for a probable era of lower reimbursements. Radiologists may want to set the stage for potential future negotiations regarding hospital employment. Another tough subject to broach is lower charges by the hospital for advanced imaging. Doing so may combat steerage by payers to lower-cost imaging providers.

10. Demonstrate to your hospital how an onsite radiology group adds value. “At every possible opportunity, onsite radiologists need to emphasize to their hospital and physician colleagues how much value they add to the care of patients and the operation of the hospital, value that is often ‘below the radar screen’ but that is real and should not be overlooked when contracts come up for renewal,” wrote the authors. Examples of value-added services include availability to answer patient questions, provision of
in-service education to technologists and evaluation of appropriateness of requests for advanced imaging. The researchers concluded by hinting of a bright future … if radiologists take all of their recommended steps.

TeraRecon introduces vendor-neutral complement to PACS

Mar 08, 2013

TeraRecon launched iNtuition REVIEW, a multimodality, multimonitor review and collaboration tool at the European Congress of Radiology (ECR) in Vienna. The iNtuition REVIEW client provides multimonitor display of multimodality data, in specialized use-cases such as cardiac (CT, MR, catheterization, echocardiography, EKG) or breast (MR, mammography, ultrasound). The system also includes features for the preparation and execution of physician conferences, demonstrations and multidisciplinary team meetings, according to TeraRecon.

iNtuition REVIEW expands on TeraRecon’s vendor-neutral approach to address clinical workflow challenges faced by imaging professionals who have otherwise relied on PACS and expected PACS to address all imaging needs. TeraRecon also showcased enhancements to iNtuition at ECR. New iNtuition tools support the practice of oncology, cardiovascular and clinical research. These are lobular decomposition for liver and lobe decomposition; findings workflow to track volumes and measurements over time; enhanced support for new PET tracers such as Florbetapir; time-volume analysis for cardiac MRI image acquisitions; 3D/4D visualization, specifically enhanced transcatheter valve implantation analysis; and lesion-specific analysis for research into the downstream impact of stenosis.

Finally, TeraRecon showed:

iNtuition Enterprise Medical Viewer (iEMV), a browser-based client that provides scalability, and is VMW are Ready and virtualizable. On the client side, iEMV is equipped to integrate with EMR/HIS/PACS for enterprise access to image and non-image data in the context of access to the complete patient medical record.

iNtuition SHARE, which makes possible CD-free transport and distribution of images between medical facilities and peers, or patients.

iNtuition CLOUD, which provides iNtuition functionality via a web browser.

Customized graft repair saves aneurysm patients from open surgery

Feb 19, 2013

This CT scan shows the patient’s ballooning aorta. When it gets large enough, the vessel is in danger of a life-threatening rupture.

Customized graft repair saves aneurysm patients from open surgery

Feb 19, 2013

This CT scan shows the patient’s ballooning aorta. When it gets large enough, the vessel is in danger of a life-threatening rupture.

Source: Johns Hopkins Hospital

A newly approved graft, which is customized for individual patients suffering from abdominal aortic aneurysm using CT models, can provide an alternative to open surgery for some patients.

On Jan. 11, Johns Hopkins Hospital in Baltimore became the first hospital in the mid-Atlantic to use the technique, according to a release from the hospital.

An abdominal aortic aneurysm can become life-threatening if it grows large enough to rupture, with less than a 10 percent chance of survival after rupture. Ideally, a synthetic graft attached via a minimally invasive endovascular procedure can prevent this from happening.

However, up to 30 percent of patients with identified aneurysms cannot undergo the endovascular repair because their aneurysm is located too close to the
renal arteries. These patients must undergo a more invasive open surgery.

The new grafts—approved by the FDA in April 2012—have two tiny holes, called fenestrations, fabricated in them to accommodate the renal arteries. Planning for the procedure involves making a 3D image of the patient’s aorta using CT, and sculpting the graft to match the anatomy, according to Johns Hopkins Hospital.

Fabrication of the graft takes about five weeks, but recovery time for the patient post-surgery is reduced. With endovascular repairs, patients can return home after three days and resume normal activity in two weeks, compared with a four- to eight-week recovery following open surgery, according to the hospital.

Rad jobs among highest paying 2-year degree jobs
Feb 11, 2013

CareerBuilder and Economic Modeling Specialists have released a list of the most lucrative professions in the U.S. Several radiology jobs appeared in the top 10 best-paying jobs requiring an associate’s degree.

The top-paying associate’s degree jobs based on median salary in the U.S. are:

Air Traffic Controller – $113,547
Radiation Therapist – $76,627
Dental Hygienist - $70,408
Nuclear Medicine Technologist - $69,638
Nuclear Technician - $68,037
Nurse - $65,853
Diagnostic Medical Sonographer - $65,499
Fashion Designer - $63,170
Aerospace Engineering and Operations Technician - $61,547
Engineering Technician (except drafters) - $58,698

The study uses Economic Modeling Specialists labor market database, which pulls from more than 90 national and state employment resources and includes information on employees and self-employed workers.

Radiologist Assistant Bill
Introduced in House

Amending Social Security Act to recognize RA State laws and allow Medicare reimbursement

(March 15, 2013) – Representatives Dave Reichert, R-WA, Jim Matheson, D-UT, Pete Olson, R-TX, and Bill Pascrell, D-NJ, yesterday introduced H.R. 1148, the “Medicare Access to Radiology Care Act of 2013.”

This bill would amend the Social Security Act to recognize radiologist assistants (RAs) as non-physician providers of healthcare services to Medicare beneficiaries, and would authorize physician reimbursement through the Centers for Medicare & Medicaid Services (CMS) for procedures performed by RAs in states that have laws establishing radiologist assistant practice guidelines.

