

# Radiation Oncology Practice Accreditation Program Requirements

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## Revisions

<b>Date</b>	<b>Page Number</b>	<b>Description of Revisions</b>
10/21/2016	4	Added Practice Guidelines to Introduction
10/21/2016	5	Removed guest log-in and added retrieve paper charts
10/21/2016	6	Added “How do I...?” link on Case Review section
10/21/2016	6	Added Business Associate Agreement information
10/21/2016	7	Added TG-119 to physics management program
10/21/2016	8-9	Added President/CEO or owner changes and nurse practitioner and physician assistant qualifications
10/21/2016	10	Updated staffing level chart
10/21/2016	17	Added Scheduled On-Site Survey (SOSS) on deferral section
10/21/2016	17-18	Added replacement certificate fee and ACR M-P PEER™ information

## Introduction

The radiation oncology practice accreditation (ROPA) program provides radiation oncologists with a third party, impartial peer review and evaluation of patient care. The facility's personnel, equipment, treatment planning and treatment records, as well as patient safety policies, quality control/quality assessment activities, are assessed. Recommendations for improvement are based on nationally recognized parameters, including ACR and American Society for Radiation Oncologist (ASTRO) parameters, ACR, and American Association of Physics in Medicine (AAPM) technical standards, and AAPM Task Group reports and Practice Guidelines.

The ACR Committee for ROPA directs the program. The accreditation process, designed to promote quality and be educational in nature, includes an on-site survey performed by board certified radiation oncologists and board certified medical physicists.

## Application for Accreditation

Each facility applying for accreditation must submit an application through the secure website, <https://ropa.acr.org>. The application consists of submission of facility treatment and equipment information, staffing levels and qualifications, and physics Quality Assurance/Quality Control documentation. If deficiencies are noted or missing items identified, the facility will be contacted so that any missing items can be submitted before the site survey is scheduled. When the application is complete, the date (s) of the survey will be confirmed. At this time, the facility will receive a notice to submit cases (Census Data Form) from which 10 (or more) will be selected for review during the site visit.

## Preliminary Self-Assessment (ROPA Website Toolkit)

The ROPA website will include a toolkit that will help your practice prepare for your site survey. The data collection forms (physician and medical physicist) for preliminary self-assessment will be available on the website after the application has been accepted. The intention for the data collection forms is to prepare the practice for the site survey. Ten cases should be reviewed for the self-assessment activity and should be representative of your patient mix, for example, breast, prostate, lung and should include treatment modalities such as IMRT, prostate seed implant, stereotactic radiosurgery, etc. A radiation oncologist who ***did not*** provide the patient's care should complete the self-assessment forms. These data collection forms should be completed prior to your site visit. ***Please make sure the self-assessment cases are different from the cases requested by the ACR for the surveyors to review.*** This self-assessment activity is an excellent tool for physicians and medical physicist to use as part of their internal peer review activities and the facility is encouraged to use these forms as part of their Continuous Quality Improvement (CQI) program. Completing these forms is optional; however, it is recommended you review and complete the forms before your site survey. These forms will no longer be available after your site survey is complete.

## Checklist for Site Survey

The following items are required during the survey:

- If paper charts, a list of physician, physicist, and dosimetrist with their signatures and initials found in the patient records with printed identification beside each signature
- CVs for all physicians and physicists
- Quality Control and improvement documents, including:
  - Hospital, department, and physics policy and procedure manuals.
  - Radiation safety program documentation.
  - Physics Quality Control documentation.
  - Quality Assessment and Improvement meeting minutes.
  - Focus Study and internal outcome documentation.
  - Physician Peer Review documentation.
  - Physicist Peer Review documentation.
  - Continuing Medical Education (CME) credits for all staff.
  - Licenses and/or certification for all staff.

