Capital BlueCross
FREESTANDING OUTPATIENT RADIATION 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
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 policy for transfer to acute care ☐ Yes ☐No
Written transfer agreement with acute care ☐ Yes ☐No
If **yes**, list facilities: _____

Written agreement with an emergency transport service ☐ Yes ☐No
Reliance on 911 system ☐ 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

Physician Satisfaction
Physician Satisfaction Surveys utilized ☐ Yes ☐No
Results forwarded to PI Committee ☐ 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

Clinical Management
Written policy on addressing advance directives ☐ Yes ☐No

Patient Education
Patient/family education ☐ Yes ☐No
Documented in 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
Complications ☐ Yes ☐No
Incident Reports ☐ Yes ☐No
Radiation burns ☐ Yes ☐No
Transfers to inpatient facility ☐ Yes ☐No
List other data: _____

Provider Name:

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 all of the following for all clinical staff:

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

Number of mandatory inservices 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 of:

- 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: _____

Oncologist ☐ Yes ☐No

Pulmonologist ☐ Yes ☐No

Radiation Physicist ☐ Yes ☐No

Other ☐ Yes ☐No

If **yes**, please list: _____

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

Other Staff

_____ Number of Registered Nurses

_____ Number of RNs with oncology/radiation experience

_____ Number of Certified Radiation Therapists

_____ Number of Radiation Therapists

Written policy defining staff requiring CPR certification ☐ Yes ☐No

_____ **%** Clinical staff CPR certified

SERVICES

Brachytherapy ☐ Yes ☐No

Laboratory ☐ Yes ☐No

Respiratory ☐ Yes ☐No

Social Service ☐ Yes ☐No

All equipment models FDA approved ☐ Yes ☐No

List types of radiation therapies available: _____

FACILITIES & EQUIPMENT

Bioengineering specialist ☐ Yes ☐No

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

Written preventive maintenance plan ☐ Yes ☐No

Written record of equipment maintenance ☐ 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

Written policy for handling radioactive materials ☐ Yes ☐No

As a reminder, please be sure to include:

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

COMMENTS

_____

_____

_____

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_____

_____

_____

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 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: ______________________

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

Provider Name:

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

Other ☐