RAs work under radiologist supervision and perform select imaging and patient-care duties traditionally performed by the radiologist. While they do not prescribe medication or therapies, diagnose or interpret medical images, RAs perform procedures and patient assessment and management that increase patient access to critical radiology services and augment the delivery of optimal, timely and safe radiology care – leading to greater efficiencies and value for patients and providers.

RAs are educated in an advanced medical imaging academic program specifically designed to complement the work of radiologists. Currently, 12 universities offer accredited education programs with radiologist-supervised clinical training, and 29 states license or certify RAs. Upon graduation from an accredited program, radiologist assistants take a national certification examination developed by The American Registry of Radiologic Technologists (ARRT) or the Certification Board for Radiology Practitioner Assistants (CBRPA). To maintain their national ARRT or CBRPA certification, RAs must maintain certification and registration in radiography, complete
approved continuing education every two years, and comply with strict professional standards of ethical conduct as administered by ARRT.

Better Patient Access, More Promptly

“With radiologist oversight, RAs are perfectly qualified to perform aspects of imaging, patient assessment, management and procedures that allow radiologists the time to focus on procedures and consultations that can be performed only by a radiologist,” says Joy Renner, M.A., R.T.(R)(ARRT), FAEIRS, Radiologist Assistant program director at The University of North Carolina at Chapel Hill and chair of the Radiologist Assistants Educators Council (RAEC). “RAs allow radiologists to devote more focused, uninterrupted time reviewing and interpreting medical images and providing timely diagnoses which will provide for efficient, appropriate medical treatment. This means greater timeliness, accuracy and quality of care provided to Medicare beneficiaries. Consumers demand this level of care and are certainly entitled to this level of care, as well.”

“I’m happy I can help skilled students in my district find jobs by making a common-sense change to Medicare’s classification of radiologist assistants,” said Rep. Dave Reichert. “These bright professionals train for years at accredited schools to master the complex technologies necessary to safely and effectively perform medical imaging services. At a time when many Americans are looking for work and high numbers of Medicare beneficiaries are increasing the demand for services, this legislation will be highly supportive for both radiologist assistants and patients.”

Reimbursement by CMS Needed

The bill would enable healthcare facilities and radiology practices to be reimbursed for RA-performed services. By establishing a reduced reimbursement level for the professional component of procedures performed by RAs, the bill should result in savings to the healthcare system.

“I’m pleased to join my colleagues in introducing this common-sense legislation,” Rep. Olson said. “This measure will promote more efficient healthcare for America’s seniors, save jobs and help the Medicare program by expanding the role of radiologist assistants and reducing costs for quality care.”

“Although not a complete solution to the patient access problems that this country is facing, making this modest change to the Medicare law will enable radiologist assistants to provide care to the full extent of their training and scope of practice, thereby improving patient care and satisfaction, lowering costs and meeting patient demand,” said Jerry B. Reid, Ph.D., executive director with The American Registry of Radiologic Technologists (ARRT). “We applaud Rep. Reichert and the other cosponsors who recognize the need to adopt common-sense, bipartisan changes to the Medicare program so that seniors can benefit from innovations in health care delivery. ARRT is grateful to Reps. Reichert, Matheson, Olson and Pascrell for working to improve access and lower the cost of radiology services for Medicare patients. We look forward to working with them to achieve passage of this legislation.”

H.R. 1148 is strongly supported by ARRT as well as the American College of Radiology (ACR), the American Society of Radiologic Technologists (ASRT), and the Society of Radiology Physician Extenders (SRPE).

“Patients, state medical boards and the medical imaging community have embraced the radiology physician extender community and relied upon it to provide timely imaging access, says Jason Barrett, SRPE president. “Passage of this bill would allow Medicare beneficiaries to utilize this crucial access resource that some states have already recognized as a necessary component of healthcare delivery.”

“We believe this bill will preserve RA educational programs and jobs while saving needed health care dollars,” said ASRT president Donna L. Thaler Long, M.S.M., R.T.(R)(M)(QM)(ARRT), FASRT. “In addition, it will ensure that patients continue to have timely access to quality medical imaging services.”
At the annual meeting this year in New Orleans, the organization will be celebrating its 25th anniversary. There will be special events to help celebrate this special milestone. There will be our Gold Medal Lecture with special recognition to Shari Ullman and an anniversary reception on Tuesday evening. This year the opening ceremony is Saturday night and will be at the Hilton New Orleans Riverside, which is right across the street from the convention center. The meeting space at the Hilton is excellent and we will be able to use the classroom setting (tables) in the lecture rooms. The rooms are beautiful, spacious and the adjacent space should be perfect for networking with your colleagues. Invitations to speak have been sent and the program co-chairs with the assistance of the AVIR home office staff are in the process of solidifying the program. Our goal is to offer a well-rounded and interesting program that includes high caliber speakers and topics that will be beneficial for all participants.

This year’s meeting will include several product symposiums in which our corporate supporters and partners can highlight their products and help educate the attendees on their products and the latest technology. These sessions allow for networking with colleagues from across the country. Networking is a very important element when attending professional meetings.

During the meeting site visit, we were told that the area is known for its lively social scene. Saturday evening is the opening reception. Sunday, April 14th should be a good night to visit Bourbon Street and there are several great restaurants and Pubs, as we are located in the heart of all of this. Tuesday evening is the AVIR 25th anniversary celebration.