Please arrange for the following:

- A quiet room to work located within the radiation oncology department.
- A table surface large enough to review several charts/films/scans.
- Chairs for two surveyors.
- Two or more view boxes (if applicable).
- Two computers with dual monitors and wired internet access for each computer.
- Workstations with access to record and verify system, hospital/facility electronic medical records (EMR).
- If recent conversion to paperless medical records and cases the surveyors are reviewing were in the transition, please retrieve paper charts from offsite storage if any of them contain items not available in EMR.
- Two facility staff members who can assist surveyors during the site visit.

If your site cannot comply with the necessary items specified on the checklist, you will need to contact an ACR staff member.

A member of the ACR staff will contact you prior to the survey for details such as parking, directions to the site, the day of survey agenda, etc.

## Case Review

When your survey date is confirmed, you will receive an e-mail asking you to submit cases of *definitively treated* patients who have *recently completed treatment* at your facility and have had at least *one follow-up visit*. Please submit your cases *no later than 30 days prior* to the survey date. Please reference the “[How](#) do I...?” document on submitting cases. During the on-site survey, 10 cases will be reviewed. For multi-site surveys, 10 cases will be reviewed at the main site and at least 3-4 cases at each satellite. For multi-site surveys, you only need to submit 2-3 cases from each disease site for each satellite. To ensure that all physicians in the practice are reviewed, physician initials must be included with random ID numbers. A minimum of two cases per physician will be reviewed. Random ID numbers, not patient names, must be submitted for 5 breast, 5 prostate, 5 head and neck, 5 lung and 5 “generic” disease sites (colorectal, seminoma, brain, Hodgkin’s disease, cervix, etc.) on the census data sheets provided. If you do not have five cases from a disease site (such as head and neck), you may submit additional generic cases. In addition, cases selected should include all treatment modalities offered at your facilities, such as IMRT, prostate seed implant, stereotactic radiosurgery, etc. For all cases, patient records including simulation information, DRRs, port films (hard copies if appropriate), and CT planning documentation must be available for the surveyors. If your facility has electronic images and/or medical records, you will need to provide electronic access to this information. Since the data collection is performed on site using a web-based process, please review the Checklist for Site Survey section on page 5.

## Business Associate Agreement

The ACR understands that as providers, facilities are subject to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and that is why the ACR executes a HIPAA business associate agreement (BAA) with facilities. This agreement allows the collection of patient information in the performance of ACR accreditation activities that are specifically mentioned in the HIPAA regulations. If the facility has a BAA with ACR, they are covered under HIPAA. If not, contact the ACR to obtain an agreement for signature.

## On-Site Survey

The on-site survey is conducted over one business day (for a single facility). Multi-site surveys will require more days, based on the number of sites, geographic locations, and practice patterns. During the visit, the surveyors will tour the facility, verify the information submitted in the facility’s application, conduct an interview with the Chief/Medical Director of Radiation Oncology, the chief physicist, department administrator/chief therapist, dosimetrist, nurse, and other key personnel; and collect information about the facility’s patient treatment policies and procedures, safety initiatives and review the selected cases.

The radiation oncologist and medical physicist review charts and complete a set of questions developed by the ROPA Committee. Chart reviews include components such as complete and signed prescriptions, consent forms, pathology reports, history and physical, physician management during treatment and follow-up, appropriateness of treatment, simulation/treatment planning, and dosimetry activities. At the end of the day, the surveyors will again meet with the group for a brief “exit” interview. This is primarily to clarify any issues prior to their departure; the team will not be providing their recommendations at this time since that is a Committee

decision made following a review of the results of the survey. For multi-site surveys, ACR and facility staff will determine the exit interview time and place.

A comprehensive review of the facility's physics program will be included as part of the application process and verified during the on-site survey. The Radiation Oncology Physicist is responsible for the design and implementation of the **physics quality management program**.

The following areas **will require documentation** submitted with the application:

- Documentation of compliance with AAPM TG-51, TG-106, TG-119, TG-120, and TG-142.
- Documentation of treatment planning system quality assurance program in accordance with TG-53 or relevant AAPM Medical Physics Practice Guideline.
- Independent verification of output of each beam.

