



**FACILITY ASSESSMENT TOOL  
FOR IN-OFFICE DIAGNOSTIC IMAGING**

***NUCLEAR MEDICINE***

**(e.g., CPT codes\* 78451, 78452, 78453, 78454, 78466, 78468, 78469, 78472, 78473,  
78481, 78483, 78494, 78496)**

***SELECTED DIAGNOSTIC ULTRASOUND STUDIES***

**(e.g., CPT codes\* 76801 - 76814, 76818 – 76821)**

***AND/OR***

***FETAL ECHOCARDIOGRAPHY STUDIES***

**(e.g., CPT codes\* 76825, 76826, 76827, 76828)**

***\*CPT codes subject to change***

.....  
**Please complete the form below and return with all required documentation to:**

**HealthPlus Privileging  
Attention: QM/Credentialing  
2050 S. Linden Rd.  
Flint, MI 48532**

**Or fax all documentation to HealthPlus QM/Credentialing at 810.230.2106.**

**If you have questions, contact the HealthPlus QM/Credentialing Department at  
810.230.2058.**

.....

**FACILITY ASSESSMENT TOOL**

**Note: This tool must be completed only if you perform nuclear medicine or selected diagnostic ultrasound studies in your office. HealthPlus requires that providers performing these tests be accredited through ICANL, ACR, or AIUM.**

**I. PROFESSIONAL INFORMATION**

**A. Practice Name:** Group or Practice

Name\*: \_\_\_\_\_

Specialty: \_\_\_\_\_

*\*Complete a separate FACILITY ASSESSMENT TOOL form for each site at which you perform imaging if your practice is at multiple locations.*

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ County: \_\_\_\_\_ State: \_\_\_\_\_

Zip: \_\_\_\_\_

Telephone: \_\_\_\_\_ Facsimile: \_\_\_\_\_

E-mail: \_\_\_\_\_

Please provide qualifications of person(s) performing the test:

Certified by American Registry of Radiology Technologists

Certified by American Registry of Radiology Technologists in Mammography

Certified by American Registry of Diagnostic Medical Sonographers

State Licensed

Please indicate who is performing the professional interpretation of the exams for this practice:

Board Certified Physician within the practice  Specialty? \_\_\_\_\_

A contracted Board Certified Radiologist

Other  (specify) \_\_\_\_\_

**II. SITE INFORMATION**

*\*Include only those facilities participating in the HealthPlus of Michigan network*

**A. Facility Name (if different from name of Group):**

\_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ County: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone: \_\_\_\_\_ Facsimile: \_\_\_\_\_

Tax ID Number \_\_\_\_\_

**B. Type of Facility**

Radiology Service within a Multi-Specialty Group Practice

Private Practice other than radiology specialty practice

**C. Equipment Owner's Name, Address, Telephone, Fax, and Tax ID Number (If Different Than Above):**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**D. Practice Ownership/Operational Structure (check all that apply)\*:**

Corporation     Partnership     Professional Corporation

Sole Proprietorship     Faculty Practice Plan

\* If more than one is checked, please explain:

\_\_\_\_\_

Do any physicians who make referrals to your practice have any of the following financial relationships with your practice:

\_\_ Yes \_\_ No    Have an ownership or other financial interest in any of the equipment utilized by your practice?

\_\_ Yes \_\_ No    Have an ownership or other financial interest in any of the office space utilized by your practice?

\_\_ Yes \_\_ No    Have any form of compensation arrangement with your practice (e.g., provide medical, consulting, administrative, billing, etc.)?

• If any answer above is YES please provide details in a separate letter.

**E. Physicians** – List\* all physicians who practice within your entity and their relationship to your entity, e.g., shareholder, partner, member, employee, etc. In addition, please list board certification status of each physician. \*Attach a separate sheet if needed.

Name	Relationship	Board Certified Yes or No?	If Yes, Name of Board	Indicate Specialty

**F. Equipment On-Site** (Presence of equipment does not guarantee privileging):

- X-Ray   
  Mammo   
  Fluoroscopy   
  Nuc Med\*\*   
  CT  
 MRI   
  DEXA   
  Ultrasound\*\*   
  MRA   
  PET   
  PET/CT

Special Invasive Procedures (Detail) \_\_\_\_\_

Other (Describe) \_\_\_\_\_

**\*\* For nuclear cardiology, please provide copy of ACR/ICANL accreditation**  
**For fetal echocardiography, please provide a copy of ICAEL accreditation**  
**For complex OB ultrasounds, please provide copy of AIUM/ACR accreditation**

**G. Equipment Specifications** (Complete for each piece of equipment):

Type of Equipment	Manufacturer	Model #	Year Manufactured	Year Installed	Date of Last Upgrade

**H. Critical Operating Policies/Procedures:** (Please indicate for which of these you have written policies)

Policy	Yes	No	N/A	Policy	Yes	No	N/A
Quality Assurance Plan				Fire and Disaster Plan			
Emergency Cart Policy				Patient Reaction Policy			
Nuclear Medicine Spills Policy				Results Reporting Policy			
Film labeling Standards				Radiation Safety			
Written Techniques/protocols for each individual study				Quality Control Plan for each piece of equipment			
Film Processor Maintenance Policy				Chemical Hazards Safety Plan			
Bloodborne Pathogen Compliance Policy and Procedure				Complaints Policy and Procedures			
PACS Quality Assurance Program				Teleradiology Quality Assurance Program			

***I HEREBY CERTIFY THE ABOVE INFORMATION TO BE COMPLETE AND CORRECT.***

**Group Name:** \_\_\_\_\_

**Name: (Please Print)** \_\_\_\_\_

**Signature:** \_\_\_\_\_

**Title:** \_\_\_\_\_

**Date:** \_\_\_\_\_

***Please note: This must be signed by the Lead Physician or Officer of the group, preferably the President.***

### III. STANDARDS OF PARTICIPATION

#### A. Performance Standards:

- All equipment will be inspected, licensed, and approved by the appropriate government regulatory authority.
- All equipment will be maintained so that it will meet ACR recommended performance guidelines.
- All diagnostic-imaging procedures must be performed by professionals licensed and registered/certified as appropriate. (See Accreditation Guidelines 1.A. Qualifications for Diagnostic Imaging Technologists for details).
- A physician privileged to perform the diagnostic imaging exam must be immediately available to supervise cases and/or respond to requests for protocol alterations by the technologist 100% of the time that any site is in operation.
- Positive or unexpected significant findings will be directly communicated by the interpreting, privileged physician to the patient or patient designee and the referring physician or healthcare provider upon interpretation. The final report will be typed and proofread and in compliance with written report requirements within 48 hours of the exam.
- All chest x-rays performed by a Primary Care Physician require 100% over-read by a Board Certified Radiologist.

#### **Report Requirements:**

Reports should:

- (1) Be legibly printed,
  - (2) Include sufficient identification of the patient, referring and interpreting physicians,
  - (3) Be specific as to the date and time (if appropriate) of the examination, interpretation, and transcription,
  - (4) Include appropriate clinical history and indication for the examination, including ICD9 codes when available.
  - (5) Describe any drugs, contrast material, catheters and other materials administered during the course of the examination in full detail. Dosages, concentrations, means of injection, and routes of administration should be recorded, along with any reactions or other complications.
  - (6) Describe the findings of the study, and include an interpretation of those findings.
    - (a) A differential diagnosis should be provided where appropriate.
    - (b) Recommendations for further studies or follow up should be included where appropriate.
  - (7) Reports should be made available to the requesting physician in a timely manner, and should be delivered as rapidly as possible.
    - (a) Positive findings are to be communicated to the referring physician, if applicable, or designee upon interpretation.
    - (b) All dictated reports are to be printed and targeted to be mailed to the referring physician within 48 hours of dictation.
    - (c) Standards will be based on those promulgated by the American College of Radiology and such other professional organizations, as it deems appropriate.
- Patient films and reports will be maintained as required by the appropriate regulatory agencies and practice policy. The final report should be retrievable. A uniform policy regarding the release of films will be established and will include provisions for routine monitoring of film release and return.
  - All offices will be staffed and supervised by privileged physicians.
  - A patient incident report will be completed for all (100%) reactions and complications of

procedures including but not limited to failure to identify pregnant patients prior to performance of an x-ray examination, contrast reactions, seizures, patient mishaps, etc. Patient incident reporting will include, at a minimum, the following information: patient demographics, description of incident, treatment, resolution, or follow-up. Each incident will be evaluated immediately by the board certified supervising physician.

- All imaging studies must be interpreted by and reports signed by a board certified privileged physician who meets the credentialing standards in the credentialing section of this document.

These policies may be amended from time to time.

#### **IV. ACCREDITATION GUIDELINES**

##### **A. General:**

1. Qualifications for Diagnostic Imaging Technologists
  - a) General Radiography: All diagnostic-imaging technologists must have current registration by the American Registry of Radiologic Technologists (ARRT) or an unrestricted license from the state in which they work and a record of no less than 15 hours of continuing education for the prior two years.
  - b) Nuclear Medicine:
    - All nuclear medicine technologists must have successfully completed an accredited training program in nuclear medicine technology. The technologist must satisfy all state and federal regulations pertaining to in vivo and in vitro use of radiopharmaceuticals and performance of imaging procedures.
    - Or
    - Special current registration by the ARRT (N) or equivalent body as recognized by the American College of Radiology, certification by the Nuclear Medicine Technology Certification Board (NMTCB), or state licensure for nuclear medicine technology.
  - c) Diagnostic Medical Ultrasound: Diagnostic medical sonographer qualifications must be demonstrated by certification or eligibility for same by a nationally recognized certifying body.
2. All facilities with radiology equipment must have a current license from the Michigan Department of Community Health (or other appropriate state licensing board(s) on site which must be available for inspection. When requested by CCN, Facility agrees to arbitrate when conflicts and questions about any equipment specifications and/or performance arise.