New Orleans is a wonderful location for the meeting. There is so much to see and do and many attractions are within walking distance or a short cab ride away. Flying into New Orleans Airport is only thirty minutes from the convention center and the Hilton Hotel Riverside is right beside it.

Please join us in New Orleans and help us celebrate this very special milestone for the organization. If you have any questions regarding the program, please feel free to contact Andrew Amorrossa our Program Chair.

On Behalf of the 2013-2014 Board of Directors and appointed officers, we would like to first thank you, the members for electing us to lead AVIR through these exciting times. We have the utmost confidence that this team of dedicated professionals are up to the task. AVIR has always been there for us as we developed and expanded our professional scope and we will ensure that AVIR continues to provide the same opportunities for new members, new graduates, and all professionals related to Interventional Radiology. This year, the table is set for advanced learning through interactive media and live events. With our new Management team, and board members, Spencer, Bruce, Tony, Rob, Crystal, Andrew, Dave D, Jared, Dave N, Dana, and myself, Izzy. We would like to thank you for this opportunity and look forward to taking AVIR to new heights. We want to also recognize and thank the previous BOD, Physicians, Corporate Sponsors and all those who have supported the AVIR in leadership and partnership roles throughout the years; we hope to keep to the highest standards set by all of you alive for decades to come.
**AVIR 2013 Schedule**

**Sunday April 14th 2013,**
**This Entire Day Will Take Place At The Hotel**

<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
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<tbody>
<tr>
<td>7:00</td>
<td>Gary Siskin M.D., Interventional Radiology Chairman, Albany Medical Center, 2013 SIR Conference Chairman</td>
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<td>President's Welcome and Gold Medal Lecture</td>
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<td>2:15</td>
<td>Missy and the Board of Directors</td>
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<tr>
<td>3:00</td>
<td>Break sponsored by Sirtex</td>
</tr>
<tr>
<td>4:15</td>
<td>Rob Sheridan, Director Of Interventional Radiology Services, Massachusetts General Hospital</td>
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<tr>
<td>4:15</td>
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</tr>
<tr>
<td>6:30</td>
<td>SIR Meet and greet</td>
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**Monday April 15th 2013**
**This Day Will Be A Half Day And Will Take Place In The Convention Center**

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<td>Time</td>
<td>Session Description</td>
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<tr>
<td>10:00 AM</td>
<td>LuAnn Greiner ANP, Nurse Practitioner, Interventional Radiology Service, University of Wisconsin Hospital &amp; Clinics, Madison WI</td>
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<tr>
<td></td>
<td>Vascular Malformations Below The Neck: Clinical Presentation And Treatment Options</td>
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<tr>
<td>11:00 AM</td>
<td>Wael Saad MD FSIR Professor of Radiology</td>
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<td></td>
<td>BRTO</td>
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<tr>
<td>12:00 PM</td>
<td>VIR Program Director, University of Virginia Medical Center, Charlottesville, Virginia</td>
</tr>
<tr>
<td>11:00 AM</td>
<td>12:00 PM</td>
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<tr>
<td>12:00 PM</td>
<td>OFF for the afternoon</td>
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<tr>
<td>12:00 PM</td>
<td>Opportunity To See Vendors</td>
</tr>
<tr>
<td>12:00 PM</td>
<td>Opportunity To Attend SIR Lectures</td>
</tr>
<tr>
<td>12:00 PM</td>
<td>Opportunity To Network</td>
</tr>
<tr>
<td>12:00 PM</td>
<td>Opportunity To Explore New Orleans</td>
</tr>
<tr>
<td>12:00 PM</td>
<td>Enjoy!!!</td>
</tr>
<tr>
<td>12:00 PM</td>
<td>Business meeting For Board Of Directors</td>
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<tr>
<td>12:00 PM</td>
<td>Business Meeting</td>
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<tr>
<td>12:00 PM</td>
<td>Business Meeting</td>
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<tr>
<td>7:30 AM</td>
<td>Breakfast Still needs to be sponsored!!!!</td>
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<tr>
<td>8:00 AM</td>
<td>Radiation Protection And All That Encompasses</td>
</tr>
<tr>
<td>9:00 AM</td>
<td>Deep Venous Thrombosis: Clinical Cases And Treatment</td>
</tr>
<tr>
<td>10:00 AM</td>
<td>Break still needs to be sponsored!!! *Business Meeting For Members</td>
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<td>10:30 AM</td>
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<tr>
<td>1:00 PM</td>
<td>Endovascular Aneurysm Repair</td>
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<tr>
<td>2:00 PM</td>
<td>Portal Vein Embolization</td>
</tr>
<tr>
<td>3:00 PM</td>
<td>Break still needs to be sponsored!!!!</td>
</tr>
<tr>
<td>3:15 PM</td>
<td>Everything You Ever Wanted To Know About Embolic Agents But Were Afraid To Ask</td>
</tr>
<tr>
<td>3:15 PM</td>
<td>Breakstill needs to be sponsored!!!!</td>
</tr>
<tr>
<td>3:15 PM</td>
<td>Robert Velez R.T., Department of Interventional Radiology, Albany Medical Center, Albany NY</td>
</tr>
<tr>
<td>3:15 PM</td>
<td>Everything You Ever Wanted To Know About Embolic Agents But Were Afraid To Ask</td>
</tr>
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</table>