In addition, during the on-site survey, the qualified medical physicist's documentation of the following will be reviewed:

- Procedures for instrument calibration and periodic instrument constancy checks.
- Procedures to verify the manufacturer's specifications and to establish baseline performance values for radiation therapy equipment.
- Quality management program for radiation therapy equipment, simulators, treatment planning systems, and monitor unit calculation algorithms.
- Monitor units' calculation procedures and protocols.
- Physics chart check protocol for reviewing treatment delivery
- Procedures for checking the integrity of mechanical and electrical patient care devices.
- Radiation protection program as it pertains to radiation oncology.
- Calculations related to patient dosimetry and/or physics measurements when such needs arise or per clinician's requests.

## Random On-Site Surveys

In order to verify that accredited facilities maintain consistent quality during the three-year accreditation period, on-site surveys may also be performed at any time during the accreditation period. These surveys provide an excellent opportunity for a positive educational exchange with experts in the field, as well as providing validation of continued compliance with ACR parameters and technical standards. Radiation oncologists and medical physicists from the ROPA program will conduct these surveys. Any facility chosen for a random on-site survey will be notified in advance. There is no additional cost to the facility for the random survey. The practice site must maintain on-site an updated personnel summary list of all radiation oncologists, medical physicists, and therapists.

## Multiple Sites

A practice that has multiple sites may be eligible for a single survey, with a limited case review from each additional site. The criteria to determine eligibility include but are not limited to:

- The physician group has a single medical director.
- The physicist group has a single director.
- Physicians' peer review includes all the practice sites.
- All practice sites utilize uniform treatment methods.
- All practice sites have uniform chart organization and forms.
- Geographic accessibility (**site(s) is within one hour drive from the main site**).

If the practice does not meet the criteria, a full survey will be required for each site.

## Personnel Qualifications

### 1. The Medical Director

- Each radiation oncology program must have a medical director who is a radiation oncologist as described below:
  - a. The medical director will be responsible for oversight of the department, including policies, procedures, and personnel.
  - b. The medical director will be responsible for instituting and supervising the continuing quality improvement (CQI) program through direct or delegated leadership.

*If the practice site's medical director or president/CEO or owner changes, the site must submit a new Survey Agreement to the ACR. The personnel summary list and the Survey Agreement may be obtained on the ACR accreditation website.*

### 2. Radiation Oncologist

- A. Certification in Radiology by the American Board of Radiology (ABR) of a physician who confines his/her professional practice to radiation oncology or certification in Radiation Oncology or Therapeutic Radiology by the ABR, the American Osteopathic Board of Radiology, the Royal College of Physicians and Surgeons of Canada, or the Collège des Médecins du Québec may be considered proof of adequate physician qualifications.
  - i. Radiation oncologists with time-limited certificates of board certification are to be enrolled in the certifying board's maintenance of certification program and satisfactorily renew certification in a timely fashion.
  - ii. Radiation oncologists with non-time-limited certificates are strongly encouraged to voluntarily participate in the maintenance of certification program.

Or

- B. Satisfactory completion of a radiation oncology residency program approved by the American Council of Graduate Medicine Education (ACGME), the Royal College of Physicians, and Surgeons of Canada (RCPSC), the Collège des Médecins du Québec, or the American Osteopathic Association (AOA).
  - For Radiation Oncologists who are eligible but not yet certified by the date of initial employment, a pathway would be defined for individuals to become licensed and certified in accordance with 2A.

### 3. Qualified Medical Physicist

The ACR strongly recommends that the individual is certified in the appropriate subfield (s) by the American Board of Radiology (ABR), the Canadian College of Physicists in Medicine, or by the American Board of Medical Physics (ABMP). The appropriate subfield of medical physics for this guideline is Therapeutic Medical Physics. (Previous medical physics certification categories including Radiological Physics and Therapeutic Radiological Physics are also acceptable.)



#### **4. Radiation Therapists and Simulation Staff**

Radiation therapists and simulation staff should fulfill state licensing requirements. Radiation therapists should be certified in radiation therapy by the American Registry of Radiologic Technologists (ARRT), or be eligible for such certification. Simulation staff should be certified by ARRT in either radiation therapy or diagnostic imaging or eligible for such certification.

#### **5. Dosimetrist**

Medical dosimetrists should fulfill state licensing requirements. Medical dosimetrists should be certified in medical dosimetry by the Medical Dosimetrist Certification Board (MDCB), or be eligible for such certification.

#### **6. Patient Support Staff**

Individuals involved in the nursing care of patients should have appropriate nursing credentials and appropriate experience in the care of radiation therapy patients. Oncology nursing certification is encouraged. Access to qualified nutritionists or social workers should be in place.

#### **7. Physician Assistant**

A qualified physician assistant is an individual who has completed postgraduate education and possesses a current certification from the National Commission on Certification of Physician Assistants (NCCPA). Continuing education of a physician assistant should be in accordance with NCCPA guidelines and has obtained the specified licensure in accordance with the state(s) in which they are practicing as well as the required continue medical education.

#### **8. Nurse Practitioner**

A qualified nurse practitioner is an individual who has completed postgraduate education in nursing and possesses current licensure/certification as a nurse practitioner in accordance with the state(s) in which they are practicing.

#### **9. Administrative Support**

Administrative staffs are valuable for budgeting and managing resources that enable the facility to acquire and maintain the equipment needed for standard treatment practices and quality assurance procedures and to achieve and sustain adequate clinical staffing levels that assure a safe and effective treatment environment.

## Staffing Levels\*

In the final report, the facility's staffing levels for radiation oncologists, physicists, radiation therapists, and dosimetrists are compared to the accredited facility averages and averages for the facility's stratum as defined in the following table. The table allows facilities to identify personnel and equipment utilization issues. Staffing recommendations may be part of the final report; however, variations from these levels generally do not result in the withholding of accreditation unless inadequate staffing levels result in non-compliance with ACR Practice Parameters and Technical Standards and/or compromise patient safety.

The strata are defined as:

**Academic/CCC** Comprehensive Cancer Center or main teaching hospital of a medical school

**H1** Hospital based; 600 or more patients

**F1** Freestanding; 600 or more patients

**H2** Hospital based; 201-599 patients

**F2** Freestanding; 201-599 patients

**H3** Hospital based; 200 or fewer patients

**F3** Freestanding; 200 or fewer patients

*(Updated July 1, 2016)*

	<b>ALL ACCREDITED FACILITIES</b>	<b>ACADEMIC/ CCC</b>	<b>H1</b>	<b>H2</b>	<b>H3</b>	<b>F1</b>	<b>F2</b>	<b>F3</b>
<b>New patients/ radiation oncologist</b>	<b>205</b>	<b>174</b>	<b>263</b>	<b>228</b>	<b>141</b>	<b>231</b>	<b>230</b>	<b>153</b>
<b>New patients/ Physicist</b>	<b>258</b>	<b>181</b>	<b>286</b>	<b>260</b>	<b>221</b>	<b>294</b>	<b>313</b>	<b>230</b>
<b>New patients/ FTE dosimetrist</b>	<b>263</b>	<b>243</b>	<b>319</b>	<b>269</b>	<b>202</b>	<b>284</b>	<b>280</b>	<b>249</b>
<b>New patients/ FTE therapist</b>	<b>77</b>	<b>73</b>	<b>90</b>	<b>76</b>	<b>58</b>	<b>85</b>	<b>86</b>	<b>81</b>
<b>FTE therapist/ Rx machine</b>	<b>2.9</b>	<b>3.3</b>	<b>3.3</b>	<b>3.0</b>	<b>2.6</b>	<b>3.6</b>	<b>3.0</b>	<b>2.3</b>
<b>New patients/ Rx machines</b>	<b>211</b>	<b>229</b>	<b>286</b>	<b>218</b>	<b>136</b>	<b>282</b>	<b>249</b>	<b>136</b>

