ABRET

LAB-NIOM REACCREDITATION FORM

Hospital:		
Laboratory:		
Contact Person:		
Title:		
Address:		
City:	State:	Zip:
Phone:	Fax:	
Email:		

Medical Director Name:
Address:

Renewing LAB-NIOM Accreditation requires the following:

- Documentation of compliance with standards based on guidelines for performance, interpretation, established by CMS, AAN, ACNS, ABCN, AANEM, and ASET.
- Submission of a $500 reaccreditation fee.
- Submission of the requirement documentation.

Goals:

- To maintain awareness of expectations and standards.
- Provides the opportunity to receive feedback on any changes that may affect their accreditation status and receive suggested actions to take to maintain compliance.

Submission requirements:

All renewal forms must be submitted to the **ABRET Executive Office or uploaded through ShareFile.** Request a ShareFile link from the executive office. Attachments must be appropriately labeled.

Note:

If the reaccreditation application is not received by the end of the year, the laboratory is no longer accredited and will need to reapply for accreditation.

Please call 217-726-7980 or e-mail janice@abret.org if you have any questions.

What has changed since your initial accreditation? For any YES responses, include documentation/policies.

Hospital

	Yes	No
1. Relationship with the hospital?	☐	☐
2. Scope of services?	☐	☐
3. Current Joint Commission Certification?	☐	☐

Directors, Physicians and Administration

	Yes	No
4. Has the Medical Director changed? (If yes, complete Appendix A)	☐	☐
5. Have there been any changes in Interpreting Physicians? (If yes, complete Appendix B)	☐	☐
6. Has the Technical Director changed? (If yes, complete Appendix C)	☐	☐
7. Has the Administrator changed? (If yes, attach name and contact information – Attachment 1)	☐	☐

NIOM Technologists

	Yes	No
8. List current monitoring technologists. (Attach list – Attachment 2)	☐	☐
9. Does at least one of your current monitoring technologists hold a CNIM credential?	☐	☐
10. Do you have a requirement regarding credentials for staff?	☐	☐
11. Do you have a continuing education requirement for staff?	☐	☐
12. Have there been any changes in the other program personnel? (Attach list – Attachment 3)	☐	☐

13. Case Load Indicate if the modalities listed below are performed. If they are, complete the information about each modality.

Modality	Performed		Stimulating montage	Recording montage	Filter settings	No. of responses averaged	Criteria for raising alert
	Yes	No					
SEP Upper	☐	☐					
SEP Lower	☐	☐					
MEP	☐	☐				XXXXXXXXXX	
BAEP	☐	☐					
EEG	☐	☐	XXXXXXXXXXXX			XXXXXXXXXX	
Nerve to nerve	☐	☐					
Facial nerve EMG	☐	☐				XXXXXXXXXX	
Limb EMG	☐	☐				XXXXXXXXXX	
Corticography	☐	☐				XXXXXXXXXX	
Other (specify)	☐	☐					

If additional explanation is needed, provide it here.

14. If cranial nerve monitoring (other than BAEP) is performed, describe which nerves are monitored, number of procedures performed in the last year, and how the monitoring is performed.
15. If functional cortical localization mapping is performed, describe the technique used and number of procedures performed in the last year.
16. If movement disorder surgery is performed, describe it here. Include number of procedures performed as well as technique and interpretation criteria.

17. Indicate if the following types of surgery are performed.

Type of surgery	NIOM Performed		Number monitored in last year
	Yes	No	
Vertebral column surgery	☐	☐	
Spinal cord surgery	☐	☐	
Spinal dysraphism surgery	☐	☐	
Selective dorsal rhizotomy	☐	☐	
DREZ and other pain procedures	☐	☐	
CPA surgery (tumor/MVD)	☐	☐	
Brainstem surgery	☐	☐	
Intracranial cerebral open surgery	☐	☐	
Epilepsy surgery	☐	☐	
Functional Brain mapping	☐	☐	
Other cerebral hemisphere surgery	☐	☐	
Carotid artery surgery	☐	☐	
Aortic surgery open/endovascular	☐	☐	
Cardiac surgery	☐	☐	
Peripheral nerve and plexus surgery	☐	☐	
Movement disorder surgery	☐	☐	
ENT surgery	☐	☐	
Cerebral/spinal endovascular surgery	☐	☐	
Other	☐	☐	

Hospital Name: ____

Interpretation

18. Are all NIOM cases interpreted by a physician interpreter? If not, provide explanation.
19. When does the interpreting physician interpret a NIOM case?
20. How does the interpreting physician review the NIOM data?
21. If an alert is noted, how is it communicated to the surgeon?
22. How many NIOM cases can the physician interpreter be involved with simultaneously? What happens if more than this number of cases is on-going simultaneously?
23. Are all local Medicare rules and regulations regarding NIOM interpretations followed? If no, provide explanation.

Documentation

24. Discuss the process by which NIOM reports are created and posted on the patient's chart.
25. How quickly are reports made available on the patient's chart?
26. Are the number of hours of physician and technologist involvement in the NIOM case noted on the reports? If not, provide an explanation.
27. What information is kept in the NIOM case event log?

Education and Scholarship

28. What types of educational activities are available within the department for staff? Provide a list of topics addressed in the last year in Attachment 4.
29. How do physician interpreters get continuing medical education?
30. How do technologists (and other monitoring staff) get continuing education credits? Is funding available for technologists (and other monitoring staff) get continuing education credits? Is funding available for technologists (and other monitoring staff) to obtain continuing education?
31. When a new NIOM technique is instituted how are staff trained?
32. When new NIOM equipment is purchased how is the relevant training provided and documented?

Hospital Name: ______________________________

Policies and Procedures

33. How often is the Policies and Procedures Manual reviewed and updated?	
What is the date of the last P&P Manual update?	
34. Describe a quality improvement project completed in the last five years that resulted in improved patient care. (Attachment 5)	

35. Have there been any changes in the following policies? **Yes** **No**

(If yes, attach revised policy Attachment 6)

	Yes	No
a. Staffing policies	☐	☐
b. Interpretation policy (include information on who interprets, when they interpret, and on report generation)	☐	☐
c. Infection prevention	☐	☐
d. Quality Improvement - Name of project:	☐	☐
e. Continuing education requirement for staff	☐	☐
f. Training for new equipment	☐	☐
g. Training for new types of surgeries/types of monitoring	☐	☐
h. Emergency coverage	☐	☐
i. Policy on record retention	☐	☐

Hospital Name: ____

Attestation and Signature

*I have read the ACNS Guidelines that pertain to Evoked Potentials, NIOM and the ASET IONM National Competencies for Monitoring and, to the best of my knowledge and belief, our NIOM program complies with the Guidelines and Standards. (Must be **signed** by the department manager/director and medical director.)*

______________________________	______________________________
Director/Manager Name	Title
______________________________	______________________________
Signature	Date

______________________________	______________________________
Medical Director Name	Title
______________________________	______________________________
Signature	Date

Include a new letter of support from Administration – Attachment 7

Reaccreditation forms may be submitted electronically or by mail to janice@abret.org

ABRET Neurodiagnostic Credentialing & Accreditation

ABRET Executive Office
2908 Greenbriar Dr., Suite A
Springfield, IL 62704

2908 Greenbriar Dr., Ste. A, Springfield, IL 62704
Phone: (217) 726-7980 Fax: (217) 726-7989

LAB-NIOM

APPENDICES

Appendix 1
Curriculum Vitae

Medical Director

<table>
<tr><td colspan="3">Name:</td></tr>
<tr><td colspan="3">Degree(s):</td></tr>
<tr><td colspan="2">Medical School (name and location):</td><td>Year of Graduation:</td></tr>
<tr><th colspan="3">Certification(s)</th></tr>
<tr><td>American Board of Psychiatry and Neurology-Clinical Neurophysiology</td><td>YES
NO</td><td>Date:
Certificate number:
Expiration:</td></tr>
<tr><td>American Board of Clinical Neurophysiology</td><td>YES
NO</td><td>Date:
Certificate number:
Expiration:</td></tr>
<tr><td>American Board of Electrodiagnostic Medicine</td><td>YES
NO</td><td>Date:
Certificate number:
Expiration:</td></tr>
<tr><td>Other Board</td><td>YES
NO</td><td>Date:
Certificate number:
Expiration:</td></tr>
<tr><td colspan="2">Residency (type and location):</td><td>Date(s):</td></tr>
<tr><td colspan="2">Fellowship (type and location):</td><td>Date(s):</td></tr>
<tr><td colspan="2">Training in NIOM (description of self-taught courses, workshops, etc.) over past five years:</td><td>Date(s):</td></tr>
</table>

