

**Physical
Medicine and
Rehabilitation**
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

PHYSICAL MEDICINE PROCEDURES

1. Please indicate with an X which of the following procedures you perform and provide the estimated number that you perform per year.

If you do not perform any of the procedures listed below, please check here.

Procedure	Estimated Number Performed Per Year
<input type="checkbox"/> Acupuncture	
<input type="checkbox"/> Anesthetic or Corticosteroid Injection	
<input type="checkbox"/> Intercostal	
<input type="checkbox"/> Joint (other than spinal)	
<input type="checkbox"/> Myofascial Trigger Point	
<input type="checkbox"/> Peripheral Nerve	
<input type="checkbox"/> Botulinum Toxin Injection for Pain Management	
<input type="checkbox"/> Electrodiagnostic Evaluations	
<input type="checkbox"/> Electromyography (EMG)	
<input type="checkbox"/> Nerve Conduction Studies	
<input type="checkbox"/> Manipulation (specify): <input type="text"/>	
<input type="checkbox"/> Physical Therapy and Other Rehabilitative Therapies	
<input type="checkbox"/> Transcutaneous Electrical Nerve Stimulation	

2. 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:

3. Do you perform manipulations on patients under anesthesia or moderate/deep sedation? Yes No

If yes, please identify at what location(s) you perform the manipulations, where on the body you perform the manipulations, the type(s) of anesthesia used and the qualifications of the person(s) administering the anesthesia:

SECTION II

INTERVENTIONAL AND PAIN MANAGEMENT PROCEDURES

1. 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="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="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="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="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="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="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"/>

Procedure	Estimated Number Performed Per Year	Location(s) Where Performed
<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"/>
<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: <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.

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 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. 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:

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)