*\*While it may be instructive to compare staffing data to the facility's stratum and to the national average for accredited facilities, note that this data is incomplete in some important aspects. The data does not account for the staff's other duties (e.g. simulation for therapists) nor is the data scaled for complexity or the proportion of different pathologies treated at any given clinic. Each facility should, when comparing their staffing data to stratum and national averages, consider their patient population, range, and complexity of services provided, and any staff duties outside of the core duties assumed in this data table.*

## Continuous Quality Improvement (CQI)

The Medical Director of Radiation Oncology will be responsible for the institution and ongoing supervision of the continuous quality improvement program. Elements of the program include:

- Chart review is required and should include cases in which there is a variation from the prescription of greater than 10% of the intended total dose, new modalities or techniques, and charts in which an incident report is filed.
- Morbidity and mortality review.
- Review of internal outcome studies (patient related to post-treatment issues, i.e., side effects, quality of life) which include radiation oncology patients.
- Focus studies (Facility Practice Improvement- department improvement activities/projects that are measured).
- Individual physician/physicist peer review (AAPM TG-103 for solo physicist only).
- Patient satisfaction surveys.
- New patient conferences.
- Port film/image review.
- Chart rounds.

## Practice Parameters and Technical Standards

We highly recommend that you become familiar with the ACR Practice Parameters and Technical Standards. These serve as the foundation for each of our accreditation programs and may be accessed by both ACR members and non-members through our Web site at [www.acr.org](http://www.acr.org).

<http://www.acr.org/Quality-Safety/Standards-Guidelines/Practice-Guidelines-by-Modality/Radiation-Oncology>

## ACR Appropriateness Criteria<sup>®</sup>

We highly recommended using ACR Appropriateness Criteria<sup>®</sup>. The ACR Appropriateness Criteria<sup>®</sup> are evidence-based guidelines to assist referring physicians and other providers in making the most appropriate imaging or treatment decision for a specific clinical condition. Employing these guidelines helps providers enhance the quality of care and contribute to the most efficacious use of radiology. Both ACR members and non-members through our website at [www.acr.org](http://www.acr.org) may access the link

<http://www.acr.org/Quality-Safety/Appropriateness-Criteria>

## Requirements for Accreditation:

If a facility does not meet these requirements, accreditation may be deferred or denied until a corrective action plan is submitted and approved by the ROPA Committee. The following are required:

## **Radiation Oncologist Availability**

A radiation oncologist should be available for direct care and quality review and should be on the premises whenever radiation treatments are being delivered. The radiation oncologist, facility, and support staff should be available to initiate urgent treatment within a medically appropriate response time on a 24-hour basis or refer to a facility that is available to treat on a 24-hour basis. When unavailable, the radiation oncologist is responsible for arranging appropriate coverage.

## **Medical Physicist Availability**

The medical physicist must be available when necessary for consultation with the radiation oncologist and to provide advice or direction to technical staff when a patient's treatments are being planned or patients are being treated. The center should have written policies specifying any special procedures (e.g., high-dose-rate brachytherapy, stereotactic radiosurgery, or stereotactic body radiation therapy) that require the presence of the medical physicist. When a medical physicist is not immediately available on-site during routine patient treatment, clinical needs should be met by using documented procedures. Authority to perform specific clinical physics duties must be established by the medical physicist for each member of the physics staff in accordance with his or her competence. The radiation oncologist should be informed of the clinical activities authorized for each member. Refer to the ACR Technical Standard for the Performance of Radiation Oncology Physics for External Beam Therapy for minimal requirements for physics support.

### **The process of radiation therapy should include the following:**

- Each patient chart should contain a documented, comprehensive history and physical examination performed by the radiation oncologist, including a comprehensive history of the present illness, past medical history, review of systems, review of imaging studies and laboratory data, histopathology diagnosis and recommendations for treatment, and signed and dated consent form.

