McLaren
GREATER LANSING

DEPARTMENT OF RADIOLOGY
Core Privileges

Name: _____

Purpose
The purpose of the Department of Radiology (Department) shall be to perform the organizational responsibilities incumbent upon Professional Staff Departments as prescribed in the Bylaws of the McLaren Greater Lansing (MGL) Professional Staff (Bylaws) and specifically to address issues related to the practice of Radiology.

Qualifications
To be eligible for core privileges in the Department of Radiology, the applicant must meet the following qualifications:

- Successful completion of an ACGME or AOA-recognized accredited residency program in radiology.

Active participation in the examination process leading to certification in radiologic medicine or current certification by the American Board of Radiology or the American Osteopathic Board of Radiology is highly recommended.

Privileges included in the General Diagnostic Radiology Core
☐ I request General Diagnostic Radiology core privileges ☐ I do not request General Diagnostic Radiology core privileges

General diagnostic radiology core privileges include but are not limited to, general diagnostic radiology, diagnostic ultrasound, diagnosis and treatment using radionuclides, nuclear medicine studies, diagnostic neuroradiology, diagnostic invasive procedures and diagnostic body imaging, computerized tomography, MRI, mammography, and myelography, except for those special procedure privileges listed below.

Teleradiology Core Privileges
☐ I request Teleradiology core privileges ☐ I do not request Teleradiology core privileges

The reading and interpretation of any diagnostic imaging study that can be sent over a telemedicine link, including but not limited to the following: CT, ultrasound, plain films, MRI scans, X-Ray, and nuclear medicine.

Special extension procedures privileges with observation requirements
To be eligible to apply for a special procedure privilege listed below, the applicant must demonstrate successful completion of an approved and recognized course or acceptable supervised training in residency, fellowship, or other acceptable experience; and provide documentation of competence in performing that procedure consistent with the criteria set forth in the Professional Staff policies governing the exercise of specific privileges.

Name: _____

Requested	Procedure	Criteria	Recommend	Do Not Recommend
	Admitting privileges	Provide letter of explanation, to include sub-specialty and documentation of training in patient management.		
	Stereotactic breast biopsy, Ultrasound-guided breast biopsy	(1) Documentation of qualification under MQSA to perform interpretation; (2) documentation of at least three category I CME hours in stereotactic breast biopsy which should include instruction in imaging triangulation for lesion location; (3) satisfactorily perform at least six stereotactic breast biopsies under a physician who is qualified to interpret mammography under MQSA, and has performed at least 24 stereotactic breast biopsies as primary physician (4) be experienced in post-biopsy management of the patient. Biennial Renewal Benchmark: (1) Documentation of performance of at least 12 stereotactic breast biopsies per year; and (2) Documentation of maintenance of CME and MQSA requirements for mammography interpretation		
	Other:			

General observation includes the provisional Member's clinical abilities, his participation in Department educational and quality care activities, timely performance of duties, productivity, and ability to interact with other Members of the Department, Professional Staff and other health care professionals.

Observation Requirements for Ultrasound, CT & MRI: At least fifty (50) cases in each discipline are to be reviewed by an observer. The first nine (9) cases to be observed by three (3) Active and/or Emeritus Members of the Department, and the remainder of the 50 cases in each discipline to be reviewed as part of the ongoing quality improvement activities

Privileges included in the Interventional/Therapeutic Radiology Core
☐ **Requested** ☐ **Not Requested**

Interventional/Therapeutic radiology core privileges include but are not limited to, percutaneous antegrade pyelography, stent placement (non-vascular), angioplasty, percutaneous procedures, CT-assisted therapeutic procedures, venography (catheter), and lymphangiography, except for those special procedure privileges listed below.

Observation Requirements for Interventional Procedures: At least fifty (50) cases are to be reviewed by an observer. The first nine (9) cases to be observed by three (3) Active and/or Emeritus Members of the Department, and the remainder of the 50 cases in each discipline to be reviewed as part of the ongoing quality improvement activities

Name: _____

Special extension procedures privileges with observation requirements
To be eligible to apply for a special procedure privilege listed below, the applicant must demonstrate successful completion of an approved and recognized course or acceptable supervised training in residency, fellowship, or other acceptable experience; and provide documentation of competence in performing that procedure consistent with the criteria set forth in the Professional Staff policies governing the exercise of specific privileges.

Requested	Procedure	Criteria	Recommend	Do Not Recommend
	Biliary drainage and stone retrieval and/ or stent placement	Documentation of training and experience. Concurrent review of first nine (9) cases by three members of the Department, at the discretion of the Department chairman.		
	Nephrostomy & Percutaneous antegrade pyelography	Documentation of training and experience. Concurrent review of first nine (9) cases by one or two members of the Department, at the discretion of the Department chairman.		
	Angiography	Documentation of training and experience. Concurrent review of first nine (9) cases by one or two physicians with privileges, at the discretion of the Department chairman.		
	Percutaneous cholangiography	Documentation of training and experience. Concurrent review of first nine (9) cases by one or two qualified physicians, at the discretion of the Department chairman.		
	Percutaneous transluminal angioplasty (PTA) and vascular stent placement	If requested, specific privileging information will be sent to you		
	Embolization	If requested, specific privileging information will be sent to you		
	Thrombolytic therapy	If requested, specific privileging information will be sent to you		
	Moderate sedation	If requested, specific privileging information will be sent to you.		
	Other:			

Provisional year chart review requirement
All of the extension cases will be retrospectively reviewed, during the quality improvement process, during the first year at 6 and 12-month intervals.

If there is not a sufficient level of activity during the provisional period, recommendations for privileges or an extension of provisional status will be at the discretion of the Department chair.

Approved:
Dept of Radiology - 4/17/06
Credentials Comm - 5/11/06
PSEC - 6/26/06

Name: _____

Acknowledgement of practitioner
I have requested only those privileges for which by education, training, current experience, and demonstrated performance I am qualified to perform, and that I wish to exercise at **McLaren Greater Lansing**,
and
I understand that:

(a) In exercising any clinical privileges granted, I am constrained by Hospital and Professional Staff policies and rules applicable generally and any applicable to the particular situation.
(b) Any restriction on the clinical privileges granted to me is waived in an emergency situation and in such a situation my actions are governed by the applicable section of the Professional Staff Bylaws or related documents.

Signed: _____ Date: _____

Recommendation:

☐ Approve as requested

☐ Approve with modifications as noted below

☐ Denial of privileges

Modifications: _____

_____

_____

Observers: _____

I (we) attest that in recommending these privileges, due consideration has been given to the Applicant's professional performance, training, experience, judgment, and technical skills.

_____ _____
Chairman, Department of Radiology *Date*

_____ _____
Co-Chief of Staff (for interim privileges only) *Date*

Name: _____

Action:

Credentials Committee Date: _____

Professional Staff Executive Committee: Date: _____

Board of Trustees Date: _____

Comments:_____

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