



Accreditation Program Policies & Procedures

(reviewed annually)

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Introduction: About the Intersocietal Accreditation Commission (IAC)

Mission Statement

Improving health care through accreditation®.

The **Intersocietal Accreditation Commission (IAC)** is an international, nonprofit organization in operation to evaluate and accredit facilities that perform diagnostic imaging and therapeutic procedures, thus improving the quality of patient care in private offices, clinics and hospitals where such services are provided. There are nine divisions within the IAC:

- IAC Vascular Testing (*created in 1990*)
- IAC Echocardiography (*created in 1996*)
- IAC Nuclear/PET (*created in 1997*)
- IAC MRI (*created in 2000*)
- IAC CT / Dental CT (*created in 2007 and 2011*)
- IAC Carotid Stenting (*created in 2010*)
- IAC Vascular Interventional (*created in 2012*)
- IAC Cardiac Electrophysiology (*created in 2014*)
- IAC Cardiovascular Catheterization (*created in 2017*)

Designed to help facilities attain the highest possible quality to improve patient care, each of the accreditation programs is composed of two critical steps. The first is an **internal self-assessment** by facility staff. During the accreditation process, applicant facilities must submit documentation of their daily operations, including sample case studies along with their corresponding final reports. While completing the application, facilities are required to identify and correct potential problems, revising protocols and validating Quality Improvement (QI) programs. The second step in the process is a **confidential peer review** by members of the medical community. Accreditation is granted only to those facilities that are found to be providing quality patient care, in compliance with the published *Standards*. Participation in the accreditation process demonstrates the facility's commitment to the provision of quality care. Facilities are encouraged to use accreditation as the foundation to create and achieve realistic patient care goals. Because accreditation is renewed every three years, a long-term commitment to quality care and self-assessment is developed and maintained.

Each division is led by a Board of Directors. Using common goals and methods, each Division Board establishes the *Standards* and policies for accreditation within its specific specialty and renders accreditation decisions. The Division Boards are comprised of representatives from organizations outside of the IAC who support the division's activities, as well as members at large with specific expertise. (A list of the sponsoring organizations and their current representatives can be located on the IAC website.) These representatives come from a variety of specialties delivering and/or utilizing specific imaging/procedure modalities. To the extent possible, all are required to work in or be affiliated with an IAC-accredited facility, and they cannot be employed by industry or provide accreditation consulting services. Representatives from each of the eight divisions compose the Board of Directors that governs the IAC as a whole.

For additional information regarding each of the IAC divisions, please visit the websites:

- Vascular Testing (intersocietal.org/vascular)
- Echocardiography (intersocietal.org/echo)
- Nuclear/PET (intersocietal.org/nuclear)
- MRI (intersocietal.org/mri)
- CT (intersocietal.org/ct)
- Dental CT (intersocietal.org/dental)
- Carotid Stenting (intersocietal.org/carotid)
- Vascular Interventional (intersocietal.org/vascular-interventional)
- Cardiac Electrophysiology (intersocietal.org/ep)
- Cardiovascular Catheterization (intersocietal.org/cath)

The IAC accreditation programs are similarly structured across divisions and whenever possible utilize common operational policies and procedures. However, due to the inherent differences between the modalities and the functioning of each division, there are some policies that differ and these exceptions are noted within the IAC Policies & Procedures. A grant of accreditation by the IAC is recognition of a facility's performance at the time of application. Accreditation does not constitute a warranty of complete or continuous compliance. Each facility is solely responsible for ensuring the quality and safety of its services.

Section 1: Changes to the Standards

- 1.1 *Standards* are periodically reviewed and updated. All *Standards* will be published in a standardized IAC format.
- 1.2 Once approved by the Division Board of Directors, a copy of the draft *Standards* is posted for a 60-day public comment period. Notice of the comment period is posted on the IAC and the division websites. The IAC will specify the method of submission and date by which written comments must be received in the IAC office. Comments become the property of the IAC and are not confidential.
- 1.3 After considering public comments at the close of the comment period the Division Board will review comments and vote for final approval of the *Standards*. The decision of the Division Board regarding a comment is final.
- 1.4 Facilities will be notified of changes to the published *Standards*, and the most current version of the *Standards* can be viewed or printed from the IAC websites.
- 1.5 Accredited facilities must continuously adhere to the *Standards* in order to maintain accreditation. The IAC will typically extend a grace period of six months in order for facilities to adjust their practices if necessary in order to meet updated *Standards*. However, the IAC reserves the right to require compliance within a shorter period of time if determined necessary for public health and safety.
- 1.6 The IAC will conform the *Standards* to any changes in Medicare statutory requirements authorized by section 1834(e) of the Social Security Act. The IAC will maintain or adopt *Standards* that are equal to, or more stringent than, those of Medicare.
- 1.7 The IAC will notify the Centers for Medicare and Medicaid Services (CMS), in writing, at least 30 calendar days in advance of the effective date of any significant proposed changes in the *Standards*.

Section 2: Application Requirements

- 2.1 **Newly Operational Facilities** – Facilities are eligible to apply for accreditation at any time after becoming operational. However, a facility must be able to supply the required application information and representative case studies with required pathology.
- 2.2 **International Facilities** – Facilities located outside of the United States are eligible to apply for accreditation through the online accreditation portal. All fees are to be paid in U.S. currency. The applicant facility may be billed for foreign transaction fees if applicable.
- 2.3 **Documentation** – The application and other required documents must be submitted in English.
- 2.4 **Expedited Application Review** – Facilities have the option through the online accreditation application to select an expedited application review. Additional non-refundable fees will apply. The facility will be required to agree to the terms and conditions of the expedited process.

Expedited Application Review Terms and Conditions: Expedited application processing assures only that a complete application submission from the entity seeking accreditation will be processed and an accreditation decision rendered within seven weeks. **This process does not guarantee accreditation will be granted within seven weeks.**

Vascular Testing, Echocardiography and Nuclear/PET facilities must have no more than 10 sites to be eligible to apply for the expedited application review.

MRI and CT facilities must have no more than 10 pieces of equipment to be eligible to apply for the expedited application review process.

The facility is solely responsible for the completeness, accuracy and quality of the application submission as well as providing information that demonstrates adherence to the division *Standards*. If upon review of the application substantial adherence to the *Standards* has not been met or required information is missing, the applicant facility will be required to provide additional information or undergo an onsite inspection documenting adherence to the *Standards* prior to being granted accreditation.

All fees are non-refundable regardless of the accreditation decision outcome.

