ACR Accreditation
Toolkit for Validation Site Surveys

The ACR performs announced and unannounced (MIPPA) virtual or in person validation site surveys as part of the accreditation process. This checklist is designed to assist you in gathering and maintaining the documentation that is required for accreditation and will be reviewed during the survey. It is recommended you create a binder to keep this information in one place. Facilities will be surveyed with unannounced visits by representatives of the ACR or CMS at any time during the 3-year accreditation period.

This checklist can also be used to prepare for a pre-accreditation and/or post-accreditation on-site survey as outlined in the Practice Site Accreditation Survey Agreement.

Table of Contents

Revised 9/15/21

Revisions

Date	Page Number	Description of Revisions
7/8/13	15,16	Added the MIPPA requirement of patient record retention/retrieval, primary source verification, Office of Inspector General's exclusion list and consumer complaint policies. Also, the consumer complaint notice that must be publicly available. Added the new CT requirements for the medical physicist annual equipment evaluation and technologist QC
3/25/14	N/A	Removed the decal requirement for each unit and appropriateness/Outcome analysis for CT-guided interventional procedures.
4/30/15	3, 11, 18	Added information for Ultrasound Accreditation and Lung Cancer Screening.
12/10/15	7, 8	Added the checkbox for the XR 29 mandate for CT units and updated MRI Annual Medical Physicist's/MR Scientist's QC Tests that are **required testing after July 1, 2016**.
3/18/16	7	Clarification that XR 29 is not an ACR accreditation requirement but must be checked during the site visit per federal regulation requirements.
5/5/16	4,5	Added column for Maintenance of Certification (MOC) and Osteopathic Continuous Certification (OCC) for AOBR to Physician CME and CU requirements.
6/23/16	6	Added column for Maintenance of Certification (MOC) for the medical physicist.
4/9/18	4, 9, 8, 11, 15, 18, 19, 21, 22	Added MOC for ABIM for the interpreting physicians. Removed ACLS from page 9 and moved it to page 18. Updated the equipment evaluation tests for MR and ultrasound. Deleted notices to be posted for pregnant or potentially pregnant patients. Require documentation that peer review is performed and updated exam labeling for CT, MR.
1/8/19	Numerous	Total revamp – removed many 'recommended' policies, report ID, and streamlined the process. Added XR-29 verification
6/23/21	Numerous	Combined MIPPA and Non-MIPPA toolkits to one combined toolkit. Made updates for any changes to accreditation programs, links to current information and forms on accreditationsupport.acr.org
9/15/21	1, 20, 21, 24	Physician QA program updates - page 20 to include peer learning, added page 21 for Peer Learning checklist and page 24 included link to accreditation support information/checklist for peer learning

Tab 1

Facility Information				
Facility Name:				
Facility Address:				
Facility ID #:				
Facility Supervising Physician: *				
Facility Administrator name: *				
Facility Administrator email: *				
Accredited Modalities:	**Modality**	**ID #**	**Modules Accredited In**	**Contact Person***
	CT			
			Lung Cancer Screening Designation Y ☐ N ☐	
	MRI			
	Breast MRI			
	NM			
	PET			
	UAP			

*If information is not correct in ACR accreditation database, please update to ensure report and corrective action emails get to the appropriate person.

TAB 2

Interpreting Physician Personnel Qualifications Sheet

Make additional copies of this form as needed. Please include copies of each physician's board certification (including modality supervising physicians). *(Please refer to the accreditationsupport.acr.org for a list of the Boards and alternate pathways accepted).* Provide ***documentation of primary source verification***. Also include **documentation** of continuing experience and continuing medical education credits or proof of meeting MOC requirements. Facilities ***must*** also verify that personnel are not included on the Office of Inspector General's (OIG) exclusion list at https://exclusions.oig.hhs.gov (MIPPA sites only)

