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**
❒ Epidural Injection ❒ Caudal ❒ Cervical ❒ Lumbar ❒ Thoracic	❒ Steroid Only ❒ Local Anesthetic With or Without Steroid ❒ Other:		❒ Hospital/Hospital Surgery Center ❒ Accredited Surgery Center (nonhospital)* ❒ Nonaccredited Facility With Crash Cart ❒ Other:
❒ Facet Joint Injection ❒ Cervical ❒ Lumbar ❒ Thoracic			❒ Hospital/Hospital Surgery Center ❒ Accredited Surgery Center (nonhospital)* ❒ Nonaccredited Facility With Crash Cart ❒ Other:
❒ Sympathetic Nerve Injection ❒ Celiac Plexus ❒ Lumbar ❒ Stellate Ganglion ❒ Other:	❒ Local Anesthetic ❒ Neurolytic ❒ Other:		❒ Hospital/Hospital Surgery Center ❒ Accredited Surgery Center (nonhospital)* ❒ Nonaccredited Facility With Crash Cart ❒ Other:
❒ Discography ❒ Cervical ❒ Lumbar ❒ Thoracic			❒ Hospital/Hospital Surgery Center ❒ Accredited Surgery Center (nonhospital)* ❒ Nonaccredited Facility With Crash Cart ❒ Other:
❒ Epidural Lysis of Adhesions			❒ Hospital/Hospital Surgery Center ❒ Accredited Surgery Center (nonhospital)* ❒ Nonaccredited Facility With Crash Cart ❒ Other:
❒ Epidural/Spinal Endoscopy			❒ Hospital/Hospital Surgery Center ❒ Accredited Surgery Center (nonhospital)* ❒ Nonaccredited Facility With Crash Cart ❒ Other:

SECTION I (Cont.) PROCEDURES AND SERVICES

Procedure	Estimated Number Performed Per Year	Location(s) Where Performed
❐ Epidural/Spinal Catheter Placement		❐ Hospital/Hospital Surgery Center ❐ Accredited Surgery Center (nonhospital)* ❐ Nonaccredited Facility With Crash Cart ❐ Other:
❐ Single-Shot Intrathecal Injection		❐ Hospital/Hospital Surgery Center ❐ Accredited Surgery Center (nonhospital)* ❐ Nonaccredited Facility With Crash Cart ❐ Other:
❐ Intrathecal/Epidural Infusion Pump Implant		❐ Hospital/Hospital Surgery Center ❐ Accredited Surgery Center (nonhospital)* ❐ Nonaccredited Facility With Crash Cart ❐ Other:
❐ Intrathecal/Epidural Infusion Pump Refilling and Reprogramming		❐ Hospital/Hospital Surgery Center ❐ Accredited Surgery Center (nonhospital)* ❐ Nonaccredited Facility With Crash Cart ❐ Other:
❐ Fluoroscopy ❐ Diagnostic ❐ Fluoroscopically Guided Procedures		❐ Hospital/Hospital Surgery Center ❐ Accredited Surgery Center (nonhospital)* ❐ Nonaccredited Facility With Crash Cart ❐ Other:
❐ Lumbar Discograms		❐ Hospital/Hospital Surgery Center ❐ Accredited Surgery Center (nonhospital)* ❐ Nonaccredited Facility With Crash Cart ❐ Other:
❐ Neuroablative Techniques ❐ Cryoneurolysis (aka Cryoanalgesia or Cryoneuroablation) ❐ Radiofrequency Nerve Ablation ❐ Other:		❐ Hospital/Hospital Surgery Center ❐ Accredited Surgery Center (nonhospital)* ❐ Nonaccredited Facility With Crash Cart ❐ Other:
❐ Neurostimulation Device Implants ❐ Peripheral Nerve Stimulation ❐ Spinal Cord Stimulation		❐ Hospital/Hospital Surgery Center ❐ Accredited Surgery Center (nonhospital)* ❐ Nonaccredited Facility With Crash Cart ❐ Other:
❐ Neurostimulation Device Reprogramming ❐ Peripheral Nerve Stimulation ❐ Spinal Cord Stimulation		❐ Hospital/Hospital Surgery Center ❐ Accredited Surgery Center (nonhospital)* ❐ Nonaccredited Facility With Crash Cart ❐ Other:
❐ Nucleoplasty		❐ Hospital/Hospital Surgery Center ❐ Accredited Surgery Center (nonhospital)* ❐ Nonaccredited Facility With Crash Cart ❐ Other:
❐ Percutaneous Lumbar Discectomy		❐ Hospital/Hospital Surgery Center ❐ Accredited Surgery Center (nonhospital)* ❐ Nonaccredited Facility With Crash Cart ❐ Other:
❐ Vertebroplasty/Kyphoplasty		❐ Hospital/Hospital Surgery Center ❐ Accredited Surgery Center (nonhospital)* ❐ Nonaccredited Facility With Crash Cart ❐ Other:

SECTION I (Cont.) PROCEDURES AND SERVICES

Procedure	Estimated Number Performed Per Year	Location(s) Where Performed
❐ Other (specify):		❐ Hospital/Hospital Surgery Center ❐ Accredited Surgery Center (nonhospital)* ❐ Nonaccredited Facility With Crash Cart ❐ 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.

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)