- 2.5 **Testing Areas** – Facilities may apply for a single testing area or multiple areas within each division. It is recommended that facilities apply for accreditation in all testing areas they perform. Accreditation applies only to the specific testing area(s) for which it was granted and does not include any other testing services offered by the facility.
- 2.6 **Procedure Volumes** – The volume of studies or procedures specified in the *Standards* are recommendations only and not an application requirement. Facilities are not prohibited from applying for accreditation if they do not meet the recommended volumes.
- 2.7 **Multiple Sites**
- 2.7.1 Multiple sites refer to two or more sites where diagnostic testing/imaging is performed.
- 2.7.2 The accreditation will be “owned” only by the legal entity with the Federal Tax I.D. number (EIN) listed on the Agreement.
- 2.7.3 Organizations performing testing at multiple sites may apply on a single application if the sites meet all of the multiple site requirements published in the division *Standards*. Additional application information will be required and additional fees will apply.
- 2.7.4 For multiple site applications:

- a. All correspondence will go through the main site address indicated in the accreditation application.
 - b. Each site may be granted accreditation independently based on adherence to the *Standards*. The accreditation for all sites will be “owned” only by the legal entity with the EIN listed on the Agreement.
 - c. Certificates are provided to each site granted accreditation and each site is published on the IAC website.
 - d. In general, the site with the highest testing volumes will be named as the main site. However, this may vary based upon the operational structure of the facility.
- 2.7.5 Multiple sites are not required to apply for identical testing areas. Each site may apply only for the examinations or procedures that are performed at the site.
- 2.7.6 An accredited facility may add an additional site at any time during the period when accreditation is valid by adding the site information to the Online Accreditation portal, completing the multiple site application supplement and submitting the required additional fees. Sites to be added to a current accreditation are not considered accredited until the additional site application is submitted and granted accreditation. If granted, all of the sites will expire at the time of the original accreditation decision.

Section 3: Accreditation Agreement, Application Fees and Documentation Retention

- 3.1 A facility is required to truthfully complete an application and attest to the information submitted in the form provided by the IAC and provide additional information as requested. Failure to do so may be grounds for the IAC to suspend or terminate its review of the application.
- 3.2 Each facility seeking accreditation must submit a signed Accreditation Agreement to the IAC. Facilities should review this document carefully. It creates a contract between the facility and the IAC, and the IAC is committed to enforcing its terms in order to protect the integrity of the accreditation program and the general public as consumers.
- 3.3 An application decision will not be rendered without a signed Accreditation Agreement on file.
- 3.4 The following items should be given particular attention when completing the Accreditation Agreement:
 - 3.4.1 The most current Accreditation Agreement document must be submitted via the IAC portal.
 - 3.4.2 The individual signing the document may be anyone authorized by the facility to enter into the Accreditation Agreement on its behalf. Another member of the staff may sign as the witness. There is no need to have the signatures notarized.
- 3.5 The Accreditation Agreement includes a Business Associate Agreement which covers IAC responsibilities under the Health Insurance Portability and Accountability Act (HIPAA) regarding individually identifiable health information submitted through the application process.
- 3.6 An application decision will not be rendered without full payment of application fees. Fees are non-refundable.
- 3.7 Applications previously submitted by the facility can be viewed through the online portal for seven years, after which the information will be destroyed in accordance with the IAC document retention policy. Copies of materials, such as case studies submitted to the IAC may be obtained from the IAC, subject to duplication fees.
 - 3.7.1 Document File: If IAC requests a copy of the facility's document file, a copy of the document file must be submitted within 30 days of IAC's request.
 - 3.7.2 Facility must maintain a file of the documents listed below (the document file). These records must be kept up-to-date, and retained for the duration of the application review period and accreditation (if granted):
 - a. medical licenses for all physicians;
 - b. credential cards for all technologists/sonographers;
 - c. continuing medical education documentation;
 - d. policy for the method and frequency of replenishing emergency supplies;
 - e. infectious disease policy;
 - f. equipment cleaning policy;
 - g. policy for handling acute medical emergencies;
 - h. maintenance policies and agreements for diagnostic equipment;
 - i. policies and forms regarding patient assessment and monitoring;
 - j. conscious sedation policy (if applicable);
 - k. policy for primary source verification; and
 - l. policy for patient complaint submission;
 - m. policy for patient confidentiality.

Section 4: Application Submission & Accreditation Cycles

- 4.1 Applications are processed upon receipt.
- 4.2 Accreditation may be granted for a maximum of a three-year period. The accreditation cycle begins on the date indicated in the initial notification letter received by the facility. Accreditation is not extended beyond the three-year period for any reason.
- 4.3 In order for a facility to avoid a lapse in its accreditation at the end of a three-year period, it must submit a reaccreditation application at least three months prior to the expiration date. The IAC will make efforts to remind a facility of its reaccreditation submission deadline 12 to 14 months prior to the expiration date. However, it is the facility's responsibility to apply for reaccreditation by the deadline.
- 4.4 Facilities applying for reaccreditation by expiration date listed on accreditation certificate are extended a 60-day grace period in order to provide the requested information and avoid a lapse in their accreditation. This 60-day grace period is automatically reflected in the expiration dates of the facility listing on the IAC websites. However, if the information is not received within this time period, the accreditation will expire.
- 4.5 If accreditation expires the facility will no longer be considered accredited, will be removed from the IAC website and is prohibited from using the IAC Seal of Accreditation.

Section 5: Application Review Process

5.1 In-House Review

- 5.1.1 Each submitted application is assigned an identification number and information is entered in the IAC database.
- 5.1.2 An in-house review is performed by IAC staff and consists of a review of the application only for completeness: that application questions have been answered, attachments are included and the appropriate numbers of case studies have been submitted. The technical aspects of the application (such as the content of protocols, quality assurance statistics or the quality of the case studies) are not reviewed during this phase. The facility will not be notified at this time of any lack of adherence to the *Standards*. The goal of the in-house review is only to help ensure that every application is as complete as possible for the clinical reviewers.
- 5.1.3 Through the Office of the Inspector General (OIG) website, the IAC will identify any providers and/or entities included in the **list of excluded individuals/entities**. Per the Centers of Medicare and Medicaid Services (CMS), providers or entities included in the list at the time of review may not be eligible for accreditation.
- 5.1.4 If missing information is identified, the facility is notified via e-mail. The facility will have 5 business days to submit the missing information (unless submitting under the expedited application process, which requires information to be returned within two business days). If the information is not provided within this time, the application may be held until the next month, returned to the facility, or (if the lack of information will not preclude a review) submitted for review without the information.
- 5.1.5 Any requested information submitted to the IAC office is included with the application whenever possible. If the application has been sent out for review prior to receiving the requested items, attempts are made to have this additional material included in the application and reviewed. However, this may not always be possible and the facility might be notified of the missing items after the final application review by the Division Board.