Consultation/History and physical should include:

- Overall stage grouping and TNM classification of tumor in the consult note and staging sheet.
  - Performance classification (Karnofsky or ECOG).
  - Chemotherapy information (Drugs, schedule, etc.) (If applicable).
  - Documentation of physical examination done by a radiation oncologist.
- The treatment prescriptions should include: volume (site) to be treated, description of ports (i.e., AP, PA, lateral, etc.), radiation modality, dose per fraction, number of fractions per day, number of fractions per week, total number of fractions, total tumor dose and prescription point or isodose.
  - Simulation of Treatment
    - A simulation order should be signed and dated by the radiation oncologist and include the following:
      - Treatment site.
      - Treatment position.
      - Immobilization devices (if applicable).

- Use of contrast (if applicable).

Simulation and treatment photos should include the following:

- Patient's name.
- Date of the photo.
- Treatment set-up information (immobilization devices, position, tattoos, etc.).

### **Treatment Planning:**

- Documentation of delivered doses to volumes of the target and non-target tissues, in the form of dose volume histograms and representative cross-sectional isodose treatment diagrams, should be maintained in the patient's written or electronic record.
- Treatment prescription and the isodose plan must be signed or electronically approved by the radiation oncologist and medical physicist prior to the initiation of radiation therapy.
- The patient specific goals and requirements of the treatment plan, including the specific dose constraints for the target(s) and nearby critical structure(s), should be documented.

### **Patient Evaluation:**

Patient evaluation and, when appropriate, physical examination by a radiation oncologist during treatment should be performed weekly and more often when warranted.

### **Treatment Summary:**

- After a course of treatment is completed, the radiation oncologist should document a summary of the treatment delivered including site treated, modality used, dose per fraction, total dose, elapsed time, treatment response (if applicable), relevant side effects (if applicable) and other observations.

### **Follow-Up:**

- At the completion of treatment, a follow-up plan should be documented in the patient chart, and the radiation oncologist should see patients at regular, on-going intervals. If direct follow-up is not possible or practical because of issues such as patient medical condition, patient choice or unreasonable travel, the radiation oncologist should review follow-up documentation provided by other pertinent medical providers regarding the patient's condition.

### **General Brachytherapy Requirements:**

- Written directive should be signed and dated by a physician prior to the procedure.
- Complete documentation should be included in the patient record when brachytherapy is performed. Written directives documented for each procedure should include the treatment site, isotope, number of sources, and the planned dose to designated points. After brachytherapy is completed, a written summary of treatment delivery should include a total

dose of brachytherapy and external beam therapy, time of source insertion and removal and documentation of a radiation safety survey of the patient and room.

- A policy requiring two forms of patient identification as well as verification of treatment parameters prior to each treatment must be documented.

### **Policy and Procedures:**

The following policies and procedures should be in place:

- Timeout policy for simulation and treatment.
- Administration of contrast (if applicable)
- Image guidance and port film policy: A set of patient positioning or target localization images should be taken at least weekly and for any new fields. The radiation oncologist should then review verification images prior to the next treatment.
- Disaster Plan: The facility should have a written disaster plan based on an assessment of contingencies appropriate for the local practice environment, incorporating plans for:
  1. Prolonged power failure.
  2. Prolonged information system failure, with provisions to address operational continuity including data redundancy and recovery.
  3. Loss or release of radioactive materials.
  4. External threats including natural disasters.
    - The disaster plan should be designed to ensure that the facility staff could respond to patients and other care providers within 24 hours of the contingency condition, with plans for resuming or transferring patient care within 5 days of the contingency condition.
- Infection Control.
- Radiation Safety.

### **Physics Quality Control:**

- A formal physics policy and procedure manual should be in place and reviewed on an annual basis.
- The department should have a documented, formal treatment planning system quality assurance plan, including the periodic confirmation of the treatment planning system consistency.
- Patient-specific quality assurance (QA) for IMRT, SBRT, SRS, etc. should be documented and approved prior to initiation of treatment. It is recommended that the facility establishes a standard for QA and set their pass/ fail criteria.
- The treatment planning system quality assurance should be performed on an annual basis.
- Hardware and software updates need to be documented.
- Thermometer and barometer comparison/calibration must be performed and documented.

- At the completion of treatment, the qualified medical physicist shall review the entire chart to affirm the fulfillment of the initial and/or revised prescription dose. The review should be documented by the physicist, initialed/signed and dated **no later than one week** after the end of treatment.

### **Other Recommendations:**

- The prescription must be linked to an anatomical site and not just state PTV1, PTV2, and PTV3, for example, right upper lobe, left breast, etc. The point or volume that is being prescribed, for example, to 95% IDL or 95% volume should be included.
- A total cumulative dose should be entered in the prescription to indicate a dose beyond which they cannot treat.
- For IMRT, SBRT, SRS, etc. treatment, heterogeneity correction should be used in treatment planning and its commissioning documented in a written report.
- AAPM TG-66 recommends an annual evaluation of the "electron density to CT number conversion" to be consistent with commissioning and manufacturer recommendations. There should be evidence of the implementation of this recommendation.
- An independent MU/backup calculation check program should be available.
- During treatment set-ups and treatment of patients, there should be two radiation therapists per treatment machine.
- All staff must comply with their appropriate licensure and/or certification requirements.

### **Final Report**

The report is issued to the radiation oncologist who requested the survey. The Committee issues a final report after the on-site survey. The report is generally sent within 8-12 weeks following the on-site survey. The report is based on the findings of the surveyors, as well as information provided in the initial application and verified by the surveyors. The accreditation report includes:

- Comparison of facility/staffing data with the accredited facilities data.
- Evaluation of facility's compliance with parameters, technical standards, and program requirements from application information and review by surveyors.
- Surveyor comments on individual case reviews.
- Specific recommendations for improvement.

## Accreditation Status

The term of accreditation is three years. Facilities that are not granted accreditation will either be:

- **Deferred** with 90 days to submit a Corrective Action Plan. After the Corrective Action Plan is approved by the Committee, the facility may be required to perform a self-audit (measures for self-audit will be selected by the Committee) and submit the results no later than 6 months after receipt of a response to the corrective action. Following Committee approval of the self-audit, the facility may be granted a three-year accreditation. The Committee may request a scheduled on-site survey (SOSS) if Corrective Action Plan is approved. Additional fees may be applied such as On-Site Surveyors' expenses including travel and lodging.
- **Denied** with 90 days to submit a Corrective Action Plan. After the Committee approves the Corrective Action Plan, the facility will be required to participate in a follow-up survey (6-9 months after receipt of a response to corrective action). **A re-application fee of \$5,000 must be submitted with the survey agreement.** Additional fees may be applied such as On-Site Surveyors' expenses including travel and lodging. The surveyors will complete a report of their findings, which will be reviewed by the Committee. Following Committee approval of this report, the facility may be granted a three-year accreditation.

## Marketing Your Accreditation

Once accreditation has been achieved, the facility will receive a marketing package (link to documents is included in your final report) to assist in promoting this success within the community. In addition, all sites fully accredited, (and those under review) will be listed by program and state on the ACR Web site at [www.acr.org](http://www.acr.org).

The marketing tools include:

- Camera-ready ad.
- Press release.
- Certificate suitable for framing.
- Certification mark provided in decal and electronic format.

## Application for Renewal

The application process for sites applying for renewal is essentially the same as for new sites; however, a facility's previous recommendations will be carefully reviewed to ensure that recommendations for improvement have been implemented. In order to maintain accreditation, it is recommended that facilities begin the application process nine months prior to the expiration date of their accreditation.

## Appeal Mechanism

An appeal process is available to a radiation oncology facility that disagrees with the accreditation report. To appeal, the chief of radiation oncology submits a written request to the



Chair of the Committee on Radiation Oncology Practice Accreditation within thirty days of receipt of the accreditation report.

## Survey Fees

Survey fee for the main facility is \$9,500.00 and \$3,000.00 for each additional site. **Fees are non-refundable and subject to change without notice.** If a facility has not been granted accreditation and requires participating in a follow-up survey, a fee of \$5,000 must be submitted prior to scheduling the site visit. Checks should be made payable to The American College of Radiology.