Name	Copy of Board Cert/Alternate Pathway	MOC with ABR, ABNM, AOBR or ABIM	Modalities	Continuing Experience		CME	
				Requirements met	Documentation available	Requirements met	Documentation available
	❑	❑	CT	❑	❑	❑	❑
			MRI	❑	❑	❑	❑
			Breast MRI	❑	❑	❑	❑
			NM	❑	❑	❑	❑
			PET	❑	❑	❑	❑
			UAP	❑	❑	❑	❑
	❑	❑	CT	❑	❑	❑	❑
			MRI	❑	❑	❑	❑
			Breast MRI	❑	❑	❑	❑
			NM	❑	❑	❑	❑
			PET	❑	❑	❑	❑
			UAP	❑	❑	❑	❑
	❑	❑	CT	❑	❑	❑	❑
			MRI	❑	❑	❑	❑
			Breast MRI	❑	❑	❑	❑
			NM	❑	❑	❑	❑
			PET	❑	❑	❑	❑
			UAP	❑	❑	❑	❑
	❑	❑	CT	❑	❑	❑	❑
			MRI	❑	❑	❑	❑
			Breast MRI	❑	❑	❑	❑
			NM	❑	❑	❑	❑
			PET	❑	❑	❑	❑
			UAP	❑	❑	❑	❑

TAB 3

Medical Physicist/MR Scientist Personnel Qualifications Sheet

Make additional copies of this form as needed. Please include copies of each medical physicist/MR scientist's board certification *(Please refer to accreditationsupport.acr.org for a list of the Boards and alternate pathways accepted).* Provide ***documentation of primary source verification.*** Also include **documentation** of continuing experience and continuing medical education credits *(there are no qualifications for ultrasound)* or proof of meeting MOC requirements. Facilities ***must*** also verify that personnel are not included on the Office of Inspector General's (OIG) exclusion list at https://exclusions.oig.hhs.gov. (MIPPA sites only)

Name	Copy of Board Cert or alternate pathway	Modalities	Continuing Experience		CME	
			Requirements met	Documentation available	Requirements met	Documentation available
	❑	CT	❑	❑	❑	❑
		MRI	❑	❑	❑	❑
		Breast MRI	❑	❑	❑	❑
		NM	❑	❑	❑	❑
		PET	❑	❑	❑	❑
		UAP	❑	❑	❑	❑
	❑	CT	❑	❑	❑	❑
		MRI	❑	❑	❑	❑
		Breast MRI	❑	❑	❑	❑
		NM	❑	❑	❑	❑
		PET	❑	❑	❑	❑
		UAP	❑	❑	❑	❑
	❑	CT	❑	❑	❑	❑
		MRI	❑	❑	❑	❑
		Breast MRI	❑	❑	❑	❑
		NM	❑	❑	❑	❑
		PET	❑	❑	❑	❑
		UAP	❑	❑	❑	❑
	❑	CT	❑	❑	❑	❑
		MRI	❑	❑	❑	❑
		Breast MRI	❑	❑	❑	❑
		NM	❑	❑	❑	❑
		PET	❑	❑	❑	❑
		UAP	❑	❑	❑	❑

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TAB 4

Technologist Personnel Qualifications Sheet

Make additional copies of this form as needed. Please include copies of each technologist's state license (if applicable) and/or certification *(Please refer to accreditationsupport.acr.org for the certifications accepted)*. Provide ***documentation of primary source verification***. Facilities ***must*** also verify that personnel are not included on the Office of Inspector General's (OIG) exclusion list at https://exclusions.oig.hhs.gov. (MIPPA sites only) If the technologist meets an alternative pathway from the modality program requirements, an attestation or documentation must be signed and available for review.

Name & Certification(s)	Meets ACR Certification Requirements	Copy of Certification(s)	Copy of State License (if applicable)	Copy documented training (if applicable)	Modalities	
	❑	❑	❑	❑	CT	❑
					MRI	❑
					Breast MRI	❑
					NM	❑
					PET	❑
					UAP	❑
	❑	❑	❑	❑	CT	❑
					MRI	❑
					Breast MRI	❑
					NM	❑
					PET	❑
					UAP	❑
	❑	❑	❑	❑	CT	❑
					MRI	❑
					Breast MRI	❑
					NM	❑
					PET	❑
					UAP	❑
	❑	❑	❑	❑	CT	❑
					MRI	❑
					Breast MRI	❑
					NM	❑
					PET	❑
					UAP	❑

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TAB 5

Annual Physics Survey/Performance Evaluation Checklist

Make additional copies of the pages as needed. Please complete the date of the most recent and the prior *CT Annual System Performance Evaluation Summary Form*. Leave it blank if that modality is not ACR accredited, or it was a new unit. Provide documentation of **XR-29 compliance status** for each CT unit.

