Introductory Memorandum

TO: Radiation Oncologist

FROM: Brian Monzon, MBA, RT(R) (T), Manager
Radiation Oncology ACR R-O PEER™ Program

SUBJECT: Radiation Oncology ACR R-O PEER™ Program for Maintenance of Certification

The American College of Radiology is pleased to offer radiation oncologists the opportunity to fulfill Part IV: Assessment of Performance in Practice for the Maintenance of Certification (MOC) program for the American Board of Radiology (ABR) through the Radiation Oncology Practice Accreditation Program. This Practice Quality Improvement (PQI) program will not require the submission of any additional cases but does require that at least two charts per physician be reviewed during the on-site survey.

Following the survey, a final report and certificate of satisfactory completion of practice assessment will be issued to each participating radiation oncologist. If any recommended action measures are identified, the last information will request additional documentation demonstrating that such efforts have been appropriately addressed.

The application for ACR R-O PEER™ is attached. When your site is applying for accreditation, you may include this application and the appropriate fee with the site's application. ***All applicants participating in ACR R-O PEER™ must submit their application before their scheduled site survey.***

If you would like additional information, please contact the Radiation Oncology ACR R-O PEER™ Program at 1-800-770-0145 x3 or visit www.acr.org/ROInfo to submit a ticket.

Submit a Ticket with the completed form through accreditation support

https://accreditationsupport.acr.org/support/tickets/new

Original or digital signatures are required on this form. Stamps are unacceptable.

American College of Radiology (ACR)
1892 Preston White Drive
Reston, Virginia 20191-4397

R-O PEER™ AGREEMENT

The undersigned at this moment requests a review of his/her patient cases and relevant clinical documentation, including but not limited to patient treatment records (charts), simulation films, port films, DRRs, isodose plans, and any other treatment planning or patient information necessary to complete case reviews.

The purpose of this request is to fulfill the Practice Quality Improvement (PQI) component of Maintenance of Certification (MOC) for the American Board of Radiology (ABR) through the Radiation Oncology Practice Accreditation Program. The cost of the review will be paid for by:

Name of Participating Radiation Oncologist: _____

Name and Address of Professional Corporation/Partnership: _____

_____

E-mail Address: _____

As a condition of receiving the requested review, I agree to:

1. ☐ A fee of $200.00 (ACR member) for review of patient cases for practice assessment during the Radiation Oncology Practice Accreditation Survey
   Enter ACR Member ID#_____

   ☐ A fee of $300.00 (non-ACR member) for review of patient cases for practice assessment during Radiation Oncology Practice Accreditation Survey

   The fee should be submitted to the ACR office with this signed agreement and the ACR R-O PEER™ application components. Payments are not refundable.

2. Provide any necessary additional information requested by the review team, including an improvement plan in response to recommendations and appropriate follow-up data.

3. Receive the written final report and any peer review information.

The undersigned hereby releases and forever discharges the ACR, its directors, officers, members agents, volunteers, and employees from and against any and all claims, suits, damages, losses, expenses (including attorneys' fees) and liabilities by reason of, arising out of, or related to participation in the aforesaid review of the practice assessment of radiation oncology and the making of any report, statement, or recommendation, or failure to make a report, statement or recommendation, or the loss, damage or destruction of any image, record or other items received from the facility with respect to the aforesaid practice assessment of radiation oncology, including but not limited to any such claims or other matters based on alleged or actual negligence, antitrust, misconduct, defamation, personal injury or economic loss, catastrophic event (flood, fire, wind or other similar event), failure to receive a satisfactory report or any actions that may be taken by others as a result of this review, when such activities performed by or on behalf of ACR are done in good faith and without malice in connection with conducting this review.

The undersigned also agrees that the ACR is a health care entity as defined by the Health Care Quality Improvement Act of 1986 (HCQIA) and thus is afforded all the protections due to such entities under HCQIA. All documentation collected as part of the review process be considered peer review, privileged and confidential communications.

The above obligations are agreed to and understood. These obligations will survive the grant or denial of a certificate of satisfactory completion of practice assessment by the American College of Radiology.

I certify that the information provided is true and correct.

Executed on _____ 20_____ _____

Date Signature Radiation Oncologist

_____

Printed Name Radiation Oncologist

The ACR R-O PEER™ report will be issued to the above-signed Radiation Oncologist.

☐Check enclosed, made payable to ACR ***OR***
☐Charge credit card

Please fill in all credit card information except the card number and CVV number. DO NOT fill in the card number or CVV number before faxing for security reasons. Please provide the contact person and telephone number at the bottom of this form so that an ACR representative can call them to obtain the credit card number.

Card No. ____XXXX-XXXX-XXXX-_____ **Exp. Date** _____ **CVV #**___ XXXX _____

☐ VISA ☐ MasterCard ☐ American Express

Name of Cardholder: _____

Billing Address: _____

_____

_____

Pay by ACH:	***Bank of America American College of Radiology ACH ABA Number: 051-000-017*** ***Account Number: 435029079108 Reference: Invoice# XXXXFML_YY/DD/MM*** ***Send remittance advice to AcctReceivable@acr.org***
Pay by Check (USPS only):	***The American College of Radiology*** ***Attn: Radiation Oncology Practice Accreditation (ROPA) Program*** ***P.O. Box 412722*** ***Boston, MA 02241-2722***
Pay by Check (courier service packages such as FedEx and UPS only):	***ACR, Lbx 412722*** ***MA5-527-02-07*** ***2 Morrissey Blvd.*** ***Dorchester, MA 02125*** ***Attn: Radiation Oncology Practice Accreditation (ROPA) Program***
Sending payments to the ACR office in Reston may cause a delay in the processing of your application.	

OR you may **FAX** to **(703) 390-9836.**

DO NOT MAIL AND FAX THE SAME PAYMENT FORM!

Contact Person_____

Telephone Number_____ Fax Number_____

Email address _____

For ACR Office Use Only:

Executed on _____ _____
Date ACR Program Manager, Radiation Oncology Accreditation

The ACR retains the right to issue a written report upon written request to any of the signatories of this agreement.