BlueDistinction® Specialty Care

BlueCross BlueShield Association

Blue Distinction® Centers for Knee and Hip Replacement 2025 Provider Survey

Printed version of this document is for reference purposes only.

A completed Provider Survey will need to be submitted via the online web application BD Portal℠.

Paper copies of the Provider Survey will not be accepted.

Review instructions below to complete the Provider Survey via the online web application BD Portal.

BD Portal Instructions:

- In the Survey Actions screen, under Survey, click on "**Check Out**" and then **"Take Survey"** to open the Provider Survey.
- To save your responses, click **"Save."**
- If you need to edit the Provider Survey at a later time, click "**Check In."** This will save your responses and exit the Provider Survey.
- You must also "**Release**" the Provider Survey on the Survey Actions screen, as applicable, if other contacts need to access the Provider Survey.
- Once the Provider Survey is complete and ready to be submitted, click on "**Submit."** Close the Survey window to bring you back to the Survey Actions screen.
- Each applicant facility must submit a complete electronic version of the Provider Survey in BD Portal for a **complete submission.**
- Please be sure that the status of your electronic application displays "**Submitted,**" which will confirm that the applicant facility has successfully submitted a complete Provider Survey. (You may need to refresh your browser for the status to update.)

Program Materials

These 2025 Blue Distinction Centers® for Knee and Hip Replacement (BDC Knee and Hip Replacement) program materials are available to help applicant facilities gather the necessary information ahead of time, prior to completing the online application in BD Portal:

- ***Provider Survey*** *(PDF version)*
  - NOTE: Each applicant facility must submit an electronic version of the 2025 BDC Knee and Hip Replacement Provider Survey in BD Portal; paper responses will not be accepted.
- ***Supplemental Instructions*** to complete the 2025 BDC Knee and Hip Replacement Provider Survey are available in the BD Portal Facility Community Library.
- ***Evaluation Components***

Program materials for the BDC for Knee and Hip Replacement program are also available on www.bcbs.com.

Open all hyperlinks in a separate window throughout the document.

PROVIDER SURVEY

Please complete all Provider Survey information pertaining to the applicant facility's current and active knee and hip replacement program for **adults** (18 years and older). For guidance in completing the Provider Survey, please refer to the Supplemental Instructions, available in the BD Portal Facility Community Library. Check to make sure that all Provider Survey responses are complete before submitting.

Provider Survey Tabs	Question Numbers
Facility Information	1 - 17
Facility Procedure Volume	18 - 22
Knee and Hip Replacement Program Information	23 - 28
Team Table	29
Terms & Conditions	N/A

FACILITY INFORMATION

The Blue Distinction Specialty Care designation is for individual facilities only and does not designate hospital systems or groups. The data and information submitted in this Provider Survey should be ONLY for the individual applicant facility located at the address listed below. Each facility that provides knee and hip replacement services will need to complete its own BDC Knee and Hip Replacement 2025 Provider Survey.

APPLICANT FACILITY'S ADDRESS AND IDENTIFIERS WILL BE PRE-POPULATED IN THE ONLINE VERSION OF THIS PROVIDER SURVEY IN BD PORTAL.

APPLICANT FACILITY'S NAME:
ADDRESS:
CITY:
STATE:
ZIP:

If any of the applicant facility's information shown above is incorrect, **submit a Case** in **BD Portal** or contact your local Blue Cross and/or Blue Shield Plan directly to have the information corrected.

To **submit a Case in BD Portal,** go to **Case Management → New → Provider Case** - then enter the correct information in the **Description Box.**

To access your **Provider Record**, click on your facility's name on the 'Survey Actions' tab in BD Portal. Please review your National Provider Identifier (NPI), Federal Tax Identification Number (FEIN), and CMS Certification Number (CMS ID) on your Provider Record in BD Portal, to confirm accuracy. These Key Identifiers referenced are **essential to data collection**, and when incorrect, can jeopardize the completeness and accuracy of eligibility results.