CT Unit #: _____

❑	Date of Most Recent:	❑ Corrective Action Needed
❑	Date of Prior (if applicable):	

Annual Medical Physicist Survey

The medical physicist must evaluate the performance of each CT unit at least annually. This evaluation should include, but not be limited to the tests listed below. A continuous QC program must be established for all CT units with the assistance of a qualified medical physicist utilizing the ACR's CT QC Manual. *Corrective action documentation must be available for deficient tests.*

Annual Medical Physicist's QC Tests	
Review of CT protocols	Spatial resolution
Scout Prescription accuracy and alignment light accuracy	CT number accuracy
Image thickness	Artifact evaluation
Table travel accuracy	Dosimetry
Radiation beam width	CT number uniformity
Low-contract performance	Acquisition display calibration *(grey level performance)*

XR 29 Compliance

Per federal regulation, XR 29 compliance must be verified as a part of periodic accreditation of CT facilities. Compliance with XR-29 is not required for accreditation. ACR surveyors will check the ACR database for compliance status and if a certificate of compliance (or other acceptable documentation) has been uploaded in the database and is available on site for each ACR accredited CT unit.

❑	XR 29 Compliant	❑ Certificate of compliance
❑	Compliance status updated in Accreditation Database	

TAB 5

Annual Physics Survey/Performance Evaluation Checklist

Make additional copies of the pages as needed. Please complete the date of the most recent and the prior *MRI Annual Equipment Evaluation Summary Form*. Leave it blank if that modality is not ACR accredited, or it was a new unit.

MR Unit #: _____

❑	Date of Most Recent:	❑ Corrective Action Needed
❑	Date of Prior *(if applicable)*:	

Annual Medical Physicist Survey

The following is a list of QC tests that must be included in the Annual Medical Physicist Survey and technologist's QC:
Corrective action documentation must be available for deficient tests.

Medical Physicist's/MR Scientist's Annual QC Tests	
• Setup and Table Position Accuracy • Center Frequency • Transmitter Gain or Attenuation • Geometric Accuracy Measurements • High-Contrast Spatial Resolution • Low-contrast Detectability • Artifact Evaluation • Film Printer Quality Control (if applicable) • Visual Checklist	• Magnetic Field Homogeneity • Slice Position Accuracy • RF Coil checks RF Coil checks: SNR Volume coil percent image uniformity (PIU) RF Coil checks: Percent Signal Ghosting (PSG) • Soft-Copy Displays (Monitors) • MR Safety Program Assessment • Review of Technologist Weekly QC

TAB 5

Annual Physics Survey/Performance Evaluation Checklist

Make additional copies of the pages as needed. Please complete the date of the most recent and the prior Annual Physics Survey/Performance Evaluation. Leave it blank if that modality is not ACR accredited, or it was a new unit.

NM Unit #: _____

❑	Date of Most Recent:	❑ Corrective Action Needed
❑	Date of Prior:	

Annual Medical Physicist Report

The following test results must be reviewed by a qualified medical physicist and documented in an annual survey report. *Corrective action documentation must be available for deficient tests.*

Annual Medical Physicist's QC Tests	
• Intrinsic Uniformity • System Uniformity • Intrinsic or System Spatial Resolution • Sensitivity • Energy Resolution • Count Rate Parameters • Monitor Display • Overall System Performance for SPECT Systems *(if performed)* • System Interlocks	Dose Calibrator Tests *(If have a dose calibrator)* • Linearity • Accuracy with NIST Thyroid uptake and counting systems *(If have a thyroid probe)*

TAB 5

Annual Physics Survey/Performance Evaluation Checklist

Make additional copies of the pages as needed. Please complete the date of the most recent and the prior *PET Equipment Evaluation Summary Form and QC Review*. Leave it blank if that modality is not ACR accredited, or it was a new unit.

PET Unit #: _____

❑	Date of Most Recent:	❑ Corrective Action Needed
❑	Date of Prior:	

Annual Physics Survey

The following test results must be reviewed by a qualified medical physicist and documented in an annual survey report. Corrective action documentation must be available for deficient tests.

