GEORGIA DEPARTMENT OF COMMUNITY HEALTH

2023 Annual Radiation Therapy Services Survey

Part A : General Information

1. Identification

UID:

Facility Name:

County:

Street Address:

City:

Zip:

Mailing Address:

Mailing City:

Mailing Zip:

Medicaid Provider Number:

Medicare Provider Number:

2. Report Period

Report data for the full twelve month period- January 1, 2023 through December 31, 2023. ***Do not use a different report period.***

Check the box to the right if your facility was **not** operational for the entire year. ☐
If your facility was **not** operational for the entire year, provide the dates the facility was operational.

Part B : Survey Contact Information

Person authorized to respond to inquiries about the responses to this survey.

Contact Name:

Contact Title:

Phone:

Fax:

E-mail:

Part C : Ownership, Operation and Management

1. Ownership, Operation and Management

As of the last day of the report period, indicate the operation/management status of the facility and provide the effective date. Using the drop-down menus, select the organization type. If the category is not applicable, the form requires you only to enter Not Applicable in the legal name field. You must enter something for each category.

A. Facility Owner

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date

B. Owner's Parent Organization

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date

C. Facility Operator

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date

D. Operator's Parent Organization

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date

E. Management Contractor

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date

F. Management's Parent Organization

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date

2. Changes in Ownership, Operation or Management

Check the box to the right if there were any changes in the ownership, operation, or management of the facility during the report period or since the last day of the Report Period. ☐
If checked, please explain in the box below and include effective dates.

Part D : Services/Volume by Technology or Type

Please Report the following utilization numbers for all non-special and special purpose radiation therapy units. The grand total of visits in Questions 1, 2a, 2b, and 3 should match the reported visit totals in Parts E and F.

1. Conventional Radiation Therapy

Report conventional, non-special purpose megavoltage radiation therapy linear accelerators and cobalt therapy units, visits, and patients. All such units should be reported here including those units that were approved under the utilization exception to the MegaVoltage Radiation Therapy rules. Do not report units capable of providing stereotactic radiosurgery treatment visits in Question 1.

Type of Machine/Therapy	Number of Machines	Number of Visits	Number of Patients
Linear Accelerator/Radiation Therapy			
Cobalt Therapy			

2a. Combined Radiation Therapy

For Question 2 (a & b) provide the number of machines with which both conventional, non-special purpose radiation therapy and stereotactic radiosurgery could be performed. Provide the number of visits and patients treated under each specific modality and for each type of treatment category for the report year and report any treatments performed on other machines that were capable of providing both conventional radiation therapy and stereotactic radiosurgery.

Equipment	Number of Machines	Conventional Visits	Conventional Patients
Trilogy			
Synergy			
Other Technology			

2b. Combined Radiation Therapy/Stereotactic Radiosurgery- Intracranial and Extracranial/Body Utilization

Equipment	Intracranial Stereotactic Radiosurgery Visits	Intracranial Stereotactic Radiosurgery Patients	Stereotactic Body Radiotherapy (SBRT) Visits	Stereotactic Body Radiotherapy (SBRT) Patients
Trilogy				
Synergy				
Other Technology				

Total Non-Special Purpose Visits from Questions 1, 2a and 2b:___

3. Special Purpose MRT Units and Volume

Provide the number of SRS-only machines and the number of visits and patients treated on each by the treatment categories provided. For purposes of the survey, stereotactic radiosurgery consists of procedures utilizing accurately targeted doses of radiation in multiple treatments over a short period of time (usually 1 week).

Equipment	Number of Machines	Intracranial Stereotactic Radiosurgery Visits	Intracranial Stereotactic Radiosurgery Patients	Stereotactic Body Radiotherapy (SBRT) Visits	Stereotactic Body Radiotherapy (SBRT) Patients
Gamma Knife					
Cyber Knife					
Other Technology					

Total Special Purpose Visits from Question 3:___

Grand Total of Special Purpose and Non-Special Purpose Visits

The grand total here should match the reported visit totals in Parts E and F.

Special Purpose Visits	Non-Special Purpose Visits	Grand Total Visits

4. Non-Special MRT Treatment Visits by Type

Please report the following utilization numbers for non-special MRT treatments by type and the number of patients receiving those treatments.Note that any non-special purpose unit and its associated volumes hat were approved under the high utilization rule exception should be listed separately. Volumes should reflect only those units reported in Part D, Questions 1 and 2 above. Patients can be duplicated across treatment categories.

Treatment Type	Non-Rule Exception Units Visits	Non-Rule Exception Units Patients	90% Utilization Exception Units Visits	90% Utilization Exception Units Patients
Simple Treatment				
Intermediate Treatment				
Complex Treatment				
Intensity Modulated Radiation Therapy (IMRT)				
Stereotactic Radiosurgery on Machines also performing radiation therapy				
Total				

5. Other Radiation Therapy

Report visits and patients receiving non-linear accelerator/penetrating ray radiation therapy.

Type of Therapy	Number of Visits	Number of Patients
Radium Therapy		
Cesium Therapy		
Superficial Radiation Therapy		
Brachytherapy		
Other Radiation Therapy		

6. Inventory of Radiation Therapy and Stereotactic Radiosurgery Technology

Provide the brand name, model number, date purchased, technology type (Conventional Radiation Therapy Only, Combined Radiation Therapy/Stereotactic Radiosurgery, or SRS-only), and number of treatment visits for all radiation therapy and stereotactic radiosurgery machines that were in operation during the report year. For linear accelerators also indicate if the unit is operating at greater than or equal to 1 million electron volts or less than 1 million electron volts.