1. Populate the following information for the person responsible for completing and submitting this Provider Survey: (Required Response)

   Primary Contact

Name:
Title:
Phone: [Format: xxx-xxx-xxxx]
Email:

2. Populate the following information for the applicant facility's legal contact. This individual may be contacted in the event there are questions related to potential brand conflicts that need to be addressed. (Required Response)

   Legal Counsel/Representative Contact:
   Name:
   Title:
   Phone: [Format: xxx-xxx-xxxx]
   Email:

3. Indicate the applicant facility's intent to submit a full Provider Survey response for the Blue Distinction Centers for Knee and Hip Replacement designation, as appropriate below. Read each one carefully before choosing. (Required response, can only check 1 box)

   ☐ **For Hospitals:** The facility listed above is a hospital **(with or without an onsite Intensive Care Unit [ICU])** and intends to complete a Provider Survey for the Blue Distinction Centers for Knee and Hip Replacement designation.

   ☐ **For ASCs:** The facility listed above is an **ambulatory surgery center (ASC)** and intends to complete a Provider Survey for the Blue Distinction Centers for Knee and Hip Replacement designation.

   ☐ For Hospitals or ASCs: The facility listed above **does not intend** to complete a Provider Survey for the Blue Distinction Centers for Knee and Hip Replacement designation. ***If this option is selected, please 'Check In.' Do not complete the remaining the questions.*** (If box checked, can the survey automatically close or go to end of survey.)

4. The Blue Distinction Centers for Knee and Hip Replacement designation is awarded to individual facilities (i.e., unique bricks-and-mortar facilities with unique addresses), only. Any applicant facility with multiple locations (different addresses) must complete a separate ***Provider Survey*** for each location. Health systems and other groups of multiple facilities will not be designated collectively.

   Is the quality information submitted in this Provider Survey (e.g., accreditations, volume, outcomes, etc.) **only for the single applicant facility whose name and address are listed in the Facility Information Section,** above, and for no other facilities or locations?

   ☐ YES ☐ NO (Required Response)

   If NO, please explain. (unlimited text box, optional)

5. Which of the following statements describes the applicant facility's current accreditation status. Accreditation status must be fully approved, without provision or condition. **Select all that apply**.
   (Required Response; must check at least 1 box)

   Hospital Level Accreditations:

   ☐ The Joint Commission (TJC) in the Hospital Accreditation Program.
   ☐ Accreditation Commission for Health Care (ACHC) in the Acute Care Hospital Accreditation Program

☐ DNV GL Healthcare in the National Integrated Accreditation for Healthcare Organizations (NIAHO®) Hospital Accreditation Program
☐ Center for Improvement in Healthcare Quality (CIHQ) in the CIHQ Hospital Accreditation Program

Ambulatory Surgery Center (ASC) Level Accreditations:

☐ The Joint Commission (TJC) in the Ambulatory Health Care Accreditation Program
☐ Accreditation Commission for Health Care (ACHC) in the Ambulatory Care Accreditation Program
☐ QUAD A for Ambulatory Surgery Centers
☐ Accreditation Association for Ambulatory Health Care (AAAHC**)** as an Ambulatory Surgery Center

☐ Applicant facility is **not** fully accredited by any of the above organizations. (If selected, cannot select any boxes above)

6. Is the applicant facility certified in at least one of the following advanced orthopedic certifications? **Select all that apply**. (Required Response; must check at least 1 box)

☐ Advanced Total Hip and Total Knee Replacement | The Joint Commission
☐ Advanced Hip and Knee Replacement Certification | DNV Healthcare
☐ Advanced Orthopedic and Spine Certification | DNV Healthcare
☐ Advanced Joint Replacement | Accreditation Commission for Health Care (ACHC)
☐ Advanced Joint Replacement with Distinction | Accreditation Commission for Health Care (ACHC)
☐ Comprehensive Joint Replacement | Accreditation Commission for Health Care (ACHC)
☐ Orthopaedic Certification – Advanced Total Joint | Accreditation Association for Ambulatory Health Care (AAAHC)
☐ Orthopaedic Certification – Advanced Total Joint and Complex Spine | Accreditation Association for Ambulatory Health Care (AAAHC)
☐ The Mark of Distinction for Joint Replacement Surgery | Center for Improvement in Healthcare Quality (CIHQ) Disease Specific Certification (DSC)

