Capital BlueCross
PROSTHETICS & ORTHOTICS SURVEY

Provider Name: _____
CBC #: _____ **Medicare #:** _____ **Medicaid #:** _____
Accrediting Organization: _____ **Date of most recent accrediting survey:** _____
Person completing survey: _____ **Phone:** _____ **Date:** _____
Contact person (if different than above): _____ **Phone:** _____

Directions: Please complete each line with appropriate information.
Where applicable please indicate with a check mark (☐).

ADMINISTRATION

Days & Hours of operation: _____
Handicap access ☐ Yes ☐No
Services available within 24 hours of intake on request ☐ Yes ☐No
Written compliance program ☐ Yes ☐No
Compliance program officer ☐ Yes ☐No
Internal compliance audits ☐ Yes ☐No
Review of the Medicare/Medicaid sanction report ☐ Yes ☐No
Frequency of review: _____
Written policy on patient confidentiality ☐ Yes ☐No
Written policy on medical record confidentiality ☐ Yes ☐No
Written policy for release of medical records ☐ Yes ☐No
Written policy for maintenance/retention of medical Records ☐ Yes ☐No
Written patient medical emergency plan ☐ Yes ☐No
Emergency medical equipment/supplies available ☐ Yes ☐No
Written policy for checking emergency medical equipment/supplies ☐ Yes ☐No
Include frequency of checks ☐ Yes ☐No
Written on-call policy ☐ Yes ☐No
Customer service/Technical support toll-free number ☐ Yes ☐No

QUALITY MANAGEMENT

Quality Activities

Performance Improvement Program ☐ Yes ☐No
Performance Improvement Program includes utilization review ☐ Yes ☐No
Development of improvement activities based on identified issues ☐ Yes ☐No
Performance Improvement Committee ☐ Yes ☐No
Frequency of meetings: _____

List two Current Quality Studies:
1. _____
2. _____

Written infection control policies ☐ Yes ☐No
Written policy regarding in-house repairs ☐ Yes ☐No
Written policy for follow-up evaluations for proper use and/or functioning of equipment/device ☐ Yes ☐No
Written policy regarding delivery times ☐ Yes ☐No
Maximum response time for delivery: _____
Written policy for treatment of patients with open wounds ☐ Yes ☐No
Written policy for addressing advance directives ☐ Yes ☐No

Client Satisfaction

Client Satisfaction Surveys utilized ☐ Yes ☐No
Annual return rate for surveys: _____ **%**
Issues identified:
1. _____
2. _____
Results forwarded to PI committee ☐ Yes ☐No
Written patient/family complaint process ☐ Yes ☐No

Physician Satisfaction

Physician Satisfaction Survey utilized ☐ Yes ☐No
Annual return rate for surveys: _____ **%**

Patient Education

Patient/Family education ☐ Yes ☐No
Documented in the clinical record ☐ Yes ☐No
Services for hearing impaired ☐ Yes ☐No
Services for speech impaired ☐ Yes ☐No
Services for visually impaired ☐ Yes ☐No
Bilingual services ☐ Yes ☐No
Bilingual patient education materials ☐ Yes ☐No
Languages offered: _____

Provider Name:

SERVICES

Durable Medical Equipment ☐ Yes ☐No
Prosthetics ☐ Yes ☐No
Orthotics ☐ Yes ☐No
On-site repairs ☐ Yes ☐No
On-site fabrication of prosthetic devices ☐ Yes ☐No
Molded shoes ☐ Yes ☐No
List other services: _____

Data Collection

Emergency calls per month ☐ Yes ☐No
Incident reports ☐ Yes ☐No
Delivery times ☐ Yes ☐No
List other data: _____

CLINICAL STAFF

Written policy for clinical competency evaluation ☐ Yes ☐No
Evaluated during probationary period ☐ Yes ☐No
Evaluated annually ☐ Yes ☐No
Written policy for verification of the following for all certified/registered staff:

- Certification ☐ Yes ☐No
- Education ☐ Yes ☐No
- License ☐ Yes ☐No

Written policy for recredentialing of:

- Clinical Staff ☐ Yes ☐No
- Frequency: _____

Number of mandatory educational programs staff is required to attend annually: _____
Written policy for routine testing of employees for infectious diseases ☐ Yes ☐No
Certified Prosthetist ☐ Yes ☐No
Certified Orthotist ☐ Yes ☐No
Certified Prosthetist/Orthotist ☐ Yes ☐No
Certified Pedorthist ☐ Yes ☐No
Certified Fitters ☐ Yes ☐No
Written policy defining staff requiring CPR certification ☐ Yes ☐No

