

Interim Facility Site Review

California | Anthem Blue Cross | Medi-Cal Managed Care

Site address:	City:
PCP name(s):	Phone:
Date of last periodic review: Facility site review (FSR) score: Medical records review (MRR) score:	Clinic contact name: Clinic contact title: FSR nurse reviewer:

The Department of Health Care Services requires the monitoring of PCP offices between regularly scheduled site reviews. If the site is requested to conduct their own self-assessment, have the physician or designee complete the self-assessment of compliance using the **critical element** criteria below and fax or email the completed form **within 10 business days due** ______ to:

- Fax: 855-316-0913
- Email: InterimFSR@anthem.com

Cri	tical element	Yes	No	N/A	Comments
1.	Exit doors and aisles are unobstructed and egress (escape)				
	accessible Accessible pedestrian paths of travel provide a clear				
	circulation path, including exit door, at all times.				
2.	Timely review and follow-up of referral/consultation reports				
	and test results				
	The office referral process for tracking and follow-up includes				
	documentation of physician review.				
3.	Airway management				
	Must have a wall oxygen delivery system or portable oxygen				
	tank that is maintained at least 3/4 full with flow meter, bulb				
	syringe, nasal cannula or mask, and Ambu bag (appropriate				
_	sizes).				
4.	Emergency medications				
	Emergency medicine such as asthma, chest pain,				
	hypoglycemia, and anaphylactic reaction management:				
	epinephrine 1:1000 (injectable), and Benadryl® 25 mg (oral) or				
	Benadryl 50 mg/ml injectable, naloxone, chewable aspirin 81				
	mg, nitroglycerin spray/tablet, bronchodilator medication				
	(solution with nebulizer equipment or metered dose inhaler),				
	and glucose; appropriate sizes of engineered sharps injury				
	protection (ESIP) needles/ syringes and alcohol wipes.				
5.	Qualified personnel prepare/administer medication				

Cri	tical element	Yes	No	N/A	Comments
	There must be a licensed practitioner (medical doctor [MD],				
	nurse practitioner [NP], physician assistant [PA], or certified				
	nurse midwife [CNM]) physically present in the treatment				
	facility during the performance of authorized procedures by				
	the medical assistant (MA). The supervising physician must				
	specifically authorize all medications administered by an MA.				
	Prelabeled medication container and prepared dose must be				
	presented to and verified by a licensed person prior to				
	administration.				
6.	Authorized persons dispense medications				Mark N/A if
	Drugs are dispensed only by a physician, pharmacist, or other				no
	persons lawfully authorized to dispense medications upon the				medications
	order of a licensed physician or surgeon. Drug dispensing is in				are
	compliance with all applicable state and federal laws and				dispensed.
	regulations.				
7.	Drugs and vaccines				
	Drugs and vaccines are prepared and drawn only prior to				
	administration.				
8.	Needle stick precautions are practiced on-site				
	Safety needles are used on-site and are discarded				
	immediately in sharps containers. All sharps containers are				
	secured and inaccessible to unauthorized persons.				
9.	Personal protective equipment (PPE) PPE is available for staff use on-site and includes water-				
	repelling gloves, water-resistant gowns, face/eye protection (for				
	example, face shield or goggles), and respiratory infection				
	protection (for example, mask).				
10.	Blood and other infectious materials storage and handling Blood, other potentially infectious materials (OPIM), and				
	regulated waste are placed in leak-proof, labeled and/or color-				
	coded containers for collection, handling, processing, storage				
	(secure location), transport, and shipping.				
11.	Cold chemical sterilization/high-level disinfection				Mark N/A if
	Staff demonstrate/verbalize necessary steps/process to ensure				cold
	sterility and/or high-level disinfection to ensure sterility/disinfection of equipment.				chemical solution is
	stenaty/distincetion of equipment.				not used.
12.	Cold chemical sterilization/high-level disinfection				Mark N/A if
	Appropriate PPE is available, along with an exposure control				cold
	plan, MSDS, and cleanup instructions in the event of a cold				chemical
	chemical sterilant spill.				solution is not used.
13.	Autoclave/steam sterilization				Mark N/A if
	Management of positive mechanical, chemical, and/or	_			autoclave is
	biological indicators of the sterilization process.				not used.
14.	Autoclave/steam sterilization				Select N/A if
	Autoclave spore testing is performed at least monthly with				autoclave is not used.
	documented results. (If sterilization is conducted by the				HUL USEU.

Critical element	Yes	No	N/A	Comments
clinic/organization at another location, monthly spore test				
results are available at this location.)				
Has the site been remodeled since last audit?	Has the site moved from this address?			
□Yes □No	🗆 Yes 🗆 No			

Attestation: I hereby affirm that the information indicated on this form and any documents thereto is true, current, correct, and complete to the best of my knowledge and belief and is furnished in good faith. I understand that material omissions or misrepresentations may result in denial of my application or termination of my privileges or physician participation agreement.

Physician or	designee	signature/title: _
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_____ Date: _____

Health plan office use only	
Interim review approved: Yes \Box No \Box	<i>Corrective Action Plan (CAP)</i> requested for item(s) #:
Follow-up required: Yes 🗆 No 🗆	
Date follow-up completed:	Date CAP due:
	Date CAP completed:
Nurse reviewer comments:	
□ Fax back □ On-site verification	
Health plan nurse reviewer signature	Date