5.2 Application Review

- 5.2.1 Application reviewers use uniform review forms in their evaluation of the application data. It is during this review that substantial compliance or non-compliance to the *Standards* is documented.
- 5.2.2 The recommendations and comments of the reviewers are compiled and reviewed by IAC division clinical staff.
- 5.2.3 The review findings and recommendations are presented to the Division Board at its next meeting. The Division Board makes the accreditation decision.

Section 6: Application Reviewers

- 6.1 To be eligible to serve as an application reviewer, an individual must meet the following requirements:
 - 6.1.1 appropriate technical credentials and/or medical experience and training as required by the *Standards*;
 - 6.1.2 a minimum of five years' full-time experience within the specialty field specific to the IAC Division; and
 - 6.1.3 familiarity with the accreditation process and *Standards*.
- 6.2 Individuals who retire from practice may participate as application reviewers if the appropriate specialty credentials are maintained.
- 6.3 Application reviewer candidates must complete an IAC Contractor Profile, undergo a background check prior to approval and sign an IAC Clinical Contractor Agreement prior to approval.
- 6.4 Application reviewers must complete an IAC training course prior to reviewing any application and are required to participate in subsequent training at least annually.
- 6.5 Application reviewers must sign an IAC Clinical Contractor Agreement and abide by IAC requirements regarding conflicts of interest, confidentiality and HIPAA compliance.
- 6.6 Application reviewers receive an honorarium for their participation.

Section 7: Accreditation Decisions

- 7.1 **Decision-makers** – The Division Board makes the accreditation decision. The members of each Division Board are divided into groups so that in the event of an appeal, the appeal can be considered by individuals who were not involved in the original decision.
- 7.2 **Accreditation Decisions** – The four decisions that can be rendered by the Division Board are listed below. A decision is made for each section of the application; all areas may not receive the same decision.
- 7.2.1 **Granted:** The facility is granted accreditation.
- 7.2.2 **Limited Grant:** The facility is granted accreditation for a period of time (not to exceed one year) contingent on required site visit findings. If the IAC discovers a possible violation of IAC rules during a site visit, the matter will be handled in accordance with the policy in Section 12, Grounds & Procedure for Adverse Action Against Accreditation.
- 7.2.3 **Delayed:** The facility is required to submit additional evidence of compliance prior to the final decision. However, accreditation (if granted) will expire three years from the date of the original “delayed” decision.
- 7.2.4 **Site Visit:** The facility is required to undergo a site visit prior to the Division Board making a final decision. However, accreditation (if granted) will expire three years from the date of the original “site visit” decision.
- 7.2.5 **Denied:** Accreditation is denied.
- 7.3 **Denial of Accreditation.** A facility may be denied accreditation for reasons that include (but are not limited to) the following:
- 7.3.1 the maximum number of delay material submissions has been submitted (total of three) and substantial compliance to the *Standards* has not been documented;
- 7.3.2 the facility has remained in a delayed status for one year from the date of the initial delayed decision;
- 7.3.3 the facility refuses to complete a random audit or site visit;
- 7.3.4 all facility appeal requests have been exhausted; and/or
- 7.3.5 grounds for adverse action exist as described in the policy in Section 12, Grounds & Procedure for Adverse Action Against Accreditation.
- 7.4 **Notification of Accreditation Decisions**
- 7.4.1 The facility will receive notification within two weeks after the Division Board issues its decision. Notification letters contain the following information:
- a. **Grant:** A letter of notification is included in a portfolio that contains a certificate listing each area in which the accreditation is granted, a press release and instructions to download the facility’s Application Review Findings (ARF) summary from the online application portal. Granted facilities will have access to the IAC Seal of Accreditation through the online application portal.
 - b. **Delay:** The letter of notification will outline the deficiencies identified during the application review (and site visit, if applicable) and the additional information requested by the Division Board.
 - i. Upon receiving a delayed accreditation decision, the facility will:

- have one year to provide the additionally requested documentation demonstrating adherence to the *Standards* as outlined in the accreditation notification letter; Payment policies may dictate a shorter time frame for reimbursement purposes (CMS, private insurers);
 - be assessed a review fee (as listed in the Accreditation Agreement) for each submission of additional material;
 - have a maximum of three delay material submissions to demonstrate compliance;
 - if continued noncompliance is documented after review of the three submissions, the application will be denied and the facility will be required to resubmit a complete accreditation application and application fees in order to seek accreditation.
- ii. The additional material is reviewed within four weeks after receipt by the IAC. Facilities are then notified of the findings of the delay material review.
 - iii. If granted accreditation, the accreditation portfolio is sent.
 - iv. Facilities can be granted accreditation in some areas while delayed in others. This notification will include a certificate for those areas granted accreditation and details regarding the delay of any other section(s).
- c. **Site Visit:** The facility will be notified that a site visit is required and will be completed within 30-60 days of the notification.

7.4.2 Notification letters are sent electronically via the IAC Online Accreditation portal. Certificates are shipped via a traceable delivery service to the attention of the Technical Director* at the main site address listed in the application. Facilities are invited to review and order their complimentary certificates within a few weeks of receiving a grant notification letter. Facilities that do not login to review and order their certificates are automatically shipped 2 complimentary copies per site after 6 weeks of non-response.
**For Dental CT, Vein Center, Vascular Interventional, Carotid Stenting, Cardiac Electrophysiology, Cardiovascular Catheterization, the certificates are shipped to your appointed Medical Director.*

7.5 Application Review Findings

- 7.5.1 The Application Review Findings (ARF) document is provided to facilities following the accreditation decision. The ARF is meant to provide the facility feedback regarding the review of their application and is designed as an educational tool for evaluating and improving the overall quality of the facility. Instructions to download the ARF from the online accreditation portal are included with the initial notification letter.
- 7.5.2 The ARF document is a compilation of the combined answers from the reviewers to each review question and represents their findings based on the review of the original application material.

7.5.3 Decision Appeals Process

- a. Only “Denial” or “Delayed” decisions can be appealed. “Site Visit” decisions cannot be appealed.
- b. A facility’s failure to comply with any IAC deadline may not be appealed.
- c. A facility may request an appeal within 30 calendar days after receipt of the decision letter. After this time, the facility may not request an appeal.
- d. All appeal requests and supporting information must be submitted in writing and sent to the IAC by a traceable delivery service.
- e. The appeal request must specify a valid basis for the appeal. If the Chief Executive Officer determines that the request is frivolous, then the appeal will not proceed.
- f. The facility will be allowed a period of 60 days after the IAC’s receipt of the appeal request in which to submit a written brief in support of its appeal.