Annual Medical Physicist's QC Tests
• Spatial Resolution • Sensitivity • Image Uniformity • Image Quality Phantom • Accuracy of CT# (if applicable) • Accuracy of Standard Uptake Value (SUV) Measurement • Image Co-registration • Safety Evaluation (Mechanical and Electrical)

TAB 5

Annual Physics Survey/Performance Evaluation Checklist

Make additional copies of the pages as needed. Please complete the date of the most recent and the prior *Ultrasound/Breast Ultrasound Equipment Evaluation Summary*. Leave it blank if that modality is not ACR accredited, or it was a new unit.

UAP Unit #: _____

❑	Date of Most Recent:	❑ Corrective Action Needed
❑	Date of Prior:	

Annual Physics Survey

The following test results must be reviewed by a qualified medical physicist or designee. Corrective action documentation must be available for deficient tests.

Annual Medical Physicist's or Designee QC Tests
Mandatory Tests • Physical and Mechanical inspection • Image uniformity & artifact survey • System sensitivity • Scanner electronic imaging display performance

TAB 5

Technologist QC Checklist

When surveyed, you will be asked to provide the past three months of QC performed on each unit (or the last performed if the frequency of the test is less than three months). Leave it blank if that modality is not ACR accredited.

❑ CT Quality Control Tests

The continuous QC program must include, but not be limited to the following.

Technologist's QC Tests	
• Water CT number and SD *(daily)* • Artifact evaluation *(daily)* • Wet laser QC *(weekly – if applicable)*	• Visual checklist *(monthly)* • Dry laser QD *(monthly – if applicable)* • Acquisition display QC *(monthly)*

❑ MR Quality Control Tests

The following is a list of QC tests that must be performed <u>weekly</u> by technologists:

Technologist's QC Tests (weekly)	
• Setup and table positioning accuracy • Center frequency • Transmitter gain or attenuation • Geometric accuracy	• High contrast resolution • Low-contrast detectability • Artifact analysis • Film quality control *(if applicable)* • Visual checklist

TAB 5

Technologist QC Checklist

❑ NM Quality Control Tests

The following is a list of QC tests and frequencies that must be performed by technologists:

Technologist's QC Tests	
• Intrinsic or system uniformity *(each day of use)* • Intrinsic or system spatial resolution *(weekly)* • Center-of-rotation (monthly if applicable) • High-count floods for uniformity correction for **SPECT systems** *(frequency as recommend by medical physicist)* • Overall system performance for **SPECT systems** *(Semi-annual; recommend quarterly)*	• **Dose Calibrator Tests (daily, quarterly and semiannual for each dose calibrator)** Daily - Tests are performed to verify that the calibrator is accurate and reliable for the assay of doses administered to patients. Quarterly - A linearity test must be performed to document that accurate readings are provided through the entire range of activities used clinically. Other qualified personnel may do these tests. Semiannual -All non-exempt radionuclide sources must be tested to verify that radioactivity is not leaking from the sources. Other qualified personnel may also do these tests. • **Thyroid Uptake and Counting Systems (each day of use, if system at facility)** - Standards are measured to verify energy calibration and sensitivity for the measurement of organ function and the assay of patient samples.

❑ PET Quality Control Tests

The following is a list of QC tests that must be performed by technologists:

Technologist's QC Tests
• **Dose Calibrator Tests (daily, quarterly and semiannual for each dose calibrator)** Daily - Tests are performed to verify that the calibrator is accurate and reliable for the assay of doses administered to patients. Quarterly - A linearity test must be performed to document that accurate readings are provided through the entire range of activities used clinically. Other qualified personnel may do these tests. Semiannual -All non-exempt radionuclide sources must be tested to verify that radioactivity is not leaking from the sources. Other qualified personnel may also do these tests.

TAB 5

NRC/State Inspection Report Checklist

Please complete the date of the most recent NRC and State Inspection report (if applicable). Attach copies of each report and be sure to include any corrective action documentation if appropriate. Leave it blank if that modality is not ACR accredited.

Nuclear Medicine

❑	Date of Most Recent NRC inspection:	❑ Corrective Action Needed
❑	Date of Most Recent state inspection:	❑ Corrective Action Needed

PET

❑	Date of Most Recent NRC inspection:		❑ Corrective Action Needed
❑	Date of Most Recent state inspection:		❑ Corrective Action Needed

TAB 6

Policies and Procedures Checklist

Please have your policy and procedure manual available for the surveyors to review. Please check off all policies or procedures included in your manual and if a policy is not applicable to your site, write NA (not applicable) after the specific policy.

