

## 2006 ANNUAL POSITRON EMISSION TOMOGRAPHY (PET) SERVICES SURVEY INSTRUCTIONS

January 1, 2006 through December 31, 2006

### - IMPORTANT NOTICE ABOUT SURVEY ACCURACY AND COMPLIANCE -

The information and data collected through this survey are used for state regulatory and planning purposes and are made available to public officials, advocacy groups, health care purchasers, and consumers. This survey is required under Department of Community Health Rule 111-2-2-.04 and other regulations. The failure to properly submit and/or fully complete all required surveys may result in adverse regulatory action pursuant to DCH Rules 111-2-2-.05, .09 and other regulations or statutes.

The chief executive officer or principal administrator of the facility (who shall attest to the accuracy and completeness of the information provided) and your organization are responsible for ensuring the accuracy of the information and data reported in this survey. The sole responsibility for accuracy resides with the organization and the officials filing the survey. Accuracy at time of submission is particularly important. See Rule 111-2-2-.04(e) prohibiting survey revisions unless approved by the Department at its sole discretion.

Providing false or inaccurate information may result in adverse regulatory action pursuant to DCH Rules 111-2-2-.04(1)(b), 111-2-2-.05(1)(a)1, and 111-2-2-.05(1)(a)7, other regulations and statutes, and may constitute a crime under O.C.G.A. §§ 16-10-20 and 16-14-1.

### 2006 PET SERVICES SURVEY ACCESS FORM

The 2005 PET Services Survey (PETSS) is a Microsoft Access database. You must have Microsoft Access 2000 or a later version of Access in order to open the database and complete your survey. **Microsoft Access 97 is no longer supported.**

### IF YOU NEED ASSISTANCE

When you are working in the database, you may view these instructions by clicking the Help button found on each form. You can get specific instructions for any **item in blue** on the form by clicking the item.

If you can't find the answer to your problem on the Help screens, check the "Frequently Asked Questions" document on the web page where you downloaded the database. This document will be updated periodically as new questions arise.

If you still have any questions after reviewing the documentation above **please contact Carlos Williams, II with the Division of Health Planning at (404) 656-0464, or [cawilliams@dch.ga.gov](mailto:cawilliams@dch.ga.gov).**

## INSTRUCTIONS FOR SUBMITTING THE DATABASE

**The deadline for filing the completed survey database for your facility is July 20, 2007.**

Once you have completed your survey and resolved any data validation issues, you should electronically submit the survey to the Department of Community Health (DCH). ***Please do not fax or mail a hard copy.*** Follow the steps below to submit your survey:

1. You must sign the Signature Form before submitting the database. The survey will not be deemed complete without an authorized signature.
2. Please be sure to print a copy of your completed forms before submission and retain a copy of the Access file for your records.
3. To submit your database, click the green Upload button on the survey opening screen and follow the on-screen instructions.

**Survey Completion Status** – Typically, a survey will be considered complete when a signed, completed version is received by the Division of Health Planning. All requested data elements must be provided; edit check, error messages, and validation rules must be addressed or in balance; and the survey must be signed in the appropriate location and manner. Once received and determined to be complete by the Division, the survey is considered a public record. DCH staff may not be able to process your survey immediately due to high volumes of survey submissions. You may follow-up a few days after submitting your survey to make sure your survey has been processed and is considered complete by the Division of Health Planning. The completed survey will be deemed complete on the day it is received by DCH even if it is processed later. The completion status of all surveys for each facility will be published on the DCH website on or after the survey due date. **It is extremely important that you retain a copy of your completed survey (both the Access database and a printed copy).**

**Revising or Amending the Survey** – Pursuant to Rule 111-2-2-.04(1)(e) surveys that are received and determined to be complete by the Division of Health Planning may not be revised after the survey due date without approval by DCH. Requests to revise must be submitted in writing to the Division of Health Planning with a detailed explanation of the revisions and any necessary documentation. The Division of Health Planning will consider revisions on a case-by-case basis and reserves the right to deny a request to revise. The Division may also determine that additional data, information, or documentation is needed to support the proposed revisions.