**Tuesday, April 16th 2013**

This day will take place at the Hotel

<table>
<thead>
<tr>
<th>Time</th>
<th>Session Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>7:30 AM</td>
<td>Breakfast Still needs to be sponsored!!!!</td>
</tr>
<tr>
<td>8:00 AM</td>
<td>Bob Dixon M.D., Interventional Radiologist, Interventional Service, UNC Healthcare, Chapel Hill, NC</td>
</tr>
<tr>
<td>9:00 AM</td>
<td>Akhilesh Sista, Attending Interventional Radiologist, New York Presbyterian Hospital, NY NY</td>
</tr>
<tr>
<td>10:00 AM</td>
<td>Gail Peters M.D., Interventional Radiologist, Interventional Service, Emory Healthcare</td>
</tr>
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<td>Lunch Symposium sponsored by Electronic Whiteboard Solutions Speaker TBD</td>
</tr>
<tr>
<td>1:00 PM</td>
<td>John E. Aruny M.D. Co-Section Chief Of Vascular And Interventional Radiology, Yale Medical Group</td>
</tr>
<tr>
<td>2:00 PM</td>
<td>David MadofM.D., Chief Of Interventional Radiology, New York Presbyterian Hospital, NY NY</td>
</tr>
<tr>
<td>3:00 PM</td>
<td>Break still needs to be sponsored!!!!</td>
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<tr>
<td>3:15 PM</td>
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<td>Everything You Ever Wanted To Know About Embolic Agents But Were Afraid To Ask</td>
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</table>

**AVIR 2013 Schedule**
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<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
<th>Speaker(s)</th>
<th>Venue</th>
</tr>
</thead>
<tbody>
<tr>
<td>4:15 PM</td>
<td>Janice Newsome M.D., Interventional Radiologist, Riverside Regional Medical Center</td>
<td>15 Shades or Gray 1 CEU</td>
<td>Grove</td>
</tr>
<tr>
<td>Evening</td>
<td>Evening Anniversary And Award Ceremony</td>
<td>A New Orleans Style Party Sponsored By Grove</td>
<td>Grove</td>
</tr>
</tbody>
</table>

### Wednesday, April 17th 2013
**This Day Will Take Place At The Hotel**

<table>
<thead>
<tr>
<th>Time</th>
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<td>Continental Breakfast sponsored by Mobile Aspects</td>
<td></td>
<td>Grove</td>
</tr>
<tr>
<td>8:00 AM</td>
<td>Mark Schiffman M.D., Attending Interventional Radiologist, New York Presbyterian Hospital, NY NY</td>
<td>Uterine Artery Embolization For Treatment Of Fibroids 1 CEU</td>
<td>Grove</td>
</tr>
<tr>
<td>9:00 AM</td>
<td>Adam Talenfeld, M.D. Attending Interventional Radiologist, NY Presbyterian Hospital, NY NY</td>
<td>Radiation Segmentectomy for HCC 1 CEU</td>
<td>Grove</td>
</tr>
<tr>
<td>10:00 AM</td>
<td>Break sponsored by Mobile Aspects</td>
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<td>Grove</td>
</tr>
<tr>
<td>10:30 AM</td>
<td>Dr Joshua A Hirsch, Vice Chair Interventional Radiology, Massachusetts General Hospital</td>
<td>Neuro-interventional Radiology 1 CEU</td>
<td>Grove</td>
</tr>
<tr>
<td>11:30 AM</td>
<td>Lunch Symposium sponsored by Mobile Aspects Speaker TBD</td>
<td>Lunch Symposium sponsored by Mobile Aspects Speaker TBD 1 CEU</td>
<td>Grove</td>
</tr>
<tr>
<td></td>
<td><strong>Concurrent Sessions</strong></td>
<td><strong>Concurrent Sessions: Management and Exam Review</strong></td>
<td>Grove</td>
</tr>
<tr>
<td>12:30 PM</td>
<td>David Rosman, M.D.</td>
<td>A Discussion About The Healthcare Bill 1 CEU</td>
<td>Grove</td>
</tr>
<tr>
<td>1:30 PM</td>
<td>Rob Sheridan, Director Of Interventional Radiology, Massachusetts General Hospital</td>
<td>Radio Frequency Identification Charge Capture 1 CEU</td>
<td>Grove</td>
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<td>Break sponsored by Mobile Aspects</td>
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<tr>
<td>3:00 PM</td>
<td>Anita Bell R.T., Manager, Department Of Interventional Radiology, UVA Health System</td>
<td>Topic still to be announced 1 CEU</td>
<td>Grove</td>
</tr>
<tr>
<td>4:00 PM</td>
<td>Amanda Popovitch R.T.(R), Interventional Technologist, Children's Hospital Of Boston</td>
<td>Center For Excellence Discussion And Universal Protocol 1 CEU</td>
<td>Grove</td>
</tr>
<tr>
<td>5:00 PM</td>
<td><strong>Concurrent Session</strong></td>
<td><strong>Concurrent Sessions: Management and Exam Review</strong></td>
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<td>12:30 PM</td>
<td>Deb Scroggins MSRS, (R)(CT)(CV)(M) Diagnostic Imaging Professor, MD Anderson Medical Center</td>
<td>Exam Review – 1 CEU</td>
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With just 20 months until the go-live date of Oct. 1, 2014, the International Classification of Diseases, 10th Edition diagnosis and procedure codes—better known as ICD-10—offers an updated medical coding system replacing ICD-9, now in use for more than 30 years. Compliance with ICD-10 means that “everyone covered by the HIPAA is able to successfully conduct health care transactions using ICD-10 codes,” a statement from the Centers for Medicare & Medicaid Services Transition Basics.

ICD-10 directly impacts patient care and the practice of medicine. It is the way providers are paid and should be among the highest priorities. In fact, the transition to ICD-10 is critical to a successful launch of the healthcare transformation components of the Patient Protection and Affordable Care Act of 2010, and vital to transforming health and healthcare for the 21st century practice of medicine.

The following are five benefits of ICD-10, information of interest to physicians and their colleagues.

1. **Patient experience:** Patient care and experience will be enhanced, as healthcare costs begin to reduce, in the long-term, to more manageable levels. ICD-10 is expected to reduce provider overhead costs over the long term by minimizing the need for prior authorization episodes, which tend to delay patient course of treatment.

2. **Health IT as foundation for healthcare transformation:** ICD-10 will provide a 21st century standard coding system, a vital step to realize the full benefits of healthcare transformation in the U.S. This evolution to better care via ICD-10 includes: Meaningful Use of EHRs; interoperable exchange of health information; improving quality of care and clinical outcomes; improved secondary use of data for clinical research; vastly improved public health; and population health management.

3. **Population health:** The quality of population health and healthcare delivery will likely improve with a resolute definition of the current state of America’s health. A better understanding of population health would offer a more accurate picture of prevention and treatment needs, a positive impact on patient safety. In addition, staying ahead of disease progression can help determine the best course for evidence-based medicine.

4. **Eliminating waste:** ICD-10 will provide better clinical and business intelligence that will improve decision-making algorithms in patient care at the time of visit. It will better guide the development of preventive and self-care models, as well as needed education vehicles that will further improve consumer engagement, compliance and accountability. ICD-10 has the potential to reduce costs, or “waste,” by accurately pinpointing the severity of disease and helping create medically necessary plans of care and courses of treatment.

5. **Cost savings:** Using the correct medical code for the patient’s health status means information and billing, is of higher quality and accuracy.

For more information on ICD-10 compliance, HIMSS offers several interactive and online resources, as noted below.

- ICD-10 PlayBook has background information, templates and step-by-step ICD-10 guidance for providers to meet the compliance deadline for ICD-10. Updated on a regular basis, the PlayBook contains materials contributed by more than 30 organizations.
- ICD-10 Provider Podcast Series includes podcasts on topics geared to providers transitioning to ICD-10. HIMSS G7 Reports has analysis on ICD-10 implementation and compliance from provider, health plans, banks, government, consumer, employer and technology firms focused on healthcare transformation.
- An effective ICD-10 compliance strategy should include a comprehensive assessment of all personnel, processes, and technologies impacted. Dedicated governance and project teams should prepare a detailed budget, work plan, and awareness campaign. An experienced ICD-10 solutions provider can support an organization’s ICD-10 transition, helping in-house staff to maintain efficient day-to-day operations through implementation. Your staff may be able to manage the transition, but can it maintain operating efficiency at the same time?
R.T.s have long told us how challenging it can be to find CE activities that are appropriate for them. They come to ARRT for assistance because it’s ARRT requirements they are trying to fulfill.

On the other hand, CE sponsors are always trying to get the word out about CE activities that R.T.s ought to know about. But the sponsors often don’t have the resources to reach out to many of our nearly 300,000 R.T.s.

CE|R.T. is a free search service that anyone may browse by type of activity (e.g., Online Study, Journal Reading, Self Study, and Lecture), location, and discipline.

If you’re a CE sponsor interested in listing your programs, click on the link below. If you’re a technologist who’s interested in finding CE activities, click on the other link.

Online CE Database For R.T.s

Welcome to the free online database of continuing education activities for radiologic technologists. CE|R.T. lists some of the available CE activities that have been approved for credit by a RCEEM.

You can search for specific CE opportunities using various criteria to best meet your needs. CE sponsors and providers can add their approved CE activities to the database or create a link to the CE activities listed on their own website.

ARRT verifies that CE activities listed in this database have been approved for credit by an ARRT-recognized mechanism. ARRT does not directly evaluate the content of the CE activities and does not evaluate any claims made by the CE sponsors and providers.

Get Started Now

Searching

To launch a search for online CE activities in the CE|R.T. database, step one is to select at least one activity type (Online Study, Journal Reading, Self Study, and/or Lecture) shown on the upper left corner of this page.

If you are selecting Online Study, Journal Reading, or Self Study, you may skip to the next section, “Selecting Discipline(s).” If you are searching for a lecture, follow the instructions in the rest of this section.

For lecture activities, specify area and/or event date. You may search on either one or both, but you must specify at least one of them to initiate a search. Area is the location where a lecture is going to be delivered. Event date may be specified as a single date or a range of dates. If you wish to find lectures only after a certain date, then specify only the “From” date and leave the “To” date blank. If you are looking for lectures only before a certain date, then specify only the “To” date and leave the “From” date blank.

You can search for lectures by any of the following options:

• state only
• state and city
• state, city, and miles
• zip only
• zip and miles
• “From” date and/or “To” date

Selecting Discipline(s)

In order to search you must also specify at least one discipline. You may click on the “Check All” link at the bottom if you wish to see activities in all disciplines.

After determining the activity type and discipline(s) as described above, just click on the “Search” button. Search results will appear in a table.

Sorting Search Results

To sort your results click on the heading of the column by which you wish to sort. For example, to sort in a “Descending” order, check the “Descending” button, then click on the column heading again.

Paging

For your convenience, only 40 records are shown on each page. You can browse to other pages by clicking on the page number links shown at the top of the table.

Viewing Details of an Activity

To view detail of an activity, click on the title of an activity. Click on the “More Detail” link at the bottom of the activity detail page to jump to the sponsor’s actual website.
What an exciting time for the AVIR!

The AVIR has a newly enhanced mobile device friendly website, linked with our social media tools allowing people to share information and discuss all things IR. In fact, a long standing struggle in one of our IR units at MGH was solved through shared experiences enabled by our social media tools!