- g. The Chief Executive Officer may file a written response to the appeal brief.
- h. The Chief Executive Officer will appoint an Appeal Committee to consider the appeal. The Appeal Committee is ad hoc and is composed of three members selected from the Division Board. Appeal Committee members may not:
 - i. be the same individuals who initially reviewed the application;
 - ii. review any matter in which their impartiality might reasonably be questioned;
 - iii. review any matter involving a facility located within 50 miles of where the member lives or works; or
 - iv. review any matter which presents an actual, apparent, or potential conflict of interest. Committee action is determined by majority vote.
- i. The Appeal Committee will render a decision based on the written record. Documentation not previously submitted to the IAC will not be considered. An oral hearing is not permitted.
- j. The Appeal Committee may accept, reject or modify the decision. In order to overturn the decision, the facility must demonstrate that the decision was inappropriate because of: (a) material errors of fact, or (b) failure to conform to the IAC's rules. Proof is by preponderance of the evidence.
- k. The decision of the Appeal Committee is final.
- l. The facility will be notified in writing of the decision.
- m. Only one appeal per application is permitted. If that appeal upholds the original denial or delay, the facility must complete and submit a new application in order to seek accreditation at another time.
- n. The facility is responsible for all expenses related to the appeal. In addition, it must pay the appeal fee listed in the Accreditation Agreement.

Section 8: Site Visits & Audits

The IAC conducts random or required on-site visits or audits as part of the application review process or during the period of accreditation.

- 8.1 **Random Site Visits** – Random site visits are the IAC’s means to assess continued compliance to the *Standards*, policies and procedures. A computerized program selects facilities to receive random site visits.
- 8.1.1 The IAC will conduct a random site visit at no charge to the facility.
 - 8.1.2 Facilities selected for random site visits are notified in writing via e-mail and the site visit will be performed on an undisclosed date within 60 days of the notification.
 - 8.1.3 It is the facility’s responsibility to notify the IAC of business hours or day’s procedures are not performed. If a site visitor arrives at a site and is unable to complete the site visit, the facility will be charged the costs associated with the site visit attempt and will be required to undergo a site visit on an undisclosed date at another time.
 - 8.1.4 One site visit representative will be sent to conduct the site visit.
 - 8.1.5 The date of the site visit will be determined by the IAC staff and site visitor.
 - 8.1.6 The facility can access a sample agenda for the site visit day and blank copies of the site visit forms to be used by the site visit representative in assessing the facility through the IAC website.
 - 8.1.7 Whenever possible the Medical Director and Technical Director should be available during the site visit.
 - 8.1.8 Patient testing/procedures will be observed as part of the site visit.
 - 8.1.9 All records must be easily accessible in the facility for review by the site visitor.
 - 8.1.10 Identified areas of non-compliance not deemed a threat of immediate and irreparable injury to the public, the facility may be required to submit a corrective action plan.
 - 8.1.11 Facilities are sent a site visitor evaluation survey to complete. This information assists the IAC in assessing site visitors, the site visit process and IAC staff members.
- 8.2 **Random Audits** – Random audits are the IAC’s means to further assess continued compliance with the IAC *Standards*, policies and procedures. A computerized program selects facilities to receive random audits.
- 8.2.1 Facilities selected for an audit are initially notified of the audit requirements in writing via e-mail.
 - 8.2.2 Audit materials may be reviewed by IAC staff or by application reviewers.
 - 8.2.3 If audit materials are requested they must be received by the IAC within 30 days after the facility receives the audit notice.
 - 8.2.4 If audit materials are not submitted within 30 days, facilities will receive additional notification via traceable carrier and may be subject to sanctions as provided in the policy in Section 13, Grounds & Procedure for Adverse Action Against Accreditation.
- 8.3 **Required Site Visits** – The IAC may also conduct an on-site visit for cause (an “investigative site visit”). “Cause” to conduct an on-site visit includes (but is not limited to): (a) the IAC is unable to make an accreditation determination based on the written information submitted by a facility, and (b) the IAC is investigating a complaint that a facility has failed to adhere to IAC *Standards*, policies and procedures.

- 8.3.1 When a site visit is required related to an application, the facility is generally notified of the necessity of the site visit in writing within two weeks after the Division Board meeting where the application was reviewed. If the site visit is requested after additional material is submitted due to a delay decision, the facility is notified within two to four weeks after the additional material submission and review. If a complaint has been received, it will be handled in accordance with Section 12, Grounds & Procedure for Adverse Action Against Accreditation.
 - 8.3.2 An investigative site visit will be completed on an undisclosed date within 60 days of the notification. However, if the cause for the site visit is thought to pose immediate jeopardy to the patient and/or general public the site visit will occur within two business days and where applicable reported to CMS.
 - 8.3.3 IAC staff members and/or site visit representatives make the arrangements for the site visit.
 - 8.3.4 The facility is responsible for all costs associated with an investigational site visit.
 - 8.3.5 Two site visit representatives will perform an investigational site visit.
 - 8.3.6 Investigative site visit fees are listed in the Accreditation Agreement. Accreditation decisions will not be released until site visit costs have been paid by the facility.
 - 8.3.7 The facility will receive the agenda for the site visit day and blank copies of the site visit forms to be used by the site visit representative in assessing the facility.
- 8.4 **Findings** – If the IAC discovers a possible violation of IAC rules during a site visit or audit, the matter will be handled in accordance with the policy in Section 12, Grounds & Procedure for Adverse Action Against Accreditation.

Section 9: Site Visitors

- 9.1 To be eligible to serve as a site visitor, an individual must meet the following requirements:
 - 9.1.1 Possess appropriate technical credentials and/or medical experience and training as required by the *Standards*.
 - 9.1.2 Have a minimum of five years of full-time experience within the specialty field specific to the Division.
 - a. Individuals who retire from practice may participate as site visitors if the appropriate specialty credentials are maintained.
 - 9.1.3 Have familiarity with the accreditation process and *Standards*.
 - 9.1.4 Site visitor candidates must complete an IAC Contractor Profile, undergo a background check prior to approval and sign an IAC Clinical Contractor Agreement once approved.
 - a. In general, current IAC or IAC division board members and staff are prohibited from performing site visits. Exception to this policy includes but is not limited to newly formed IAC divisions and for training purposes.
 - 9.1.5 Upon approval, site visitors must complete an IAC training course prior to conducting any site visit and are required to participate in subsequent training at least annually.
 - 9.1.6 Site visitors must abide by IAC requirements regarding conflicts of interest, confidentiality and HIPAA compliance.
 - 9.1.7 Site visitors may receive an honorarium for their participation.