Brand Name	Model #	Type of Unit	Visits	Electron Volts	Date Purchased

7. Inventory of Other Technology

Provide the brand name, model number, type of machine and date purchased for all other types of technology/machines that were in operation during the report year.

Brand Name	Model #	Type of Machine	Date Purchased

Part E : Financial and Utilization Information for MegaVoltage Radiation Therapy Services

1. Megavoltage Radiation Therapy Patients and Treatment Visits by Primary Payment Source

Please report the total megavoltage radiation therapy patients and treatment visits by primary payment source. Please unduplicate the number of patients by primary payment source. Please report Peachcare For Kids under Third-Party.

Primary Payment Source	Number of Radiation Therapy Patients (unduplicated)	Number of Treatment Visits
Medicare		
Medicaid		
Third-Party		
Self-Pay		
Other Payers (Tricare, Other Govt. etc.)		
Total		

2a. Total Charges

Please report the total charges for megavoltage radiation therapy services provided during the report period.

Total Charges

2b. Reimbursement

Please report the actual reimbursement received for charges for megavoltage radiation therapy services provided during the report period.

Reimbursement

2c. Adjusted Gross Revenue

Please report the adjusted gross revenue for megavoltage radiation therapy services provided during the report period.

Adjusted Gross Revenue

3a. Total Uncompensated Indigent and Charity Care Charges

Please report the total uncompensated megavoltage radiation therapy Indigent and Charity Care charges.

Total Uncompensated Charges

3b. Total Patients with Uncompensated Charges

Please report the total number of patients for megavoltage radiation therapy services for patients that are indigent or covered by charity care services.

Total Patients with Uncompensated Charges

4. Average Patient Charge

Report the average charge per patient for Non-Special Purpose MRT treatment visits and for Special Purpose MRT treatment visits.

Average Patient Charge- Non Special Purpose MRT	Average Patient Charge- Special Purpose MRT

5. Patients and Visits by Race/Ethnicity

Please report the number of megavoltage radiation therapy services patients (unduplicated) and treatment visits during the report period by the following race and ethnicity categories.

Race/Ethnicity	Number of Patients	Number of Treatment Visits
American Indian/Alaska Native		
Asian		
Black/African American		
Hispanic/Latino		
Pacific Islander/Hawaiian		
White		
Multi-Racial		
Total		

6. Patients and Visits by Gender

Please report the number of megavoltage radiation therapy services patients and treatment visits during the report period by gender.

Gender	Number of Patients	Number of Visits
Male		
Female		
Total		

7 Patients and Visits by Age Group

Please report the number of megavoltage radiation therapy services patients and treatment visits during the report period by the following age groupings.

Age of Patient	Number of Patients	Number of Treatment Visits
Ages 0-14		
Ages 15-29		
Ages 30-64		
Ages 65-84		
Ages 85 and Up		
Total		

8. Participation in Reporting

Please check the box to the right if your facility participates in reporting to the Georgia Comprehensive Cancer Registry. ☐

9. Patients by Principle Diagnosis

Report the number of patients, total visits, and total gross charges during the report period by the patient's principle diagnosis as indicated below.

Principle Diagnosis	Number of Patients	Number of Treatment Visits	Gross Treatment Charges
Malignant Neoplasms of Female Breast (ICD10=C50			
Colon and Rectum (ICD10=C18-C21			
Prostate Cancer (ICD10=C61			
Lung and Bronchus (ICD10=C33-C34			
All Other			
Total			

10. Estimated Patients and Treatments in the Next Calendar Year

Please provide the number of patients and treatments estimated, expected, or scheduled in the next calendar year (CY2014) for conventional radiation therapy.

Number of Patients	Number of Treatments

Part F : Patient Origin for Radiation Services

1. Patient Origin

By the patient's county of origin report the total number of radiation therapy services treatment visits and patients at your facility. Also report the number of visits and patients treated using the linear accelerator(s).

County	Total Non-Duplicated Patients	Total Visits	Non-Special Purpose MRT Patients	Non-Special Purpose MRT Visits	Special Purpose MRT Patients	Special Purpose MRT Visits
Total						

Electronic Signature

Please note that the survey WILL NOT BE ACCEPTED without the authorized signature of the Chief Executive Officer or Executive Director (principal officer) of the facility. The signature can be completed only AFTER all survey data has been finalized. By law, the signatory is attesting under penalty of law that the information is accurate and complete.

I state, certify and attest that to the best of my knowledge upon conducting due diligence to assure the accuracy and completeness of all data, and based upon my affirmative review of the entire completed survey, this completed survey contains no untrue statement, or incaccurate data, nor omits requested material information or data. I further state, certify and attest that I have reviewed the entire contents of the completed survey with all appropriate staff of the facility. I further understand that inaccurate, incomplete or omitted data could lead to sanctions against me or my facility. I further understand that a typed version of my name is being accepted as my original signature pursuant to the Georgia Electronic Records and Signature Act.

Authorized Signature:

Date:

Title:

Comments: