BRITISH COLUMBIA | Ministry of Health

DIAGNOSTIC FACILITIES ADMINISTRATION

PUBLIC AND PRIVATELY-OWNED FACILITY APPLICATION

FORM D – ADD OR CHANGE OF DISTANCE-READING (DIAGNOSTIC ULTRASOUND TELEMETRY) CERTIFICATE OF APPROVAL

For all other applications, please review information available at: https://www2.gov.bc.ca/gov/content/health/practitioner-professional-resources/diagnostic-services/acdf-application-forms

DISTANCE-READING (DIAGNOSTIC ULTRASOUND TELEMETRY) POLICY

a) Both public and privately-owned facilities may apply for Distance-Reading (Diagnostic Ultrasound Telemetry) for ultrasound services they are approved to perform.

b) Both sending (transmitting) and receiving sites must hold an ultrasound Certificate of Approval from the Committee or the Commission.

c) Applications will be assessed based on patient access needs and the general and specific criteria in the *Policies and Guidelines of the Medical Services Commission's Advisory Committee on Diagnostic Facilities*.

d) An application must be submitted and approval received prior to any change in a facility's Distance Reading approval, including the type of ultrasound services transmitted or any change in receiving sites. Applications must include the addresses of all current and proposed sites.

IMPORTANT APPLICANT INFORMATION

Any publicly or privately-owned Diagnostic Facility in British Columbia intending to bill the British Columbia Medical Services Plan (MSP) for outpatient diagnostic services must obtain a *Certificate of Approval,* granted by the Advisory Committee on Diagnostic Facilities (ACDF) or the Medical Services Commission (MSC).

All Certificates of Approval are **site and owner-specific and cannot be transferred or assigned.** If a facility is sold, the new owner must apply for a new Certificate of Approval in order to bill MSP for the provision of outpatient services.

Once an application is approved, the applicant must ensure all required facility accreditation and practitioner credentialing is in place prior to billing MSP for outpatient services.

HOW TO COMPLETE AND SUBMIT THIS APPLICATION

Applicants should complete the entire application, including the Conflict of Interest Declaration and Disclosure, in as much detail as possible. Additional pages should be added and uploaded along with the application when additional space is required to provide complete information (please clearly indicate which questions/information you are providing additional information for).

When complete and authorized, the application must be submitted through the Ministry of Health's secure upload tool located at: https://www2.gov.bc.ca/submitacdf

It is the responsibility of the applicant to demonstrate the need for the diagnostic facility or service(s) that are the subject of this application.

For more information on the application and assessment process and the policies that govern it, it is recommended that all applicants review the Policies and Guidelines of the Medical Services Commission's Advisory Committee on Diagnostic Facilities, at: http://www.gov.bc.ca/diagnosticfacilitiespolicies

Personal information on this form (MSP Practitioner Number) is collected under the authority of the *Medicare Protection Act* and the Medical and Health Care Services Regulation. The information will be used as part of the assessment of an application pertaining to a diagnostic services facility. If you have any questions about the collection of this information, please contact Diagnostic Facilities Administration at DFAdmin@gov.bc.ca. Personal information is protected from unauthorized use and disclosure in accordance with the *Freedom of Information and Protection of Privacy Act* and may only be disclosed as allowed by that Act.

DISTANCE-READING (DIAGNOSTIC ULTRASOUND TELEMETRY)
PUBLIC AND PRIVATELY-OWNED FACILITY APPLICATION

FORM D

Application Date (YYYY / MM / DD)

TYPE OF APPLICATION (check *one* response)

- ◯ Add Distance-Reading to Existing Facility Certificate of Approval
- ◯ Change Conditions of Existing Distance-Reading Facility Certificate of Approval
  - ☐ Add Service
  - ☐ Add Receiving Site

PART A: DIAGNOSTIC ULTRASOUND TRANSMITTING FACILITY

Diagnostic Facility Name	Facility Number *(e.g. U1234)*	Facility Payee Number *(MSP billing)*

Diagnostic Facility Location *(unit/suite, street address, city, postal code)*

Diagnostic Facility Mailing Address *(if different from above)*

Current hours of ultrasound outpatient operation	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

Facility Phone Number	Facility Email *(if applicable)*	Facility Website *(if applicable)*

Name of Ultrasound Medical Director

Facility Ownership *(Health Authority/Agency/Corporation Name)*	Ownership type ◯ Publicly owned ◯ Privately owned

