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Supplemental Application — Imaging Center

IMPORTANT NOTICE
This is a SUPPPLMENT to an MIEC application. This document alone is insufficient to apply for and be approved for coverage with MIEC. Be sure to submit this along with your complete signed and dated MIEC application.

APPLICANT

Entity or Last name, first name

IMAGING CENTER — ANSWERS A-I

A. Please list all locations where you provide services, and the corresponding estimated and actual number of reads information.

Name of Location (include the address)	Years in operation	Lease/ own space	Estimated # of reads for next 12 months	Actual # of reads for last 12 months

B. Please indicate the annual amount and percent of total of each type of image/read performed across **ALL** locations.

Type of Read	# of annual images/reads	Percent of total
Bone Density Scan		
X-ray		
Ultrasound		
Mammogram		
CT/PET/CAT scan		

Type of Read	# of annual images/reads	Percent of total
Sonogram		
MRI		
EKG/EEG		
Other not described or listed above		

C. What type of MRI do you perform? (check all that apply) ☐Open ☐Closed ☐N/A

D. Do you provide any Interventional Radiology procedures? ☐Yes ☐No

If yes, which ones? (check all that apply)

- ☐ Angioplasty
- ☐ Vein/vascular therapy
- ☐ Pain Management

E. Do you provide any mobile operations? ☐Yes ☐No **If yes,** what percent of services? _____%

F. Please indicate the number of physicians that read imaging from the center? _____

G. Do you allow physicians who are **NOT** owners/members/shareholders of the imaging center to perform reads at any location? ☐Yes ☐No

If yes, what percentage of the overall reads are performed by these physicians? _____%

H. Do you require physicians providing services at the facility to maintain their own SEPARATE professional liability insurance? ☐Yes ☐No

If yes, are they required to maintain limits of at least $1/3M? ☐Yes ☐No

If no, please explain: _____

I. Are the credentials of each physician reviewed by a medical staff committee and approved by the governing body prior to granting privileges? ☐Yes ☐No

IMAGING CENTER (continued) — ANSWERS J-W

J. Are peer review and quality improvement review conducted for all physicians and licensed independent practitioners? ☐ Yes ☐ No

If yes, how often: _____

K. Please indicate the number of the following types of professionals **EMPLOYED** by the imaging center:

- ☐ Nurse Practitioner
- ☐ Physician Assistants
- ☐ Nurse (RN, LPN)
- ☐ Technician (EKG, X-ray, Lab)
- ☐ Phlebotomist
- ☐ Medical Assistant
- ☐ Other (please describe): _____

L. Do you have a medical director? ☐ Yes ☐ No **If yes,** provide Name, Specialty, and license number.

Name _____ Specialty _____ License Number _____

M. Is the facility licensed? ☐ Yes ☐ No

N. Has the facility/operational license ever been revoked, suspended or voluntarily surrendered? ☐ Yes ☐ No

If yes, please explain: _____

O. Is the facility accredited/certified? ☐ Yes ☐ No **If yes,** by whom (check all that apply)

☐ CMS ☐ JCAHO ☐ AAAHC ☐ IAC ☐ ACR ☐ Other: _____

P. Do you perform: ☐ Initial reads ☐ Over reads/2nd reads ☐ External peer review services? (check all that apply)

Q. Do you administer contrast media? ☐ Yes ☐ No **If yes,** what type? (check all that apply) ☐ Ionic ☐ Non-ionic ☐ Low osmolar ☐ Other

Is a physician present during the injection of contrast media? ☐ Yes ☐ No

Do you have written protocols for handling allergic reactions? ☐ Yes ☐ No

R. Do you maintain any of the following resuscitative equipment? (check all that apply) ☐ Crash cart ☐ Defibrillator ☐ EKG ☐ Oxygen

Is all resuscitative equipment regularly maintained and kept up to date? ☐ Yes ☐ No ☐ N/A

S. Do you have emergency and transfer protocols in writing? ☐ Yes ☐ No

T. Are staff ACLS or BCLS certified? ☐ Yes ☐ No

U. What percentage of patients are under the age of 18? _____%

V. Do you have written policies and procedures that address infection prevention and control? ☐ Yes ☐ No

If yes, which of the following guidelines are those policies based on? (check all that apply)

- ☐ CDC
- ☐ State Department of Health
- ☐ Local Ordinances/Mandates
- ☐ Medical Specialty Society
- ☐ Other: _____

W. Do you have a documented procedure or process for communicating abnormal findings to the patient or referring physician? ☐ Yes ☐ No

TELEMEDICINE — ANSWERS A-C

A. Do you read slides/images from patients who are physically located in a different state than your principal licensure/practice location/primary residence? ☐ Yes ☐ No **If yes,** what states? _____

B. What percentage of your practice does this comprise? _____%

C. Are you licensed in all the states where the slides/images of your patients originate? ☐ Yes ☐ No

SIGNATURE

SIGNATURE

Signature _____ Date _____