General

Pregnancy

- ❑ Identification, management of pregnant, potentially pregnant patients and personnel

Patient/Personnel Safety

- ❑ Policy related to radiation protection for patients and personnel including radiation monitoring (if applicable)
- ❑ Policy on sedation (if applicable)
- ❑ Policy on reducing exposure as much as reasonably possible for pediatric patients (if applicable)
- ❑ Policy on safety of patients and personnel that includes attention to the physical environment
- ❑ Policy on proper use, storage and disposal of hazardous materials and medications
- ❑ Policy on addressing medical and other emergencies
- ❑ Policy on infection control
- ❑ Policy on monitoring complications and adverse events
- ❑ Policy on crash cart/location/check
- ❑ Policy on Consumer Complaints
- ❑ Complaint Notice Posted (available on our website at *https://www.acraccreditation.org/-/media/ACRAccreditation/Documents/Resources/MIPPA/Notice-to-Patients.pdf*) Facilities must make publicly available a notification for patients, family members or consumers that they may file a written complaint with the ACR
- ❑ Policy on Patient Record Retention/Retrieval (The facility must have a process in place for all patients to obtain copies of their records and images that is HIPAA compliant. Patients should be made aware of this process at the time of examination or if requested by the patient at a later date)

Policies and Procedures Checklist

General continued

Verification of Personnel *(MIPPA Sites Only)*

- ❑ Policy on Licensing Verification (using the primary source for verification)
- ❑ Verify that personnel are not included on the Office of Inspector General's (OIG) exclusion list at http://oig.hhs.gov.

Contrast Administration per the ACR Manual on Contrast Media

- ❑ Policy on administration of IV sedatives, controlled agents and contrast agents (if applicable)
- ❑ Policy to document adequate resources to manage contrast reactions and potential adverse events
- ❑ Physician on-site when contrast is administered (if contrast administered)

Orientation

- ❑ Policy on employee orientation

Adherence to ACR Practice Guideline for Communication of Diagnostic Findings

- ❑ Policy on communication of diagnostic findings

CT Policies and Procedures

Pediatric Patients

- ❑ Specific pediatric examination protocols *(if pediatric patients scanned)*

Lung Cancer Screening Designation

- ❑ Report includes management recommendations (Lung-RADS™)
- ❑ Procedure for referring the patient to qualified health care providers if abnormal findings for self-referred patients

Smoking Cessation

- ❑ Mechanism in place to refer patients for smoking cessation counseling or provide smoking cessation materials

Imaging Protocol

- ❑ Specific protocols for lung cancer imaging that includes adjusting for patient size

TAB 6

Policies and Procedures Checklist

MR Policies and Procedures

MRI Safety

- ❑ Documentation of medical director/MR safety officer's name and responsibilities

Screening

- ❑ Screening forms for patients or their representatives

MR Education for personnel

- ❑ Policy on educating MR staff, non-MR staff and emergency personnel
- ❑ Policy on ongoing education

TAB 6

Policies and Procedures Checklist

Nuclear Medicine and PET Policies and Procedures

Laboratory Safety

❑ If accredited in **cardiology module** for nuclear medicine or PET, at least one staff person is ACLS certified.

TAB 7

Physician Quality Assurance Program Evaluation Checklist

Please have available your policies and procedures for the program your physicians use to meet the quality assurance requirement, as well as documentation of active participation.

Complete the information below for the program your site uses (RADPEER™, an alternative physician peer review program, or peer learning program).