Section 10: Reporting Changes

- 10.1 If there is any change in an accredited facility's operations that might have a bearing upon the facility's accreditation, the IAC must be notified within 30 calendar days after the change. The changes must be made in the facility's online accreditation portal or when applicable in writing, and must include the information requested by the IAC. Instructions and required forms are available from the online accreditation portal and IAC websites.
- 10.2 Changes which must be reported include (but are not limited to):
- 10.2.1 the departure of the individual serving as Medical Director or Technical Director;
 - 10.2.2 a new permanent site;
 - 10.2.3 a change in the facility's name or contact information;
 - 10.2.4 ceasing to do business;
 - 10.2.5 discontinuation of an accredited service;
 - 10.2.6 change in ownership;
 - 10.2.7 merging of facilities
 - 10.2.8 the commencement of legal action (civil or criminal) against the facility, its directors, officers, employees and/or agents; and
 - 10.2.9 other change which results in the facility no longer meeting IAC *Standards*, policies and procedures.
- 10.3 The IAC will review the change. If the IAC determines that the change has a significant impact on the facility's operations, the IAC may require the facility to submit additional evidence of continuing compliance with IAC *Standards*, policies and procedures. An opinion letter from legal counsel may be required. Additional fees may apply.
- 10.4 If ownership of a facility changes, the IAC will determine whether the facility must apply for accreditation as a new facility, or if the facility's existing accreditation remains valid. **Accreditation cannot be transferred without written approval from the IAC.**
- 10.5 Changes in ownership and/or facility mergers will incur additional fees as stated in the Accreditation Agreement.
- 10.6 Accreditation is awarded to the listed facility and permanent sites as a whole. An accreditation award may not be divided or shared following a sale, dissolution or other change in ownership or legal structure. The parties to the sale, dissolution or other change in a facility's ownership or legal structure must determine, among themselves, the one party who will continue to own the accreditation. That one party must then notify the IAC and submit an opinion letter from legal counsel confirming that the party has the right to continue to hold the accreditation. If the new and former owners/partners/etc. are unable to reach an agreement regarding which one party among them will own the accreditation award, the accreditation award will be terminated and all parties seeking accreditation will be required to submit new applications. If a major integration or ownership change is being considered the facility is encouraged to contact the IAC as far in advance as possible prior to the transaction to discuss the specifics.
- 10.7 If there is a change in the Medical or Technical Directors notification must be submitted to the IAC within 30 days. IAC must be notified of the replacement within 60 days.
- 10.8 Additional documentation will be required for individuals who were not included in the most recent accreditation application. As well, the information in the facility's Online Accreditation account must be updated. Failure to update this information prohibits the IAC from fully processing the change.
- 10.9 Facility is encouraged to provide interim information regarding any addition or deletion of medical or technical staff. New staff and any applicable reimbursement data should be entered in the facility's Online Accreditation account and deleted staff should be marked as inactive.

Section 11: Use of IAC Trademarks

- 11.1 **Ownership** – The IAC “Accredited Facility” seal is the sole and exclusive property of the IAC and is subject to all applicable trademark and other rights of the IAC as owner under United States intellectual property law and international conventions. Accredited facilities shall not use the seal, or any other intellectual property owned by the IAC, except as expressly authorized in this policy or otherwise authorized in advance and in writing by the IAC.
- 11.2 **License** – For the duration of accreditation, the IAC will permit an accredited facility to use the seal for the sole purpose of indicating accreditation by the IAC. All goodwill associated with the seal as used by accredited facilities inures solely to the benefit of the IAC.
- 11.3 **Conditions of Use**
- 11.3.1 Any use of the seal must be accurate and supportive of IAC objectives, and must do so in a manner that is compatible with the mission of the IAC.
- 11.3.2 All use of the seal must be truthful and not misleading. Specifically, facilities shall NOT:
- a. use the seal unless the IAC has made an official accreditation decision;
 - b. use the seal on reports or correspondence for areas of testing in which they are not accredited;
 - c. use the logo without the words “Accredited Facility” (this logo is for IAC use only);
 - d. use the seal (or a word or design that is confusingly similar to the IAC name or seal) as part of the facility’s name, logo, domain name, or product or service name;
 - e. use the seal in any manner that reflects negatively on the IAC or its activities;
 - f. use the seal in any manner that conflicts with IAC *Standards*, policies and procedures;
 - g. suggest or imply that the facility has any relationship with the IAC other than as an accredited facility;
or
 - h. suggest or imply that the IAC is endorsing or guaranteeing any product or service offered by the facility.
- 11.3.3 The IAC will provide instructions to download a digital version of the seal for use by accredited facilities. Facilities must use the seal in its exact form with the surrounding words “Accredited Facility”; only changes in size and color changes to black and white are permitted.
- 11.3.4 All use of the seal must:
- a. conform to the design standards issued by the IAC (a current copy of which will be provided); and
 - b. be appropriate and dignified as befits the public image of the IAC.
- 11.3.5 The seal may not be the most prominent visual element on the facility’s promotional materials. The facility name and/or logo, product or service name, and graphics should be significantly larger than the reference to the IAC seal.
- 11.3.6 Upon the termination or expiration of accreditation, or for the duration of any probation or suspension regarding accreditation, the facility:
- a. shall cease use of the seal;
 - b. shall destroy all print and electronic artwork materials provided by the IAC, without retaining copies;
and
 - c. shall not distribute any materials containing the seal that it might already have prepared.

- 11.3.7 The facility is responsible for correcting (at the facility's expense) any outdated or otherwise inaccurate use of the seal or other IAC intellectual property.
- 11.4 **Quality Control** – The IAC has the right to control the quality of all materials on which the seal is used. The IAC will have access to the materials which the facility makes publicly available (such as business cards, letterhead, etc.). Also, the facility shall submit samples of its materials if requested by the IAC. If the IAC determines that the facility is not meeting the requirements of this policy, the IAC will notify the facility and provide an explanation. The facility shall correct the violation within 30 calendar days after receipt of the notice. The IAC is the final judge as to whether any use of the seal is consistent with this policy.
- 11.5 **Consequences of Misuse** – The IAC is committed to protecting its intellectual property for the benefit of all accredited facilities and the general public as consumers. If a facility fails to comply with this policy or otherwise misuses an accreditation certificate, the IAC name, or other intellectual property of IAC, then the IAC may revoke or take other adverse action with regard to the facility's accreditation in accordance with the policy in Section 12, Grounds & Procedure for Adverse Action Against Accreditation. If the facility is not accredited by IAC at the time of the misuse, then IAC may require corrective action as a condition of eligibility for accreditation should the facility seek accreditation at a later time. In addition, the facility may be subject to criminal or civil liability.
- 11.6 **Further Information** – If a facility has a question regarding proper use of the seal, and for permission to use the seal on materials other than those listed above, it should contact the IAC.