We also have enhanced our educational offerings, added a new AVIR online store and the always fun and informative annual meeting is rapidly approaching! New Orleans is such an amazing city and venue to hold our annual meeting with all it has to offer, great southern food, an incredible array of jazz musicians, seemingly endless amounts of parades and good people enjoying the southern life, in and around the French Quarter.

As Treasurer, I am excited to report that the AVIR has been in a stable financial position since our last annual meeting and continues to grow its membership! In January alone, we had an incremental increase in our membership of over 80 new members. An impressive increase in membership as we entered the new year! We have also continued to work hard with our vendor partners to develop new or enhanced webinars with content experts to provide additional education to our membership.

As part of our education mission, the AVIR has added 12 new Directed Reading Credits and we are planning to add an additional 12 credits in the coming months for our membership with webinars and self-paced readings. The AVIR has also launched our new online ACE application process to ease the review process and increase revenue for the AVIR.

Diversifying our revenue streams will ultimately ensure long-term solvency of the organization and allow the AVIR to offer more value to it membership far beyond the annual meeting, a significant goal of the AVIR board for the coming years. At the same time, the board has been able to reduce operating cost by over 50% with new initiatives and partnerships with our banks and management partners. In these tough fiscal times, we are paying close attention to our fiscal environment and are willing to take the necessary steps to ensure we are fiscally sound and can continue to enhance what the AVIR can offer our membership!

See you all in New Orleans!
Respectfully,
Rob Sheridan
Director IR, MGH
AVIR Treasurer

The Quattro Elite and Expro Elite snares are pre-assembled for rapid deployment.
As many of us anxiously awaited the results of the recent presidential election, we kept our eye on the candidate we hoped would make it to the oval office for a host of different reasons, whether it is interest in political views, taxes or the economy. The end result was essentially status quo, and the impact to our field and society was at least in the short-term decided.

At our 2012 annual AVIR meeting in San Francisco, we heard from a nation radiology expert, Dr David Rosman regarding what the (ACA) of 2010 meant to our field and what the impact of the (ACA) meant to the average American family. What an informative lecture! Well, since the presidential election, we have certainly felt a direct impact on the AVIR.

The (ACA) will extend insurance coverage to an estimated 30 million additional Americans. Within the bill there were numerous changes that have far reaching impacts on many of the health sector population including the AVIR. A critical change was the implementation of the Medical Device Excise Tax. This is a new tax that is levied on the sale price of medical devices, including stents, balloons, and wires and advanced imaging devices. At first blush, this seems to have little impact on the AVIR, however, upon further review, consider this; yes the medical device manufactures have to pay this new tax, and yes many experts estimate the industry has an estimated sale rate of 116 billion per year and thus this 2.3% tax should have little impact on the AVIR, right? According to The Wall Street Journal article written by C. Weaver in June of 2012, companies like Cook Medical and Stryker could incur taxes of 30 to 150 million dollars annually. So how does all this affect organizations like ours? Well here is a direct quote from Vice President at DeRoyal, Rebecca Harmon, PHR:

“The ACA had a direct impact to DeRoyal via the medical device excise tax, two fold. The first was to establish a process to capture the information required to report to the government and access what products met the definition in which the tax should be accessed. This required multiple department interaction and countless hours of time to devise algorithms and programs to meet the standard. Second, was to evaluate the financial impact to our business. This is the largest cost increase in our company’s history. This increase has caused us to forgo opportunities for new employment in the U.S. and has delayed several projects.”

The first and perhaps obvious answer is that medical device companies will attempt to pass along the tax to consumers with increased cost. I content that with all the hospitals pre- negotiated contracts regarding device pricing, this will either act as an insulator or at a minimum delay any incremental pass through cost from the vendors. With the (ACA) hospitals will have to demonstrate heightened price scrutiny effectively putting higher priced manufactures at risk for not having their products on the shelves of our labs. So what will the medical device industry do?

The first core fiscal principle of maintaining margins or in some cases any level of profitability is cost reduction practices also known as slashing budgets that get termed nice to have, not need to have. The impact for us and other organizations is that in some part count on grants and vendor sponsorship to help fund educational events such as our annual meeting is real. Vendors that once committed to historical contribution of 10,000 for example, have cut that in half or worse, can no longer partner with organizations in the same manner they once had. Education and innovation are key drivers for our field, and although the (ACA) aims at many levels have the right intentions, some unintended consequences or tradeoff are certainly being felt in many areas of the health care sector including ours.

Respectfully,
Rob Sheridan, AVIR Treasurer
Great news for all local and regional chapter coordinators! Submitting activities for CE credit is now easier than ever. All applications can be completed online by going to AVIR.org and clicking on the link to ACE applications. It’s as simple as that to earn the CE credit you deserve.

Here is a sampling of some of the recent AVIR Chapter activity:

**Baltimore** – The University of Maryland Medical Center recently presented at grand rounds “The Imaging Professional Team Presents: A Multi-Disciplinary Approach to Imaging and Therapy; A patient’s Journey with SIR-Spheres”. This 1 hour program was coordinated by several staff RT’s and radiologists and submitted online through the AVIR’s website for 1 category A+ CE. While technically not an AVIR chapter activity, this is a great example of how AVIR members can get CE credits for educational activity that you may routinely attend. Thanks to Karen Finnegan, Ashley Hester, Jason Jenkins and Jamie Lepage for your efforts with this novel approach to CE.

