



**FREE-STANDING
FACILITY ASSESSMENT**

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

**Health Plus Privileging
Attention: Medical Management Department
2050 S. Linden Rd.
Flint, MI 48532**

Alternatively, fax all documentation to HealthPlus Medical Management at 810.230.2002.

If you have questions, contact the Imaging Management Project Manager at 810.733.1938

Please attach the following documents to this Free-Standing Facility Assessment Tool:

**REQUIRED DOCUMENTS
(as applicable)**

_____A copy of the Certificate of Registration for each site

_____A copy of the Premises Liability Coverage face sheet for each site (minimum \$1/3 million)

_____A copy of the Professional Liability Insurance for Non-Physician/Technicians A copy of a completed W-9 for each site

_____A copy of the site's Nuclear Medicine Radioactive Materials License if providing Nuclear Medicine or PET services

_____Current ACR, ICANL or AIUM accreditation for the following: For new/newly added equipment, ACR certification must be providing within 6 months of first clinical use or modality privilege shall be deactivated

- Mammography FDA certificate and ACR accreditation for each piece of equipment
- MRI for each piece of equipment
- CT for each piece of equipment
- PET
- Nuclear Medicine
- Obstetrical Ultrasound
- Ultrasound

_____A copy of a current State/Physicist inspection for the following and any corrective action taken for deficiencies:

- Mammography
- MRI
- CT
- Radiography and Fluoroscopy
- Nuclear Medicine
- PET or PET/CT

CARECORE NATIONAL, LLC
FREE-STANDING FACILITY ASSESSMENT TOOL

I. PROFESSIONAL INFORMATION:

A. Radiology Group:

Group Name*: _____

** Complete a separate FACILITY ASSESSMENT TOOL form for each entity if your practice utilizes multiple entities.*

Street Address: _____

City: _____ County: _____ State: _____ Zip: _____

Telephone: _____ Facsimile: _____ E-mail: _____

Tax ID Number: _____

II. FACILITY'S INFORMATION:

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

Street Address: _____

City _____ County _____ State _____ Zip _____

Telephone: _____ Facsimile: _____

Tax ID Number: _____ Website Address: _____

Type of Facility:

Free Standing Imaging Center

Radiology Service within a Private Medical Group or Practice

Mobile Service

Other (list)

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

C. Operational Structure (check all that apply):

- | | | |
|----------------------------|-------------------------------|-----------------------|
| Corporation | Limited Liability Company | Government |
| Not-For-Profit Corporation | Professional Corporation | Partnership |
| Sole Proprietorship | Limited Liability Partnership | Faculty Practice Plan |
| Subsidiary | | |

*If More than one is checked, please explain: _____

*If Subsidiary, name and address of Parent Company: _____

D. Physicians* –List all physicians who practice at this site and their relationship to this site, e.g., shareholder, partner, member, employee, etc. Please list board certification status of each physician, and if board eligible, date of initial board eligibility.

Name	State License Number	Relationship	Board Certified Yes or No?	If yes, name of Board	If no, date initially eligible

**Attach a separate sheet if needed*

E. **Physicians** - Please list location and date of fellowship training for each physician (if applicable)

Name	Fellowship Training Yes/No	If Yes, location and date

**Attach a separate sheet if needed*

F. **Ownership Status/Business Affiliations:**

1) **If any item of equipment is leased, from whom?**

- | | | |
|--|---------------------------------------|------------------------|
| Bank | Hospital | Leasing Company |
| Another Physician Group* | Equipment Manufacturer | Turnkey Facility Lease |
| Full time Equipment/
Facility Lease | Per diem Equipment/ Facility
Lease | |
| Other: (explain): _____ | | |

***If equipment is leased from another physician group, CareCore National may require further details about this arrangement.**

2) **Does your practice lease or own its office space?**

- | | | | |
|------------------------------|------------------------|---------------------------|------------|
| | | Lease | Own |
| If leased, from whom? | | | |
| Commercial Landlord | Hospital | Members of your own group | |
| Another Physician Group* | Other (explain): _____ | | |

***If office space is leased from another physician group, CareCore National may require further details about this arrangement.**

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

- a) Have an ownership or other financial interest in any of the equipment utilized by your practice? **Yes No**
- b) Have an ownership or other financial interest in any of the office space utilized by your practice? **Yes No**
- c) Have any form of compensation arrangement with your practice (e.g., provide medical, consulting, administrative, billing, etc.)? **Yes No**

2) Is the facility shared with any other physician, physician group or other legal entity?
Yes No

G. Equipment On-Site (Check All That Apply):

X-Ray	Mammography	Fluoroscopy	Nuc Me
CT	MRI	Ultrasound	DEXA
MRA	MRI Spectroscopy	PET	PET/CT
Special Invasive Procedures (Detail) _____			
Other (Describe): _____			

H. Procedure Capacity vs. Current Utilization (Number Procedures Possible per Week vs. Actual Number Performed). Example: 100/50.

