Capital BlueCross
OUTPATIENT PHYSICAL REHABILITATION 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 provided to:
- Adults ☐ Yes ☐No
- Adolescents ☐ Yes ☐No
- Children ☐ Yes ☐No
- Infants ☐ Yes ☐No

Written patient medical emergency plan ☐ Yes ☐No
Emergency medical equipment/supplies available ☐ Yes ☐No
Written procedure for checking equipment/supplies ☐ Yes ☐No
Include frequency of checks ☐ 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 agreement with emergency transportation service ☐ Yes ☐No
Reliance on 911 system ☐ 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: _____
Quality Reports forwarded to the Board of Directors ☐ Yes ☐No
List two current Quality Studies:
1. _____
2. _____

Written infection control policies ☐ Yes ☐No

Patient Satisfaction

Patient Satisfaction Surveys utilized ☐ Yes ☐No
Issues identified:
1. _____
2. _____

Results forwarded to PI committee ☐ Yes ☐No
Annual return rate for surveys: _____ **%**
Written patient/family complaint process ☐ Yes ☐No

Clinical Management

Written policy on addressing advance directives ☐ Yes ☐No
Clinical pathways utilized ☐ Yes ☐No
Written scheduling procedure ☐ Yes ☐No
Written admission criteria ☐ Yes ☐No
Written discharge criteria ☐ Yes ☐No
Written policy on development of treatment plans ☐ Yes ☐No
Include frequency of updates ☐ Yes ☐No
Written policy for team conferences ☐ Yes ☐No
Frequency of team conferences: _____
Written policy for the treatment of open wounds ☐ Yes ☐No
Discharge Planning ☐ Yes ☐No

Patient Education/ Public Health

Patient/family education ☐ Yes ☐No
Documented in the clinical record ☐ Yes ☐No
Services available for hearing impaired ☐ Yes ☐No
Services available for speech impaired ☐ Yes ☐No
Services available for visually impaired ☐ Yes ☐No

Provider Name:

Bilingual services ☐ Yes ☐No
Bilingual patient education materials ☐ Yes ☐No
Languages offered: _____

Data Collection

Average number of visits ☐ Yes ☐No
Program efficiency per diagnosis ☐ Yes ☐No
Incident Reports ☐ Yes ☐No
FIM Score ☐ Yes ☐No
List other data: _____

CLINICAL STAFF

Clinical Competency Evaluation ☐ Yes ☐No
During Probationary period ☐ Yes ☐No
Annually ☐ Yes ☐No
Written policy for verification of the following for all clinical staff:

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

Number of mandatory educational programs staff is required to attend annually: _____
Written policy for routine testing of employees for infectious diseases ☐ Yes ☐No
Written policy for credentialing of physicians ☐ Yes ☐No
Written policy for recredentialing of:

- Physicians ☐ Yes ☐No
- Clinical Staff ☐ Yes ☐No
- Frequency: _____

Medical Staff

Medical Director ☐ Yes ☐No
Specialty: _____
Board Certified ☐ Yes ☐No
If physician(s) not board certified, competency established through the facility's credentialing process ☐ Yes ☐No

Rehabilitation Staff

_____ Number of Physiatrists
_____ Number Board Certified in Rehabilitation Medicine

List Other Physician Services: _____

Other Staff

_____ Number of Registered Nurses
_____ Number of Certified Rehabilitation Nurses
_____ Number of Licensed Physical Therapists
_____ Number of Registered Physical Therapy Assistants
_____ Number of Physical Therapy Aides
_____ Number of Licensed Occupational Therapists
_____ Number of Licensed Occupational Therapy Assistants
_____ Number of Licensed Speech Therapists
_____ Number of Recreational Therapists
_____ Number of Certified Recreational Therapists
_____ Number of Prosthetists
_____ Number of Orthotists
_____ Number of Bioengineering Specialists
_____ Number of Vocational Rehab Counselors
_____ Number of Neuropsychologists
_____ Number of Psychologists
_____ Number of Social Workers
_____ Number of Case Managers

Written policy defining staff requiring CPR certification ☐ Yes ☐No

_____ **%** Clinical staff CPR certified

SERVICES

Please check the following services you provide:

- ☐ Aquatic Therapy
- ☐ Biofeedback
- ☐ Brain Injury
- ☐ Burn
- ☐ Cardiac Rehab
- ☐ Chronic Pain Management
- ☐ Day Program
- ☐ Detoxification
- ☐ Hand Clinics
- ☐ Neuro Rehab
- ☐ Orthotics
- ☐ Outpatient Day Rehab
- ☐ Oncology Rehab
- ☐ Pediatric Acute
- ☐ Prosthetics
- ☐ Pulmonary Rehab
- ☐ Spinal Cord Injury
- ☐ Vocational Rehab
- ☐ Wellness
- ☐ Work Hardening Program

Provider Name:

☐ Wound Therapy
☐ Others (please list) _____

(If services not provided Onsite please list service site on Attachment I)

Clinical Health Care

Indicate which Structured Clinics are part of the Hospital system:

(If any clinics are staffed by out of area physicians, please list the clinic and physician name on a separate attachment. For off-site clinics, identify location and services on attachment II)

	On-site	Off-site
☐ Adolescent	☐	☐
☐ Amputee	☐	☐
☐ Brain Injury	☐	☐
☐ Diabetic	☐	☐
☐ Geriatric	☐	☐
☐ Hand	☐	☐
☐ Hip & Knee	☐	☐
☐ Medical	☐	☐
☐ Orthopedic	☐	☐
☐ Pain Management	☐	☐
☐ Pediatric	☐	☐
☐ Post Polio	☐	☐
☐ Pulmonary	☐	☐
☐ Rheumatology	☐	☐
☐ Spina Bifida	☐	☐
☐ Spinal Cord	☐	☐
☐ Stroke	☐	☐
☐ Wheel chair	☐	☐
☐ Wound Care	☐	☐

Other Clinics: _____

Support Services

Cognitive Therapy ☐ Yes ☐No
Counseling ☐ Yes ☐No
Occupational Therapy ☐ Yes ☐No
Physical Therapy ☐ Yes ☐No
Recreational Therapy ☐ Yes ☐No
Respiratory Therapy ☐ Yes ☐No
Speech Therapy ☐ Yes ☐No
Vocational Rehab ☐ Yes ☐No

Facilities & Equipment

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:

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 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:

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 ☐ _____
_____
_____
_____
_____