**North Carolina** – The NCAVIR Saturday Seminar was held on February 23rd at the Embassy Suites Hotel in Concord NC. 55 attendees braved the gloomy weather and enjoyed a fantastic day with great food, great company and great lectures. Juliana Moore along with Diane Koenigshofer and Bill Greer put together an interesting full-day program. The topics included: Neurosurgery, Dialysis Access, Radiation Protection, JJ Stents, Chemo-embolization, Infection Control, Vascular Birthmarks and Radiology from the OR to the football field. The Top 10 Issues surrounding IR, as well as several others were covered. Those in attendance received up to 9 category A+ CE’s. The committee is busy planning the next meeting for February 2014!

**South Florida** – The Miami Chapter is open and ready to go. They will be meeting in BCVI in May, soon after the annual conference. All local RT’s are welcome. They will discuss local appointments and provide a CE lecture. More details will be available on the chapter website shortly. It is their goal to have all the hospitals in South Miami represented and look forward to collaborating and sharing information and knowledge with you. The Miami Chapter of the AVIR is dedicated to serving the local community of health care professionals working in the fields of interventional radiology, cardiology, and endovascular therapy. We encourage the cross-pollination of ideas through continuing education forums, discussion groups, and case reviews. As Harvey Firestone once said: “Capital isn’t so important... Experience isn’t so important. You can get both these things. What is important is ideas. If you have ideas, you have the main asset you need, and there isn’t any limit to what you can do with your business and your life” So, let’s get together and share ideas.

If you have any questions in the mean time, please contact Izzy Ramaswamy at izzyavir@gmail.com

**Southeast Wisconsin** – The SEW Chapter of the AVIR recently held their 2013 All Day Spring Symposium at the Clarion Hotel in Milwaukee on Saturday, March 9. Their 8 category A+ CE’s covered not only clinical topics like Stroke Management, Venous Compression Syndromes, Gi Bleeds, Percuaneous Bone and Pediatric Interventions; but also included a lecture on the Top Tips for Effective Workplace Communication. Congratulations to Jennifer Eklund for coordinating such a diverse and informative program.

**Nebraska** - There has recently been an interest from some staff at St Elizabeth Hospital in Lincoln in starting a Nebraska, or perhaps even a regional Midwest AVIR chapter with meetings rotating between Omaha, Kansas City, Des Moines and other area cities. If you live in Nebraska, South Dakota, Iowa, Missouri or Kansas and would like to see this happen, or even get involved, please email me and I will forward your information to the key coordinator.

Keep an eye on the website for additional information on upcoming meetings and CE opportunities. For information on individual chapters from the main page, just roll your mouse over Group, then Chapters. This will bring you to a list of Chapters that have set up their own web pages. Simply select your local chapter to see what is happening in your area.

If you would like to get your own chapter page listed, or if you don’t see any nearby chapters and would be interested in starting one, let me know. I would be happy to help in any way that I can. I can be reached at jdkins@gmail.com.

Thanks everyone!

Jeff Kins RT(R)(VI)
AVIR Director at Large
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**Boise, ID**
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xrayhunter@cableone.net

Get ready for a great fall weekend get away!

**2013 Virginia Fall Seminar**
Come spend the weekend with your family and colleagues.
Don't forget your bathing suit to enjoy the great indoor / outdoor fun offered by:
Family suites will be available for one night or weekend stay, which includes up to six Water Park passes per suite. To make reservations call 1-800-551-WOLF. Please mention the AVIR special rates.

**Williamsburg VA**
**November 8th & 9th**
Will be offering 8 CEUs with lunch & breaks along with a Vendor Reception
Seated left to right: Melissa Post, Immediate Past President; William “Tony” Walton, President; Israel “Izzy” Ramaswamy, Vice President/President Elect

Standing left to right: Robert Sheridan, Treasurer; Andrew Amorossa, Program Chair; Dana Bridges, Associate Representative; Jeffrey Kins, Director at Large; David S. Douthett, Marketing Chair

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Home Phone: 336.856.7790  
Email: dbridges@surgpro.com
Healthcare Providers; Must have a Radiation Dose Program in place!
This is going to be a reality, are you ready?

**Texas Releases Radiation Dose Mandate**

03/13/2013

In February 2008, Cedars-Sinai Medical Center overexposed 206 patients during routine brain profusion CT scans. The overexposing went undetected for over 18 months. The incident received national attention regarding the under-management of radiation dose. The new awareness urged the California Department of Health (CDPH) to mandate a radiation safety bill requiring healthcare providers to track, record, and report all CT dose information and incidents on all patients and exams, effective July 2012.

FYI—you may have read this it is from the AHRA.

After California established a mandate, it was only a matter of time until other states started following suit. By July 2012, all 50 states had gained access to the California AB510 radiation mandate and began drafting similar laws. Incidentally, large Integrated Delivery Networks (IDNs) in states like New York, Florida, and Tennessee began constructing radiation safety programs without even being mandated. Many IDNs wanted to stay ahead of the upcoming mandate, while others wanted to be the leader in their state and felt it was the right thing to do when it came to patient care. Regardless, these leading IDNs were preparing for a possible upcoming mandate.

On March 1, 2013, the Texas Department of State Health Service (TDSHS) released a mandate, effective May 1, 2013, stating that all healthcare providers utilizing fluoroscopy and computed tomography imaging services must have a radiation dose program in place.

The program must record patient radiation dose on all CT and fluoroscopy exams (CTDi, DLP, and Air Kerma values), establish and manage radiation dose thresholds on all CT and fluoroscopy procedures, notify patients of dose threshold breeches, and provide good radiation safety training to all staff members performing CT and fluoroscopy procedures. Healthcare providers in Texas have less than two months to implement a radiation safety program set forth by the TDSHS.

