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Supplemental Application — Surgery Center

IMPORTANT NOTICE
This is a SUPPPLMENT to an MIEC application. This document alone is insufficient to apply for and be approved for coverage with MIEC. Be sure to submit this along with your complete signed and dated MIEC application.

APPLICANT

____
Entity or Last name, first name

SURGERY CENTER — ANSWERS A-D

A. Please list all locations where you provide services, and the corresponding estimated and actual procedure information. Please attach procedure information for at least the last five (5) years.

Name of Location (include the address)	Years in operation	Lease/ own space	Estimated procedures for next 12 months	Actual procedures for last 12 months

B. Please indicate the annual amount and percent of total of each type of procedure performed across **ALL** locations.

Type of Procedure	# of annual procedures	Percent of total
Abortion/pregnancy termination		
Bariatric		
Cardiac catheterizations		
Cardiac – other		
Chiropractic		
Dental, Oral, Maxillofacial		
Gastrointestinal/GI		
General Surgery		
Gender Reassignment		
Gynecologic Surgery		
Obstetric (deliveries)		
Neurosurgery		
Ophthalmology – LASIK procedures		

Type of Procedure	# of annual procedures	Percent of total
Ophthalmology – all other than LASIK		
Orthopedic: spine procedures		
Orthopedic: total joint replacement		
Orthopedic: all other		
Pain Management		
Plastic Surgery – cosmetic including liposuction		
Plastic Surgery - reconstructive		
Podiatric		
Thoracic		
Vascular – Sclerotherapy/Phlebectomy		
Urologic		
Vascular – all other		
Other not described or listed above		

C. Please indicate the number of physicians providing performing procedures at the surgery center: ________

D. Do you allow physicians who are **NOT** owners/members/shareholders of the surgery center to perform procedures at the surgery center?
☐Yes ☐No **If yes,** what percentage of the overall procedures are performed by these physicians? ________%

SURGERY CENTER (continued) — ANSWERS E-U

E. Do you require physicians providing services at the facility to maintain their own **SEPARATE** professional liability insurance? ☐Yes ☐No

If yes, are they required to maintain limits of at least $1/3M? ☐Yes ☐No **If no,** please explain: ____________________

F. Are the credentials of each physician reviewed by a medical staff committee and approved by the governing body prior to granting privileges? ☐Yes ☐No

G. Are peer review and quality improvement review conducted for all physicians and licensed independent practitioners? ☐Yes ☐No

If yes, how often: ____________________

H. Please indicate the number of the following types of professionals **EMPLOYED** by the surgery center

Nurse Practitioner __________ Phlebotomist __________

Physician Assistants __________ Medical Assistant __________

Nurse (RN, LPN) __________ Other (please describe) __________

Technician (EKG, X-ray, Lab) __________

I. Do you have a medical director? ☐Yes ☐No **If yes,** provide Name, Specialty, and license number.

Name ____________ Specialty ____________ License Number ____________

J. Is the clinic licensed? ☐Yes ☐No **If yes,** please provide type of licensure and license number.

Type of Licensure ____________ License Number ____________

K. Has the facility/operational license ever been revoked, suspended or voluntarily surrendered? ☐Yes ☐No

If yes, please explain: ____________________

L. Is the clinic accredited? ☐Yes ☐No **If yes,** (check all that apply) ☐CMS ☐JCAHO ☐AAAHC ☐AAAASF ☐Other: ____________

M. Do you provide any of the following services at any location?

Pharmacy ☐Yes ☐No **If yes,** what is the annual revenue? $ __________

X- ray ☐Yes ☐No **If yes,** how many images per year? __________

Laboratory ☐Yes ☐No

Anesthesia services ☐Yes ☐No **If yes,** what kind? Conscious ______%, General ______ %, Local ______%, Other ______ %

If Yes, who is providing the anesthesia services? ____________________

N. Do you maintain any of the following resuscitative equipment? Check all that apply: ☐Crash cart, ☐Defibrillator, ☐EKG, ☐Oxygen

Is all resuscitative equipment regularly maintained and kept up to date? ☐Yes ☐No ☐N/A

O. Do you have emergency and transfer protocols in writing? ☐Yes ☐No

P. Are staff ACLS or BCLS certified? ☐Yes ☐No

Q. What percentage of patients are under the age of 18? ______%

R. Is any surgical procedure part of a clinical trial? ☐Yes ☐No

S. Do you have overnight recovery beds? ☐Yes ☐No **If yes,** how many recovery beds are allocated to overnight surgery? ________

If yes, what percentage of your patients are recovered in-house overnight annually? ______%

T. Do you offer post operative services, other than overnight recovery beds? ☐Yes ☐No

If yes, please explain: ____________________

U. Do you have written policies and procedures that address infection prevention and control? ☐Yes ☐No

If yes, which of the following guidelines are those policies based on (check all that apply)

☐ CDC

☐ State Department of Health

☐ Local ordinances/mandates

☐ Medical Specialty Society

☐ Other: ____________________

SIGNATURE

SIGNATURE

Signature ____________________ Date ____________