☐ None of the above (if this is selected, none of the others above may be selected)

Data Collection and Reporting

7. Which of the following patient self-identified demographic data does the applicant facility collect directly from its patients (or patients' legal guardian) during patient registration or during a hospital visit? **Select all that apply.** (Required Response)

☐ Race
☐ Ethnicity
☐ Spoken language preferred for healthcare (patient or legal guardian)
☐ Written language preferred for healthcare (patient or legal guardian)
☐ Sexual orientation
☐ Gender identity
☐ None of the above (If this is selected, others may not be)

8. Which of the following methods does the applicant facility use to collect the demographic data reported in Question 7? **Select all that apply. (Required Response)**

☐ Self-Reported

- ☐ Reported by Related Person/Family Representative
- ☐ Administrative (Data from previous visits or records)
- ☐ Derived/Imputed (Filling missing values based on certain rules or algorithms)
- ☐ Direct Observation (Watching behavior, events, or noting physical characteristics)
- ☐ Unknown
- ☐ None of the above (If this is selected, others may not be)

9. In the past 12 months, has the applicant facility used the data and information reported in Question 7 to improve any of the following? **Select all that apply. (Required Response)**

   - ☐ Quality Improvement Goals
   - ☐ Policies
   - ☐ Procedures
   - ☐ Patient Safety Goals
   - ☐ None of the above (If this is selected, others may not be)

10. Does the applicant facility use the patient self-identified demographic data it collects directly from patients (or patient's legal guardian), reported in Question 7 to stratify any quality measure(s) with the goal of identifying health care disparities? **Select one response. (Required Response)**

    - ☐ YES (if YES, proceed to Question 11)
    - ☐ NO (Skip to Question 12)
    - ☐ NO, facility data was not found to be accurate or usable (Skip to Question 12)
    - ☐ Not currently, but plan to do so in the next 12 months (Skip to Question 12)

11. Which type(s) of quality measure(s) does your facility stratify, with the goal of identifying health care disparities? **Select all that apply.** (Required Response)

    - ☐ Clinical process measures
    - ☐ Clinical outcome measures
    - ☐ Consumer Assessment of Healthcare Providers and Systems (CAHPS) measures (i.e., Adult CAHPS and/or Outpatient and Ambulatory Surgery [OAS] CAHPS)
    - ☐ Other patient experience measures
    - ☐ None of the above

12. Does the applicant facility collect information on patient perception of unbiased, respectful healthcare?

    ☐ YES ☐ NO

Staff Training Practices

13. Does the applicant facility provide training (at the time of onboarding and/or annually thereafter) for staff who are responsible for registering patients on how to collect self-identified demographic data, reported in Question 7 above? **Select one response. (Required Response)**

    Training Frequencies:
    - ☐ Onboarding
    - ☐ Annually after onboarding
    - ☐ Both onboarding and annually after onboarding
    - ☐ None of the above (If this is selected, others may not be)

14. Has the applicant facility implemented unconscious bias training to address healthcare team member biases and stigmas and to promote respectful and equitable care?

☐ YES ☐ NO

Enhanced Recovery After Surgery (ERAS) Program Practices

15. Which of the following Enhanced Recovery After Surgery (ERAS) perioperative structures/protocols recommended by the ERAS® Society does the applicant facility have in place? **Select all that apply**.