As the radiation safety awareness continues to gain traction, it is only a matter of time before other states get on board with similar mandates. Because radiation cannot be seen, tasted, smelt, felt, or heard, the risk of overexposure can go undetected forever and its effects unrealized. Currently, we can only understand the effects of radiation from large-scale incidents like Hiroshima and Chernobyl. It’s only a matter of time until the latent effects of the Cedars-Sinai incidents manifest.

Healthcare providers in all states have to be proactive and ethical when it comes to radiation safety. To decrease the possibility of litigation and increase patient safety and compliance, it is imperative that healthcare providers in all states create internal awareness of radiation safety and construct a robust radiation safety program. The radiation safety mandate will continue to gain national attention, and healthcare providers must include radiation safety when planning operations. So who’s next?

If you want to read the Sentinel event alert Aug 2011 — radiation — Just go to the AVIR web site and you can read it in its entirety.
The University of Virginia Health System is looking for highly motivated radiologic technologists in search of a fast-paced, challenging career.

The Charles J. Tegtmeier School of Interventional Radiology is a twelve-month postgraduate program dedicated to interventional radiology, cardiac catheterization, and special procedures. This advanced program includes the latest exams in peripheral, neuro, and cardiac intervention.

Eight individuals will be selected to train in this rapidly developing field of radiology. Upon completion of our postgraduate school, you will be knowledgeable in percutaneous transluminal angioplasty, thrombolysis, biliary drainage, central venous access, vertebroplasty, embolization, intravascular ultrasound, stenting, IVC filters, stent grafts and much, much more. Graduates from our program are all registry eligible and are in demand nationwide.

For more information regarding the program or application requests please call or write Stephen B Haug at:
SBH7U@hscmail.mcc.virginia.edu
434-465-4071
Angio/Interventional Radiology
Box 800377
Department of Radiology
University of Virginia Health System
Charlottesville, Virginia 22908

Attention All Writers
The Interventional Informer is offering $100 to the best article. This is awarded for each issue of the Informer. The article should be originals. No limit in size, but they must pertain to Interventional Medicine. Just submit your article with name and address for the AVIR Board of Directors to review. Best of Luck!

Editors Award Winner
AVIR would like to acknowledge the following writer for their publication in the past issue.

CCSVI: What is this all about?
Robert Velez RT R VI

Congratulations!
AVIR extends its appreciation to the following corporate sponsors!
MEMBERSHIP APPLICATION
ASSOCIATION OF VASCULAR AND/OR INTERVENTIONAL RADIOGRAPHERS
2201 Cooperative Way | Suite 600 | Herndon, VA 20171 | 703.234.4055 | Fax 703.435.4390 | Email: info@avir.org
FULL PAYMENT MUST ACCOMPANY COMPLETED APPLICATION FORM

**Membership Category** — Select only one | Please print or type

- **Active** | $ 75/yr *
- **Clinical Associate** | $ 65/yr
- **Corporate Associate** | $ 65/yr
- **Student** | $ 45/yr
- **International** | $85/yr

*ACTIVE – Submit ARRT Certification or Canadian Equivalent

- Mr  Mrs  Ms NAME / FIRST M.I. LAST GENERATION (JR., SR., II, III)

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**Length of Time as Tech Area of Expertise:** ________________

**Size of Institution (# of beds):** ________________

- Private
- Academic

**Number of Exams Performed at this Institution:**

- Vascular
- Interventional

**Are You a Member of: ARRT?**

- Yes
- No

**Are You a Member of: ASRT?**

- Yes
- No

(If YES, please attach photocopy of membership card/s)

**Other Professional Organizations of Which You are a Member:**

**Related Interests (CQI, Teaching, Publishing, etc.):**

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**Payment Information:**

- Check Enclosed

**OR** Charge Credit Card:

- AmEx
- MasterCard
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**Student Members Only**

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The Association of Vascular and Interventional Radiographers (AVIR) is the national organization of healthcare professionals within Vascular and Interventional Radiology and involved in standard of care issues, continuing education and related concerns.

Who Can Become a Member of AVIR?

**ACTIVE:** Radiographers with a primary focus in Vascular and/or Interventional Radiology. Active members must be ARRT registered or have Canadian equivalent. Submit copy of certification with application.

  Dues are $75 per year.

**ASSOCIATE:** Related healthcare professionals working with or having a special interest in Vascular and/or Interventional Radiology, including Nurses, Medical/Cardiovascular Technologies and Commercial Company Representatives.

  Dues are $65 per year.

**STUDENT:** Students in certified programs for Vascular and/or Interventional Radiographers.

  Dues are $45 per year.

**INTERNATIONAL:** Healthcare professionals working or having special interest in CIT and who reside outside of the United States and Canada. This category includes, but is not limited to, medical technologists, radiologic technologists, registered nurses, licensed practical nurses, Physicians and commercial company representatives.

  Dues are $85 per year.

All Memberships are renewable annually each January.

Why Is Joining AVIR Important?

The AVIR is dedicated to you and is a powerful advocate for the special interest and concerns of healthcare professionals working in Vascular and Interventional Radiology. We acknowledge the importance of continuing education, establishing high standards of practice and care, certifying Vascular and/or Interventional Radiographers, and establishing a nationwide network for obtaining information and/or employment opportunities.

What Opportunities Does AVIR Offer?

- Professional growth
- Society of Interventional Radiographers (SIR) Annual Meeting
- Exchange of information and ideas
- AVIR Annual Meeting
- Continuing education opportunities
- Quarterly newsletter
- Local chapter involvement
- National membership directory