PREFERRED PHYSICIANS MEDICAL RISK RETENTION GROUP
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QUESTIONNAIRE – PAIN MANAGEMENT

(PLEASE COMPLETE IF YOU HAVE A PAIN MANAGEMENT PRACTICE.)

PHYSICIAN'S NAME	POLICY #
CITY AND STATE	

PLEASE ANSWER THE FOLLOWING QUESTIONS RELATING TO YOUR PAIN MANAGEMENT PRACTICE.
PROVIDE NARRATIVE ANSWERS, WHERE NECESSARY, BY ATTACHMENTS.

PART I: PROCEDURES PERFORMED

A. PLEASE ESTIMATE THE ANNUAL NUMBER OF THE FOLLOWING

_____ NEUROLYTIC BLOCKS	_____ ACUPUNCTURE PATIENTS	_____ DRUG PUMP IMPLANTS
_____ EPIDURAL PAIN BLOCKS	_____ EXTERNAL PCA DEVICE PATIENTS	_____ ASSISTED BY A SURGEON
_____ OTHER BLOCKS, INJECTIONS	_____ SPINAL CORD STIMULATOR IMPLANTS	_____ PATIENT CONTROLLED
_____ CERVICAL	_____ ASSISTED BY A SURGEON	_____ FIXED FLOW
_____ TRANSFORAMINAL BLOCK	_____ CERVICAL IMPLANTS	_____ PROGRAMMABLE

B. ARE NEUROLYTIC BLOCKS DONE ON TERMINAL PATIENTS ONLY? ☐ YES ☐ NO
IF "NO", PLEASE INDICATE WHAT OTHER TYPES OF PATIENTS YOU FEEL ARE ELIGIBLE FOR NEUROLYTIC BLOCKS.
_____

C. WHAT PERCENTAGE OF YOUR PRACTICE IS NON-INVASIVE PAIN THERAPY? _____ %
IF APPLICABLE, PLEASE DESCRIBE (E.G. MEDICAL MANAGEMENT, DETOXIFICATION, PHYSICAL ACTIVITY, BIOFEEDBACK, ETC.).
_____

D. PLEASE LIST ANY OTHER PROCEDURES THAT YOU DO IN YOUR PAIN PRACTICE WHICH ARE NOT DESCRIBED ABOVE.
_____
_____

PART II: PROFESSIONAL TRAINING

A. HAVE YOU DONE A PAIN MANAGEMENT FELLOWSHIP? ☐ YES ☐ NO
IF "YES", INDICATE THE FACILITY AT WHICH YOUR TRAINING WAS RECEIVED AND THE DATES OF THAT TRAINING.
(PLEASE ATTACH COPIES OF CERTIFICATES OR DIPLOMAS. IF YOUR PRACTICE INCLUDES THE ADMINISTERING OF NEUROLYTIC BLOCKS, PLEASE BE CERTAIN THAT THE DOCUMENTATION INDICATES THAT TRAINING IN THIS AREA WAS RECEIVED.)

_____ FROM: _____ TO: _____
FACILITY MM/YYYY MM/YYYY

B. HAVE YOU COMPLETED A TRAINING COURSE APPLICABLE TO IMPLANTED STIMULATORS OR PUMPS THAT YOU MAY USE? ☐ YES ☐ NO
(PLEASE PROVIDE DOCUMENTATION OF THIS TRAINING.)

C. IF YOUR TRAINING INCLUDES NONE OF THE ABOVE, PLEASE PROVIDE US WITH A NARRATIVE DESCRIPTION OF YOUR QUALIFICATIONS TO PERFORM THOSE PROCEDURE DESCRIBED ABOVE. INCLUDE EXPERIENCE, ON THE JOB TRAINING, LENGTH OF TIME YOU HAVE PERFORMED THESE PROCEDURES AND ANY OTHER INFORMATION THAT WILL HELP US DETERMINE YOUR QUALIFICATIONS IN PAIN MANAGEMENT.

D. ARE YOU BOARD CERTIFIED IN ANESTHESIOLOGY? (IF "YES", PLEASE INDICATE CERTIFYING BOARD.) ☐ YES ☐ NO
☐ AMERICAN BOARD OF ANESTHESIOLOGY
☐ AMERICAN OSTEOPATHIC BOARD OF ANESTHESIOLOGY
☐ OTHER: _____

E. ARE YOU BOARD CERTIFIED IN PAIN MANAGEMENT? (IF "YES", PLEASE INDICATE CERTIFYING BOARD.) ☐ YES ☐ NO
☐ AMERICAN BOARD OF ANESTHESIOLOGY
ADDED QUALIFICATIONS IN PAIN MANAGEMENT
☐ AMERICAN BOARD OF PHYSICAL MEDICINE AND REHABILITATION
PAIN MEDICINE CERTIFICATE
☐ AMERICAN BOARD OF PSYCHIATRY AND NEUROLOGY
PAIN MEDICINE CERTIFICATE
☐ AMERICAN BOARD OF PAIN MEDICINE
☐ AMERICAN ACADEMY OF PAIN MANAGEMENT
☐ OTHER BOARD: _____