- ☐ Provide preoperative information, education, and counseling, using shared decision making
- ☐ Identify, investigate, and correct preoperative anemia before total hip and total knee replacement surgery
- ☐ Optimize preoperative risk factors (e.g., smoking cessation, alcohol use reduction)
- ☐ Preoperative fasting guidelines
- ☐ General anesthesia and neuraxial techniques may both be used as part of multimodal anesthetic regimes
- ☐ Use of local anesthetics for infiltration analgesia and nerve blocks in total knee replacement
- ☐ Routine use of paracetamol and non-steroidal anti-inflammatory drugs for patients without contraindications
- ☐ A multimodal opioid-sparing approach to analgesia
- ☐ Routine prophylaxis and treatment for postoperative nausea and vomiting
- ☐ Administration of systemic antimicrobial prophylaxis
- ☐ Administration of tranexamic acid to reduce perioperative blood loss
- ☐ Antithrombotic (VTE) pharmacologic and mechanical prophylaxis treatment
- ☐ Maintenance of normal body temperature peri-, post- and intraoperatively
- ☐ Early mobilization
- ☐ Objective discharge criteria used to facilitate patient discharge directly to home (i.e., can dress independently, get in and out of bed, sit and rise from a chair/toilet, independent mobilization with walker/crutches)
- ☐ Routine assessment of process measures, clinical outcomes, cost-effectiveness, and patient satisfaction/experience, in a multidisciplinary quality improvement program

☐ None of the above (If this is selected, no others may be)

Patient Assessment and Screening

16. Does the applicant facility use an industry standard assessment and screening tool for depression and/or substance use disorders on all patients, preoperatively and/or postoperatively? **Select all that apply.**

Depression Assessment and Screening (If checked, complete Question 17)
- ☐ Preoperative
- ☐ Postoperative

Substance Use Disorder Assessment and Screening (If checked, complete Question 17)
- ☐ Preoperative
- ☐ Postoperative

☐ **None of the above** (If checked, skip to Question 18, Facility Procedure Tab) (If this is selected, no others may be)

17. Does the applicant facility have a process in place for follow-up and/or referral for patients whose assessments and screening for either depression or substance use disorders were positive?

☐ YES ☐ NO

FACILITY PROCEDURE VOLUME

This section should be completed by all applicant facilities that have a knee and hip replacement program. Please refer to the Supplemental Instructions for guidance in completing the Provider Survey.

Knee and Hip Replacement Procedure Volume

Questions 18 through 22: Please complete Questions 18 through 21 for the applicant facility's total knee and total hip replacement program's procedure volume for the **most recent 12 months**. (BD Portal will automatically calculate the Total Facility Knee and Hip Replacement Procedure Volume in Question 22.)

The table below outlines the inclusion criteria to be used when responding to these questions. Refer to the Supplemental Instructions for the procedure codes needed to complete the questions below. Please include **all procedures** (primary, secondary, and/or revisional) that meet all five bullets of the inclusion criteria listed below. **This is a procedure volume, so a patient with multiple procedures may be counted more than once.**

Note: If your facility offers any of the procedures below but did not perform them during the time period requested, enter **zero (0)** into the space provided. If your facility does not offer the procedure or is unable to report the data, choose 'My facility is unable to report requested data.'

Q#	Procedures Refer to Supplemental Instructions for Procedure Codes	Facility Procedure Volume Inclusion Criteria **Include ALL cases (regardless of whether or not the patient was a Blue Cross and/or Blue Shield member), if ALL of the following criteria are met:** • Procedure was performed at the applicant facility; • Procedure has at least one of the applicable procedure codes from the Supplemental Instructions; • Procedure was performed in the **most recent 12 months;** • Patient was at least 18 years of age at time of procedure; AND • Procedure was performed as elective admission and was not considered an acute trauma case.	
18.	**Total Knee Replacement**	(Whole number ≥ 0 (zero))	☐ My facility is unable to report requested data
19.	**Total Hip Replacement**	(Whole number ≥ 0 (zero))	☐ My facility is unable to report requested data
20.	**Revision Knee Replacement**	(Whole number ≥ 0 (zero))	☐ My facility is unable to report requested data
21.	**Revision Hip Replacement**	(Whole number ≥ 0 (zero))	☐ My facility is unable to report requested data
22.	**Total Facility Knee and Hip Replacement Procedure Volume**	(Automated Calculation - Sum of Questions 18 to 21). Whole number ≥ 0 (zero)	

KNEE & HIP REPLACEMENT PROGRAM INFORMATION

This section should be completed by all applicant facilities that have a knee and hip replacement program. Refer to the Supplemental Instructions for guidance in completing the Provider Survey.