% Clinical staff CPR certified

Other Staff: _____

FACILITIES & EQUIPMENT

Private fitting rooms available ☐ Yes ☐No
Bioengineering specialist ☐ Yes ☐No
If **no**, person responsible for maintenance of biomedical equipment ☐ Yes ☐No
Written preventive maintenance plan ☐ Yes ☐No
Written plan for equipment failure ☐ Yes ☐No
Written emergency preparedness plan ☐ Yes ☐No
Plan includes:

- Fire ☐ Yes ☐No
- Loss of utilities ☐ Yes ☐No
- Inclement weather ☐ Yes ☐No

Written policy for fire/disaster drills ☐ Yes ☐No
Results of drills documented ☐ Yes ☐No
Written policy for handling biohazardous materials ☐ Yes ☐No

As a reminder, please be sure to include:

- ***Facility Information Sheet***
- ***Name sheet for branch offices***
- ***Affiliate or owned services***

COMMENTS

Provider Name:

Please complete the following based upon corporate ownership of off-site business initiatives and indicate specific services performed at the office site.

Branch Offices

Name: ______
Services Provided: ______
Billing Site Only ☐ Yes ☐No
Date of Acquisition or Establishment: ______
Address: ______
City: ______
Phone: ______
Contact Person: ______
Counties Served: ______

Name: ______
Services Provided: ______
Billing Site Only ☐ Yes ☐No
Date of Acquisition or Establishment: ______
Address: ______
City: ______
Phone: ______
Contact Person: ______
Counties Served: ______

Name: ______
Services Provided: ______
Billing Site Only ☐ Yes ☐No
Date of Acquisition or Establishment: ______
Address: ______
City: ______
Phone: ______
Contact Person: ______
Counties Served: ______

Name: ______
Services Provided: ______
Billing Site Only ☐ Yes ☐No
Date of Acquisition or Establishment: ______
Address: ______
City: ______
Phone: ______
Contact Person: ______
Counties Served: ______

Name: ______
Services Provided: ______
Billing Site Only ☐ Yes ☐No
Date of Acquisition or Establishment: ______
Address: ______
City: ______
Phone: ______
Contact Person: ______
Counties Served: ______

Name: ______
Services Provided: ______
Billing Site Only ☐ Yes ☐No
Date of Acquisition or Establishment: ______
Address: ______
City: ______
Phone: ______
Contact Person: ______
Counties Served: ______

Name: ______
Services Provided: ______
Billing Site Only ☐ Yes ☐No
Date of Acquisition or Establishment: ______
Address: ______
City: ______
Phone: ______
Contact Person: ______
Counties Served: ______

Name: ______
Services Provided: ______
Billing Site Only ☐ Yes ☐No
Date of Acquisition or Establishment: ______
Address: ______
City: ______
Phone: ______
Contact Person: ______
Counties Served: ______

Provider Name:

HEALTHCARE FACILITY INFORMATION FORM

Provider Name:_____
Parent:_____
Affiliation:_____
Affiliation:_____

Number of Years in business:_____

Type of Control

☐**Voluntary Nonprofit**

☐**Proprietary** (Identify all individuals, members of partnership, major stockholders, etc. If 'Other' explain.)

- ☐ Individual _____
- ☐ Partnership_____
- ☐ Corporation_____
- ☐ Other_____

☐ **Government**

- ☐ Federal
- ☐ State
- ☐ County
- ☐ Other, explain:_____

Additional Information Requested

Has the facility, any corporate officer, employee or any agent acting on behalf of the facility been involved in or convicted of healthcare fraud or abuse in the last five (5) years?

☐Yes, explain:_____
☐No

Have you or any of your affiliates, entered into a corporate integrity agreement with any state or federal agency?

☐Yes
☐No
If yes, provide a copy to Capital Blue Cross

Provide copies of the following:

- State Licensure certificate(s)
- List of Board of Directors
- Most recent accreditation letter
- Most recent DOH Report
- Evidence of current malpractice insurance
- Current organizational chart

COMMENTS: _____

Provider Name:

Please indicate the counties within your service area. If services are limited to only a portion of the county, please identify.

Adams ☐ _____
Berks ☐ _____
Centre ☐ _____
Columbia ☐ _____
Cumberland ☐ _____
Dauphin ☐ _____
Franklin ☐ _____
Fulton ☐ _____
Juniata ☐ _____
Lancaster ☐ _____
Lebanon ☐ _____
Lehigh ☐ _____
Mifflin ☐ _____
Montour ☐ _____
Northampton ☐ _____
Northumberland ☐ _____
Perry ☐ _____
Schuylkill ☐ _____
Snyder ☐ _____
Union ☐ _____
York ☐ _____

Other ☐ _____
_____
_____
_____
_____