

# Bariatric Surgery 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

## PRACTICE INFORMATION

1. Are you currently a member of the American Society for Bariatric Surgery?  Yes  No

If yes, please provide proof of your current membership.

If no, please explain why you are not currently a member:

2. Are you currently performing bariatric surgery?  Yes  No

If yes:

a. What percentage of your practice is devoted to the performance of bariatric surgery procedures?  %

b. Please complete the following regarding the bariatric procedures:

Name of Procedure	Total Number Performed in the Previous 12 Months	Performing Laparoscopically?
<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No

3. Do you intend to perform any bariatric surgery procedures within the next 12 months that were not identified in question 2b?

Yes  No

If yes, please complete the following regarding the bariatric procedures:

Name of Procedure	Date to Begin Performing	To be Performed Laparoscopically?
<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No

4. What is the total estimated number of bariatric surgery procedures that you intend to perform within the next 12 months?

5. If you are not currently insured with NORCAL, have you previously performed any bariatric surgery procedures not identified in question 2b?  Yes  No

**SECTION I (Cont.)****PRACTICE INFORMATION**

If **yes**, please complete the following regarding the bariatric surgery procedures:

**Name of Procedure**

**Date Procedure Last Performed**


6. Please provide the following:

- a. If you are not currently insured with NORCAL, or are but have not been approved for bariatric surgery coverage, please provide proof of your training for each procedure identified in questions 2b and 3 and a listing of the continuing medical education courses related to bariatric surgery that you have completed within the past two years.
- b. If you are currently approved for bariatric surgery coverage with NORCAL, please provide proof of your training for each procedure that you are performing and that has not been previously reviewed and approved by NORCAL, if applicable, and a listing of the continuing medical education courses related to bariatric surgery that you have completed within the past two years.

7. Do you, does the bariatric surgery team that you are a member of, or does the facility where you perform bariatric surgery advertise for bariatric surgery?  **Yes**  **No**

If **yes**, please provide copies of all advertisements.

8. Do you, does the bariatric surgery team that you are a member of, or does the facility where you perform bariatric surgery have a website related to bariatric surgery?  **Yes**  **No**

If **yes**, please provide the website address(es):

**SECTION II****PATIENT SELECTION AND EVALUATION**

1. Please provide copies of your written bariatric surgery protocols for patient selection, evaluation, denial, etc.

If you do not have written protocols, on a copy of your letterhead please explain why you do not have protocols and provide a detailed description of your patient selection criteria (e.g., BMI, age, etc. criteria).

2. Prior to you performing bariatric surgery, is each patient required to have a documented history of a failure to lose weight through conventional weight reduction methods?  **Yes**  **No**

If **no**, please explain:

3. Please identify which of the following clearances all of your bariatric surgery patients are required to have before surgery:

- Medical clearance (including cardiac)     Psychological clearance     Dietary clearance

If you did not mark all of the above, please explain:

4. Do you perform or do you intend to perform bariatric surgery on adolescent patients who are under 21 years of age?

**Yes**     **No**

If **yes**, please provide or answer the following:

a. What percentage of your bariatric surgery procedures will be performed on patients who are under 21 years of age?  %

b. If the information was not already provided in question 1, please provide a copy of your written adolescent bariatric surgery protocols or, if you do not have protocols for this, on a copy of your letterhead, please provide a detailed description of your adolescent patient selection criteria.

c. Please identify the bariatric surgery procedures you will perform on patients who are under 21 years of age:

1. Please complete the following regarding each facility where you intend to perform bariatric surgery:

Name and Location of Facility	Type of Facility (for example, hospital, surgery center, etc.)	Number of Bariatric Surgery Procedures Performed in Facility in Previous 12 Months (by all physicians)

2. If any facility identified in question 1 is not a hospital facility, please provide the following for each facility:

- Proof of its professional liability insurance
- Proof of its accreditation by JACHO, AAAHC, AAAASF, or similar organization
- The type of bariatric surgery procedure(s) performed
- Your patient selection criteria
- Your policies and procedures for handling the recovery for patients

3. Do any of the facilities identified in question 1 currently maintain "Full Approval" (not "Provisional") status in the Bariatric Surgery Centers of Excellence Program?  Yes  No

If yes, please provide proof of each facility's "Full Approval" status.

4. Do you maintain active privileges for bariatric surgery at each location identified in question 1?  Yes  No

a. If no, please explain below:

b. Please provide proof of your current privileges for bariatric surgery at each location.

5. Please provide the following:

- a. If you are not currently insured with NORCAL, or are but have not been approved for bariatric surgery coverage, on a copy of your letterhead please describe the bariatric surgery credentialing process used at the facilities identified in question 1. If the process involved a proctorship, please describe the process and provide the proctor's credentials, including copies of any documentation that you received regarding completion of the proctorship.
- b. If you are currently approved for bariatric surgery coverage with NORCAL, on a copy of your letterhead please describe the bariatric surgery credentialing process used at the facilities identified in question 1 for each procedure that you are performing and that has not been previously reviewed and approved by NORCAL, if applicable. If the process involved a proctorship, please describe the process and provide the proctor's credentials, including copies of any documentation that you received regarding completion of the proctorship.

6. Does **every** facility identified in question 1 have the following. Please check all that apply.

- Operating room tables and equipment to support the width and weight of morbidly obese patients
- Appropriate and adequately sized instruments suitable for bariatric procedures and patients
- Radiology and other diagnostic equipment capable of handling morbidly obese patients
- Recovery room and intensive care unit experienced in and capable of providing critical care to obese patients
- Recovery room staff experienced in difficult ventilatory and respirator support
- Floor nurses experienced in all aspects of morbidly obese patients

If you did not check all of the above, please identify the facility and explain:

**SECTION IV**

**PROFESSIONAL SUPPORT TEAM**

1. Please complete the following regarding your bariatric surgery support team:

Name and Designation	Discipline	Professional Relationship with You
		<input type="checkbox"/> Employee <input type="checkbox"/> Independent Contractor <input type="checkbox"/> Other: <input type="text"/>
		<input type="checkbox"/> Employee <input type="checkbox"/> Independent Contractor <input type="checkbox"/> Other: <input type="text"/>
		<input type="checkbox"/> Employee <input type="checkbox"/> Independent Contractor <input type="checkbox"/> Other: <input type="text"/>
		<input type="checkbox"/> Employee <input type="checkbox"/> Independent Contractor <input type="checkbox"/> Other: <input type="text"/>
		<input type="checkbox"/> Employee <input type="checkbox"/> Independent Contractor <input type="checkbox"/> Other: <input type="text"/>
		<input type="checkbox"/> Employee <input type="checkbox"/> Independent Contractor <input type="checkbox"/> Other: <input type="text"/>
		<input type="checkbox"/> Employee <input type="checkbox"/> Independent Contractor <input type="checkbox"/> Other: <input type="text"/>

**Please provide proof of professional liability insurance for any person who is not your employee or an employee of your NORCAL-insured group.**

2. Are the anesthesiologists/CRNAs who provide anesthesia for your bariatric surgery patients trained and experienced in administering anesthesia to bariatric surgery patients?    Yes    No

If no, please explain:

3. If not already specified in the protocol(s) that you provided, if applicable, on a copy of you letterhead please describe the extent of the collaboration between you and the support team throughout the process.

**SECTION V**

**MISCELLANEOUS**

1. Please provide a copy of your written informed consent form and, on a copy of your letterhead please provide a detailed description of your informed consent process for bariatric surgery patients.

2. If not already specified in the protocol(s) that you provided, if applicable, on a copy of your letterhead please describe the post-discharge care and evaluation that bariatric surgery patients receive.

3. Are you actively involved in your bariatric surgery patients' post-operative care?    Yes    No

If no, please explain below:

4. Do you follow (or intend to follow if not currently performing bariatric surgery) the American Society for Bariatric Surgery guidelines regarding the following of your patients on a regular basis after their surgeries\*?    Yes    No

If no, please explain below:

\* The guidelines currently recommend that at least 50% of the patients who receive restrictive and 75% of those with malabsorptive operations are seen on a regular basis for at least five years.

**SECTION V (Cont.)****MISCELLANEOUS**

5. Do you perform panniculectomy and/or abdominoplasty surgery?  Yes  No

If yes, please complete the following:

**Procedure**                      **Number Performed Annually**

Panniculectomy	
Abdominoplasty	

**SECTION VI****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)