##### **B. Facility Accreditation:**

1. Facilities performing screening and/or diagnostic mammography must be certified by the Food and Drug Administration (FDA), in accordance with the requirements of the Mammography Quality Standards Act (MQSA). This includes all facilities, whether fixed or mobile. Each mammography unit in the Facility must be individually certified in order for the Facility to be accredited. Facility must submit a copy of its' current FDA and ACR certificates to CCN upon request.
2. Facilities performing complete obstetrical ultrasound (76805, 76810, 76811, and 76812) examinations must be certified for OB Ultrasound by either the American College of Radiology (ACR) or the American Institute of Ultrasound in Medicine (AIUM). Facility must submit a copy of this certification to CCN in order for the Facility to continue

providing complete obstetrical ultrasound examinations.

3. Facilities performing Nuclear Cardiology examinations must be accredited by the Intersocietal Commission for the Accreditation of Nuclear Laboratories (ICANL) or the American College of Radiology (ACR), or comparable accreditation program as approved by CCN. Facility must submit copy of this accreditation to CCN.

## **V. REQUIRED STANDARD OPERATING PROCEDURES**

### **A. Bloodborne Pathogen Policy and Procedure (if applicable):**

- Written policy must adhere to OSHA guidelines
- Sharps containment practices must coincide with NIOSH guidelines

### **B. Complaints Policy and Procedure:**

- Written description
- Responsible party chain of command for handling complaint
- Resolution or outcome

### **C. Radiation Protection/Monitoring:**

- Film badges worn and stored appropriately
- Film badge exposure reports are current, accessible to staff
- Protective lead shielding is hung and stored appropriately
- Evidence of lead aprons and shields integrity testing biannually (record of fluoroscopic examination dates)
- Appropriate and obvious posting of Radiation Warning signs
- Appropriate and obvious posting of Pregnancy Warning signs

### **D. Fire and Disaster Plan:**

- Locations of fire extinguishers, alarms and exits
- Clear and precise plans for egress
- Responsibility of personnel to assist patients
- Responsibility of Supervisors/Director of Operations to survey the department areas ensuring all have exited the building
- Employee roster availability for removal to ensure all employees are accounted for
- Written confirmation of receipt of Fire and Disaster Plan information by all personnel

### **E. Emergency Cart Policy (if applicable):**

- Equipment list
- Medications list
- List personnel responsible for inspection and maintenance to ensure equipment is functioning and medications are current
- Dose and Indications list (Adult as well as Pediatric) posted in each contrast administration location
- Patient Incident and Reaction Policy to include:
  - Patient Demographics
  - Description of incident
  - Treatment
  - Resolution or Follow-up
  - Evaluation by Radiologist

### **F. Results Reporting Policy:**

- Must provide written reports to referring physicians within 48 hours of performing the procedure

- Significant positive findings are phoned and or faxed immediately upon interpretation

**G. Chemical Hazards Safety Plan:**

- Follow OSHA guidelines for written policies
- Include a record of any and all hazardous information sheets and make available to all personnel (if applicable)

**H. Nuclear Medicine Spills Policy (if applicable):**

- Nuclear Regulatory Commission (NRC) guidelines must be posted in isotope storage and accessible to administration areas
- Policy and Guidelines to be included in Facility Policy and Procedure Manual

**I. Overall Quality Improvement Plan, QI/QA/QC should include the following:**

- Personnel performance, evaluation criteria
- Patient satisfaction surveys and analysis
- Repeat film analysis
- Peer review
- Imaging equipment testing, calibration, and evaluation of down time
- Processor monitoring and maintenance
- Continuing education

***I HEREBY CERTIFY THAT I AM IN COMPLIANCE WITH THE QUALITY & PARTICIPATION REQUIREMENTS DETAILED HEREIN.***

**Group Name:** \_\_\_\_\_

**Name: (Please Print)** \_\_\_\_\_

**Signature:** \_\_\_\_\_

**Title:** \_\_\_\_\_

**Date:** \_\_\_\_\_

***Please note: This must be signed by the Lead Physician or Officer of the group, preferably the President.***