Registry Participation and Data

The 2025 BDC for Knee and Hip Replacement Program will evaluate outcome measures from the American Academy of Orthopaedic Surgeons (AAOS) American Joint Replacement Registry (AJRR). If the applicant facility participates in AJRR, then AAOS will provide the facility with a Data Release Consent Form that must be completed so that AAOS can provide BCBSA with access to the applicant facility's AJRR aggregate registry data.

- If you have not received or still need to complete a Data Release Consent Form, please contact AAOS at registryengagement@aaos.org.

If the applicant facility **DOES** participate currently in AJRR, then do not self-report data (skip Questions 24 through 28) because outcome measure data will be provided by AAOS after the applicant facility submits a completed Data Release Consent Form.

If the applicant facility **DOES** participate currently in AJRR, but does **NOT** have at least 12 months of data, then proceed to the quality measures in Questions 24 through 28.

If the applicant facility **DOES NOT** participate currently in AJRR, then proceed to the quality measures in Questions 24 through 28.

Note: Participation and registry collection in the AAOS AJRR will become a requirement in future designation evaluations for the BDC for Knee and Hip Replacement program.

23. Does the applicant facility participate in the American Joint Replacement Registry (AJRR)? (Required Response)

☐ Yes, participates and has 12 months of AJRR data (Skip to Question 29, Team Table Tab)
☐ No (Proceed to Questions 24 through 28)

Total Knee and Total Hip Replacement Quality Measures

Total knee and total hip replacement quality measures collected in this Provider Survey include:

- Unplanned All-Cause Readmission (Hospitals)/Admissions (ASCs)
- 90 Day Major Complication Composite
- 90 Day Postoperative Mortality
- Preoperative Functional/Health Assessment Status (THKR-IP-4; THKR-OP-4)
- Postoperative Functional/Health Assessment Status (THKR-IP-5; THKR-OP-5)

- If a patient had more than one of the above major complications within 90 days postoperatively, then they should be included in each of the applicable numerators for each of those complications.

Please report both the **numerator and denominator** for the quality measures below, for the **most recent 12 months available at the time of application.** Denominators represent the population for the individual measure (after applying all exclusions listed in the measure specifications); refer to the ***Supplemental Instructions*** for details.

- In the questions below, report:
  - Overall numerator and denominator that include all patients, after applying all exclusions. **(This is a requirement.)**

- Numerators and denominators stratified by race and/or ethnicity, based on the HL7 adopted CDC Race and Ethnicity Definitions and the updated Federal Register, OMB-2023-0001, Statistical Policy Directive No. 15: Standards for Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity, effective March 28, 2024.
    - Denominators for race and/or ethnicity should be a **subset** of those patients reported above in the overall patient denominator.
    - Of those patients reported in the race and/or ethnicity denominators, the numerator should be only for those patients who experienced the measure complication (and/or is included in the functional assessment).

Percentage Rates will be calculated automatically by the BD Portal tool, using the data reported for the numerator and the denominator.

Exact start/end time frames for the most recent 12 months of reported measures may vary slightly, depending on each applicant facility's available data; but in no event will be less than 12 consecutive months.

- If the applicant facility does not have the most recent 12 months of data, then place an 'x' in the check box exclusion.
- If the applicant facility does not have the measure data broken out into race and ethnicity, then place an 'x' in the check box exclusion.