Name:	
Active State Licensure(s):	Expiration Date(s):
Current Academic Position(s):	Date Assumed this Position:
Current Hospital Appointments:	Date of Appointments:

In the space below list the most recent publications and presentations (maximum 10). Do not include abstracts, and those "in preparation" or "submitted." Articles "in press" may be listed.

Appendix 2
Curriculum Vitae(s)

Interpreting Physicians (reproduce as necessary/make sure each page is numbered and contains a name)

Name:		
Degree(s):		
Medical School (name and location):		Year of Graduation:
Certification(s)		
American Board of Psychiatry and Neurology-Clinical Neurophysiology	YES NO	Date: Certificate number: Expiration:
American Board of Clinical Neurophysiology	YES NO	Date: Certificate number: Expiration:
American Board of Electrodiagnostic Medicine	YES NO	Date: Certificate number: Expiration:
Other Board	YES NO	Date: Certificate number: Expiration:
Residency (type and location):		Date(s):
Fellowship (type and location):		Date(s):
Training in NIOM (description and location):		Date(s):
Active State Licensure(s):		Expiration Date(s):

Name:	
Current Academic Position(s):	Date Assumed this Position:
Current Hospital Appointments:	Date of Appointments:

In the space below list the most recent publications and presentations (maximum 10). Do not include abstracts, and those "in preparation" or "submitted." Articles "in press" may be listed.

Appendix 3
Curriculum Vitae(s)

Technical Director

<table>
<tr><td colspan="3">Name:</td></tr>
<tr><td colspan="3">Highest Degree:</td></tr>
<tr><td colspan="2">College (name, location):</td><td>Year of Graduation:</td></tr>
<tr><th colspan="3">Certification(s)</th></tr>
<tr><td>CPR</td><td>YES
NO</td><td>Date:
Certificate number:
Expiration:</td></tr>
<tr><td>ABRET R. EEG T.</td><td>YES
NO</td><td>Date:
Certificate number:
Expiration:</td></tr>
<tr><td>ABRET R. EP T.</td><td>YES
NO</td><td>Date:
Certificate number:
Expiration:</td></tr>
<tr><td>ABRET CNIM</td><td>YES
NO</td><td>Date:
Certificate number:
Expiration:</td></tr>
<tr><td>ABRET CLTM</td><td>YES
NO</td><td>Date:
Certificate number:
Expiration:</td></tr>
<tr><td>AAET R. NCS T.</td><td>YES
NO</td><td>Date:
Certificate number:
Expiration:</td></tr>
<tr><td>D-ABNM</td><td>YES
NO</td><td>Date:
Certificate number:
Expiration:</td></tr>
</table>

<table>
<tr><td colspan="3">Name:</td></tr>
<tr><td>Other:</td><td>YES
NO</td><td>Date:
Certificate number:
Expiration:</td></tr>
<tr><td colspan="2">END Training Program (type and location):</td><td>Date(s):</td></tr>
<tr><td colspan="2">Other END Education (type and location):</td><td>Date(s):</td></tr>
<tr><td colspan="2">Training in NIOM (description and location):</td><td>Date(s):</td></tr>
</table>

In the space below list the most recent continuing education credits earned in the field of NIOM. Please do not include courses not related directly to NIOM, such as sleep and CPR courses.

Appendices:

A – Medical Director

B – Monitoring Physicians

C – Technical Director

Attachments:

1 – Administrator

2 – Monitoring Technologists

3 – Other Program Personnel

4 – List of educational topics/activities for the last 12 months

5 – Quality Improvement Project

6 – Policy Changes

7 – A Letter from the hospital administration supporting the NIOM program and the continuing education of its personnel