Section 12: Grounds & Procedure for Adverse Action Against Accreditation

This policy has been adopted to establish a fair process for addressing non-compliance with IAC *Standards*, policies and procedures. Matters are investigated by IAC staff and presented for judgment before a Compliance Monitoring Committee. An Appeals Body is available to hear appeals of Compliance Monitoring Committee decisions and is the final decision-maker on behalf of the IAC.

12.1 **General Principles** – Facilities and their staff must:

- 12.1.1 be truthful, forthcoming, prompt and cooperative in their dealings with the IAC;
- 12.1.2 be in continuous compliance with IAC *Standards*, policies and procedures (as amended from time to time by the IAC);
- 12.1.3 respect IAC intellectual property rights;
- 12.1.4 abide by laws related to the profession and to general public health and safety; and
- 12.1.5 carry out their professional work in a competent and objective manner.

12.2 **Grounds for Adverse Action** – Grounds for adverse action include:

- 12.2.1 providing fraudulent or misleading information;
- 12.2.2 failure to pay fees when due;
- 12.2.3 unauthorized possession or misuse of IAC accreditation marks and other intellectual property;
- 12.2.4 misrepresentation of accreditation status;
- 12.2.5 refusal to allow the IAC to conduct an on-site visit;
- 12.2.6 failure to provide requested information in a timely manner;
- 12.2.7 failure to inform the IAC as required by the Reporting Changes policy;
- 12.2.8 non-compliance with laws related to the facility’s business or to general public health and safety;
- 12.2.9 adverse action by a governmental agency or an accreditation or professional organization other than the IAC; and
- 12.2.10 other failure to maintain continuous compliance with IAC *Standards*, policies and procedures.

12.3 **Compliance with IAC *Standards*, Policies and Procedures** – A facility must be in continuous compliance with all IAC *Standards*, policies and procedures. Each facility bears the burden for demonstrating and maintaining compliance at all times.

12.4 **Sanctions**

- 12.4.1 The IAC may impose one or more of the following sanctions for failing to adhere to the IAC *Standards*, policies and procedures:
 - a. denial of accreditation;

- b. revocation of accreditation;
- c. non-renewal of accreditation;
- d. suspension of accreditation;
- e. reprimand;
- f. notification of other legitimately interested parties; or
- g. other corrective action.

12.4.2 The sanction must reasonably relate to the nature and severity of the violation, focusing on reformation of the conduct of the facility and deterrence of similar conduct by others. The sanction decision may also take into account aggravating circumstances, prior adverse action history, and mitigating circumstances. No single sanction will be appropriate in all situations.

12.5 Complaints

12.5.1 Persons concerned with possible violation of IAC *Standards*, policies and procedures are encouraged to contact the IAC. The person must complete the complaint form located on the IAC websites, and the form should be accompanied by any available documentation. The person making the complaint should identify himself/herself by name, address and e-mail address. If requested, the IAC will make efforts to protect the identity of the person filing the complaint but confidentiality cannot be guaranteed. The IAC will also consider anonymous complaints as long as sufficient information is provided to enable IAC to conduct an appropriate investigation.

12.5.2 Actions taken under this policy do not constitute enforcement of the law. Individuals bringing complaints under this policy are not entitled to any relief or damages by virtue of this process.

12.6 **Pending Allegations** – If an allegation of noncompliance is pending against a facility, then the IAC may withhold accreditation or reaccreditation until the IAC has made a final determination regarding the allegation.

12.7 Compliance Monitoring Procedures

12.7.1 Initial Evaluation

- a. Upon receipt of a complaint, the Director of Compliance will confer with the Division Board President. They may request supplemental information.
- b. If they determine that the complaint is frivolous or that the change is not relevant to accreditation program compliance, no further action will be taken. If they determine that a matter is beyond the jurisdiction of the IAC, they may refer the matter to the appropriate governmental agency or another entity engaged in the administration of law.
- c. If they determine that the complaint is not frivolous or that the change may be relevant to accreditation program compliance, IAC staff will be assigned to investigate.

12.7.2 **Audits** – The IAC may conduct one or more compliance audits. If the IAC discovers a possible violation of IAC rules, the Director of Compliance will confer with the Division Board President to determine whether IAC staff will continue to investigate the allegation.

12.7.3 IAC Staff Investigation

- a. The Director of Compliance will assign one or more staff members to investigate the complaint a IAC staff member may not:
 - i. review any matter in which his or her impartiality might reasonably be questioned; or
 - ii. review any matter which presents an actual, apparent or potential conflict of interest.

- b. Staff will investigate the matter upon assignment by the Director of Compliance, staff may contact the individual who submitted the complaint, the facility in question, and others who may have knowledge of the facts and circumstances surrounding the allegations. Staff may conduct an investigative site visit.
- c. Staff may also consult with the Complaint Review Committee. The IAC Board of Directors will appoint a Complaint Review Committee to assist the Chief Executive Officer and staff in the investigation of allegations regarding facilities. This committee will be ad hoc and composed of at least 3 members. A committee member may not:
 - i. review any matter in which his or her impartiality might reasonably be questioned;
 - ii. review any matter involving a facility located within 50 miles of where the member lives or works; or
 - iii. review any matter which presents an actual, apparent, or potential conflict of interest.
- d. If the staff member(s) determine after the investigation that the facts are inadequate to sustain a finding of a violation of IAC rules, no further action will be taken.
- e. If the staff member(s) find that good cause exists to question whether a violation of an IAC rule has occurred, the Chief Executive Officer will transmit a statement of the following information to the facility by a traceable delivery service, signature required:
 - i. the applicable rule;
 - ii. the facts constituting the alleged violation;
 - iii. that the facility may request an oral hearing (in person or by phone) or a review by written briefing for the disposition of the matter, with the facility bearing its own expenses;
 - iv. that the facility has 30 days after receipt of the statement to notify the IAC if it disputes the allegations, has comments on available sanctions, and/or requests an oral hearing in person, an oral hearing by phone or a review by written briefing;
 - v. that, in the event of an oral hearing, the facility may appear in person with or without the assistance of counsel, may examine and cross-examine any witness under oath, and produce evidence on its behalf;
 - vi. that the truth of allegations or failure to respond may result in sanctions including revocation; and
 - vii. that if the facility does not respond, or if the facility responds but does not dispute the allegations, comment on available sanctions, or request a review or hearing, then the facility waives its right to further review and appeal, and consents to the Chief Executive Officer rendering a final decision on the evidence before him/her and applying available sanctions.
- f. If the facility disputes the allegations or available sanctions, the Chief Executive Officer may offer the facility the opportunity to negotiate a specific sanction in lieu of proceeding with a written review or hearing. Any agreed-upon sanction must be documented in writing and signed by the IAC and the facility. If the facility is unwilling to accept the Chief Executive Officer's offer, the requested review or hearing will proceed as provided below.