Total Knee and Total Hip Replacement Patient Outcome Measures

24. Report the number of patients who had an unplanned all-cause inpatient readmission (Hospitals) or inpatient admission (ASCs) within **90 days** postoperative elective primary total knee and total hip replacement surgery. (Response Required; Enter Numerator or Check Radio Button)

	NUMERATOR: Patients with an unplanned all-cause inpatient readmission (Hospitals) or inpatient admission (ASCs). (Whole number only; zero is a valid response)	**DENOMINATOR:** All elective primary total knee and total hip replacements in the **most recent 12 months** (Whole number only; zero is a valid response)	**Rate** (Auto calculate) (Calculate out to the hundredths)	Facility is unable to report requested data **Place an 'x' in Check Box Exclusion**
OVERALL All patients **(REQUIRED)**				
Race and/or Ethnicity				
American Indian or Alaskan Native				
Asian				
Black or African American				
Hispanic or Latino				
Middle Eastern or North African				
Native Hawaiian or Other Pacific Islander				

Other Race				
White				

25. Report the number of patients who experienced at least one of the following complications **within 90 days** postoperative elective primary total knee and total hip replacement surgery: 1) surgical site infection, 2) deep vein thrombosis (DVT), 3) pulmonary embolism (PE), 4) mechanical complication, and/or 5) return to operating room/reoperation related to primary procedure. (Response Required; Enter Numerator or Check Radio Button)

	NUMERATOR: Patients who experienced at least one major complication. **Count each patient only Once.** (Whole number only; zero is a valid response)	**DENOMINATOR:** All elective primary total knee and total hip replacements in the **most recent 12 months**. (Whole number only; zero is a valid response)	**Rate** (Auto calculate) (Calculate out to the hundredths)	Facility is unable to report requested data **Place an 'x' in Check Box Exclusion**
OVERALL All patients **(REQUIRED)**				
Race and/or Ethnicity				
American Indian or Alaskan Native				
Asian				
Black or African American				
Native Hawaiian or Other Pacific Islander				
Other Race				
White				
Hispanic or Latino				
Not Hispanic or Latino				

26. Report the applicant facility's **90 day** postoperative mortality rate for elective primary total knee and total hip replacements. (If checked, numerator, denominator, rate should not appear)

	NUMERATOR: Patients who expired within 90 days postoperatively, includes procedure date. (Whole number only; zero is a valid response)	**DENOMINATOR:** All elective primary total knee and total hip replacements in the **most recent 12 months**. (Whole number only; zero is a valid response)	**Rate** (Auto calculate) (Calculate out to the hundredths)	Facility is unable to report requested data **Place an 'x' in Check Box Exclusion**
OVERALL All patients **(REQUIRED)**				
Race and/or Ethnicity				

	NUMERATOR: Patients who expired within 90 days postoperatively, includes procedure date. (Whole number only; zero is a valid response)	**DENOMINATOR:** All elective primary total knee and total hip replacements in the **most recent 12 months**. (Whole number only; zero is a valid response)	**Rate** (Auto calculate) (Calculate out to the hundredths)	Facility is unable to report requested data **Place an 'x' in Check Box Exclusion**
American Indian or Alaskan Native				
Asian				
Black or African American				
Hispanic or Latino				
Middle Eastern or North African				
Native Hawaiian or Other Pacific Islander				
Other Race				
White				

Preoperative and Postoperative Functional/ Health Assessment Status

Inpatient Measures

- THKR-IP-4a – Preoperative Functional/Health Assessment Status – Hip and Knee Overall
- THKR-IP-5a – Postoperative Functional/Health Assessment Status – Hip and Knee Overall

Outpatient Measures

- THKR-OP-4a – Preoperative Functional/Health Assessment Status – Hip and Knee Overall
- THKR-OP-5a – Postoperative Functional/Health Assessment Status – Hip and Knee Overall

➢ *If the applicant facility is **accredited by The Joint Commission** (TJC) and the applicant facility reports results on Total Hip and Total Knee Replacement Inpatient or Outpatient as part of TJC's certification requirements, please report those measure results below.*

➢ *If the applicant facility is **NOT** accredited by TJC, please see the Supplemental Instructions for more detailed specifications on how to identify the Initial Patient Population and calculate results for the Total Hip and Total Knee Replacement measures below.*

For additional guidance, refer to TJC Specifications Manual for Joint Commission National Quality Measures (v2023B)

27. Report the number of elective total knee or total hip replacement surgery patients who completed a **preoperative** functional/health status assessment **within 90 days preoperative.**

