BlueDistinction®
Specialty Care

BlueCross BlueShield Association

Blue Distinction® Centers for Bariatric Surgery 2017 Provider Survey

Printed version of this document is for reference purposes only.

A completed Provider Survey will need to be submitted via the BD Link℠ web portal.

Paper copies of the Provider Survey will not be accepted.

Instructions for Completion of Provider Survey via BD Link℠ Web Portal

Please complete all Provider Survey information pertaining to your facility's current and active bariatric surgery services for **adults** (18 years and older). Please be sure that your application is complete before submitting.

Additional program materials for the Blue Distinction Centers for Bariatric Surgery program are available at: www.bcbs.com

This is the Quality based Selection Criteria dimension of the evaluation process for the Blue Distinction Centers for Bariatric Surgery designation. There are 5 main sections; complete all of Sections 1, 2, and 5 (Provider Information, Facility Information, and Attestation), plus either Section 3 (Comprehensive Center Information) or Section 4 (Ambulatory Surgery Center Information), as applicable to your facility.

Provider Survey Section	Question Numbers
1. Provider Information	Not Applicable
2. Facility Information	1 – 4
3. Comprehensive Center Information	5 – 13
4. Ambulatory Surgery Center Information	14 – 25
5. Attestation	Not Applicable

Blue Cross Blue Shield Association is an association of independent Blue Cross and Blue Shield companies.

PROVIDER INFORMATION

FACILITY NAME:

ADDRESS 1:

ADDRESS 2:

CITY:

STATE:

ZIP:

FACILITY'S NATIONAL PROVIDER IDENTIFIER (NPI):

FACILITY'S TAX ID:

FACILITY'S CMS CERTIFICATION NUMBER (MEDICARE ID NUMBER):

If the National Provider Identifier (NPI) listed above is incorrect or blank, please provide the correct number:

Does your facility share a National Provider Identifier (NPI) with another facility (or facilities)?

☐YES ☐ NO

If YES, please provide each facility's name(s) and address(es).

If your facility does not have a National Provider Identifier (NPI), please provide an explanation:

If the Tax ID listed above is incorrect or blank, please provide the correct number:

Does your facility share a Tax ID with another facility (or facilities)? ☐YES ☐ NO

If YES, please provide each facility's name(s) and address(es).

If your facility does not have a Tax ID, please provide an explanation:

If the CMS Certification Number listed above is incorrect or blank, please provide the correct number:

Does your facility share a CMS Certification Number with another facility (or facilities)? ☐YES ☐ NO

IF YES, please provide each facility's name(s) and address(es).

If your facility does not have a CMS Certification Number, please provide an explanation:

If any of the Provider Information included above is incorrect, please contact your local Blue Cross and/or Blue Shield Plan contact to have the information corrected promptly.

FACILITY INFORMATION

1. Please provide the following information for the person responsible for completing and submitting this Provider Survey:
   Primary Contact

   Name:

   Title:

   Phone:

   E-mail:

2. Please provide your 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.

   Facility Legal Counsel/Representative Contact:
   Name:
   Title:
   Phone:
   E-mail:

3. The Blue Distinction for Bariatric Surgery designation is given only to individual facilities (i.e., unique bricks-and-mortar facilities with unique addresses). Any 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.

   3a. Is the Quality information submitted in this Survey (e.g., accreditations, volume, outcomes) only for the single facility whose name and address are listed in the Provider Information Section, above, and for no other facilities or locations?

   ☐YES ☐ NO

   If NO, please explain.

3b. The evaluation of Blue Plans healthcare claims data requires distinct provider identifiers to be present on submitted claims in order to match them back to your facility's application. Are claims submitted by your facility to your Blue Plan clearly distinguished from other facilities by using a **distinct** facility name, **distinct** Tax ID, **distinct** NPI, and **distinct** Plan Provider ID? If you do not have insight on this question, simply answer DO NOT KNOW. *This is for informational purposes only.*

☐YES ☐ NO ☐ DO NOT KNOW

If NO or DO NOT KNOW, please provide guidance on the best method of distinguishing your facility's claims.

4. Please indicate the intent to submit a detailed Provider Survey response for **either** the Blue Distinction Centers for Bariatric Surgery Comprehensive Center designation for inpatient acute care facilities **OR** the Blue Distinction Centers for Bariatric Surgery Ambulatory Surgery Center designation for freestanding ambulatory surgery centers.

☐ The facility listed above is an inpatient acute care facility (with/without outpatient capabilities) and intends to complete a Provider Survey for the Blue Distinction Centers for Bariatric Surgery Comprehensive Center designation.

☐ The facility listed above is a freestanding ambulatory surgery center and intends to complete a Provider Survey for the Blue Distinction Centers for Bariatric Surgery Ambulatory Surgery Center designation.

❍ The facility listed above does NOT intend to submit a Provider Survey for the Blue Distinction Centers for Bariatric Surgery designation.

COMPREHENSIVE CENTER INFORMATION

The Comprehensive Center Information section should be completed by each inpatient acute care facility (with/without outpatient capabilities) that has a bariatric surgery program that is currently accredited, or is in the process of applying for accreditation, as an MBSAQIP Comprehensive Center, Comprehensive Center with Adolescent Qualifications, or Low Acuity Center.

Please see the *Supplemental Instructions for Completing the Provider Survey* document posted in BD Link, which provides additional guidance to complete the questions below.

Questions in this section that refer to "my," "your," "my facility's," or "your facility's program" all refer to your facility's own bariatric surgery program (not the Blue Distinction Centers for Bariatric Surgery program).

5. Which of the following Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP) Accreditation status' best describes your facility's current bariatric surgery program? *(Check ONLY ONE)*

☐ My facility's bariatric surgery program has full approval as an MBSAQIP Comprehensive Center.

☐ My facility's bariatric surgery program has full approval as an MBSAQIP Comprehensive Center with Adolescent Qualifications.

☐ My facility's bariatric surgery program has full approval as an MBSAQIP Low Acuity Center.

☐ My facility's bariatric surgery program is currently **in the process** of applying for accreditation by MBSAQIP, as either a Comprehensive Center, Comprehensive Center with Adolescent Qualifications, **or** Low Acuity Center.

☐ My facility's bariatric surgery program is not currently in the process of applying, but **will be applying within the next 12 months,** for MBSAQIP accreditation, as either a Comprehensive Center, Comprehensive Center with Adolescent Qualifications **or** Low Acuity Center.

❍ My facility is NOT currently accredited, in the process of applying for, or interested in obtaining any of the MBSAQIP accreditations listed above.

6. Please indicate which of the following statements describes your facility's current accreditation status: *(Check ALL that apply)*

☐ My facility is fully accredited (without provision or condition) by **The Joint Commission (TJC)** in the **Hospital Accredited Program**. www.jointcommission.org

☐ My facility is fully accredited by **Healthcare Facilities Accreditation Program (HFAP)** of the Accreditation Association for Hospital and Health Systems (AAHHS) as an **acute care hospital**. www.hfap.org

☐ My facility is fully accredited by **DNV GL Healthcare** in the **National Integrated Accreditation for Healthcare Organizations (NIAHO®) Hospital Accreditation Program.** www.dnvaccreditation.com

☐ My facility is fully accredited by the **Center for Improvement in Healthcare Quality (CIHQ)** in the **Hospital Accreditation Program**. www.cihq.org

❍ My facility is **not** fully accredited by any of the above organizations.

Bariatric Surgery Procedure Volume

7. Please complete the following table for your facility's primary bariatric surgery procedure volume. Instructions in the table outline the inclusion/exclusion criteria to use in responding to this question.

*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.*

Q#	Primary Bariatric Surgery Procedures	Bariatric Surgery CPT Codes*	**Population for Volume:** Include procedures for ALL patients (regardless of whether or not the patient was a Blue Cross and/or Blue Shield member) who meet ALL of the following criteria: • **Procedure was performed at your facility;** • **Procedure has at least one of the applicable procedure codes in the left column; AND** • **Patient was at least 18 years old at the time of procedure.**	
			Procedure was performed during 1/1/2015 to 12/31/2015	**Procedure was performed during 1/1/2016 to 6/30/2016**
7a	**Primary Laparoscopic Sleeve Gastrectomy**	**43775**	❍ My facility did **NOT** offer Lap Sleeve Gastrectomy procedures during this timeframe.	❍ My facility did **NOT** offer Lap Sleeve Gastrectomy procedures during this timeframe.
7b	**Primary Laparoscopic Roux-en-Y Gastric Bypass**	**43644, 43645**	❍ My facility did **NOT** offer Lap Roux-en-Y Bypass procedures during this timeframe.	❍ My facility did **NOT** offer Lap Roux-en-Y Bypass procedures during this timeframe.
7c	**Primary Laparoscopic Adjustable Gastric Band**	**43770**	❍ My facility did **NOT** offer Lap Adjustable Gastric Band procedures during this timeframe.	❍ My facility did **NOT** offer Lap Adjustable Gastric Band procedures during this timeframe.
7d	**Primary Vertical Banded Gastroplasty**	**43842**	❍ My facility did **NOT** offer Vertical Banded Gastroplasty procedures during this timeframe.	❍ My facility did **NOT** offer Vertical Banded Gastroplasty procedures during this timeframe.
7e	**Primary Endoluminal Bariatric Procedures** **"Gastric Balloon"**	**43999****	❍ My facility did **NOT** offer Gastric Balloon procedures during this timeframe.	❍ My facility did **NOT** offer Gastric Balloon procedures during this timeframe.

Q#	Primary Bariatric Surgery Procedures	Bariatric Surgery CPT Codes*	**Population for Volume:** Include procedures for ALL patients (regardless of whether or not the patient was a Blue Cross and/or Blue Shield member) who meet ALL of the following criteria: • **Procedure was performed at your facility;** • **Procedure has at least one of the applicable procedure codes in the left column; AND** • **Patient was at least 18 years old at the time of procedure.**	
			Procedure was performed during 1/1/2015 to 12/31/2015	**Procedure was performed during 1/1/2016 to 6/30/2016**
7f	**Primary Open Roux-en-Y, Biliopancreatic Diversion with/without Duodenal Switch, Gastric Restrictive Procedure**	**43843, 43845,43846, 43847**	❍ My facility did **NOT** offer Open Bariatric procedures during this timeframe.	❍ My facility did **NOT** offer Open Bariatric Procedures during this timeframe.
7g	**All Revisional Gastric Banding Procedures**	**43771, 43772, 43773, 43774, 43886, 43887, 43888**	❍ My facility did **NOT** offer Revisional Gastric Banding procedures during this timeframe.	❍ My facility did **NOT** offer Revisional Gastric Banding procedures during this timeframe.
7h	**All Revisional Bariatric Surgery Procedures (Other than Gastric Banding)**	**43848, 43850, 43855, 43860, 43865**	❍ My facility did **NOT** offer Revisional Bariatric procedures (other than Gastric Banding) during this timeframe.	❍ My facility did **NOT** offer Revisional Bariatric procedures (other than Gastric Banding) during this timeframe
7i	**Total Primary Bariatric Procedures**	**Rows 7a – 7f**	**(Automatic Calculation; Add rows 7a through 7f)**	**(Automatic Calculation; Add rows 7a through 7f)**
7j	**Total Bariatric Procedures** **(Primary & Revisions)**	**Rows 7a – 7h**	**(Automatic Calculation; Add rows 7a through 7h)**	**(Automatic Calculation; Add rows 7a through 7h)**

**Refer to the Supplemental Instructions for Completing the Provider Survey for ICD-9 and ICD-10 Bariatric Procedure Codes.*

*** Since CPT Code 43999 (unlisted procedure, stomach) may be used for more than one type of bariatric procedure, please use your facility's clinical data and coding guidelines to select the Endoluminal Bariatric Procedures.*

NOTE: CPT Code 43659 (unlisted laparoscopy procedure, stomach) may be used for more than one type of bariatric procedure, please use your facility's clinical data and coding guidelines to report cases.

Bariatric Surgery Patient Outcomes

Questions 8 - 11: Please complete the following questions for your facility's risk adjusted bariatric surgery patient outcomes, using your facility's MBSAQIP Semiannual Report (SAR) from the October 2016 release (for procedures performed from 1/1/2015 to 12/31/2015).

Leave table cells blank for any measures involving data that is not reported in your facility's MBSAQIP SAR. Use a zero only if the MBSAQIP SAR has a zero as the response for that corresponding measure.

8. Laparoscopic Sleeve Gastrectomy (LSG) Patient Outcomes

	Total	Observed		Predicted	Expected	Odds	Confidence Interval	
	Cases	Events	Rate	Obs. Rate	Rate	Ratio	Lower	Upper
LSG Morbidity								
LSG All Occurrence Morbidity								
LSG Leak								
LSG Bleeding								
LSG SSI								
LSG All Cause Reoperation								
LSG Related Reoperation								
LSG All Cause Intervention								
LSG Related Intervention								
LSG All Cause Readmission								
LSG Related Readmission								

My facility is unable to report Laparoscopic Sleeve Gastrectomy Patient Outcomes, due to one of the following:

❍ My facility offered this procedure during the requested time period, but has no volume or outcomes data.

❍ My facility did not offer this procedure during the requested time period.

9. Laparoscopic Roux-en-Y Gastric Bypass (LYRGB) Patient Outcomes

	Total	Observed		Predicted	Expected	Odds	Confidence Interval	
	Cases	Events	Rate	Obs. Rate	Rate	Ratio	Lower	Upper
LYRGB Morbidity								
LYRGB All Occurrence Morbidity								
LYRGB Leak								
LYRGB Bleeding								
LYRGB SSI								
LYRGB All Cause Reoperation								
LYRGB Related Reoperation								
LYRGB All Cause Intervention								
LYRGB Related Intervention								
LYRGB All Cause Readmission								
LYRGB Related Readmission								

My facility is unable to report the Laparoscopic Roux-en-Y Gastric Bypass Patient Outcomes, due to one of the following:

❍ My facility offered this procedure during the requested time period, but has no volume or outcomes data.

❍ My facility did not offer this procedure during the requested time period.

10. Laparoscopic Adjustable Gastric Band (LAGB) Patient Outcomes

	Total	Observed		Predicted	Expected	Odds	Confidence Interval	
	Cases	Events	Rate	Obs. Rate	Rate	Ratio	Lower	Upper
LAGB Morbidity								
LAGB All Occurrence Morbidity								
LAGB Leak								
LAGB Bleeding								
LAGB SSI								
LAGB All Cause Reoperation								
LAGB Related Reoperation								
LAGB All Cause Intervention								
LAGB Related Intervention								
LAGB All Cause Readmission								
LAGB Related Readmission								

My facility is unable to report the Laparoscopic Adjustable Gastric Band Patient Outcomes, due to one of the following: [Radio button]

❍ My facility offered this procedure during the requested time period, but has no volume or outcomes data.

❍ My facility did not offer this procedure during the requested time period.

11. Enter “Your Facility” and “All Sites” unadjusted 30 day mortality rate for all cases (primary, revisional, etc.), as shown in the 30 Day Mortality Snapshot in the MBSAQIP SAR from the October 2016 release (for procedures performed from 1/1/2015 to 12/31/2015).

Site	**Number of Sites**	**Total Cases**	**Death Cases**	**30 Day Mortality Rate (%)**	**Mean Site 30 Day Mortality Rate (%)**	**Standard Deviations from Mean Site Rate**
Your Facility						
All Sites						

❍ My facility is unable to report the unadjusted 30 day mortality rate.

Bariatric Surgery Patient Satisfaction

12. Does your facility collect Patient Satisfaction data, specifically for the Bariatric Surgery Service Line (e.g., Hospital Consumer Assessment of Healthcare Providers and Systems [HCAHPS] measures)?

☐ YES ☐ NO

Bariatric Surgeon Information

13. Please complete the following table for ALL **Bariatric Surgeons** who actively perform bariatric surgery procedures at your facility.

