

# RADIOLOGY

## SUPPLEMENTAL QUESTIONNAIRE

Your Full Name: \_\_\_\_\_ Policy Number: \_\_\_\_\_  
 (Please Print)

**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 6.**

### SECTION I: PROCEDURES

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

**General Diagnostic Procedures**

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

Procedure	Estimated Number Performed Per Year	Procedure	Estimated Number Performed Per Year
<input type="checkbox"/> Arteriography – Non-Coronary		<input type="checkbox"/> Gastrostomy Tube Insertion	
<input type="checkbox"/> Biopsy – other than brain, pancreas or spine (specify types): _____ _____		<input type="checkbox"/> General Radiographic Interpretation	
<input type="checkbox"/> Central Venous Access Tube Insertion		<input type="checkbox"/> Intravenous Contrast Injections	
<input type="checkbox"/> CT Scans		<input type="checkbox"/> Mammography - Diagnostic	
<input type="checkbox"/> Coronary Vascular		<input type="checkbox"/> Mammography - Screening	
<input type="checkbox"/> Full Body		<input type="checkbox"/> MRI Interpretation	
<input type="checkbox"/> Virtual Colon		<input type="checkbox"/> MRI Guided Procedures and Contrast Injections	
<input type="checkbox"/> CT-Guided Procedures and Contrast Injections		<input type="checkbox"/> Myelography	
<input type="checkbox"/> Discography		<input type="checkbox"/> Needle Biopsy	
<input type="checkbox"/> Epidural Injection		<input type="checkbox"/> Nerve Root Block	
<input type="checkbox"/> Facet Injection		<input type="checkbox"/> Ultrasound Interpretation	
<input type="checkbox"/> Fluoroscopic Examinations		<input type="checkbox"/> Ultrasound-Guided Procedures and Contrast Injections	
<input type="checkbox"/> Fluoroscopically-Guided Procedures		<input type="checkbox"/> Venography	

**Interventional/Diagnostic Procedures**

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

Procedure	Estimated Number Performed Per Year	Procedure	Estimated Number Performed Per Year
<input type="checkbox"/> Angioplasty- Coronary		<input type="checkbox"/> Kyphoplasty	
<input type="checkbox"/> Angioplasty- Non-Coronary		<input type="checkbox"/> Radiofrequency Ablation (excluding intra-cardiac)	
<input type="checkbox"/> Arteriography – Coronary		<input type="checkbox"/> Stent Placement	
<input type="checkbox"/> Atherectomy		<input type="checkbox"/> Aortic Stent-Graft Placement	
<input type="checkbox"/> Biliary Drainage and Stenting		<input type="checkbox"/> Thrombolysis	
<input type="checkbox"/> Biopsy of the Brain, Pancreas or Spine		<input type="checkbox"/> Transjugular Intrahepatic Portosystemic Shunt (TIPS)	
<input type="checkbox"/> Cerebral Vascular Embolization and Coiling		<input type="checkbox"/> Uterine Artery Embolization	
<input type="checkbox"/> Chemoembolization		<input type="checkbox"/> Uterine Fibroid Embolization	
<input type="checkbox"/> Fallopian Tube Catheterization and Tuboplasty		<input type="checkbox"/> Vertebroplasty	
<input type="checkbox"/> Hemodialysis Access Maintenance			
<input type="checkbox"/> Inferior Vena Cava Filter Placement			

**Therapeutic Radiology and Nuclear Medicine Procedures**

If you do not perform any of the following, please check here.

Therapeutic Radiology		Nuclear Medicine	
Procedure	Estimated Number Performed Per Year	Procedure	Estimated Number Performed Per Year
<input type="checkbox"/> Brachytherapy		<input type="checkbox"/> Diagnostic	
<input type="checkbox"/> External Beam Therapy (EBT)		<input type="checkbox"/> Therapeutic	
<input type="checkbox"/> 3-D		<input type="checkbox"/> Other _____	
<input type="checkbox"/> Hyperfractionated Radiation Therapy			
<input type="checkbox"/> Intensity Modulated Radiation Therapy (IMRT)			
<input type="checkbox"/> Stereotactic Radio Surgery			

2. Do you perform any procedures not specified in question 1?  Yes  No

If yes, please identify the procedure(s) and provide the estimated number of each you perform per year:

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3. If you perform interventional procedures as listed above, and you have not completed an ACGME or AOA-approved fellowship in vascular and interventional radiology, please provide proof of your training and hospital privileges for the procedure(s), describe the proctoring procedure used at the hospital and provide the credentials of the proctoring physician:

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4. If you perform Kyphoplasty and/or Vertebroplasty, please provide documentation of training and experience, and proof of hospital privileges for these procedures.

5. If you perform therapeutic procedures as listed above, please describe your training for these procedures (e.g., training obtained through residency, fellowship program, or subsequent courses).