	NUMERATOR: All patients who had a **preoperative** functional/health status assessment (Whole number only; zero is a valid response)	**DENOMINATOR:** Patients undergoing elective total hip or total knee replacements in the **most recent 12 months**. (Whole number only; zero is a valid response)	**Rate** (Auto calculate) (Calculate out to the hundredths)	Facility is unable to report requested data **Place an 'x' in Check Box Exclusion**
OVERALL All patients **(REQUIRED)**				
Race and/or Ethnicity				
American Indian or Alaskan Native				
Asian				
Black or African American				
Hispanic or Latino				
Middle Eastern or North African				
Native Hawaiian or Other Pacific Islander				
Other Race				
White				

28. Report the number of elective total knee or total hip replacement surgery patients who completed a **postoperative** functional/health status assessment **within 90 days postoperative**.

	NUMERATOR: All patients who had a **postoperative** functional/health status assessment (Whole number only; zero is a valid response)	**DENOMINATOR:** Patients undergoing elective total hip or total knee replacements in the **most recent 12 months**. (Whole number only; zero is a valid response)	**Rate** (Auto calculate) (Calculate out to the hundredths)	Facility is unable to report requested data **Place an 'x' in Check Box Exclusion**
OVERALL All patients **(REQUIRED)**				
Race and/or Ethnicity				
American Indian or Alaskan Native				
Asian				
Black or African American				
Hispanic or Latino				

	NUMERATOR: All patients who had a **postoperative** functional/health status assessment (Whole number only; zero is a valid response)	**DENOMINATOR:** Patients undergoing elective total hip or total knee replacements in the **most recent 12 months**. (Whole number only; zero is a valid response)	**Rate** (Auto calculate) (Calculate out to the hundredths)	Facility is unable to report requested data **Place an 'x' in Check Box Exclusion**
Middle Eastern or North African				
Native Hawaiian or Other Pacific Islander				
Other Race				
White				

TEAM TABLE

This section must be completed by <u>all applicant facilities</u> that have a knee and hip replacement program. Please refer to the Supplemental Instructions for guidance in completing the Provider Survey.

Team Table

29. Please complete the Team Table for **ALL** Surgeons who have privileges **AND** are actively performing the applicable services at the applicant facility.

Exclusions:

- Exclude all Surgeons who are not currently practicing at the applicant facility (i.e., retired, left employment);
- Exclude all Surgeons who do not perform total knee or total hip replacement procedures;
- Exclude all locum tenens Surgeons;
- Exclude all Physician Assistants, Nurse Practitioners, and Medical/Surgical Residents in training; AND
- Exclude all Surgeons who do NOT treat or manage any adult patients (ages 18 and older).

Instructions for Completion of Team Table.

Choose one of the following two ways to complete the Team Table.

A. Instructions for Manual Completion of Team Table:

- Enter the Surgeon's first and last name.
- Enter the Surgeon's National Provider Identifier (NPI) number. Refer to the NPPES NPI Registry to find the NPI.

B. Instructions for Import/Export Function of Completing Team Table:

- Click Export to generate .csv file with appropriate column headers.
- Complete information for all fields in all columns, making sure each NPI number is unique.
- Save updated .csv file on your desktop.
- Click Import and select saved .csv file. This will update data in table with information from file.
- Refer to Supplemental Instructions for guidance on completing the team table.

Team Table

FIRST NAME	LAST NAME	TYPE 1 NATIONAL PROVIDER IDENTIFIER (NPI)

xxx	xxx	xxx

END OF PROVIDER SURVEY

TERMS AND CONDITIONS (All Applicants)

Terms & Conditions

A. ATTESTATION

Attestation for Provider Survey Participation
Blue Distinction® Specialty Care Program(s)

By submitting its response to this Provider Survey for consideration as a participant in this Blue Distinction Specialty Care Program (the "Program"), and, if accepted by BCBSA, as a condition to any designation and participation in the Program, this applicant facility ("Facility") represents and agrees as follows:

1. All information that Facility provides in its response to BCBSA's Provider Survey for consideration as a participant in this Program (including information provided in Facility's initial response, as well as any additional materials submitted throughout the evaluation and appeal process for this Provider Survey cycle), is and will be true and complete, as of the date Facility provides such information to BCBSA. Facility will advise BCBSA immediately of any material change in such information during this Provider Survey process, and if Facility is designated as a Blue Distinction Center under this Program, for the duration of such designation.