F. IF YOU ARE BOARD CERTIFIED IN ANY OTHER SPECIALTY, PLEASE DESCRIBE. _____

PART III: PATIENT BASE

A. WHAT PERCENTAGE OF YOUR PATIENTS ARE "SELF-REFERRED" (THOSE SEEKING TREATMENT FROM YOU WITHOUT BEING REFERRED BY ANOTHER PHYSICIAN)? _____ %

1. ARE COMPLETE PHYSICAL EXAMINATIONS GIVEN AND MEDICAL HISTORIES TAKEN CONSISTENT WITH CMS GUIDELINES? ☐ YES ☐ NO
2. ARE THESE SELF-REFERRED PATIENTS EVER PRESCRIBED NARCOTIC MEDICATIONS? ☐ YES ☐ NO

(PLEASE PROVIDE A COPY OF THE PAIN MANAGEMENT SERVICES NARCOTIC AGREEMENT)

B. IF PATIENTS ARE REFERRED BY ANOTHER PHYSICIAN, DO YOU REQUIRE THAT PHYSICIAN TO FURNISH THE PATIENT'S COMPLETE MEDICAL HISTORY TO YOU? ☐ YES ☐ NO

C. DO YOU USE TELEVISION, RADIO, NEWSPAPER OR YELLOW PAGES ADVERTISING TO SOLICIT PATIENTS? ☐ YES ☐ NO
(PLEASE ENCLOSE COPIES OF ANY PRINTED ADVERTISING MATERIALS USED TO PROMOTE YOUR PRACTICE.)

D. WHAT PERCENTAGE OF YOUR PATIENTS ARE TERMINALLY ILL PAIN PATIENTS? _____ %

E. WHAT PERCENTAGE OF YOUR PATIENTS ARE WORKERS' COMPENSATION INJURY CASES? _____ %

PART IV: PRACTICE ORGANIZATION

A. DO YOU PRACTICE AS PART OF A MULTI-SPECIALTY PAIN TREATMENT TEAM? ☐ YES ☐ NO

1. WHAT OTHER MEDICAL SPECIALISTS MAKE UP THE TEAM? _____
2. DO ALL THE SPECIALISTS PRACTICE AT THE SAME LOCATION? ☐ YES ☐ NO
3. WHO DETERMINES WHICH SPECIALIST WILL PRESCRIBE A TREATMENT PROGRAM? _____
4. WHAT IS THE PRACTICE RELATIONSHIP OF THE TEAM MEMBERS (FORMAL GROUP, INFORMAL ASSOCIATION, INDEPENDENT CONTRACTORS TO ANOTHER ENTITY, ETC.)? _____

B. DO YOU USE A SPECIFIC INFORMED CONSENT FOR PAIN MANAGEMENT? ☐ YES ☐ NO
IF "NO", PLEASE EXPLAIN HOW INFORMED CONSENT IS OBTAINED. _____

C. ARE YOU AFFILIATED WITH A HOSPITAL OR CLINIC AS RESPECTS YOUR PAIN MANAGEMENT PRACTICE? ☐ YES ☐ NO

1. WHAT HOSPITAL OR CLINIC? _____
2. DO YOU HAVE ADMITTING PRIVILEGES? ☐ YES ☐ NO
3. WHAT IS THE DISTANCE FROM YOUR PAIN PRACTICE LOCATION TO THE HOSPITAL? _____

D. IS THERE 24 HOUR COVERAGE FOR YOUR PAIN MANAGEMENT PRACTICE? ☐ YES ☐ NO
HOW ARE CALLS HANDLED AFTER OFFICE HOURS OR WHEN YOU ARE ON VACATION? _____

E. ARE CRNAS, PAS OR RNS USED IN YOUR PAIN MANAGEMENT PRACTICE? ☐ YES ☐ NO

1. ARE THEY YOUR EMPLOYEES? ☐ YES ☐ NO
IF NOT, DO YOU REQUIRE THAT THEY SUPPLY YOU WITH EVIDENCE OF MALPRACTICE INSURANCE COVERAGE WITH LIMITS AT LEAST EQUAL TO YOURS? ☐ YES ☐ NO
2. PLEASE DESCRIBE THE PROCEDURES THAT ARE PERFORMED BY THEM. ALSO DESCRIBE THEIR FORMAL AND INFORMAL TRAINING IN THE FIELD OF PAIN MANAGEMENT. _____
3. DO CRNAS, PAS OR RNS PERFORM ANY PAIN MANAGEMENT PROCEDURES UNSUPERVISED BY YOU OR WHILE YOU ARE PERFORMING YOUR OWN PROCEDURE? ☐ YES ☐ NO

F. PLEASE ENCLOSE COPIES OF ANY PUBLISHED ARTICLES ON PAIN MANAGEMENT THAT YOU HAVE AUTHORED, A COPY OF YOUR LETTERHEAD, AND ANY BROCHURES USED IN YOUR PAIN MANAGEMENT PRACTICE.

G. PLEASE PROVIDE # OF CME PAIN CREDITS EARNED IN PREVIOUS 12 MONTHS: _____

_____ SIGNATURE

_____ DATE