## INSTRUCTIONS FOR COMPLETING THE SURVEY FORM

The Access database file may either be saved to a single computer or to an internal computer network. The database can be placed on a network so that multiple users can access and complete (or review) the survey at different times. Please be sure not to make copies of the database. Only one version of the database should be sent to DHP. The Access file should open automatically to an opening screen where you can select a form to complete or view. You should be able to print a blank copy of the survey from the “print” button included on each form or from the opening screen. Enter your facility’s data using the survey form. Please be sure to provide an answer in every question. If the question does not apply to your facility please indicate “not applicable”. Access does not have a “save” feature like other applications. Each change you make to the form will be saved automatically.

## INSTRUCTIONS FOR COMPLETING THE SIGNATURE FORM

The database contains two types of forms. The first type is the survey form described above. This form is used to collect utilization data and information. The Signature Form is where the facility's chief executive or administrator electronically authorizes the survey for release to the Department of Community Health. The facility's chief executive officer or administrator must sign to certify that the responses are complete and accurate for the report period specified. A typed version of the signature is being accepted as an original signature pursuant to the Georgia Electronic Records and Signature Act.

The Signature Form also will identify any out of balance edit checks and any validation rule criteria that are not correct. The edit checks must be resolved before the authorized signature will be accepted by the database. For example, if your total patient counts are not in balance when requested, then the Signature Form will indicate that they are out of balance and will not accept the authorized signature until the patient counts are corrected. In other cases, the form may provide a warning message indicating that certain data elements are out of balance or that certain responses are not valid either for your facility type or authorization. In these instances, unresolved data issues must be addressed by an explanation in the provided comments box if the data is not changed or amended.

**Data Validation Requirements** – All edit and balance requirements and all required fields must be completed before the facility's administrator or chief executive can authorize the survey. You can determine if the required survey totals are in balance and that all required items are complete by clicking the "View Error Messages" button in the Data Validation Requirements section at the top of the Signature Form. This button produces the Data Validation Report containing a description of any out of balance totals and any required data items that are missing. The Data Validation Report can be printed and should be rerun until all items have been corrected. **Each item on the Data Validation Report must be corrected before the form will accept the authorized signature.**

### PART A: GENERAL INFORMATION

**Facility (Provider) Name and Address** – Please provide your Facility's current name and address as requested.

**Medicaid and Medicare Numbers** – Please enter the appropriate numbers for your facility. Do not enter dashes or alpha characters for either provider number.

**Report Period** - The required report period is 1/1/2006 to 12/31/2006. If the facility was in operation a full year, 12 months of data must be reported even if the ownership or management of the facility changed. It is the responsibility of the current owner or operating entity to obtain data from the prior owner/operator if necessary. Please note if the facility was not in operation for the entire report period.

### PART B: SURVEY CONTACT INFORMATION

Please provide contact information for the individual authorized to respond to questions regarding your facility's survey.

### PART C: OWNERSHIP AND ORGANIZATIONAL STRUCTURE

Please provide the following information as applicable to your facility. If certain fields do not apply the form will allow you to enter only "Not Applicable" in the Full Legal Name column.

**1.a & 1.b - Owner** - Provide the full legal name of the facility's owner and the owner's parent organization, if any, as of the last day of the report period. Include the appropriate organizational type and the effective date of any change of ownership that has occurred since 12/31/2005.

**1.c & 1.d - Operator** - If the operating entity is other than the owner, provide the full legal name of the facility's operator and operator's parent organization, if any, as of the last day of the report period. Include the appropriate organizational type and the effective date of any change in operating entity that has occurred since 12/31/2005.

**1.e & 1.f - Manager** - If a management contract is in effect, provide the full legal name of the facility manager and the manager's parent organization, if any, as of the last day of the report period. Include the appropriate organizational type and the effective date of any change in management contractor that has occurred since 12/31/2005.

**2. Changes** - If changes occurred during or after the report period, explain and include the effective dates of any change.

#### **PART D: PET IMAGING SERVICES TECHNOLOGY AND VOLUME BY DIAGNOSTIC TYPE**

**Equipment:** Using the drop-down please indicate whether the your PET scanner has a CT component. Also, please document the manufacturer and model of PET equipment in the text box. **If you operate more than one PET unit at this location, please complete one full survey for each PET Unit.**

**Diagnostic Areas:** Please identify the number of patients and scans provided by each diagnostic area. Please note that Oncology and Neurology have both fields for subcategories and totals. Within each diagnostic area or subgroup, the number of patients should reflect an **unduplicated count**. However, the total for all services (automatically calculated by the database) reflects the sum of patients for all diagnostic areas, which may result in some duplication of individual patients (e.g., a patient is scanned for both cardiovascular and oncology diagnoses).