2. BCBSA may share Facility's individual Provider Survey responses ("Raw Data") and results ("Scores") with BCBSA's member Plans and, pursuant to a confidentiality agreement, member Plans' current and prospective accounts, for purposes of evaluation, care management, quality improvement, and member Plans' design of customized products and networks. BCBSA may combine this Facility's Raw Data and Scores together with other applicant facilities' data to create aggregate information for public dissemination, provided that such aggregate information will not identify this Facility by name and will not contain any Protected Health Information ("PHI"), as defined under the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations (45 C. F. R. Parts 160-164). Facility's Raw Data and Scores will not be publicly disseminated beyond the extent permitted above without Facility's prior written consent, unless required by law (e.g., subpoena).

☐ **PROVIDER** attests that it has read, understands, and agrees with the terms set forth in the Attestation (Section A in the scroll down box, above) and represents and agrees that the statements therein are accurate.

B. OPTIONAL – PUBLIC STATEMENT ON HOSPITAL-BASED PHYSICIANS' PPO STATUS

Available Only for applicant facilities that are Hospitals or ASCs (Not Applicable to Individual Physicians or Physician Groups)
These terms apply only if this Facility elects to opt-in to this optional public disclosure feature for this Program.

Optional Public Statement:
BlueCard® PPO Network Participation Status of Hospital Based Physicians

Facility, at its option, may elect to disclose that all Hospital-Based Physicians who provide Related Services at that Facility participates in the Local Plan's BlueCard PPO network (with terms as defined and described below). This feature is not a Program requirement. Facility's decision on whether or not to participate in this feature will not impact its Designation status. If Facility consents to participate in this optional feature for the Program, then Facility represents and warrants voluntarily that, as of the Effective Date of this Agreement, all Hospital-Based Physicians who provide Related Services at this Facility participate in the Local Plan's BlueCard PPO network (with terms as defined and described below). With Facility's consent, BCBSA and the Local Plan will convey and recognize this participating physician information through transparent public messaging in the National Doctor & Hospital Finder and other related materials. Facility will provide BCBSA and the Local Plan with at least thirty (30) days' prior written notice: (a) if any Hospital-Based Physician who may provide Related Services will not participate in the Local Plan's BlueCard PPO network, or (b) if any Hospital-Based Physician who does participate in the Local Plan's BlueCard PPO network does not renew its then current participation agreement at least thirty (30) days in advance of its expiration date; and promptly thereafter, BCBSA will remove this public statement from the National Doctor & Hospital Finder and other related materials. BCBSA will provide Facility with notice of opportunities that may arise thereafter to reinstate this public statement, in the event that all Hospital-Based Physicians who provide Related Services at this Facility subsequently participate again in the Local Plan's BlueCard PPO network.

"Hospital-Based Physicians" means all the following physicians rendering services at this Facility:

- Radiologists
- Anesthesiologists
- Pathologists
- Hospitalists
- Intensivists

"Related Services" means all services provided by Hospital-Based Physicians for adult patients (age 18 years and older) for all episodes of care covered by this Program (as defined at www.bcbs.com).

☐ **OPTIONAL – CHECK IF FACILITY CONSENTS TO PARTICIPATE IN OPTIONAL PUBLIC STATEMENT FOR THIS BDC PROGRAM.** Facility has read and understands the Optional Public Statement terms (Section B in the scroll down box, above) and hereby consents to participate in this optional feature for this Blue Distinction Program, pursuant to the terms set forth therein.

Note: Contact BCBSA if this Facility desires to opt in later, or if this Facility opts in now but later needs to opt out of this feature.

Provider verifies that it responded to the Attestation and Optional Public Statement items above, by and through its duly authorized officer identified below:

Enter Officer's Name: _____

Enter Officer's Title: _____

Date: _____