



As you are aware, the performance of facility site reviews for Medi-Cal primary care physicians was changed from a two year to a three year cycle, effective 7/1/02. However, the Department of Health Care Services also mandated in MMCD Policy Letter 02-02 that,

"Nine critical elements shall be monitored on all sites between full scope site surveys".

In order for Molina Healthcare of California to comply with this requirement, we are asking you to complete the attached "Interim Facility Site Review" form and to return it, by fax or mail, **within three (3) business days of being notified to go to the website and print this audit form.**

FAX NUMBER: (562) 951-8325

or, by mail to:

Molina Healthcare of California

Attn: Credentialing / FSR

Arlene Boolay, LVN, Facility Site Review Specialist

200 Oceangate, Suite 100

Long Beach, CA 90802-4317

Should you fail to return the completed and signed form within the given time parameter, the Molina Site Review Unit is obligated to schedule an on-site visit (unless already scheduled for on site visit) to complete a Interim review of Critical Elements form. Failure to complete the Interim Review Form and/or allow an on-site review under DHCS MMCD Policy Letter 02-02, will be reported to all DHCS contracted health plans in the county in which you practice. Title 22 Section 56230 of the California Code mandates that all sites providing primary health care services shall be subject to an initial onsite inspection, and thereafter periodic inspections to evaluate the continuing capacity of the site to support the delivery of quality health care services. Failure to meet site review requirements may result in termination from any or all Medi-Cal Managed Health Care Networks.

If you have any questions regarding this Interim Review requirement, please do not hesitate to contact Arlene Boolay at (562) 499-6191, extension 120118.

Thank you for your immediate attention to this Interim Review requirement.



Interim Facility Site Review

Site Address:	Date of Review:
PCP Name(s):	Contact:
Phone #:	County:
Date of Full Scope: FSR: MRR:	Reviewer: <div style="text-align: right; font-size: small;">(Please Print Name & Title)</div>

Critical Element	Compliant	Non-Compliant	Comments
1. Exit doors and aisles are unobstructed and egress (escape) accessible	<input type="checkbox"/>	<input type="checkbox"/>	
2. Airway management: oxygen delivery system, oral airways, na cannula or mask, Ambu bag.	<input type="checkbox"/>	<input type="checkbox"/>	
3. Qualified personnel retrieve, prepare/admin medication	<input type="checkbox"/>	<input type="checkbox"/>	
4. Physician review and follow-up of referral/consultation reports and diagnostic test results	<input type="checkbox"/>	<input type="checkbox"/>	
5. Only lawfully authorized persons dispense drugs to patients.	<input type="checkbox"/>	<input type="checkbox"/>	
6. Personal Protective Equipment is readily available for staff use	<input type="checkbox"/>	<input type="checkbox"/>	
7. Needlestick safety precautions are practiced on site.	<input type="checkbox"/>	<input type="checkbox"/>	
8. Blood, other potentially infectious materials and Regulated Wastes are placed in appropriate <i>leak proof, labeled</i> containers for collection, handling, processing, storage, transport or shipping.	<input type="checkbox"/>	<input type="checkbox"/>	
9. Spore testing of autoclave/steam sterilizer with documented results (at least monthly)	<input type="checkbox"/>	<input type="checkbox"/>	

FSR deficiency CAP verification	<input type="checkbox"/>	<input type="checkbox"/>	
MRR deficiency CAP verification	<input type="checkbox"/>	<input type="checkbox"/>	

PCP/Representative and Title Signature: _____ Date: _____

HEALTH PLAN USE ONLY BELOW THIS LINE

Interim Review Approved: Yes <input type="checkbox"/> No <input type="checkbox"/>	Date CAP Due: _____
Follow-up required: Yes <input type="checkbox"/> No <input type="checkbox"/>	Date Follow-up Due: _____
Reviewer Comments:	
Nurse Reviewer Signature:	Date: _____