This data is extremely important in determining utilization of PET technology and future benefits of these scans; please make every effort to identify services and report fully and accurately.

#### **PART E: PET SERVICES FINANCIAL SUMMARY AND PATIENT DEMOGRAPHIC INFORMATION**

**1. Patients and Visits by Primary Payment Source:** Report total patients (unduplicated) receiving PET services by their primary payer source [Medicaid, Medicare, Third-Party (insurance or other), or self-pay]. This table should reflect data for the entire report period. Please note that total patient counts here (because patients are unduplicated) should balance to patient counts reported elsewhere in the PETSS.

**2. Total Charges and Adjusted Gross Revenue:** Report the total charges for PET scan services provided by your facility during the report period. Also, report the Adjusted Gross Revenue (AGR) for PET services. AGR is the gross revenue attributed to PET scan services less any Medicare and Medicaid contractual adjustments and less any bad debt.

**3a. Indigent and Charity Care:** Report the total amount of charges attributed during the report period to patients who are classified as receiving indigent or charity care. Persons classified as indigent must meet the federal guidelines (income at or below 125% of federal poverty guidelines). Charity Care should be authorized in accordance with the written policy of the facility. If the charity care is provided on a sliding fee scale basis, only that portion of the patient's account that meets the facility's policy, and that are provided without expectation of payment, may be considered as charity care.

**3b. Indigent and Charity Care:** Report the number of patients represented in the charges in 3a above. Report the number of patients who qualified as indigent or charity care cases during the report year.

**4. Average Charge:** Please report the average charge per PET scan or study as of 12/31/2006.

**5. Utilization by Race/Ethnicity of Patient** - Report the number of patients by race/ethnicity according to the indicated categories. These data are needed as an indication of the services rendered to population sub-groups. The totals here should agree with the number of patients reported elsewhere in the survey. The United States Census Bureau uses the following racial and ethnicity definitions:

*American Indian or Alaska Native:* A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.

*Asian:* A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

*Black or African American:* A person having origins in any of the black racial groups of Africa. Terms such as "Haitian" or "Negro" can be used in addition to "Black or African American."

*Hispanic or Latino:* A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race. The term, "Spanish origin," can be used in addition to "Hispanic or Latino."

*Native Hawaiian or Other Pacific Islander:* A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

*White:* A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

*Multi-Racial:* A person having racial origins from two or more of the above definitions.

**6. Utilization by Age and Gender Groupings:** Report the number of patients by the indicated age and gender groupings. These data are needed as an indication of the services rendered to population sub-groups. The totals here should agree with the number of patients reported elsewhere in the survey.

**7. State Cancer Registry:** Please indicate whether your facility participates fully in reporting to the State Cancer Registry (Department of Human Resources, Division of Public Health).

**8. Days and Hours of Operation:** Please indicate the days and hours of operation of the PET service.

## **PART F: MOBILE PET SERVICES**

**Complete Part F only if you are a provider of mobile PET services. If your PET service is a mobile provider, you must complete this part of the survey.** Please report each location served by the mobile service during 2006. Please include the name of the service site and the city along with the number of days of service provided at each location for all months.

## **PART G: PATIENT ORIGIN TABLE**

Please complete the Patient Origin Table to reflect the county (or out-of-state) residence for each patient served at your facility during the reporting period. Mobile providers must complete one patient origin sheet per service site (as identified in Part F.) Please make sufficient additional copies of the Patient Origin Table to ensure that all service sites are addressed in the reporting process.

**The PETSS is due to the Department of Community Health by July 20, 2007. Submit the survey electronically using the instructions provided above. For questions regarding the PETSS or if you are unable to submit the survey electronically, please contact Carlos Williams, II, with the Division of Health Planning at (404) 656-0464, or [cawilliams@dch.ga.gov](mailto:cawilliams@dch.ga.gov).**