Instructions for completing the table:

- **Column A**: Please enter the Surgeon's first name.
- **Column B**: Please enter the Surgeon's last name.
- **Column C**: Please enter the Surgeon's National Provider Identifier (NPI) number, which can be obtained online at: http://npidb.org/npi/.
- **Column D**: Please select 'Yes' or 'No' to indicate if the Surgeon is board certified (or is currently in the process of becoming board certified) by the American Board of Surgery or equivalent (i.e., the American Osteopathic Board of Surgery and/or Royal College of Physicians and Surgeons of Canada).
- **Column E**: Please select 'Yes' or 'No' to indicate if the Surgeon is your facility's Metabolic and Bariatric Surgery (MBS) Director.
- **Column F**: Please select 'Yes' or 'No' to indicate if the Surgeon is an MBSAQIP Verified Surgeon.

A	B	C	D	E	F
Surgeon's **First** Name	Surgeon's **Last** Name	Surgeon's **Type 1 National Provider Identifier**	Board Certified by American Board of Surgery (or Equivalent)	Facility's MBS Director?	MBSAQIP Verified Surgeon?
			❍ Yes ❍ No	❍ Yes ❍ No	❍ Yes ❍ No
			❍ Yes ❍ No	❍ Yes ❍ No	❍ Yes ❍ No

AMBULATORY SURGERY CENTER INFORMATION

The Ambulatory Surgery Center Information section should be completed by each freestanding ambulatory surgery center that has a bariatric surgery program that is currently accredited, or is in the process of applying for accreditation, as a MBSAQIP Freestanding Ambulatory Surgery Center (ASC).

Please see the *Supplemental Instructions for Completing the Provider Survey* document posted in BD Link, which provides additional guidance to complete the questions below.

Questions in this section that refer to "my," "your," "my ambulatory surgery center's" or "your ambulatory surgery center's program" all refer to your ambulatory surgery center's own bariatric surgery program (not the Blue Distinction Centers for Bariatric Surgery program).

14. Which of the following Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP) Accreditation status' best describes your facility's current bariatric surgery program? *(Check ONLY ONE)*

☐ My facility's bariatric surgery program has full approval as an MBSAQIP Ambulatory Surgery Center.

☐ My facility's bariatric surgery program is currently **in the process** of applying for accreditation by MBSAQIP as an Ambulatory Surgery Center.

☐ My facility's bariatric surgery program is not currently in the process of applying, but **will be applying within the next 12 months,** for MBSAQIP accreditation, as an Ambulatory Surgery

Center.

❍ My facility is NOT currently accredited, in the process of applying for, or interested in obtaining MBSAQIP accreditation as an Ambulatory Surgery Center.

15. Please indicate which of the following statements describes your ambulatory surgery center's current accreditation status. *(Check ALL that apply)*

☐ My Freestanding Ambulatory Surgery Center is fully accredited (without provision or condition) by **The Joint Commission (TJC)** in the **Ambulatory Care Accredited Program** www.jointcommission.org

☐ My Freestanding Ambulatory Surgery Center is fully accredited by **Healthcare Facilities Accreditation Program (HFAP)** of the Accreditation Association for Hospitals and Health Systems (AAHHS) as an **Ambulatory Surgical Center**. www.hfap.org

☐ My Freestanding Ambulatory Surgery Center is fully accredited by the **American Association for Accreditation of Ambulatory Surgery Facilities--Surgical (AAAASF)**. www.aaaasf.org

☐ My Freestanding Ambulatory Surgery Center is fully accredited by the **Accreditation Association for Ambulatory Health Care (AAAHC)** as an **Ambulatory Surgery Center**. www.aaahc.org

☐ My Freestanding Ambulatory Surgery Center is fully accredited by the **Institute for Medical Quality (IMQ)** in the **Ambulatory Accreditation Program.** www.imq.org

❍ My ambulatory surgery center is **not** fully accredited by any of the above organizations.

Bariatric Surgery Procedure Volume

16. Please complete the following table for your ambulatory surgery centers (ASC) bariatric surgery procedure volume. Instructions in the table outline the inclusion/exclusion criteria to use in responding to this question.