RADPEER™

- ❑ Participates in RADPEER™ # _____
- ❑ Last submitted data to the ACR in prior six months

Alternative Physician Peer Review Program (*must include the following)*

- ❑ Double reading (2 MDs interpreting the same study) assessment
- ❑ Random selection of studies reviewed on a schedule basis
- ❑ Exams and procedures representative of the actual clinical practice of each physician
- ❑ Reviewer assessment of the agreement of the original report with subsequent review (or with surgical or pathological finding
- ❑ Classification of peer review findings with regard to level of quality concerns? *(e.g.; 3-point scoring scale)*
- ❑ Policies and procedures for action to be taken on significant discrepant peer review findings for the purposed of achieving quality outcomes improvement
- ❑ Summary statistics and comparisons generated for each physician by modality
- ❑ Summary data for each facility/practice by modality
- ❑ Documentation of active participation in prior 6 months

Specific Quality Assurance options

- ❑ Cardiologist only facility – Cardiac catheterization correlation performed
- ❑ BMRAP facility – maintain a medical outcomes audit program

TAB 7

Physician Quality Assurance Program Evaluation Checklist

Peer Learning Program (*must include the following)*

Written Policy

Culture

- ❑ Program description that emphasizes supporting a culture of learning and minimizing blame

Goal

- ❑ The goal of improvement of services by relying on the establishment of trust and free exchange of feedback in a constructive and professional manner

Definition of peer learning opportunities

- ❑ Definitions of peer learning opportunities that include submissions and review of peer learning cases that address actual or potential performance issues, including both discrepancies and “great calls”
- ❑ Description of case identification (routine work, case conferences, event reports or other sources) rather than randomly selected cases

Description of program structure and organization

- ❑ Definition of the roles of physician and non-physician leader(s)
- ❑ Description of responsibilities and the amount of time or the percentage of full-time equivalent (FTE) hours to be dedicated to managing the peer learning program.
- ❑ Definition of the workflow of the peer learning opportunity submission including the workflow for review of peer learning submission communication with the interpreting radiologist as appropriate and designation of the peer learning submission for group sharing

Definition of targets

- ❑ Definition of targets by defining expectations for minimum participation by radiologists in peer-learning submissions and in learning activity participation
- ❑ Minimum standards for peer learning program activities (defined as in-person or other virtual format)

Quality Improvement

- ❑ Outline of the process for coordination with appropriate practice and administrative personnel to translate findings from peer learning activities into dedicated quality improvement efforts

Reporting

- ❑ Statement of commitment to sequestering peer learning activity content from individual practitioner's performance evaluation

Annual Documentation

- ❑ Total number of case submissions to the peer learning program
- ❑ Number and percent of radiologists meeting targets as defined in the facility practice policy
- ❑ Determination of whether peer learning activities met the minimum standard as defined by the facility practice policy
- ❑ Summary of related quality improvement efforts and accomplishments

TAB 8

Image Labeling Evaluation

The surveyor will review patient logs to ensure all units are accredited in all modules and patient types performed at site. The surveyor will review one exam for labeling from each accredited modality at the facility. If exams are on a computer, have someone available to pull up images for the surveyor. The information listed below are required to be displayed on all images.

Patient Demographics for all modalities:

- Patient name (first and last)
- Patient age or date of birth
- Patient identification number
- Date of examination
- Institution name

Modality Specific Labeling

CT

- Anatomic orientation label
- mA/kV
- Pitch *(if available)*
- Rotation time
- Reconstructed image thickness *(slice width)*
- Reconstructive filter/kernel
- Display field of view (FOV)
- Table position
- Window level/Window width

TAB 8

Image Labeling Evaluation

Image labeling continued

MRI

- Interslice gap (can be inferred from slice position)
- Slice thickness
- Field of view
- Plan Scan or scout for location of sagittal or axial slices (spine exams)
- Acquired matrix
- Size scale (film only)
- Number that correlates with ‘plan scan’ or scout identifying the location of each slice
- Laterality, left or right of midline section
- Label that indicates location of slice relative to other slices

Breast MRI

- Laterality, left or right of midline section

Nuclear Medicine

- Image labeling to include orientation and laterality

PET

- Image labeling to include orientation and laterality

TAB 9

Resources

Breast MRI Program Requirements

CT Program Requirements

MRI Program Requirements

Nuclear Medicine/PET Program Requirements

Ultrasound Program Requirements

ACR Manual on MR Safety

Manual on Contrast Media

Communication of Diagnostic Imaging Findings

XR-29 FAQs

Peer Learning

Peer Learning Checklist

MR Safety Screening Form

ACR-SPR Practice Parameter for Imaging Pregnant or Potentially Pregnant Adolescents and Women with Ionizing Radiation

ACR Position Statement on Quality Control and Improvement, Safety, Infection Control and Patient Education and Improvement

ACR-SIR Practice Parameter for Sedation/Analgesia