_____ X-Ray	_____ Mammo	_____ Fluoroscopy
_____ Nuc Med	_____ CT	_____ MRI
_____ MRA	_____ Ultrasound	_____ DEXA
_____ PET	_____ PET/CT	_____ MRI Spectroscopy
_____ Special Invasive Procedures (describe): _____		
_____ Other (describe): _____		

I. Contact Names/Telephone Numbers/Email Addresses:

Medical Director: _____

Billing/Collection: _____

Business Manager: _____

J. Days and Hours of Operations:

DAY:	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
AM:							
PM:							

K. Physician Site Coverage?

1) Does the site have on-site staffing by a board certified radiologist for a minimum of seven hours per day during normal business hours (Monday – Friday) Yes No

Sites within a 0.25 mile radius of each other shall be treated as a single site location for the purposes of meeting physician staffing requirements.

L. 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 Improvement 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			
Blood borne Pathogen Compliance Policy and Procedure				Complaints Policy and Procedures			
Incident Reporting Policy							

III. EQUIPMENT - DESCRIPTION, STANDARDS AND CAPABILITIES

If your facility operates more than one of the following pieces of equipment, please complete a copy of this Section for EACH individual system as well as for each machine.

A. **Magnetic Resonance Imaging:**

Manufacturer: _____ Model No.: _____

Year Manufactured _____ Date Installed _____

Date of last upgrade _____

Field Strength _____

- Open Fixed Stand-up
- Closed Mobile No Stand-up but has weight-bearing device

If Mobile, days of the week available: _____

- Capabilities (Check All That Apply): Staffed by Licensed, Registered Technologist(s)
- 3-D Spectroscopy Sedation Available on Site MRA

If MRA, list body parts imaged: _____

Breast MRI Provided: Yes No

Breast MRI Provided

List coils: _____

Additional Comments: _____

B. Computerized Tomography:

Manufacturer: _____ Model No.: _____

Year Manufactured: _____ Date Installed _____

Date of Last Upgrade _____ Fixed / Mobile

- Capabilities (Check All That Apply):
3-D Reformation Multi slice, specify (4, 16, 32): _____
Has weight-bearing device
Staffed, at all times, by Licensed, Registered Technologist(s)

Additional Comments: _____

C. Mammography

Manufacturer: _____ Model No.: _____

Year Manufactured: _____ Date Installed: _____

Date of Last Upgrade: _____ Fixed Mobile

Computer Aided Detection: Yes /No BIRADS Lexicon and Report Structure: Yes/No

- Capabilities (Check All That Apply):
Stereotactic Biopsy Needle Localization
Staffed by Mammography Certified Technologist(s)
- Do you utilize a processor dedicated just for Mammography use? Yes/No

D. Digital Mammography

Manufacturer: _____ Model No.: _____

Year Manufactured: _____ Date Installed: _____

Staffed by Licensed, Registered Technologist(s)

E. DEXA - BONE DENSITY

Manufacturer: _____

Model No. _____

Year Installed: _____

Date of Last Upgrade _____

• Equipment is staffed at all times by a: Licensed RT Physician

• Additional Comments: _____

F. Nuclear Medicine:

NUCLEAR CAMERA: Mobile Stationary non-SPECT Stationary SPECT

Number of Detectors: _____ Manufacturer: _____

Model _____ Year Manufactured _____ Serial Number _____

Check all that apply:

_____ Cardiovascular Nuclear Medicine

_____ Staffed at all times by NMTCB and certified ARRT(s) Technologist(s)

G. PET SCANNER or PET/CT PET / PET/CT

CT utilized without PET? Yes No

Do you use fusion software imaging? Yes / No If yes, fusion with: CT or MRI

Date of Last Upgrade: _____ Manufacturer _____

Model _____ Year Manufactured _____ Serial Number _____

H. Ultrasound:

Manufacturer: _____ Model No.: _____

Year Manufactured: _____ Date Installed _____

Date of Last Upgrade: _____ Fixed Mobile

Utilizes State-of-the-Art Technology (Check All That Apply):

- | | | |
|--------------|---------------------|------------------------|
| _____ 3.5MHZ | _____ 5MHZ | _____ 7.5MHZ |
| _____ Breast | _____ Cartoid | _____ Testicles |
| _____ P/V | _____ Endovaginal | _____ Endorectal |
| _____ Biopsy | _____ Color Doppler | _____ Echocardiography |
| _____ 3 D | _____ Other _____ | |

Staffed at all times by ARDMS certified Sonographer(s)

• Additional Comments: _____

I. Imaging

Film Processor Digital Radiology Computed Radiology

Manufacturer _____

Model # _____

J. Radiography and Fluoroscopy: (*Complete for each piece of equipment)

Manufacturer: _____ Model No.: _____

Year Manufactured: _____ Date Installed: _____ Date of last upgrade: _____

Staffed, at all times by Licensed, Registered Certified Technologist(s)

Additional Comments: _____

I HEREBY CERTIFY THE ABOVE INFORMATION TO BE COMPLETE AND CORRECT

RADIOLOGY GROUP: _____

NAME (PLEASE PRINT): _____

SIGNATURE BY LEAD PHYSICIAN: _____

TITLE: _____

DATE: _____