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6. Do you have hospital privileges for all invasive/interventional procedures you perform?  Yes  No  N/A

If no, please explain:

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## SECTION II: CT SCANS

**NOTE: Please complete this section only if you indicated in Section I that perform CT scans.**

1. Do you require a written referral from a primary care physician for the indicated procedure(s)?  Yes  No

If yes, do you notify the patient's primary care physician of the results?  Yes  No

If you *do* notify the patient's primary care physician of the results, please describe your notification process.

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If you *do not* notify the patient's primary care physician of the results, please describe your mechanism for ensuring that the patient follows up with his or her primary care physician, especially in the event that the results are abnormal or positive.

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2. In instances where the patient is referred by a specialist, do you *always* notify the patient's primary care physician in addition to notifying the referring physician?  Yes  No

If no, please explain.

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3. Do you accept self-referred patients for these types of CT scans?  Yes  No

a. If you accept self-referred patients, do you require the patient to provide the name of his or her primary care physician?  
 Yes  No

If yes, do you always send the results to his or her primary care physician?  Yes  No

If you *do not* send the results to the primary care physician, please describe your mechanism for ensuring that the patient follows up with his/her primary care physician, especially in the event that the results are abnormal or positive.

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b. What is your protocol for self-referred patients who do not have a primary care physician?

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4. Do you personally conduct an informed consent discussion with the patient in advance of the procedure?  Yes  No

a. If yes, how is the discussion documented?

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b. If you *do not* personally conduct an informed consent discussion, does a trained staff member conduct such a discussion?  
 Yes  No

If yes, please describe the training and supervision of that staff member. Please include the kind of continuing education you require or have in place to keep him or her current.

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### SECTION III: BREAST IMAGING AND DIAGNOSIS

1. Do you interpret mammograms?  Yes  No

If yes, please complete the remaining questions. If no, please go to Section IV.

2. What is the average number of mammograms that you interpret on an average day of practice? \_\_\_\_\_

3. What is the approximate number of mammograms that you interpret per year? \_\_\_\_\_

4. Please indicate the types of images that you interpret:

Screen-film Mammography  Full-field Digital Mammography

5. Are you currently qualified as an interpreting physician in accordance with the Mammography Quality Standards Act for the type(s) of images identified above?  Yes  No

If no, please explain:

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6. Please answer the following regarding previous breast imaging studies:

a. Before you interpret a mammogram, do you *always* inquire as to whether any previous breast imaging was performed?  
 Yes  No

b. If a previous breast image had been performed, do you *always* attempt to attain and review the prior breast imaging study(ies)?  Yes  No

c. If you are unable to access a previous breast imaging study or film, do you indicate failure of access in your report?  
 Yes  No

If you answered no to 6a, 6b, or 6c, please explain.

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7. Do you interpret mammograms on behalf of any facility **not** certified by the FDA to perform mammography?  Yes  No

If yes, please explain and provide the name of each facility:

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8. Do you personally perform clinical breast exams?  Yes  No

If yes, please answer the following:

a. Do you order, perform and/or supervise additional imaging studies to further define abnormalities?  Yes  No

b. Do you perform aspirations/biopsies?  Yes  No

If you answered no to 8a or 8b, please explain:

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**Non-Physician-Referred Screening Mammography**

1. Do you screen mammograms for *non-physician-referred* patients?  **Yes**  **No**

**If yes, please complete the remaining questions. If no, please go to Section IV.**

2. Do you document that a manual breast exam has or has not been performed by a licensed and trained health professional before the mammogram is taken?  **Yes**  **No**

**If no, please explain:**

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3. Do you have an informed consent form that the non-physician-referred patient signs?  **Yes**  **No**

a. **If yes**, please submit a copy of the informed consent form.

b. **If no**, please explain:

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4. Please explain your process for notifying the patient of the results. For example, do you send them a certified letter with a return receipt, in order to ensure that the patient received your letter?

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If the letters sent are returned, what is your mechanism to follow-up with the patient?

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5. Please explain your process for notifying patients with abnormal/positive results. Include your follow-up mechanism.

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**SECTION IV: OFF-HOURS COVERAGE (“NIGHTHAWK” SERVICES)**

1. Do you or does your medical group contract with an entity or physician to provide nighthawk services on your behalf or your medical group’s behalf?  **Yes**  **No**

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

a. Please provide a copy of each contract.

b. Please provide proof of professional liability insurance for the entity or physician.

c. Please provide the name of each nighthawk entity and each state/country where the interpreting physicians are located:

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d. Do you overread all studies performed on your behalf by the physician(s) providing nighthawk services?  **Yes**  **No**

d1. **If yes**, how long after the initial read is your overread performed? \_\_\_\_\_

d2. **If no**, please explain:

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d3. Who provides the official report to the ordering physician? \_\_\_\_\_

## SECTION V: REMARKS

Please provide any additional information to further describe your practice that has not otherwise been addressed in this questionnaire:

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## 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.

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Signature

\_\_\_\_\_  
Date (mm/dd/yyyy)

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Print Name