

CHRONIC PAIN MANAGEMENT SUPPLEMENTAL QUESTIONNAIRE

(For specialties other than Anesthesiology, Neurology, and Physical Medicine and Rehabilitation)

Your Full Name (please print)

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. What percentage of your practice is devoted to treating chronic pain management? _____ %
2. What percentage of your chronic pain management practice is:
 - a. Conservative (e.g., physical therapy, chiropractic, acupuncture) _____ %
 - b. Medication-controlled _____ %
 - c. Other Noninterventional (e.g., biofeedback, relaxation techniques, counseling) _____ %
 - d. Interventional or Operative (e.g., epidural injections, infusion pumps, neurostimulation devices) _____ %

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="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="checkbox"/> Facet Joint Injection <input type="checkbox"/> Cervical <input type="checkbox"/> Lumbar <input type="checkbox"/> Thoracic		<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="checkbox"/> Sympathetic Nerve Injection <input type="checkbox"/> Celiac Plexus <input type="checkbox"/> Lumbar <input type="checkbox"/> Stellate Ganglion <input type="checkbox"/> Other: _____ <input type="checkbox"/> Local Anesthetic <input type="checkbox"/> Neurolytic <input type="checkbox"/> Other: _____		<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: _____

Procedure	Estimated Number Performed Per Year	Location(s) Where Performed
<input type="checkbox"/> Discography [†] <input type="checkbox"/> Cervical <input type="checkbox"/> Lumbar <input type="checkbox"/> Thoracic		<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="checkbox"/> Epidural Lysis of Adhesions [†]		<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="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="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="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="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="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="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="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="checkbox"/> Neuroablative Techniques [†] <input type="checkbox"/> Cryoneurolysis (aka Cryoanalgesia or Cryoneuroablation) <input type="checkbox"/> Radiofrequency Nerve Ablation <input type="checkbox"/> Other: _____		<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="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="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: _____

Procedure	Estimated Number Performed Per Year	Location(s) Where Performed
<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="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="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="checkbox"/> Other (specify): _____ _____ _____		<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: _____

* 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 4.

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 chronic pain management procedures, please answer and provide the following:

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

If no, please explain:

- b. Is an ACLS certified health care provider always present when an interventional chronic 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

Print Name