If *your ambulatory surgery center offers any of the procedures below, but did not perform them during the time period requested enter **zero (0)** into the space provided.*

Q#	Primary Bariatric Surgery Procedures	Bariatric Surgery CPT Codes*	**Population for Volume:** Include procedures for ALL patients (regardless of whether or not the patient was a Blue Cross and/or Blue Shield member) who meet ALL of the following criteria: • **Procedure was performed at your ASC;** • **Procedure has at least one of the applicable procedure codes in the left column; AND** • **Patient was at least 18 years old at the time of procedure.**	
			Procedure was performed during 1/1/2015 to 12/31/2015	**Procedure was performed during 1/1/2016 to 6/30/2016**
16a	**Primary Laparoscopic Sleeve Gastrectomy**	**43775**	❍ My ASC did **NOT** offer Lap Sleeve Gastrectomy procedures during this timeframe.	❍ My ASC did **NOT** offer Lap Sleeve Gastrectomy procedures during this timeframe.
16b	**Primary Laparoscopic Roux-en-Y Gastric Bypass**	**43644, 43645**	❍ My ASC did **NOT** offer Lap Roux-en-Y Bypass procedures during this timeframe.	❍ My ASC did **NOT** offer Lap Roux-en-Y Bypass procedures during this timeframe.
16c	**Primary Laparoscopic Adjustable Gastric Band**	**43770**	❍ My ASC did **NOT** offer Lap Adjustable Gastric Band procedures during this timeframe.	❍ My ASC did **NOT** offer Lap Adjustable Gastric Band procedures during this timeframe.
16d	**Primary Vertical Banded Gastroplasty**	**43842**	❍ My ASC did **NOT** offer Vertical Banded Gastroplasty procedures during this timeframe.	❍ My ASC did **NOT** offer Vertical Banded Gastroplasty procedures during this timeframe.
16e	**Primary Endoluminal Bariatric Procedures** **"Gastric Balloon"**	**43999****	❍ My ASC did **NOT** offer Gastric Balloon procedures during this timeframe.	❍ My ASC did **NOT** offer Gastric Balloon procedures during this timeframe.

Q#	Primary Bariatric Surgery Procedures	Bariatric Surgery CPT Codes*	**Population for Volume:** Include procedures for ALL patients (regardless of whether or not the patient was a Blue Cross and/or Blue Shield member) who meet ALL of the following criteria: • **Procedure was performed at your ASC;** • **Procedure has at least one of the applicable procedure codes in the left column; AND** • **Patient was at least 18 years old at the time of procedure.**	
			Procedure was performed during 1/1/2015 to 12/31/2015	**Procedure was performed during 1/1/2016 to 6/30/2016**
16f	**Primary Open Roux-en-Y, Biliopancreatic Diversion with/without Duodenal Switch, Gastric Restrictive Procedure**	**43843, 43845,43846, 43847**	❍ My ASC did **NOT** offer Open Bariatric procedures during this timeframe.	❍ My ASC did **NOT** offer Open Bariatric Procedures during this timeframe.
16g	**All Revisional Gastric Banding Procedures**	**43771, 43772, 43773, 43774, 43886, 43887, 43888**	❍ My ASC did **NOT** offer Revisional Gastric Banding procedures during this timeframe.	❍ My ASC did **NOT** offer Revisional Gastric Banding procedures during this timeframe.
16h	**All Revisional Bariatric Surgery Procedures (Other than Gastric Banding)**	**43848, 43850, 43855, 43860, 43865**	❍ My ASC did **NOT** offer Revisional Bariatric procedures (other than Gastric Banding) during this timeframe.	❍ My ASC did **NOT** offer Revisional Bariatric procedures (other than Gastric Banding) during this timeframe
16i	**Total Primary Bariatric Procedures**	**Rows 16a – 16f**	**(Automatic Calculation; Add rows 16a through 16f)**	**(Automatic Calculation; Add rows 16a through 16f)**
16j	**Total Bariatric Procedures (Primary & Revisions)**	**Rows 16a – 16h**	**(Automatic Calculation; Add rows 16a through 16h)**	**(Automatic Calculation; Add rows 16a through 16h)**

**Refer to the Supplemental Instructions for Completing the Provider Survey for ICD-9 and ICD-10 Bariatric Procedure Codes.*

*** Since CPT Code 43999 (unlisted procedure, stomach) may be used for more than one type of bariatric procedure, please use your facility's clinical data and coding guidelines to select the Endoluminal Bariatric Procedures.*

NOTE: CPT Code 43659 (unlisted laparoscopy procedure, stomach) may be used for more than one type of bariatric procedure, please use your facility's clinical data and coding guidelines to report cases.

