SURGICARE OF BROOKLYN

(347) 599-2100
(347) 599-2633
313 43rd Street, Brooklyn, NY 11232

SCOB, LLC
Delineation of Privileges for Pain Management Services

Applicant Name: _____

Category: ☐ Initial Appointment ☐ Reappointment ☐ Other: _____

Procedure Name	Requested	Approved	Denied
Atlanto-Occipital Block			
Atlantoaxial Block			
Sphenopalatine Ganglion Block			
Greater and Lesser Occipital Nerve Block			
Gasserian Ganglion Block			
Trigeminal Nerve Block			
Auriculotemporal Nerve Block			
Greater Auricular Nerve Block			
Glossopharyngeal Nerve Block			
Cervical Section Nerve Root Block			
Facial Nerve Block			
Superficial Cervical Plexus Block			
Deep Cervical Plexus Block			
Superior Laryngeal Nerve Block			
Recurrent Laryngeal Nerve Block			
Stellate Ganglion Block			
Cervical Facet Block: Medial Branch Technique			
Cervical Facet Block: Intra-Anticular Technique			
Cervical Epidural Nerve Block			
Brachial Plexus Block			
Suprascapular Nerve Block			
Intravenous Regional Anesthesia			
Radial Nerve Block at the Humerus			
Median Cutaneous and Intercostobrachial Nerve Block			
Radial Nerve Block at the Elbow			
Median Nerve Block at the Elbow			
Ulnar Nerve Block at the Elbow			
Radial Nerve Block at the Wrist			
Median Nerve Block at the Wrist			
Ulnar Nerve Block at the Wrist			
Metacarpal and Digital Nerve Block			
Thoracic Epidural Nerve Block/Steroid/Neurolysis			
Thoracic Paravertebral Nerve Block			
Thoracic Facet Block: Medial Branch Technique			
Thoracic Facet Block: Intra-Articular Technique			

Procedure Name	Requested	Approved	Denied
Thoracic Sympathetic Ganglion Block			
Intercostal Nerve Block			
Interpleural Nerve Block: Percutaneous Technique			
Splanchnic Nerve Block			
Celiac Plexus Block			
Ilioinguinal Nerve Block			
Iliohypogastric Nerve Block			
Lumbar Sympathetic Ganglion Block			
Lumbar Paravertebral Nerve Block			
Lumbar Facet Block: Medial Branch Technique			
Lumbar Facet Block: Intra-Articular Technique			
Lumbar Epidural Nerve Block			
Lumbar Subarachnoid Nerve Block			
Caudal Epidural Nerve Block			
Sacral Nerve Block: Transsacral			
Genitofemoral Nerve Block			
Hypogastric Plexus Block			
Ganglion of Walther (Impar) Block			
Pudendal Nerve Block			
Lumbar Plexus Nerve Block			
Femoral Nerve Block			
Lateral Femoral Cutaneous Nerve Block			
Obturator Nerve Block			
Sciatic Nerve Block			
Tibial Nerve Block at the Knee			
Tibial Nerve Block at the Ankle			
Saphenous Nerve Block at the Knee			
Saphenous Nerve Block at the Ankle			
Common Peroneal Nerve Block at the Knee			
Deep Peroneal Nerve Block at the Ankle			
Superficial Peroneal Nerve Block at the Ankle			
Sural Nerve Block at the Ankle			
Metatarsal and Digital Nerve Block of the Foot			
Lysis of Epidural Adhesions: Racz Technique			
Cervical Subarachnoid Neurolytic Block			
Thoracic Subarachnoid Neurolytic Block			
Lumbar Subarachnoid Neurolytic Block			
Implantation of Subcutaneously Tunneled Epidural Catheter			
Spinal Cord Stimulation: Stage I Trial Stimulation			
Spinal Cord Stimulation: Stage II Pulse Generator			
Implantation/Receiver Antenna			
Implantation of Totally Implantable Reservoirs & Injection Ports			
Implantation of Totally Implantable Infusion Pumps			
Epiduroscopy			
Radiofrequency Lumbar			

Procedure Name	Requested	Approved	Denied
Radiofrequency Cervical			
Cryoablation			
Intradiscal Electrothermal Therapy			
Manipulation Under Anesthesia			
Kyphoplasty			
Discogram Cervical			
Discogram Lumbar			
Percutaneous Discectomy Cervical			
Percutaneous Discectomy Lumbar			
Trigger Point Injection			
Local Infiltration of Anesthesia			
C-Arm Fluoroscopy			
Radiologic Interpretation			
Manipulation Under Anesthesia			
Postoperative Pain Management			
Other:			

Provider Acknowledgement: I have requested privileges marked in the above list. I certify that I have training and experience in performing these procedures and have never been denied or have never relinquished (voluntary or involuntary) privileges to perform these procedures at other institutions. I attest that I do not have any health issues which could impact my ability to perform the privileges I requested.

Signature of Requesting Provider: _____ Date: _____

RECOMMENDATION: I have reviewed the applicant's request for Pain Management Services and recommend that the requested privileges be approved and granted.

Medical Director Signature: _____ Date: _____

Board of Directors Confirmation by: _____ Date: _____