12.7.4 Compliance Monitoring Committee

- a. The IAC Board of Directors will appoint a Compliance Monitoring Committee to consider allegations. This committee will be ad hoc and composed of three members, no more than two from the same division, as needed. A Compliance Monitoring Committee member may not:
 - i. have participated in the initial review as part of the Complaint Review Committee;
 - ii. review any matter in which his or her impartiality might reasonably be questioned;

- iii. review any matter involving a facility located within 50 miles of where the member lives or works; or
 - iv. review any matter which presents an actual, apparent, or potential conflict of interest. Committee action is determined by majority vote.
- b. **Written Review** – If the facility requests a review by written briefing, the Chief Executive Officer will forward the allegations, the record of the investigation, the determination of a violation, the recommendation regarding sanction(s), and the response of the facility to the Compliance Monitoring Committee. Written briefing may be submitted within 30 days following receipt of the written review request by the Compliance Monitoring Committee. The Compliance Monitoring Committee will render a decision based on the record below and written briefs (if any) without an oral hearing.
- c. **Oral Hearing** – If the facility requests a hearing:
- i. The Chief Executive Officer will:
 - forward the allegations, the record of the investigation, the determination of a violation, the recommendation regarding sanction(s), and the response of the facility to the Compliance Monitoring Committee; and
 - designate one staff member to present the allegations and any substantiating evidence, examine and cross-examine witnesses and otherwise present the matter during the hearing.
 - ii. The Compliance Monitoring Committee will:
 - schedule a hearing after the request is received, allowing for an adequate period of time for preparation; and
 - send by traceable delivery service, signature required, a Notice of Hearing to the facility. The Notice of Hearing will include a statement of the time and place selected by the Compliance Monitoring Committee. The facility may request modification of the time and place for good cause. Failure to respond to the Notice of Hearing will be deemed to be the facility’s consent for the Chief Executive Officer to administer any sanction that he/she considers appropriate.
 - iii. The Compliance Monitoring Committee will maintain a verbatim oral or written transcript.
 - iv. The IAC and the facility may consult with and be represented by counsel, make opening statements, present documents and testimony, examine and cross-examine witnesses under oath, make closing statements and present written briefs as scheduled by the Compliance Monitoring Committee.
 - v. The Compliance Monitoring Committee will determine all matters related to the hearing.
 - vi. Formal rules of evidence do not apply. Relevant evidence may be admitted. Disputed questions will be determined by the Compliance Monitoring Committee.
 - vii. The right to the hearing may be forfeited if the facility fails to appear without good cause.
 - viii. In all written reviews and oral hearings:
 - the Compliance Monitoring Committee may accept, reject, or modify the recommendation of the Chief Executive Officer, either with respect to the determination of a violation or the recommended sanction; and
 - proof is by preponderance of the evidence.

- 12.7.5 The Compliance Monitoring Committee will issue a written decision following the review or hearing and any briefing. The decision will contain factual findings, conclusions regarding the IAC's rules, and any sanctions applied. It will be mailed promptly by traceable delivery service, signature required, to the facility.
- 12.7.6 If the decision rendered by the Compliance Monitoring Committee finds that the allegation is not established, no further action on the matter will occur.
- 12.7.7 If the decision rendered by the Compliance Monitoring Committee is not favorable to the facility, the facility may appeal the decision to the Appeals Body.
- 12.7.8 Facilities submitting change notices and persons submitting complaints will be notified of the decision of the Compliance Monitoring Committee.

12.8 Appeals Body

- 12.8.1 The IAC Chairperson will appoint an Appeals Body to consider the appeal. The Appeals Body is composed of three members drawn from the IAC Board of Directors. An Appeals Body member may not:
 - a. have participated in the initial review as part of the Complaint Review Committee or in the initial hearing as part of the Compliance Monitoring Committee;
 - b. review any matter in which his or her impartiality might reasonably be questioned;
 - c. review any matter involving a facility located within 50 miles of where the member lives or works; or
 - d. review any matter which presents an actual, apparent, or potential conflict of interest. When an Appeals Body member is unavailable, the IAC Chairperson will designate another individual to serve as an interim member. Appeals Body action is determined by majority vote.
- 12.8.2 The facility may request an appeal within 30 calendar days after its receipt of the Compliance Monitoring Committee's decision. After this time, the facility may not request an appeal.
- 12.8.3 All appeals must be submitted in writing and sent to the IAC by traceable mail or delivery service.
- 12.8.4 The appeal request must specify a valid basis for the appeal. If the IAC Chairperson determines that the request is frivolous, then the appeal will not proceed.
- 12.8.5 The facility will be allowed a period of 30 days after the IAC's receipt of the appeal request in which to submit a written brief in support of his/her appeal.
- 12.8.6 The Chief Executive Officer may file a written response to the appeal request.
- 12.8.7 The Appeals Body will render a decision based on the record below and written briefs (if any) without an oral hearing. Alternatively, the Appeals Body may choose to conduct a new in-depth review of all the facts and rules (a "de novo" review). Only facts and conditions up to and including the time of the Compliance Monitoring Committee's determination are considered during an appeal.
- 12.8.8 In all reviews:
 - a. In order to overturn a decision of the Compliance Monitoring Committee, the facility must demonstrate that the Committee's decision was inappropriate because of (a) material errors or fact or (b) failure to conform to the IAC's rules. Proof is by preponderance of the evidence.
 - b. The Appeals Body may accept, reject, or modify the decision of the Compliance Monitoring Committee, either with respect to the determination of a violation or the recommended sanction. The Appeals Body will issue a written decision following the review and any briefing. The decision will

contain factual findings, conclusions regarding the IAC's rules, and any sanctions applied. It will be mailed promptly to the facility by traceable delivery service, signature required.