Facility Ownership Primary Contact Information	Facility Ownership Alternate Contact Information
Name	Name
Title	Title
Phone	Phone
Email	Email

CURRENT ULTRASOUND APPROVAL STATUS	
Does the applicant facility hold a current ultrasound Certificate of Approval? ◯ Yes *(please indicate ultrasound approval below)* ◯ No *(has an application for an ultrasound Certificate of Approval been submitted?)* ◯ No ◯ Yes *(date submitted):*	
CURRENT ON-SITE ULTRASOUND FACILITY APPROVED CATEGORIES/FEE ITEMS	
Approved Ultrasound Category ***(check all that apply)***	**Approved fees items** ***(list approved fee items if not approved for full category)****
☐ I – Ophthalmology	
☐ II – Obstetrics & Gynecology	
☐ III – Trans-Thoracic Echocardiography	
☐ Trans-Esophageal Echocardiography	
☐ IV – Limited Ultrasound	
☐ IV – Full	
☐ Doppler Studies	
☐ Nuchal Translucency	
CURRENT OFF-SITE ULTRASOUND FACILITY DISTANCE READING APPROVED CATEGORIES/FEE ITEMS (IF APPLICABLE)	
Approved Ultrasound Category ***(check all that apply)***	**Approved fees items** ***(list approved fee items if not approved for full category)****
☐ I – Ophthalmology	
☐ II – Obstetrics & Gynecology	
☐ III – Trans-Thoracic Echocardiography	
☐ Trans-Esophageal Echocardiography	
☐ IV – Limited Ultrasound	
☐ IV – Full	
☐ Doppler Studies	
☐ Nuchal Translucency	

If required, please attach additional pages

PART B: APPLICATION FOR DISTANCE READING SERVICES – TRANSMITTING FACILITY

Select the category/fee items being applied for (new or change of current distance reading approval) and list the facility numbers of the corresponding receiving sites

Ultrasound Category	Fee items (list fee items if not applying for full category)	Receiving (reading) sites
☐ II – Obstetrics & Gynecology		
☐ IV – Limited Ultrasound		
☐ IV		
☐ Nuchal Translucency		
Restricted to public ownership only		
☐ I – Ophthalmology		
☐ III – Trans-Thoracic Echocardiography		
☐ Trans-Esophageal Echocardiography		
☐ Doppler Studies		

If this application is approved, what is your estimated implementation date?	Month	Year

FACILITY ACCREDITATION

Has the diagnostic facility received appropriate accreditation from the Diagnostic Accreditation Program (DAP) to provide the service(s) referenced in this application?

◯ Yes *(please attach a copy of DAP Accreditation for Diagnostic Imaging with your application)* ◯ No ◯ Pending Approval

1. Primary Receiving Diagnostic Facility

Facility Name			Facility Number
Facility Location *(unit/suite, street address, city, postal code)*			
Medical Director	Department	Medical Director Email	Medical Director Phone

2. Alternate Receiving Diagnostic Facility

Facility Name			Facility Number
Facility Location *(unit/suite, street address, city, postal code)*			
Medical Director	Department	Medical Director Email	Medical Director Phone

3. Alternate Receiving Diagnostic Facility

Facility Name			Facility Number
Facility Location *(unit/suite, street address, city, postal code)*			
Medical Director	Department	Medical Director Email	Medical Director Phone

4. Alternate Receiving Diagnostic Facility

Facility Name			Facility Number
Facility Location *(unit/suite, street address, city, postal code)*			
Medical Director	Department	Medical Director Email	Medical Director Phone

If additional sites are required, please attach additional pages

TRANSMITTING FACILITY EQUIPMENT *(Provide details of equipment to be utilized for the service for which you are applying)*

Total Number of Outpatient Ultrasound Rooms:

Name/Brand of Equipment	Year/Make/Model	Year Installed	Daily Exam/Test Limit	Detail (as relevant)

RATIONALE FOR APPLICATION

- ◯ Medical Need
- ◯ Health & Safety
- ◯ Other (please specify)

Please provide detailed rationale for application. Specify any gaps in current availability of this diagnostic service for the geographic area the applicant diagnostic facility is expected to serve (as applicable). Append additional information as required.

CURRENT ULTRASOUND FACILITY COVERAGE

Describe current coverage arrangement of the transmitting facility.

