Printed version of this document is for reference purposes only.

A completed Provider Survey will need to be submitted via the BD PortalSM web 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.

PROVIDER SURVEY

This Provider Survey is the Quality based Selection Criteria dimension of the evaluation pertaining to your current and active autologous and allogeneic bone marrow/stem cell transplant (also referred as hematopoietic cell transplant) program(s) for adults (18 years and older) and/or pediatrics (< 17 years and younger) for the Blue Distinction® Centers for Transplants designation(s).

BD PortalSM Instructions:

IMPORTANT: This survey will display program tabs based on your responses to question 8 in the PROVIDER INFORMATION tab. Please provide responses to all questions in the PROVIDER INFORMATION tab, then respond to questions in program tabs that appear at top of page, thereafter.

- 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 on “Save and Exit”. This will save your responses and exit the survey. You must also “Release” the survey on the Survey Actions screen, if other contacts need to access the Provider Survey, if applicable.
- 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.
- Providers must submit an electronic version of the Provider Survey in BD Portal for a complete submission. Please be sure that the status of your application displays “Submitted” (You may need to refresh your browser for the status to update).

Program Materials
PDF version of 2019 Provider Survey for Autologous and Allogeneic Bone Marrow/Stem Cell Transplants can be found on the Blue Distinction Specialty Care page
A PDF copy of the Provider Survey is available so you can gather the necessary information ahead of time, prior to completing the online application through BD Portal.

**Note:** Facilities must submit an electronic version of the Provider Survey in BD Portal; paper responses will not be accepted.

Additional program materials for the Blue Distinction Centers for Transplants are available on the [Blue Distinction Specialty Care](#) page.

<table>
<thead>
<tr>
<th>Provider Survey</th>
<th>Question Numbers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Information</td>
<td>1 – 8</td>
</tr>
<tr>
<td>Adult Bone Marrow/Stem Cell Transplant</td>
<td>9 – 12</td>
</tr>
<tr>
<td>Pediatric Bone Marrow/Stem Cell Transplant</td>
<td>13 – 16</td>
</tr>
</tbody>
</table>

**PROVIDER INFORMATION**

Facility address and identifiers will be pre-populated in the online version of this survey.

- **FACILITY NAME:**
- **ADDRESS:**
- **CITY:**
- **STATE:**
- **ZIP:**

If any of the Facility information shown above is incorrect, please email BDCAdmins@bcbsa.com or contact your local Blue Cross and/or Blue Shield Plan directly to have the information corrected.

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.

If any of the facility identifiers shown on the ‘Details’ sub-tab are incorrect, please email BDCAdmins@bcbsa.com or contact your local Blue Cross and/or Blue Shield Plan directly to have the information corrected.

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

   **Primary Contact**
   - Name:
   - Title:
   - Phone:
   - Email:
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: 
Email: 

3. Please provide the following information for the primary Blue Distinction Center for Transplants contracting contact.

Facility Primary Transplants Contracting Contact:
Name: 
Title: 
Phone: 
Email: 

4. The Blue Distinction Centers for Transplants 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.

Is the Quality information submitted in this Provider 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  ☐ DO NOT KNOW

If NO, please explain.

5. The evaluation of Blue Plans’ healthcare claims data requires distinct facility 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.

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.

7. Is your facility a comprehensive acute care facility that offers ALL of the following services on site?
   ● Intensive care unit;
   ● Emergency Room OR Emergency Services that include plans or systems for onsite emergency admission of post-operative patients with 24/7 availability of onsite medical response teams;
   ● 24/7 availability of in-house emergency physician coverage;
   ● Diagnostic radiology including MRI and CT;
   ● 24/7 availability of inpatient pharmacy services (may include alternative nighttime access when pharmacy is closed);
   ● Blood bank or 24/7 access to blood bank services; AND
   ● 24/7 availability of Clinical Laboratory Improvement Amendments (CLIA) accredited laboratory services.

☐ YES  ☐ NO

8. Please identify the transplant program(s) for which you intend to submit a Provider Survey. Questions specific to individual transplant program(s) will be displayed based on your response provided below.

My Facility intends to submit a Provider Survey for the following Autologous and Allogeneic Bone Marrow/Stem Cell Transplant program(s) (Check all that apply):

☐ Adult Autologous and Allogeneic Bone Marrow/Stem Cell Transplant
☐ Pediatric Autologous and Allogeneic Bone Marrow/Stem Cell Transplant
☐ My facility does NOT intend to submit a Provider Survey for either the Adult or Pediatric Autologous and Allogeneic Bone Marrow/Stem Cell Transplant program designations.
Questions in this section that refer to “my,” “your,” “my program/facility” or “your program/facility” all refer to your facility’s own adult autologous/allogeneic bone marrow/stem cell transplant program (not the Blue Distinction Centers for Transplants program).

Questions 9 through 12 pertain to your facility’s Adult (18 years and older) Autologous and Allogeneic Bone Marrow/Stem Cell Transplant Program.

9. Is your facility accredited by the Foundation for the Accreditation of Cellular Therapy (FACT) for Adult Autologous and Adult Allogeneic Bone Hematopoietic Progenitor Cell Transplantation?

☐ YES  ☐ NO

10. Enter your program’s most recent 12 month adult autologous bone marrow/stem cell transplant volume.

Include all adult autologous bone marrow/stem cell transplants regardless of whether or not the patient was a Blue Cross and/or Blue Shield member, if ALL of the following criteria are met:
• Transplant was an autologous bone marrow/stem cell transplant;
• Transplant was performed at your facility;
• Transplant was performed during the most recent 12 months; AND
• Patient was at least 18 years of age at the time of transplant.

Note: Only enter zero (0) if the reported volume is zero (0) and do not leave blank. If your facility does not have the requested data, check ‘Data Not Available.’

<table>
<thead>
<tr>
<th># Of adult autologous bone marrow/stem cell transplants in the most recent 12 months.</th>
<th>Number of Adult Autologous Bone Marrow/Stem Cell Transplants</th>
<th>Data Not Available</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>#</td>
<td>☐</td>
</tr>
</tbody>
</table>

11. Enter your program’s most recent 12 month adult allogeneic bone marrow/stem cell transplant volume.

Include all adult allogeneic bone marrow/stem cell transplants regardless of whether or not the patient was a Blue Cross and/or Blue Shield member, if ALL of the following criteria are met:
• Transplant was an allogeneic bone marrow/stem cell transplant (include both related and unrelated; peripheral blood stem cells, bone marrow, and cord blood);
• Transplant was performed at your facility;
• Transplant was performed during the most recent 12 months; AND
• Patient was at least 18 years of age at the time of transplant.

Note: Only enter zero (0) if the reported volume is zero (0) and do not leave blank. If your facility does not have the requested data, check ‘Data Not Available.’
### Physician Team Tables

Please complete the Team Table for **ALL** Physicians who have privileges **AND** are actively managing Adult Autologous and Allogeneic Bone Marrow/Stem Cell transplants at this facility.

**Instructions for Team Table Completion:**

**Step 1** - Manually enter Physician information into the table below.

**Step 2** - The column labeled ‘FACT Medical Director’ choose ‘Yes or No’ from the drop down to indicate which physician is the FACT Medical Director for the Adult Autologous/Allogeneic Bone Marrow/Stem Cell Transplant program.

**Exclusions:**
- Exclude all Physicians who are not currently practicing at your facility at the time of this application’s submission (i.e., retired, left employment).
- Exclude all Physicians who do not manage adult autologous/allogeneic bone marrow/stem cell transplant patients.
- Exclude all locum tenant Physicians.
- Exclude all Physician Assistants, Nurse Practitioners, and Medical/Surgical Residents in training.

#### 12. Adult Autologous and Allogeneic Bone Marrow/Stem Cell Transplant Physician Team Table

<table>
<thead>
<tr>
<th>FIRST NAME</th>
<th>LAST NAME</th>
<th>TYPE 1 NATIONAL PROVIDER IDENTIFIER (NPI)</th>
<th>FACT MEDICAL DIRECTOR</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### PEDIATRIC AUTOLOGOUS AND ALLOGENEIC BONE MARROW/STEM CELL TRANSPLANT

*Questions in this section that refer to “my,” “your,” “my program/facility” or “your program/facility” all refer to your facility’s own pediatric autologous/allogeneic bone marrow/stem cell transplant program (not the Blue Distinction Centers for Transplants program).*

**Questions 13 through 16 pertain to your facility’s Pediatric (17 years or younger) Autologous and Allogeneic Bone Marrow/Stem Cell Transplant Program.**

13. Is your facility accredited by the Foundation for the Accreditation of Cellular Therapy
(FACT) for Pediatric Autologous and Pediatric Allogeneic Bone Hematopoietic Progenitor Cell Transplantation?

☐ YES  ☐ NO

14. Enter your program's **most recent 12 month pediatric autologous** bone marrow/stem cell transplant volume.

Include all pediatric **autologous** bone marrow/stem cell transplants regardless of whether or not the patient was a Blue Cross and/or Blue Shield member, if ALL of the following criteria are met:
- Transplant was an **autologous** bone marrow/stem cell transplant;
- Transplant was performed at your facility;
- Transplant was performed during the most **recent 12 months**; AND
- Patient was 17 years of age or younger at the time of transplant.

**Note**: Only enter zero (0) if the reported volume is zero (0) and do not leave blank. If your facility does not have the requested data, check 'Data Not Available.'

<table>
<thead>
<tr>
<th>Number of Pediatric Autologous Bone Marrow/Stem Cell Transplants</th>
<th>Data Not Available</th>
</tr>
</thead>
<tbody>
<tr>
<td># Of pediatric autologous bone marrow/stem cell transplants in the most recent 12 months.</td>
<td>#</td>
</tr>
</tbody>
</table>

15. Enter your program's **most recent 12 month pediatric allogeneic** bone marrow/stem cell transplant volume.

Include all pediatric **allogeneic** bone marrow/stem cell transplants regardless of whether or not the patient was a Blue Cross and/or Blue Shield member, if ALL of the following criteria are met:
- Transplant was an **allogeneic** bone marrow/stem cell transplant (include both related and unrelated; peripheral blood stem cells, bone marrow, and cord blood);
- Transplant was performed at your facility;
- Transplant was performed during the most **recent 12 months**; AND
- Patient was 17 years of age or younger at the time of transplant.

**Note**: Only enter zero (0) if the reported volume is zero (0) and do not leave blank. If your facility does not have the requested data, check 'Data Not Available.'

<table>
<thead>
<tr>
<th>Number of Pediatric Allogeneic Bone Marrow/stem Cell Transplants</th>
<th>Data Not Available</th>
</tr>
</thead>
<tbody>
<tr>
<td># of pediatric allogeneic bone marrow/stem cell transplants in the most recent 12 months.</td>
<td>#</td>
</tr>
</tbody>
</table>
Physician Team Tables

Please complete the Team Table for ALL Physicians who have privileges AND are actively managing Pediatric Autologous and Allogeneic Bone Marrow/Stem Cell transplants at this facility.

Instructions for Team Table Completion:

Step 1 - Manually enter Physician information into the table below.
Step 2 - The column labeled ‘FACT Medical Director’ choose ‘Yes or No’ from the drop down to indicate which physician is the FACT Medical Director for the pediatric bone marrow/stem program that your facility is applying for.

Exclusions:
• Exclude all Physicians who are not currently practicing at your facility at the time of this application’s submission (i.e., retired, left employment).
• Exclude all Physicians who do not manage pediatric autologous/allogeneic bone marrow/stem cell transplant patients.
• Exclude all locum tenant Physicians.
• Exclude all Physician Assistants, Nurse Practitioners, and Medical/Surgical Residents in training.

16. Pediatric Autologous and Allogeneic Bone Marrow/Stem Cell Transplant Physician Team Table

<table>
<thead>
<tr>
<th>FIRST NAME</th>
<th>LAST NAME</th>
<th>TYPE 1 NATIONAL PROVIDER IDENTIFIER (NPI)</th>
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</tbody>
</table>

END OF PROVIDER SURVEY
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(s) (the “Program(s)”), and, if accepted by BCBSA, as a condition to any designation and participation in the Program(s), this provider (“Provider”) represents and agrees as follows:

1. All information that Provider provides in its response to BCBSA’s Provider Survey for consideration as a participant in this Program(s) (including information provided in Provider’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 Provider provides such information to BCBSA. Provider will advise BCBSA immediately of any material change in such information during this Provider Survey process, and if Provider is designated as a Blue Distinction Center under this Program(s), for the duration of such designation.

2. BCBSA may share Provider’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 Provider’s Raw Data and Scores together with other Providers’ data to create aggregate information for public dissemination, provided that such aggregate information will not identify Provider 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). Provider’s Raw Data and Scores will not be publicly disseminated beyond the extent permitted above without Provider’s prior written consent, unless required by law (e.g., subpoena).
B. OPTIONAL – PUBLIC STATEMENT ON HOSPITAL BASED PHYSICIANS’ PPO STATUS
Available Only for Providers that are Hospitals, Ambulatory Surgery Centers, and Outpatient Clinics
(Not Applicable to Individual Physicians or Physician Groups)

These terms apply only if Provider 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

Provider, at its option, may elect to disclose that all Hospital Based Physicians who provide Related Services at that Provider participate in the Local Plan’s BlueCard PPO network (with terms as defined and described below). This feature is not a Program requirement. Provider’s decision on whether or not to participate in this feature will not impact its Designation status. If Provider consents to participate in this optional feature for the Program, then Provider represents and warrants voluntarily that, as of the signature date (below), all Hospital Based Physicians who provide Related Services at this Provider participate in the Local Plan’s BlueCard PPO network (with terms as defined and described below). With Provider’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. Provider 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 Provider 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 Provider subsequently participate again in the Local Plan’s BlueCard PPO network.

"Hospital Based Physicians" means all of the following physicians rendering services at this Provider:
• Radiologists;
• Anesthesiologists;
• Pathologists;
• Hospitalists; and
• Intensivists.

"Related Services" means all services provided by Hospital Based Physicians for all patients for all episodes of care for this Program. Episodes of care for Blue Distinction Centers for Transplants are all services and treatment corresponding to the Organ/Tissue type and Adult/Pediatric elements of Hospital’s BDCT Designations(s), related to the following:
• All inpatient and outpatient services/treatments related to the transplant episode;
• All subsequent planned inpatient and outpatient services/treatments following the transplant episode;
• All inpatient and outpatient services/treatments resulting from complications following the transplant episode;
• Additionally, for all Living Donor Liver Transplants, only: all inpatient and outpatient services/treatments resulting from complications for donors associated with living donor liver transplants; and
• Additionally, for all Bone Marrow/Stem Cell transplants, only: all inpatient and outpatient services/treatment related to:
  ▪ Cord Blood (allogeneic or autologous transplants);
  ▪ Stem Cell collection and storage; and
  ▪ Stem Cell mobilization.
☐ 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.

☐ OPTIONAL – CHECK IF PROVIDER CONSENTS TO PARTICIPATE IN OPTIONAL PUBLIC STATEMENT FOR THIS BD PROGRAM. PROVIDER 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 Provider desires to opt in later, or if this Provider 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:_____________