Bariatric Surgery Patient Outcomes

Questions 17 - 20: Please complete the following questions for your ambulatory surgery center's risk adjusted bariatric surgery patient outcomes, using your ambulatory surgery center's MBSAQIP Semiannual Report (SAR) from the October 2016 release (for procedures performed from 1/1/2015 to 12/31/2015).

Leave table cells blank for any measures involving data that is not reported in your facility's MBSAQIP SAR. Use a zero only if the MBSAQIP SAR has a zero as the response for that corresponding measure.

17. Laparoscopic Sleeve Gastrectomy (LSG) Patient Outcomes

	Total	Observed		Predicted	Expected	Odds	Confidence Interval	
	Cases	Events	Rate	Obs. Rate	Rate	Ratio	Lower	Upper
LSG Morbidity								
LSG All Occurrence Morbidity								
LSG Leak								
LSG Bleeding								
LSG SSI								
LSG All Cause Reoperation								
LSG Related Reoperation								
LSG All Cause Intervention								
LSG Related Intervention								
LSG All Cause Readmission								
LSG Related Readmission								

My ambulatory surgery center is unable to report the Laparoscopic Sleeve Gastrectomy Patient Outcomes, due to one of the following:

❍ My ambulatory surgery center offered this procedure during the requested time period, but has no volume or outcomes data.

❍ My ambulatory surgery center did not offer this procedure during the requested time period.

18. Laparoscopic Roux-en-Y Gastric Bypass (LYRGB) Patient Outcomes

	Total	Observed		Predicted	Expected	Odds	Confidence Interval	
	Cases	Events	Rate	Obs. Rate	Rate	Ratio	Lower	Upper
LYRGB Morbidity								
LYRGB All Occurrence Morbidity								
LYRGB Leak								
LYRGB Bleeding								
LYRGB SSI								
LYRGB All Cause Reoperation								
LYRGB Related Reoperation								
LYRGB All Cause Intervention								
LYRGB Related Intervention								
LYRGB All Cause Readmission								
LYRGB Related Readmission								

My ambulatory surgery center is unable to report the Laparoscopic Roux-en-Y Gastric Bypass Patient Outcomes, due to one of the following:

❍ My ambulatory surgery center offered this procedure during the requested time period, but has no volume or outcomes data.

❍ My ambulatory surgery center did not offer this procedure during the requested time period.

19. Laparoscopic Adjustable Gastric Band (LAGB) Patient Outcomes

	Total	Observed		Predicted	Expected	Odds	Confidence Interval	
	Cases	Events	Rate	Obs. Rate	Rate	Ratio	Lower	Upper
LAGB Morbidity								
LAGB All Occurrence Morbidity								
LAGB Leak								
LAGB Bleeding								
LAGB SSI								
LAGB All Cause Reoperation								
LAGB Related Reoperation								
LAGB All Cause Intervention								
LAGB Related Intervention								
LAGB All Cause Readmission								
LAGB Related Readmission								

My ambulatory surgery center is unable to report the Laparoscopic Adjustable Gastric Band Patient Outcomes, due to one of the following:

❍ My ambulatory surgery center offered this procedure during the requested time period, but has no volume or outcomes data.

❍ My ambulatory surgery center did not offer this procedure during the requested time period.

20. Enter “Your Facility” and “All Sites” unadjusted 30 day mortality rate for all cases (primary, revisional, etc.), as shown in the 30 Day Mortality Snapshot in the MBSAQIP SAR from the October 2016 release (for procedures performed from 1/1/2015 to 12/31/2015).

Site	**Number of Sites**	**Total Cases**	**Death Cases**	**30 Day Mortality Rate (%)**	**Mean Site 30 Day Mortality Rate (%)**	**Standard Deviations from Mean Site Rate**
Your Facility						
All Sites						

❍ My ambulatory surgery center is unable to report the unadjusted 30 day mortality rate.

