

Anesthesiology Supplemental Questionnaire



INTRODUCTION

Your Full Name:

Policy Number:

Directions: Please answer all questions fully and completely. If a question does not apply to your practice, state "N/A." Use the Remarks section if you need additional space or attach additional pages as necessary. **Please ensure that you sign and date the questionnaire on page 5.**

SECTION I

MISCELLANEOUS

1. When applicable, do you always follow the American Society of Anesthesiologists "Standards for Basic Anesthetic Monitoring", "Guidelines for Regional Anesthesia in Obstetrics" and "Guidelines for Non-Operating Room Anesthetizing Locations?" Yes No

If no, please explain:

2. Do you supervise any CRNAs? Yes No

If yes:

- a. What is the maximum number of CRNAs that you supervise at one time?

- b. Do you supervise any CRNAs who provide services without you being physically present in the facility? Yes No

If yes, please explain and identify the level of supervision provided and the facility(ies):

- c. Identify who employs the CRNAs:

You or your group

Hospital

Self employed

Other:

- d. If the CRNAs are not your or your group's employees, please:

- Provide proof of their professional liability insurance
- Provide a copy of the contract(s) or, if there is not a contract, please explain the practice arrangement below:

- e. Please provide a copy of the protocol(s) that address supervision.

3. Do you cover labor and delivery? Yes No

If yes:

- a. If the patient has been administered regional analgesia for labor, do you (or does a physician trained in anesthesia or a CRNA) remain in the hospital until the patient has delivered and the patient's condition has stabilized? Yes No

If no, please identify your (or a physician trained in anesthesia or a CRNA's) maximum response time to the hospital:

SECTION I (Cont.)

MISCELLANEOUS

b. Are VBACs performed in your hospital? Yes No

If VBACs are performed in your hospital, is an anesthesiologist immediately available in the hospital during active labor to provide anesthesia for an immediate Cesarean delivery? Yes No

If an anesthesiologist is not immediately available in the hospital, please explain your availability and how anesthesia coverage is provided:

4. Do you administer anesthesia for patients who undergo spinal manipulation under anesthesia? Yes No

If yes, please identify the name(s) and designation(s) of the practitioner(s) who perform the manipulations, identify the locations where the manipulations are performed and provide proof of professional liability insurance for the practitioner(s).

5. Do you interpret electrodiagnostic studies? Yes No

If yes, please provide proof of your training.

6. Do you administer general anesthesia in any dentists' offices? Yes No

SECTION II

INTERVENTIONAL CHRONIC PAIN MANAGEMENT PROCEDURES

1. Do you perform any procedures listed in the following table or any other interventional chronic pain management procedures? Yes No

If yes, please complete the following table:

Procedure	Estimated Number Performed Per Year	Location(s) Where Performed
<input type="checkbox"/> Epidural Injection <input type="checkbox"/> Caudal <input type="checkbox"/> Cervical <input type="checkbox"/> Lumbar <input type="checkbox"/> Thoracic <input type="checkbox"/> Steroid Only <input type="checkbox"/> Local Anesthetic With or Without Steroid <input type="checkbox"/> Other: <input type="text"/>	<input type="text"/>	<input type="checkbox"/> Hospital/Hospital Surgery Center <input type="checkbox"/> Accredited Surgery Center (nonhospital)* <input type="checkbox"/> Nonaccredited Facility With Crash Cart <input type="checkbox"/> Other: <input type="text"/>
<input type="checkbox"/> Facet Joint Injection <input type="checkbox"/> Cervical <input type="checkbox"/> Lumbar <input type="checkbox"/> Thoracic	<input type="text"/>	<input type="checkbox"/> Hospital/Hospital Surgery Center <input type="checkbox"/> Accredited Surgery Center (nonhospital)* <input type="checkbox"/> Nonaccredited Facility With Crash Cart <input type="checkbox"/> Other: <input type="text"/>
<input type="checkbox"/> Sympathetic Nerve Injection <input type="checkbox"/> Celiac Plexus <input type="checkbox"/> Lumbar <input type="checkbox"/> Stellate Ganglion <input type="checkbox"/> Other: <input type="text"/> <input type="checkbox"/> Local Anesthetic <input type="checkbox"/> Neurolytic <input type="checkbox"/> Other: <input type="text"/>	<input type="text"/>	<input type="checkbox"/> Hospital/Hospital Surgery Center <input type="checkbox"/> Accredited Surgery Center (nonhospital)* <input type="checkbox"/> Nonaccredited Facility With Crash Cart <input type="checkbox"/> Other: <input type="text"/>
<input type="checkbox"/> Discography† <input type="checkbox"/> Cervical <input type="checkbox"/> Lumbar <input type="checkbox"/> Thoracic	<input type="text"/>	<input type="checkbox"/> Hospital/Hospital Surgery Center <input type="checkbox"/> Accredited Surgery Center (nonhospital)* <input type="checkbox"/> Nonaccredited Facility With Crash Cart <input type="checkbox"/> Other: <input type="text"/>
<input type="checkbox"/> Epidural Lysis of Adhesions†	<input type="text"/>	<input type="checkbox"/> Hospital/Hospital Surgery Center <input type="checkbox"/> Accredited Surgery Center (nonhospital)* <input type="checkbox"/> Nonaccredited Facility With Crash Cart <input type="checkbox"/> Other: <input type="text"/>

Procedure	Estimated Number Performed Per Year	Location(s) Where Performed
<input type="checkbox"/> Epidural/Spinal Endoscopy†		<input type="checkbox"/> Hospital/Hospital Surgery Center <input type="checkbox"/> Accredited Surgery Center (nonhospital)* <input type="checkbox"/> Nonaccredited Facility With Crash Cart <input type="checkbox"/> Other: <input type="text"/>
<input type="checkbox"/> Epidural/Spinal Catheter Placement		<input type="checkbox"/> Hospital/Hospital Surgery Center <input type="checkbox"/> Accredited Surgery Center (nonhospital)* <input type="checkbox"/> Nonaccredited Facility With Crash Cart <input type="checkbox"/> Other: <input type="text"/>
<input type="checkbox"/> Single-Shot Intrathecal Injection		<input type="checkbox"/> Hospital/Hospital Surgery Center <input type="checkbox"/> Accredited Surgery Center (nonhospital)* <input type="checkbox"/> Nonaccredited Facility With Crash Cart <input type="checkbox"/> Other: <input type="text"/>
<input type="checkbox"/> Intrathecal/Epidural Infusion Pump Implant†		<input type="checkbox"/> Hospital/Hospital Surgery Center <input type="checkbox"/> Accredited Surgery Center (nonhospital)* <input type="checkbox"/> Nonaccredited Facility With Crash Cart <input type="checkbox"/> Other: <input type="text"/>
<input type="checkbox"/> Intrathecal/Epidural Infusion Pump Refilling and Reprogramming		<input type="checkbox"/> Hospital/Hospital Surgery Center <input type="checkbox"/> Accredited Surgery Center (nonhospital)* <input type="checkbox"/> Nonaccredited Facility With Crash Cart <input type="checkbox"/> Other: <input type="text"/>
<input type="checkbox"/> Fluoroscopy <input type="checkbox"/> Diagnostic <input type="checkbox"/> Fluoroscopically Guided Procedures		<input type="checkbox"/> Hospital/Hospital Surgery Center <input type="checkbox"/> Accredited Surgery Center (nonhospital)* <input type="checkbox"/> Nonaccredited Facility With Crash Cart <input type="checkbox"/> Other: <input type="text"/>
<input type="checkbox"/> Lumbar Discograms†		<input type="checkbox"/> Hospital/Hospital Surgery Center <input type="checkbox"/> Accredited Surgery Center (nonhospital)* <input type="checkbox"/> Nonaccredited Facility With Crash Cart <input type="checkbox"/> Other: <input type="text"/>
<input type="checkbox"/> Neuroablative Techniques† <input type="checkbox"/> Cryoneurolysis (aka Cryoanalgesia or Cryoneuroablation) <input type="checkbox"/> Radiofrequency Nerve Ablation <input type="checkbox"/> Other: <input type="text"/>		<input type="checkbox"/> Hospital/Hospital Surgery Center <input type="checkbox"/> Accredited Surgery Center (nonhospital)* <input type="checkbox"/> Nonaccredited Facility With Crash Cart <input type="checkbox"/> Other: <input type="text"/>
<input type="checkbox"/> Neurostimulation Device Implants† <input type="checkbox"/> Peripheral Nerve Stimulation <input type="checkbox"/> Spinal Cord Stimulation		<input type="checkbox"/> Hospital/Hospital Surgery Center <input type="checkbox"/> Accredited Surgery Center (nonhospital)* <input type="checkbox"/> Nonaccredited Facility With Crash Cart <input type="checkbox"/> Other: <input type="text"/>
<input type="checkbox"/> Neurostimulation Device Reprogramming† <input type="checkbox"/> Peripheral Nerve Stimulation <input type="checkbox"/> Spinal Cord Stimulation		<input type="checkbox"/> Hospital/Hospital Surgery Center <input type="checkbox"/> Accredited Surgery Center (nonhospital)* <input type="checkbox"/> Nonaccredited Facility With Crash Cart <input type="checkbox"/> Other: <input type="text"/>
<input type="checkbox"/> Nucleoplasty†		<input type="checkbox"/> Hospital/Hospital Surgery Center <input type="checkbox"/> Accredited Surgery Center (nonhospital)* <input type="checkbox"/> Nonaccredited Facility With Crash Cart <input type="checkbox"/> Other: <input type="text"/>
<input type="checkbox"/> Percutaneous Lumbar Discectomy†		<input type="checkbox"/> Hospital/Hospital Surgery Center <input type="checkbox"/> Accredited Surgery Center (nonhospital)* <input type="checkbox"/> Nonaccredited Facility With Crash Cart <input type="checkbox"/> Other: <input type="text"/>

Procedure	Estimated Number Performed Per Year	Location(s) Where Performed
<input type="checkbox"/> Vertebroplasty/Kyphoplasty†	<input type="text"/>	<input type="checkbox"/> Hospital/Hospital Surgery Center <input type="checkbox"/> Accredited Surgery Center (nonhospital)* <input type="checkbox"/> Nonaccredited Facility With Crash Cart <input type="checkbox"/> Other: <input type="text"/>
<input type="checkbox"/> Other (specify): <input type="text"/>	<input type="text"/>	<input type="checkbox"/> Hospital/Hospital Surgery Center <input type="checkbox"/> Accredited Surgery Center (nonhospital)* <input type="checkbox"/> Nonaccredited Facility With Crash Cart <input type="checkbox"/> Other: <input type="text"/>

* Please provide proof that this location is accredited by the AAAASF, AAAHC or similar type of organization, or proof that it is certified by Medicare as an ambulatory surgery center.

† Please provide proof of your training for this procedure and the estimated number that you have performed in the Remarks section on page 5.

2. If you indicated that you perform any interventional pain management procedure(s) in a nonaccredited facility with a crash cart, is the crash cart equipped with at least cardiac drugs, basic airway and IV access equipment, a cardiac monitor/defibrillator and supplemental oxygen? Yes No

If no, please explain:

3. Do any nonphysician personnel perform any interventional chronic pain management procedure(s) on your behalf? Yes No

If yes, please identify each individual, his or her designation and the procedure(s) performed by him or her:

4. If you (or someone else on your behalf) is performing interventional pain management procedures, please answer and provide the following:

- a. Do you have hospital privileges for all interventional chronic pain management procedures that you perform? Yes No

If no, please explain and identify the procedure(s) for which you do not have hospital privileges:

- b. Is an ACLS certified health care provider always present when an interventional pain management procedure is performed? Yes No

If no, please explain:

SECTION III**REMARKS**

Please provide any additional information to further describe your practice that has not otherwise been addressed in this questionnaire:

REPRESENTATIONS AND WARRANTIES

NOTE: "Warrant" in the following statement is not applicable to Alaska or Arizona health care providers. By statute, Alaska or Arizona health care providers are only required to represent the truth of their statements and information.

I represent and warrant the truth of my statements and information mentioned herein, and that I have not withheld any information that may be relevant to my coverage. I agree to notify NORCAL Mutual Insurance Company immediately if my practice changes in any way and of any change in the information contained on this questionnaire.

Signature

Date

(mm/dd/yyyy)

Name (Print)