12.8.9 A decision rendered by the Appeals Body is final.

12.8.10 Facilities submitting appeals and persons submitting complaints will be notified of the decision of the Appeals Body.

- 12.9 **Summary Procedure** – If the Chief Executive Officer and Division Board President determine that there is cause to believe that a threat of immediate and irreparable injury to the public exists, they will forward the allegations to the IAC Board of Directors. The Board of Directors will review the matter immediately and provide telephonic or other expedited notice and review procedures to the facility. If the Board of Directors determines (following this notice and opportunity to be heard) that a threat of immediate and irreparable injury to the public exists, accreditation may be suspended for up to 90 days pending a full review as provided above.
- 12.10 **Reinstatement of Eligibility.** Following a period of ineligibility based on noncompliance with IAC *Standards*, policies and procedures, the facility may apply for reinstatement of eligibility by demonstrating that it has taken corrective action. Unless and until clear and convincing evidence is submitted, the facility will remain ineligible.
- 12.11 **Continuing Jurisdiction.** The IAC retains jurisdiction and may review and issue decisions regarding any matter which occurred prior to the termination, expiration, or relinquishment of accreditation.

Section 13: Corrective Action Policy

This policy has been adopted to establish a fair process for addressing corrective action to be taken by a facility seeking accreditation following a violation of the “Use of IAC Trademarks” policy.

13.1 **General Principle.** Eligibility with conditions may be appropriate when a facility requires greater supervision but is still able to perform quality professional services.

13.2 **Conditions Upon Eligibility.**

13.2.1 As a condition of eligibility to seek accreditation, IAC may impose one or more of the conditions listed below following a violation of the “Use of IAC Trademarks” policy:

- a. an in-person appearance before IAC to present an explanation and answer questions;
- b. reimbursement of IAC’s costs related to the matter;
- c. a delay in eligibility;
- d. supplemental monitoring, such as additional site visits by IAC or practice/billing monitors;
- e. supplemental continuing education or training;
- f. self-reporting to CMS, state boards, insurers and other legitimately interested parties; and
- g. other corrective action.

13.2.2 The condition(s) must reasonably relate to the nature and severity of the violation, focusing on reformation of the conduct of the facility and deterrence of similar conduct by others. The condition decision may also take into account aggravating circumstances, prior adverse action history and mitigating circumstances. No single condition will be appropriate in all situations.

13.3 **Review Request.** A facility may initiate this review process by submitting the following documents to IAC.

13.3.1 **Written Statement.** The facility shall submit a written explanation of the matter. In order to be eligible to proceed with its accreditation, the facility must demonstrate that measures have been implemented to prevent a recurrence of the violation.

13.3.2 **Application.** The facility may also submit any additional testing areas, equipment or sites however, the IAC will place the application on hold until the matter is resolved.

13.4 **IAC Staff Review.**

13.4.1 The Chief Executive Officer (CEO) will assign one or more staff members to review the matter. Staff may contact the facility in question and others who may have knowledge of the facts and circumstances surrounding the matter. Staff may also consult with the IAC Executive Committee.

13.4.2 The CEO may offer the facility the opportunity to negotiate one or more specific conditions. Any agreed-upon condition(s) must be documented in writing and signed by IAC and the facility. If the facility is unwilling to accept the CEO’s offer, then the matter will be forwarded to the Executive Committee.

13.5 **Review by Executive Committee.**

13.5.1 The CEO will forward the request and the record of the staff review to the Executive Committee.

13.5.2 The Executive Committee will render a decision based on the record without an oral hearing.

13.5.3 The decision of the Executive Committee is final and may not be appealed.

Section 14: Release of Information

- 14.1 Information regarding accreditation decisions will not be disclosed until written notice of that decision has been sent to the facility.
- 14.2 Application information and accreditation decisions will not be released to an accreditation consultant without documented authorization from the facility.
- 14.3 If accreditation is granted, the IAC will publish the facility's accreditation status and the expiration in a directory of accredited facilities. The IAC may also post a link on the IAC website to the facility's website.
- 14.4 The IAC may also publish the following information:
 - 14.4.1 whether a facility's application is pending; and
 - 14.4.2 whether any adverse action has been taken regarding a facility, such as revocation or suspension of accreditation. Regarding adverse actions, the IAC will release the effective date of the action and a summary of the reasons for the action. Information regarding adverse actions is released only after the facility's right of appeal has been exhausted.
- 14.5 Centers for Medicare & Medicaid Services (CMS) and other insurers require certain information be provided by recognized health care accreditation organizations. The IAC will provide CMS and other insurers, on an ongoing basis, the information listed below:
 - 14.5.1 copies of all accreditation applications, together with any site visit-related information that CMS may require (including corrective action plans and summaries of findings with respect to unmet CMS requirements);
 - 14.5.2 notice of all accreditation decisions;
 - 14.5.3 notice of complaints related to the suppliers or providers;
 - 14.5.4 information about accredited suppliers against which the IAC has taken remedial or adverse action, including revocation, withdrawal, or revision of the supplier's accreditation (with notice given in writing within 30 calendar days of any such action being taken);
 - 14.5.5 information about any deficiency that poses an immediate jeopardy to the facility's beneficiaries or a hazard to the general public (with notice given in writing [electronically or hard copy] within two business days of the IAC's discovery of the deficiency); and
 - 14.5.6 summary aggregate data specified by CMS and other insurers that relates to the past year's accreditations and trends (provided on an annual basis).
- 14.6 The IAC rents its mailing list to organizations and companies who offer products that might be of interest to facilities. A facility with an online accreditation account may opt-out of this use via the IAC online accreditation profile section or written notification.
- 14.7 The IAC shares data about facilities for research purposes. No patient identifiable information is shared. A facility may opt-out of this use via the IAC Online Accreditation profile section or written notification.
- 14.8 Application reviewers' identities are never disclosed and are not released under any circumstances. The only information released regarding site visit representatives is name and place of employment. The names of IAC Directors and Division Board members are published on the IAC websites. If CMS takes an adverse action based on accreditation findings, the IAC must allow its representatives to serve as witnesses.

- 14.9 As a general rule, all other facility and IAC information is treated as confidential and privileged. The IAC will, in its discretion, exercise sound judgment with respect to assistance in an investigation by other parties, such as a regulatory agency, another accreditation organization or a payer. However, the IAC must release information as required by law or court order, and will notify governmental agencies if it discovers a performance deficiency that violates federal, state or local laws or otherwise presents a threat to the public.
- 14.10 The IAC, its staff and board members will not serve as or suggest an expert witness under any circumstance.