

# **Dermatology**

## 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 4.**

## SECTION I

## PROCEDURES

### Skin Resurfacing

1. Do you perform skin resurfacing procedures?  Yes  No

If yes, please complete the following:

Procedure	Estimated Number Performed Per Year	Procedure	Estimated Number Performed Per Year
<input type="checkbox"/> Chemical Peel	<input type="text"/>	<input type="checkbox"/> Dermaplaning	<input type="text"/>
<input type="checkbox"/> AHA Peel	<input type="text"/>	<input type="checkbox"/> Laser Resurfacing	<input type="text"/>
<input type="checkbox"/> TCA Peel	<input type="text"/>	<input type="checkbox"/> Microdermabrasion	<input type="text"/>
<input type="checkbox"/> Phenol Peel	<input type="text"/>	<input type="checkbox"/> Other: <input type="text"/>	<input type="text"/>
<input type="checkbox"/> Dermabrasion	<input type="text"/>		

2. If you indicated that you are performing phenol chemical peels, dermabrasion or dermaplaning and you have not completed a fellowship in procedural dermatology (dermatologic surgery) approved by the Accreditation Council for Graduate Medical Education (ACGME), please provide proof of your training for each procedure.

### Dermatologic Surgery

1. Do you perform skin flap surgery that includes muscle, myocutaneous or fasciocutaneous flaps (consisting of muscle, vascular supply, overlying skin and intervening tissue), and/or "distant" flaps that are axial based (arterial), pedicled (carrying blood supply from the donor site to the transfer site by means of a stem{pedicle} of skin) or tubed (the sides of the pedicle are sewn together, forming a tube)?  Yes  No
2. Do you perform skin graft surgery that includes grafts more than 100 square cm or those used in the functional reconstruction of, for example, eyelids, digits, external auditory canal, etc?  Yes  No
3. Do you perform Mohs micrographic surgery?  Yes  No
4. Do you perform wound repairs?  Yes  No

If yes, please identify the type(s) of wounds that you repair:

- Simple:** superficial wounds (i.e., involving primarily epidermis or dermis, or subcutaneous tissues without significant involvement of deeper structures, and requiring simple one layer closure).
- Intermediate:** wounds that require layered closure of one or more of the deeper layers of subcutaneous tissue and superficial (nonmuscle) fascia, in addition to the skin (epidermal and dermal) closure, as well as wounds that require the single-layer closure of heavily contaminated wounds that have required extensive cleaning or removal of particulate matter.
- Complex:** wounds that require more than layered closure; repairs considered more than layered are scar revision, debridement, extensive undermining, stents or retention sutures.

5. If you indicated yes for question 1, 2 and/or 3, or if you indicated that you perform intermediate or complex wound repairs, and you have not completed a fellowship in procedural dermatology (dermatologic surgery) approved by the ACGME, please provide one of the following for each procedure:

- Proof that you received training during your residency (e.g., letter from the program director), or
- Proof of training you received subsequent to completion of your residency

**Cosmetic Surgery**

1. Do you perform cosmetic surgery?  Yes  No

**NOTE:** NORCAL uses the American Medical Association’s (AMA) definition of cosmetic surgery. According to the AMA, cosmetic surgery is “surgery performed to reshape normal structures of the body in order to improve the patient’s appearance and self-esteem.”

If no, please go to Section II.

If yes, please complete the following:

Procedure	Estimated Number Performed Per Year	Procedure	Estimated Number Performed Per Year
<input type="checkbox"/> Ambulatory Phlebectomy	<input type="text"/>	<input type="checkbox"/> Liposuction specify type(s) (e.g., Tumescent):	<input type="text"/>
<input type="checkbox"/> Blepharoplasty	<input type="text"/>	<input type="checkbox"/> Lower Body Lift	<input type="text"/>
<input type="checkbox"/> Breast Augmentation specify type(s) (e.g., Enlargement)	<input type="text"/>	<input type="checkbox"/> Microlipoinjection (i.e., Autologous Fat Injection)	<input type="text"/>
<input type="checkbox"/> Facelift	<input type="text"/>	<input type="checkbox"/> Otoplasty	<input type="text"/>
<input type="checkbox"/> Facial Implants	<input type="text"/>	<input type="checkbox"/> Rhinoplasty	<input type="text"/>
<input type="checkbox"/> Forehead Lift	<input type="text"/>	<input type="checkbox"/> Other: <input type="text"/>	<input type="text"/>
<input type="checkbox"/> Hair Restoration Surgery specify type(s) (e.g., Minigrafts):	<input type="text"/>		

2. If you perform cosmetic surgery, please provide the following for each procedure:

- Proof of training
- Proof of hospital privileges
- A copy of your consent form

3. Do you perform cosmetic surgery on patients younger than 21 years of age?  Yes  No

If yes, please provide a list of procedures performed and your patient selection criteria:

**Liposuction**

**NOTE:** Please complete this section only if you indicated that you perform liposuction.

1. Please indicate where on the body you perform liposuction:

<input type="checkbox"/> Abdomen	<input type="checkbox"/> Buttocks	<input type="checkbox"/> Thighs
<input type="checkbox"/> Arms	<input type="checkbox"/> Neck	<input type="checkbox"/> Other (please specify) <input type="text"/>

**SECTION I (Cont.)****PROCEDURES**

2. Do you perform liposuction in an office-based surgical suite?  Yes  No

**If yes**, please complete the following:

a. Are 5000ml or more of total aspirate extracted?  Yes  No

b. Is IV access available for procedures of less than 2000ml total aspirate?  Yes  No

c. Is an IV placed for procedures of 2000ml or more total aspirate?  Yes  No

d. Please indicate which of the following monitoring systems are available for volumes greater than 150ml and less than 2000ml of total aspirate (please mark all that apply):

<input type="checkbox"/> Pulse oximeter	<input type="checkbox"/> Blood pressure monitoring
<input type="checkbox"/> EKG monitoring	<input type="checkbox"/> Fluid loss and replacement monitoring and recording

e. Are the monitoring systems listed under 2d always used for volumes of 2000ml or more?  Yes  No

If you answered no to 2b, 2c or 2e, or did not mark every one of the items in 2d, please explain in the Remarks section on page 4.

**Miscellaneous Procedures**

1. Do you perform bovine or porcine collagen injections?  Yes  No

**If yes**, is an allergy test performed at least one month before the procedure to determine whether the patient is allergic to the applicable material?  Yes  No

**If no**, please explain:

2. Do you perform fat injections?  Yes  No

**If yes**, do you inject the fat into the breast or penis?  Yes  No

3. Do you perform radiation therapy for skin disorders?  Yes  No

**SECTION II****MISCELLANEOUS**

1. Do you read biopsy slides for other physicians?  Yes  No

**If yes**, and you have not completed a fellowship in dermatopathology approved by the ACGME, please provide proof of your training.

2. Do you use computer imaging to show patients an estimate of post-operative appearance?  Yes  No

**If yes**, is a copy of the image given to the patient?  Yes  No

If a copy of the image is given to the patient, does the image contain a disclaimer, which advises that the image is no guarantee of outcome and actual results may vary?  Yes  No

**If no**, please explain:

**SECTION II (Cont.)****MISCELLANEOUS**

3. Do you use photographs for any purpose other than medical documentation of the patient's chart?  Yes  No

If **yes**, do you obtain specific written permission in all cases?  Yes  No

If you do not obtain specific written permission, please explain for what reasons you use the pictures and why you do not obtain written permission:

**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)