Mandatory Accreditation:
PLAY OR PAY FOR IMAGING CENTERS

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It is difficult to argue with the often stated goal of improving quality in the delivery of healthcare services, and for years imaging centers have pursued accreditation as a demonstration of quality and market differentiation. The government has now upped the ante with the passage of the Medicare Improvement for Patients and Providers Act of 2008 (MIPPA), which mandates the accreditation by January 1, 2012 as a condition for technical component payment.

MIPPA does not impact the payment of the professional component, nor those procedures done in a hospital setting, and the easiest way to differentiate whether a particular imaging center will be impacted lies in how it is paid. If the facility is paid by the Medicare Physician Fee Schedule and billed on a CMS 1500 form, it falls under MIPPA.

Procedures covered by MIPPA include magnetic resonance imaging (MRI), computed tomography (CT) and positron emission tomography (PET) and earlier this year, the Centers for Medicare and Medicaid Services (CMS) announced the approval of three national accreditation organizations:

- American College of Radiology (ACR)
- Intersocietal Accreditation Commission (IAC)
- The Joint Commission (TJC)

Selecting which accreditation option to pursue will be dependent on such issues as medical specialty and/or legal structure of the imaging facility. There are numerous similarities among the accreditation agencies, but also distinct differences.

American College of Radiology

The American College of Radiology (ACR) accreditation program will be familiar to radiology practices and its modality specific accreditation programs have been in place since 1987. The ACR program is modality and equip-

ment-based (as opposed to facility-based), with applications submitted for each piece of imaging equipment and requirements based on the ACR Practice Guidelines and Technical Standards for each modality, as well as guidelines for communications.

Minimum standards are defined for physicians, medical physicists and technologists with physicist requirements updated in October 2009. The program also outlines expectations in terms of ongoing "experience requirements" (number of annual interpretations by physician in each modality), continuing medical education requirements, equipment specifications, quality assurance programs and patient safety. There is also an extensive listing of expectations for the supervising physician. Access to the various guidelines referenced is provided on the ACR website.

A focal point of ACR accreditation lies in the submission of clinical images for review and this is (anecdotally) the most frequent reason for application failure. Image quality may be central, but it must also be supported by documentation including radiation safety and quality assurance, as well as a formal peer review program.

The bar is high for ACR accreditation, but the criteria themselves represent familiar turf for radiology practices and their imaging centers. The greatest challenge is likely to occur in ensuring a formal documentation program has been established since pertinent issues regarding patient safety are a core aspect of training for radiologists and technologists. There will still be operational variability from one entity to another, however, and radiologist-owned or managed organizations should not expect to fly through the process without thorough due diligence. The process of ACR accreditation requirements is demanding, but based on well-established guidelines, which are readily available at http://www.acr.org/accreditation.aspx.

Fees for ACR accreditation are on a per-unit basis, with additional units at a reduced fee. There are also separate fees charged for resubmission (repeat) of images or phantom images, reinstatement or a corrective action plans, additional units placed mid-cycle, replacement certificates and the phantom. ACR fees are scheduled to increase July 1, 2010.

The Intersocietal Accreditation Commission (IAC)

The IAC was established with the support of the American Academy of Neuroradiology, the American Academy of Orthopaedic Surgeons, the American College of Cardiology, the American Society of Neuroimaging and the Society for Cardiovascular Magnetic Resonance.

One of the more confusing aspects of IAC accreditation lies in the fact each modality has its own website and "commission" although they appear to be relatively consistent in terms of the application process. The main website is located at http://www.intersocietal.org/ and accreditation requirements then identified at sub-sites as follows:

- CT: Intersocietal Commission for the Accreditation of Computed Tomography Laboratories at http://www.icactl.org/icactl/index.htm
- MRI: Intersocietal Commission for the Accreditation of Magnetic Resonance Laboratories at http://www.icamrl.org/icamrl/index.htm
- Nuclear Medicine/PET: Intersocietal Commission for the Accreditation of Nuclear Medicine Laboratories at http://www.icanl.org/icanl/index.htm

New IAC standards were effective January 1, 2010 and while they define experience and educational expectations, it is clear the guidelines were written to address issues related to non-radiology physician specialties involved in medical imaging. One of the distinctions of the IAC standards is that they outline minimum specifications for equipment, the physical facility (including exam and interpretation areas as well as storage space), data archiving requirements, safety and patient confidentiality. In addition, standards for organizations with multiple sites or mobile services are included.