Sites	Cost*	**Number of Days on site
Main Site	\$9,500	1
Main + 1 Satellite Site	\$12,500	2
Main + 2 Satellite Sites	\$15,500	2
Main + 3 Satellite Sites	\$18,500	3
Main + 4 Satellite Sites	\$21,500	3
Main + 5 Satellite Sites	\$24,500	4
Main + 6 Satellite Sites	\$27,500	4
Main + 7 Satellite Sites	\$30,500	5
Main + 8 Satellite Sites	\$33,500	5
Main + 9 and over Satellite Sites	Contact ACR Staff Member	-

*\*Includes surveyor team travel expenses in the United States only*

*\*\*Subject to change*

*Effective on August 5, 2013: Any requested change in the survey date by the facility or cancellation of a scheduled survey after ACR has invested funds in the survey (such as travel funds) must be reimbursed by the facility in addition to the survey fee.*

*Replacement certificates will require a fee of \$50.*

## R-O PEER™ and ACR M-P PEER™

R-O PEER™ offers radiation oncologists and M-P PEER™ offers the medical physicists the opportunity to fulfill Part IV, Evaluation of Performance in Practice for Maintenance of Certification (MOC), for the American Board of Radiology (ABR) through the Radiation Oncology Practice Accreditation Program. R-O and ACR M-P PEER™, the ACR's Practice Quality Improvement (PQI) program is offered as part of the ROPA Program. Once your practice has been accredited, a final report will be issued to each participating radiation oncologist and medical physicist. If any corrective action measures are identified, the final report will request additional documentation that demonstrates that these have been appropriately addressed. When this documentation is submitted and reviewed, a certificate of satisfactory completion of the PQI project will be issued.

R-O PEER™ is available on the ROPA website application (Part 1) or on the ACR website by paper application [R-O PEER](#). All radiation oncologists interested in participating in R-O PEER™ must submit their application and payment before the date of the scheduled site survey.

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ACR M-P PEER™ is available on the ACR website by paper application [Individual ACR M-P PEER™](#) or [Group ACR M-P PEER™](#). All medical physicists interested in participating in ACR M-P PEER™ must submit their application and payment before the date of the scheduled site survey.

## **For Additional Information**

Contact the ACR Radiation Oncology Practice Accreditation Program office in Reston, Virginia at 800-770-0145 ext. 3711 or [rad-onc-accred@acr.org](mailto:rad-onc-accred@acr.org).

## References

The following list of references is by no means complete, but it may be used as a starting point to assist you with your application and survey process:

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American Association of Physicists in Medicine, (AAPM). Comprehensive QA for Radiation Oncology: Report of AAPM Radiation Therapy Committee Task Group 40, 1994 [http://aapm.org/pubs/reports/RPT\\_46.PDF](http://aapm.org/pubs/reports/RPT_46.PDF)

American Association of Physicists in Medicine, (AAPM). Dosimetry tools and techniques for IMRT, Task Group 120 Report, 2011 [http://aapm.org/pubs/reports/RPT\\_120.pdf](http://aapm.org/pubs/reports/RPT_120.pdf)

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American Association of Physicists in Medicine, (AAPM). Quality Assurance for Clinical Radiotherapy Treatment Planning Report of AAPM Radiation Therapy Committee Task Group 53, 1998 [http://aapm.org/pubs/reports/RPT\\_62.pdf](http://aapm.org/pubs/reports/RPT_62.pdf)

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American Association of Physicists in Medicine, (AAPM). Task Group 142 Report, Quality Assurance of Medical Accelerators, 2009 [http://aapm.org/pubs/reports/RPT\\_142.pdf](http://aapm.org/pubs/reports/RPT_142.pdf)

American College of Radiology Practice Parameters and Technical Standards, Reston, VA <http://www.acr.org/Quality-Safety/Standards-Guidelines/Practice-Guidelines-by-Modality/Radiation-Oncology>

<http://www.acr.org/Quality-Safety/Standards-Guidelines/Technical-Standards-by-Modality/Medical-Physics>