IMPACT/ACCESS

Describe how the proposed service will improve the delivery and management of patient services and/or improve access and availability of the service(s) being applied for at the transmitting facility.

DISTANCE READING VOLUME ESTIMATES		
Category, test and/or fee items	**On-site Ultrasound Services**	**Off-site Ultrasound Services**
	Projected Monthly Volume of Total MSP Billable Services	***Projected Number/Percent of Total Volume to be sent by Distance Reading***
☐ II – Obstetrics & Gynecology		
☐ IV – Limited Ultrasound		
☐ IV		
☐ Nuchal Translucency		
Restricted to public ownership only		
☐ I – Ophthalmology		
☐ III – Trans-Thoracic Echocardiography		
☐ Trans-Esophageal Echocardiography		
☐ Doppler Studies		

Note: If facility is seeking to increase approved monthly volume of ultrasound services, please submit a facility expansion application

STAFFING

As human resources are a key component of any diagnostic facility, the Advisory Committee on Diagnostic Facilities requires details of current/projected clinical and technical staffing levels.

Transmitting Facility Staff

What is the basis of the Medical Director's remuneration?

◯ Fee-for-service ◯ Contract ◯ Salary ◯ Other (specify):

Please provide the name (if available), title, qualifications, and basis of remuneration for the scientific, technical and supervisory staff involved in providing services applied for at the transmitting facility. If the number of staff exceeds the available space, please append additional practitioner listings to this application.

Name of Scientific, Technical and Supervisory Staff	**Title**	**Qualifications**	**Remuneration** *(e.g. fee-for-service, contract, salary)*	**Hours of Work** *(e.g., M-F, 9am - 4pm)*

Is there any additional clinical and/or technical expertise required to provide the diagnostics service(s) noted in this application?

◯ Yes* ◯ No

**(If yes, please provide details on the number of experts required, how they will be obtained (e.g. staff recruitment, contracted resources, telemetry etc.) and when they will be available to provide service.)*

RECEIVING FACILITY MEDICAL PRACTITIONERS

Please list ALL medical practitioners who will interpret and bill the Medical Services Plan for the services applied for. Include Fee-for-Service as well as those medical practitioners who will perform the services and be reimbursed through other methods, i.e., contract, salary. If more space is needed, please append additional listings to this application.

Name of Medical Practitioner	MSP Practitioner Number	Qualifications if No MSP Practitioner Number	Basis for Remuneration (fee-for-service, contract, salary, other)

PRACTITIONER CREDENTIALING

Many modalities under the ACDF require additional credentialing before physicians/practitioners can undertake and bill the Medical Services Plan for that work.

Have all required credentialing documents granted through the appropriate health authority or the College of Physicians and Surgeons of BC (for those practitioners working solely in privately-owned facilities) been obtained by all physicians/practitioners seeking to bill the Medical Services Plan for delivering the services currently provided or applied for here?

◯ Yes *(Please submit all appropriate credentialing letters with this application)*

◯ No *(Please indicate the number of physicians/practitioners that require additional credentialing and when this credentialing will be obtained)*

CONFLICT OF INTEREST

Appendix A (Conflict of Interest Declaration) and Appendix B (Conflict of Interest Disclosure) must be completed and submitted with the application in order for this application to be considered. For the relevant policies, see Policy 2.4.4 of the *Policies and Guidelines of the Medical Services Commission's Advisory Committee on Diagnostic Facilities and the Diagnostic Facility Conflict of Interest Policy* at http://www.gov.bc.ca/diagnosticfacilitiespolicies

Are Appendix A and Appendix B included with this application? ◯ Yes ◯ No

PART C: TRANSMITTING FACILITY AUTHORIZATION

Diagnostic Facility Medical Director*	Regional Head of Diagnostic Service	Corporate Owner/Health Authority or Agency CEO
Name	Name	Name
Title	Title	Title
Date	Date	Date
Signature	Signature	Signature

**Medical Director responsible for the onsite diagnostic service(s) referenced in this application*

ELECTRONIC COMMUNICATION AUTHORIZATION

If this application is approved, do you agree to receive formal approval notification/Certificate of Approval by electronic means?*		Email Address (if yes selected)
◯ Yes *(By selecting **'Yes'** you agree to receive formal approval notification/Certificate of Approval **by e-mail**)*		Date
◯ No *(By selecting **'No'** you agree to receive formal approval notification **by mail**)*		
Name	Title	Signature

