GEORGIA DEPARTMENT OF COMMUNITY HEALTH

2009 Open Heart Surgery Survey

Part A : General Information

1. Identification

UID:

Facility Name:

County:

Street Address:

City:

Zip:

Mailing Address:

Mailing City:

Mailing Zip:

Medicare Provider Number:

Medicaid Provider Number:

2. Report Period

Report Data for the full twelve month period, January 1,2009 - December 31, 2009 (365 days).
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 : Utilization Data

1. Open Heart Surgery Operations

Report the total number of open heart surgery operations performed during the report period by age and type of operation. Do not include any closed heart surgeries or cardiac catheterization procedures.

Type of Operation	Ages 0-14	Ages 15+	Total
Coronary bypass	0	0	0
Coronary bypass plus valves	0	0	0
Aortic valve replacement	0	0	0
Mitral valve replacement	0	0	0
Heart transplant	0	0	0
Atrial septal defect	0	0	0
Ventricular septal defect	0	0	0
Tetralogy of fallot	0	0	0
	0	0	0
	0	0	0
	0	0	0
Total	**0**	**0**	**0**

2. Close Heart Surgery Operations

Report the total number of closed heart surgery operations performed during the report year by age and type of operation. Do not include any open heart surgeries or procedures performed by cardiac catheterization.

Type of Operation	Ages 0-14	Ages 15+	Total
Coronary bypass	0	0	0
Coarctation of the aorta	0	0	0
Closure of patent ductus arteriosus, age>28 days, by CHS	0	0	0
Closure of patent ductus arteriosus, age<28 days, by CHS	0	0	0
Palliative shunts for cyanotic heart disease	0	0	0
	0	0	0
	0	0	0
	0	0	0
Total	**0**	**0**	**0**

3. Coronary Angioplasties Resulting in Emergency Open Heart Surgery Operations

During the report period, how many coronary angioplasties performed at your hospital resulted in immediate emergency open heart surgery operations? (Estimate, if necessary.)

Check box if Estimated. ☐

4. Open Heart Surgery Patients by Race/Ethnicity

Please report the number of unduplicated open heart surgery patients your facility served during the report period using the following race and ethnicity categories.

Race/Ethnicity	Number of Patients
American Indian/Alaska Native	0
Asian	0
Black/African American	0
Hispanic/Latino	0
Pacific Islander/Hawaiian	0
White	0
Multi-Racial	0
Total	**0**

5. Open Heart Surgery Patients by Gender

Please report the number of open heart surgery patients by gender served during the report period.

Gender	Number of Patients
Male	0
Female	0
Total	**0**

Part D : Financials and Average Charges

1. For the report period, report the average total hospital charge, length of stay and number of cases from admissions to discharge, excluding Medicare outliers, for each of the following DRGs. Use the blank lines to specify other DRGs not included in the table.

Selected DRGs	Average Total Hospital Charge	Average Length of Stay (in Days)	Number of Cases Included in Calculation of Averages	Actual Hospital Total Cases
DRG 103: Heart Transplant (MS-DRG 001 & 002)	0	0	0	0
DRG 104: Cardiac valve with cardiac catheterization (MS-DRG 216, 217, & 218)	0	0	0	0
DRG 105: Cardiac valve without cardiac catheterization (MS-DRG 219, 220, & 221)	0	0	0	0
DRG 106: Coronary bypass with PTCA (MS-DRG 231 & 232)	0	0	0	0
DRG 110: Major cardiovascular procedures with CC (MS-DRG 237)	0	0	0	0
DRG 111: Major cardiovascular procedures without CC (MS-DRG 238)	0	0	0	0
DRG 108: Other cardiothoracic procedures (MS-DRG 228, 229 & 230)	0	0	0	0
	0	0	0	0
	0	0	0	0
	0	0	0	0
	0	0	0	0
	0	0	0	0

2. Heart Surgery Patients and Operations by Primary Payment Source

Please report the total number of unduplicated open heart surgery patients and operations by primary payment source. Report Peachcare for Kids patients under Third-Party.

	Primary Payment Source			
	Medicare	Medicaid	Third Party (Including Peachcare)	Self-Pay
Number of Open Heart Surgery Patients	0	0	0	0
Number of Operations	0	0	0	0

3. Total Charges and Actual Reimbursement for Open Heart Surgeries

Please report the total charges for open heart surgeries provided during the report period. Also, report the actual reimbursement received for charges for open heart surgeries provided during the report period.

Total Charges	Actual Reimbursement
0	0

4. Total Uncompensated Charges and Total Uncompensated Patients

Please report the uncompensated charges for open heart surgeries for patients that are indigent or covered by charity care services. Also, report the number of patients.

Total Uncompensated Charges	Total Uncompensated Patients
0	0

5. Adjusted Gross Revenue

Please report the adjusted gross revenue for open heart surgery services during the report period.

Adjusted Gross Revenue
0

Part E : Peer Review

1. Check the box to the right if your program/facility participates in an external or national peer review and outcomes reporting system. ☐

If you indicated yes above, please provide the name(s) of the peer review/outcomes reporting organization(s) below:

2. How many community education programs did your program/facility participate in during the reporting period?

Part F : Patient Origin

Please report the number of open heart surgery patients by county and age category. The grand totals must agree with the calculated totals of open heart operations by race and gender found in Part C, Questions 4 and 5.

County	Ages 0-14	Ages 15+	Total
0			

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: