

# Neurology

## 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 AND SERVICES

1. Do you interpret electrodiagnostic evaluations that were performed by others?  Yes  No

If yes, please identify who performs the evaluations, his or her designation and qualifications, your professional relationship with him or her, the location(s) where the evaluations are performed and who communicates the results to the patients:

2. Do you perform electroconvulsive therapy?  Yes  No

3. Do you perform any of the procedures listed in the following table or any other interventional 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"/>
<input type="checkbox"/> Epidural/Spinal Endoscopy	<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 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"/>
<input type="checkbox"/> Vertebroplasty/Kyphoplasty		<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"/> Other (specify): <div style="border: 1px solid black; height: 50px; width: 100%;"></div>	<div style="border: 1px solid black; height: 20px; width: 100%;"></div>	<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: <div style="border: 1px solid black; width: 100px; height: 15px;"></div>

\* 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.

4. 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:

5. Do any nonphysician personnel perform any interventional 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:

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

a. Provide proof of your training and hospital privileges for the procedures, as well as the estimated number of the procedures you have performed since you completed your training. If proof of your training is not available, please describe your training, including the date(s), location(s), number of hours, etc.

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

If no, please explain:

7. Do you perform the following procedures?

- Carotid angioplasty and stenting             Yes     No
- Endovascular GDC coils                       Yes     No
- External ventricular drainage (EVD)         Yes     No
- Phrenic nerve pacing                           Yes     No
- Vagus nerve stimulator implants             Yes     No

If you indicated that you perform any one of the above procedures, please provide proof of your training for each applicable procedure.

**SECTION II****MISCELLANEOUS**

1. If you are practicing in California, do you report all patients (over the age of 14) diagnosed with a disorder characterized by lapses of consciousness to a local health officer in compliance with the California Health and Safety Code?

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)