**All other ongoing communication will be conducted by e-mail*

PART D: RECEIVING FACILITY APPLICATION AUTHORIZATION

1. PRIMARY RECEIVING DIAGNOSTIC FACILITY

Medical Director of Distance Reading Receiving Site	Corporate Owner/Health Authority or Agency CEO
Name	Name
Title	Title
Date	Date
Signature	Signature

2. ALTERNATE RECEIVING DIAGNOSTIC FACILITY

Medical Director of Distance Reading Receiving Site	Corporate Owner/Health Authority or Agency CEO
Name	Name
Title	Title
Date	Date
Signature	Signature

PART D: RECEIVING FACILITY APPLICATION AUTHORIZATION continued

3.ALTERNATE RECEIVING DIAGNOSTIC FACILITY

Medical Director of Distance Reading Receiving Site	Corporate Owner/Health Authority or Agency CEO
Name	Name
Title	Title
Date	Date
Signature	Signature

4. ALTERNATE RECEIVING DIAGNOSTIC FACILITY

Medical Director of Distance Reading Receiving Site	Corporate Owner/Health Authority or Agency CEO
Name	Name
Title	Title
Date	Date
Signature	Signature

If additional signatures are required, please attach additional pages

APPENDIX A: CONFLICT OF INTEREST DECLARATION

To: Secretariat and Chair, ACDF

I have read and understood the Diagnostic Facility Conflict of Interest Policy (the "Policy"), and I undertake to be bound by the obligations contained therein.

I understand that it is my responsibility to report to the ACDF the information described in the Policy, and I undertake to do so.

I understand that the information I disclose will be held by the ACDF and that the information may be shared with members of the Medical Services Commission, as necessary.

I agree to inform the ACDF of any change in circumstances that may give rise to a conflict of interest with respect to a diagnostic facility, as soon as it is practicable.

ATTENTION: The person completing/signing this Declaration Form (the "Declarant") must be duly authorized to make the declaration on behalf of the person/entity submitting an application.

Name of diagnostic facility to which this conflict of interest declaration is in respect of:

SIGNATURE **If Publicly Owned Facility: CEO of Health Authority or Agency*** **If Privately Owned Facility: Owner of Facility**
Name
Title
Date
Signature

** or formally authorized designate*

APPENDIX B: CONFLICT OF INTEREST DISCLOSURE

To: Secretariat and Chair, ACDF

Is there a (potential) conflict of interest to disclose in relation to the diagnostic facility? Check one:

◯ Yes, there is a (potential) conflict of interest to disclose in relation to the diagnostic facility. If yes, provide details of the (potential) conflict of interest in Parts I and II of Appendix B.

◯ I am unsure if the circumstances constitute, or may constitute, a (potential) conflict of interest. If unsure, provide details of the (potential) conflict of interest in Parts I and II of Appendix B.

◯ No, there is no conflict to interest to disclose in relation to the diagnostic facility.

If no conflict of interest is indicated, Appendix B must be completed by signing and completing the Appendix B signature block information.

ATTENTION: The person completing/signing this Disclosure Form (the "Declarant") must be duly authorized to make the declaration/ disclosure on behalf of the subject person/entity; that is the person who owns or intends to own the diagnostic facility (as applicable).

If applicable, provide full detail and circumstances that relate to potential conflicts of interest by completing Parts I and II.

APPENDIX B PART I

Append additional pages as necessary, to provide all relevant information.

Diagnostic Facility Name(s)	List the names of all relevant practitioners, family members, diagnostic facility owners (including the declarant) or business associates who hold or may hold a relevant financial or material interest	Any relevant affiliations or relationships with the owner or intended owner of the diagnostic facility and the details of any interest or benefit that may relate to a conflict of interest	Any other information, including dates, that is relevant to understanding and assessing the nature, scope and degree/extent of potential conflicts of interest

APPENDIX B PART II

In the space below, provide any additional information (not covered in Part I) that is relevant to understanding and assessing the nature, scope and degree/extent of potential conflicts of interest. Include any detail regarding proposed avoidance or mitigation measures relating to any actual or potential conflicts of interest. Append additional pages as necessary to provide all relevant information.

Name of diagnostic facility to which this conflict of interest disclosure is in respect of:

SIGNATURE **If Publicly Owned Facility: CEO of Health Authority or Agency*** **If Privately Owned Facility: Owner of Facility**
Name
Title
Date
Signature

** or formally authorized designate*

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