21. Enter your Ambulatory Surgery Centers (ASC) 30 Day, Post Principal, Operative Procedure Emergency Room Department (ED) patient visits (for procedures performed from **1/1/2016 to 6/30/2016)**.

    Number of ED Patient Visits

    Total Number of Bariatric Surgery Cases (Patients)

    ED Patient Visit Rate % (Automatic Calculation)

    ❍ My Ambulatory Surgery Center is unable to report the emergency room department patient visits.

22. Enter your Ambulatory Surgery Centers (ASC) 30-day, Post Principal, Operative Procedure Patient Transfers from your ASC facility to an inpatient acute care facility for the time period of **7/1/2015 to 6/30/2016**.

    Number of Patient Transfers

    Total Number of Bariatric Surgery Cases (Patients)

    Patient Transfer Rate % (Automatic Calculation)

    ❍ My Ambulatory Surgery Center is unable to report the post-operative patient transfers.

23. Please complete the following table for ALL **Inpatient Facilities** for which your ambulatory surgery center has admitting privileges to transfer acute care bariatric surgery patients. Instructions for completing the table:

    - **Column A**: Please enter the Inpatient Facility's Name.
    - **Column B**: Please enter the Inpatient Facility's Address.
    - **Column C**: Please enter the Inpatient Facility's City.
    - **Column D**: Please enter the Inpatient Facility's State Abbreviation.
    - **Column E**: Please select 'Yes' or 'No' to indicate if the Inpatient Facility is accredited by the Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (MBSAQIP).

A	B	C	D	E
Inpatient Facility Name	Address	City	State	Is the Inpatient Facility MBSAQIP Accredited?
				❍ Yes ❍ No
				❍ Yes ❍ No

Bariatric Surgery Patient Satisfaction

24. Does your ambulatory surgery center collect Patient Satisfaction data, specifically for the Bariatric Surgery Service Line (e.g., Hospital Consumer Assessment of Healthcare Providers and Systems [HCAHPS] measures)?

☐YES ☐ NO

Bariatric Surgeon Information

25. Please complete the following table for ALL **Bariatric Surgeons** who actively perform bariatric surgery procedures at your ambulatory surgery center.

Instructions for completing the table:

- **Column A**: Please enter the Surgeon's first name.
- **Column B**: Please enter the Surgeon's last name.
- **Column C**: Please enter the Surgeon's National Provider Identifier (NPI) number, which can be obtained online at: http://npidb.org/npi/.
- **Column D**: Please select 'Yes' or 'No' to indicate if the Surgeon is board certified (or is currently in the process of becoming board certified) by the American Board of Surgery or equivalent (i.e., the American Osteopathic Board of Surgery and/or Royal College of Physicians and Surgeons of Canada).
- **Column E**: Please select 'Yes' or 'No' to indicate if the Surgeon is your facility's Metabolic and Bariatric Surgery (MBS) Director.
- **Column F**: Please select 'Yes" or 'No' to indicate if the Surgeon is an MBSAQIP Verified Surgeon.

A	B	C	D	E	F
Surgeon's **First** Name	Surgeon's **Last** Name	Surgeon's **Type 1 National Provider Identifier**	Board Certified by American Board of Surgery (or Equivalent)	Ambulatory surgery center's MBS Director?	MBSAQIP Verified Surgeon?
			❍ Yes ❍ No	❍ Yes ❍ No	❍ Yes ❍ No
			❍ Yes ❍ No	❍ Yes ❍ No	❍ Yes ❍ No

Attestation for Provider Survey Participation

Blue Distinction® Specialty Care Program

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 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 Facility's Raw Data and Scores together with other facilities' data to create aggregate information for public dissemination, provided that such aggregate information will not identify 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). Hospital'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).

FACILITY, by the signature below of its duly authorized officer and by submitting its response to this Provider Survey agrees to the terms above and represents and agrees that the statements above are accurate.

FACILITY attests and agrees:

Facility Name: _____

By its duly authorized Officer:

Enter Officer's Name: _____

Enter Officer's Title: _____

Date: _____