

Capital BlueCross
MAGNETIC RESONANCE IMAGING CENTER SURVEY

Provider Name: _____
CBC #: _____ **Medicare #:** _____ **Medicaid #:** _____
Accrediting Organization: _____ **Date of most recent accrediting survey:** _____
Person completing survey: _____ **Phone:** _____ **Date:** _____
Contact person (if different than above): _____ **Phone:** _____

Directions: Please complete each line with appropriate information.
Where applicable please indicate with a check mark (☐).

ADMINISTRATION

Days & Hours of operation: _____
Handicap access Yes No
Written compliance program Yes No
Compliance program officer Yes No
Internal compliance audits Yes No
Review of the Medicare/Medicaid sanction report Yes No
Frequency of review: _____
Written policy on patient confidentiality Yes No
Written policy on medical record confidentiality Yes No
Written policy for release of medical records Yes No
Written policy for maintenance/retention of medical records Yes No
Written patient medical emergency plan Yes No
Emergency medical equipment/supplies available Yes No
Written policy for checking emergency medical equipment/supplies Yes No
Includes frequency of checks Yes No
Written transfer agreement with acute care Yes No
Written policy for transfer to acute care Yes No
If yes, list facilities: _____

Written agreement with emergency transportation service Yes No
Reliance on 911 system Yes No
Written on-call policy Yes No

QUALITY MANAGEMENT

Quality Activities
Performance Improvement Program Yes No
Performance Improvement Program includes utilization review Yes No
Development of Improvement activities based on identified issues Yes No

Performance Improvement Committee Yes No
Frequency of meetings: _____
List two Current Quality Studies:
1. _____
2. _____
Written infection control policies Yes No
Established screening criteria/protocol for performing an MRI Yes No
Written policy on use of contrast Yes No
Written policy on use of sedation Yes No
Written policy on addressing advance directives Yes No

Patient Satisfaction

Patient Satisfaction Surveys utilized Yes No
Annual return rate for surveys: _____ %
Issues identified:
1. _____
2. _____
Results forwarded to PI committee Yes No
Written patient/family complaint process Yes No

Physician Satisfaction

Physician Satisfaction Surveys utilized Yes No
Annual return rate for surveys: _____ %

Patient Education

Patient/Family education Yes No
Documented in the clinical record Yes No
Services available for hearing impaired Yes No
Services available for speech impaired Yes No
Services available for visually impaired Yes No
Bilingual services Yes No
Bilingual patient education materials Yes No
Languages offered: _____

Data Collection

Incident Reports Yes No
Types of procedures Yes No
Transfers to inpatient facilities Yes No
Repeat studies Yes No

Provider Name: _____

- Technology related Yes No
- Equipment related Yes No
- Patient related Yes No

List other data: _____

CLINICAL STAFF

Written policy for clinical competency evaluation

Yes No

Evaluated during probationary period Yes No

Evaluated annually Yes No

Written policy for verification of the following for all clinical staff:

- Certification Yes No
- Education Yes No
- License Yes No

Number of mandatory educational programs staff is required to attend annually: _____

Written policy for routine testing of employees for infectious diseases Yes No

Written policy for credentialing of physicians Yes No

Written policy for recredentialing Yes No

- Physicians Yes No
- Clinical Staff Yes No
- Frequency: _____

Medical Staff

Medical Director Yes No

Specialty: _____

Board Certified Yes No

Number of Radiologists on staff: _____

Number of Board Certified Radiologists: _____

Number of Interventional Radiologists: _____

If physician(s) not board certified, competency established through the facility's credentialing process Yes No

Other Staff

_____ Number of Registered Nurses

_____ Number of Certified MRI technicians

_____ Number of Registered Radiology Technicians

Written policy defining staff requiring CPR certification Yes No

 % Clinical staff CPR certified

List other certified/registered employees: _____

SERVICES

Number of MRI units: _____

Open MRI available Yes No

Mobile unit Yes No

Open unit Yes No

Days & Hours of operation: _____

Number of magnets certified: _____

Magnet strength: _____

Extremity MRI Yes No

MRA Yes No

All equipment models FDA approved Yes No

Other: _____

FACILITIES & EQUIPMENT

Bioengineering specialist Yes No

If no, person responsible for maintenance of biomedical equipment Yes No

Written preventive maintenance plan Yes No

Written plan for equipment failure Yes No

Written emergency preparedness plan Yes No

Plan includes:

- Fire Yes No
- Loss of utilities Yes No
- Inclement weather Yes No

Written policy for fire/disaster drills Yes No

Results of drills documented Yes No

Written policy for handling biohazardous materials Yes No

As a reminder, please be sure to include:

- *Facility Information Sheet*
- *Name sheet for branch offices*
- *Affiliate or owned services*

COMMENTS

Provider Name: _____

Please complete the following based upon corporate ownership of off-site business initiatives and indicate specific services performed at the office site.

Branch Offices

Name: _____
Services Provided: _____
Billing Site Only Yes No
Date of Acquisition or Establishment: _____
Address: _____
City: _____
Phone: _____
Contact Person: _____
Counties Served: _____

Name: _____
Services Provided: _____
Billing Site Only Yes No
Date of Acquisition or Establishment: _____
Address: _____
City: _____
Phone: _____
Contact Person: _____
Counties Served: _____

Name: _____
Services Provided: _____
Billing Site Only Yes No
Date of Acquisition or Establishment: _____
Address: _____
City: _____
Phone: _____
Contact Person: _____
Counties Served: _____

Name: _____
Services Provided: _____
Billing Site Only Yes No
Date of Acquisition or Establishment: _____
Address: _____
City: _____
Phone: _____
Contact Person: _____
Counties Served: _____

Name: _____
Services Provided: _____
Billing Site Only Yes No
Date of Acquisition or Establishment: _____
Address: _____
City: _____
Phone: _____
Contact Person: _____
Counties Served: _____

Name: _____
Services Provided: _____
Billing Site Only Yes No
Date of Acquisition or Establishment: _____
Address: _____
City: _____
Phone: _____
Contact Person: _____
Counties Served: _____

Name: _____
Services Provided: _____
Billing Site Only Yes No
Date of Acquisition or Establishment: _____
Address: _____
City: _____
Phone: _____
Contact Person: _____
Counties Served: _____

Name: _____
Services Provided: _____
Billing Site Only Yes No
Date of Acquisition or Establishment: _____
Address: _____
City: _____
Phone: _____
Contact Person: _____
Counties Served: _____

Provider Name: _____

**HEALTHCARE FACILITY
INFORMATION FORM**

Provider Name: _____

Parent: _____

Affiliation: _____

Affiliation: _____

Number of Years in business: _____

Type of Control

- Voluntary Nonprofit**
- Proprietary** (Identify all individuals, members of partnership, major stockholders, etc. If 'Other' explain.)
 - Individual _____
 - Partnership _____
 - Corporation _____
 - Other _____
- Government**
 - Federal
 - State
 - County
 - Other, explain: _____

Additional Information Requested

Has the facility, any corporate officer, employee or any agent acting on behalf of the facility been involved in or convicted of healthcare fraud or abuse in the last five (5) years?

- Yes, explain: _____
- No

Have you or any of your affiliates, entered into a corporate integrity agreement with any state or federal agency?

- Yes
- No

If yes, provide a copy to Capital Blue Cross

Provide copies of the following:

- State Licensure certificate(s)
- List of Board of Directors
- Most recent accreditation letter
- Most recent DOH Report
- Evidence of current malpractice insurance
- Current organizational chart

COMMENTS: _____

Provider Name:

Please indicate the counties within your service area. If services are limited to only a portion of the county, please identify.

- Adams _____
- Berks _____
- Centre _____
- Columbia _____
- Cumberland _____
- Dauphin _____
- Franklin _____
- Fulton _____
- Juniata _____
- Lancaster _____
- Lebanon _____
- Lehigh _____
- Mifflin _____
- Montour _____
- Northampton _____
- Northumberland _____
- Perry _____
- Schuylkill _____
- Snyder _____
- Union _____
- York _____

- Other _____
- _____
- _____
- _____
- _____