The IAC also defines QA measures and documentation requirements, parameters for documentation of clinical indications for the study, ordering and scheduling of procedures, patient identification and preparations, exam techniques, report format for interpretations and image quality/interpretation QA processes.

IAC standards clearly differentiate between the responsibilities of the Medical Director as opposed to the physician who may be responsible for interpretations of the studies and also address instances where a physician may actually be performing the studies (rather than a technologist).

There is an initial base fee per unit for IAC accreditation and additional fees for "testing areas" which include in CT for example, "body CT (chest non-cardiac, abdomen, pelvis,

extremity) and Body CTA (chest non-cardiac, abdomen, pelvis, peripheral/extremity). The IAC also charges an application fee and the IAC website states "additional fees, based upon size and complexity, apply to eligible laboratories with multiple sites and/or mobile services." It should be noted the IAC changed its previous quarterly application submission schedule to an ongoing option, with applications reviewed on a monthly basis.

The Joint Commission

The Joint Commission (TJC) is probably equated by most radiology practices with hospital-based practice settings. However, TJC accredits advanced imaging modalities under its Ambulatory Care Accreditation Program, which can be reviewed at http://www.jointcommission.org/AdvImaging2012. One of the distinctions of this option is that it is not equipment/machine focused but includes the entire operational infrastructure of the facility, with diagnostic testing as a service within the overall organization. For example, staff qualifications are handled under the Human Resources Standard, communication of test results is under National Patient Safety Goals and equipment maintenance/safety would fall under multiple standards.

The Joint Commission offers two publications on its website that are helpful in terms of understanding their approach: "Accreditation Handbook for Diagnostic Imaging" and "Standards Sampler for Diagnostic Imaging," although the scope of the entire program is defined in the "Comprehensive Accreditation Manual for Ambulatory Care (CAMAC)." The comprehensive manual lists the 13 standards included in the accreditation process for diagnostic imaging centers and in each case the standard is stated, followed by specific performance elements.

The submission of diagnostic images is not part of the application process but instead, images are selected randomly during a site visit. Joint Commission accreditation focuses on the site visit to review and validate the clinical environment, safety precautions, patient communications, peer review processes, staff credentials and other critical documentation to support a demonstration of quality and environment of performance improvement.

The Joint Commission accreditation program will likely be more familiar to large multispecialty groups offering diagnostic services in an accredited facility, to multi-sited imaging providers, or to hospitals, which might be faced with only modifications to an existing hospital relationship in a joint venture imaging center, for example, to comply under the ambulatory care option.

Fees for Joint Commission site surveys are facility-based and vary with the size of the entity based on procedure volume or if there are additional sites. Joint Commission fees are posted publicly on the website. Fees for the three year accreditation period include both the on-site fee component, and annual fees that are spread out over the three year accreditation term. Their fee structure, since it is based on facility procedure volumes, may make accreditation financially reasonable for the smaller entity.

In Conclusion

CMS, in its selection of accreditation agencies, seems to have allowed for differences in medical specialties and practice configurations so one of the accrediting organizations should meet the needs and characteristics of a given facility. Each organization offers excellent website support, although wading through all options to evaluate and compare them is a formidable project.

Industry predictions favor the prepared organization. In other words, imaging facilities should anticipate the process to take several months to complete and if resubmissions are required, the timeline can extend. The rush to accredit mammography facilities in 1994 resulted in sizeable backlogs and for a number of reasons it is not wise to wait until 2011 to begin the accreditation process, since backlogs are most likely to occur in the second half of that year.

Anecdotally, several radiology practices have also reported an expansion of documentation and scope as they are renewing their accreditations so it would be a good idea to review requirements now to determine if additional staff and processing time should be anticipated.

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