Professional SOLUTIONS | INSURANCE COMPANY

Pain Management Supplemental Application

Please remember to attach a copy of the following:

- Any policies noted in Section B
- Job descriptions for physician extenders
- Continuing Medical Education information
- Pre-surgical checklists and guidelines

A. APPLICANT INFORMATION

Name: _____
First Name Middle Last Name

Name of employer: _____

PSIC policy number (If applicable): _____

B. PAIN MANAGEMENT INFORMATION

1. Do you have policies and/or procedures in place regarding Certified Registered Nurse Anesthetist (CRNA), Physician Assistant (PA), and Nurse Practitioner (NP) utilization, including verification of current state licensure and national certification; physician supervision and practice guidelines? ❑Yes ❑No
2. Do CRNAs, Physician Assistants, or Nurse Practitioners/Advanced Practice Nurses perform interventional pain procedures and/or injections in the practice? ❑Yes ❑No
3. Do you use only physicians who are Board eligible/certified or fellowship trained in Pain Medicine to perform and/or supervise interventional procedures? ❑Yes ❑No
4. Do you use only practitioners (physicians, CRNAs, PAs, NPs) who maintain the minimum annual requirements for Continuing Medical Education (CME) in Pain Medicine? ❑Yes ❑No

   Do the practitioners you use hold any certifications other than ABA Board Certification in Pain Medicine? ❑Yes ❑No
5. Do your clinicians provide new patient consultations, evaluations and management, and maintain the pain management of pain patients? ❑Yes ❑No
6. Do you document a SOAP note to support prescribed Pain Management medications? ❑Yes ❑No
7. Do you have written policies for coverage of after-hours calls? ❑Yes ❑No
8. Do you have written policies for the documentation of recovery for sedated patients in an outpatient setting and/or clinic? ❑Yes ❑No
9. Do you use pre-surgical procedure checklists and guidelines for outpatient procedure suites? ❑Yes ❑No

   If yes, do the checklists and/or guidelines include the following? (Check all that apply.):

   ❑Procedural consent
   ❑NPO Guidelines
   ❑Anticoagulation Guidelines
   ❑Transportation Guidelines
   ❑Time out procedures
10. Do you have written policies for the administration of conscious sedation in outpatient settings/clinics (if applicable)? ❑Yes ❑No

    If yes, do the checklists and/or guidelines include the following? (Check all that apply.):

    ❑Availability of emergency response team, or certification in ACLS, ATLS, PALS of a licensed nurse or MD other than the proceduralist

B. PAIN MANAGEMENT INFORMATION (continued)

❑Availability of licensed nurse or MD to monitor patient and administer sedation other than the proceduralist

❑Accountability of controlled substances

❑Availability of standard ASA monitoring and resuscitation code cart

11. Do you have written policies for medical device maintenance? ..... ❑Yes ❑No

Do you have an annual biomedical check of medical equipment? ..... ❑Yes ❑No

12. Please check all procedures you perform by indicating the number per month:

____Peripheral Nerve Block

____Superficial head and neck blocks

____Paravertebral injections

____Interlaminar Spinal and Epidural Injections of the Lumbar or Thoracic Spine

____Fluoroscopic or computerized tomographic (CT) imaging for needle guidance about the spine or joints

____Transforaminal epidural injections (lumbar, thoracic, or cervical)

____Deep head and neck blocks (trigeminal blocks, stellate ganglion blocks, cervical epidural blocks)

____Facet injections or medial branch blocks (lumbar, thoracic, cervical)

____Sacroiliac joint or lateral branch blocks

____Visceral sympathetic blocks (celiac plexus blocks, splanchnic blocks, superior hypogastric plexus blocks, ganglion impar blocks)

____Lumbar sympathetic blocks

____Lumbar discography or intradiscal electrothermal therapy

____Cervical or thoracic discography

____Neuroablative procedures (cryo, radiofrequency, chemical)

____Spinal cord stimulator trial or implantation

____Intrathecal drug delivery device trial or implantation

____Minimally invasive lumbar decompression

C. SIGNATURE REQUIRED

DO NOT CANCEL YOUR CURRENT INSURANCE POLICY UNTIL A BINDER OR POLICY HAS BEEN RECEIVED AND IS IN EFFECT FROM PROFESSIONAL SOLUTIONS.

By signing this application, I certify and attest that the statements, information, and answers provided herein are true and accurate. I understand that Professional Solutions Insurance Company (PSIC) shall rely upon the statements, information, and answers provided on this application to determine whether to accept this application for insurance and, if the application is accepted, to determine at what rate to insure.

I understand that the insurance for which I have applied is not in effect unless and until this application is accepted by PSIC and I am notified by the company of said acceptance.

I further acknowledge that, as a condition precedent to my acceptance, a detailed inquiry and investigation of my professional background, competence and qualifications may be conducted by PSIC. In consideration of the foregoing, I hereby expressly consent to any such inquiry and investigation through the use of any means legally available to PSIC, and I expressly release and discharge the company from any and all liability that might otherwise be incurred as a result of acts performed in connection with any inquiry or investigation as well as in the evaluation of information so received from whatever source.

I further expressly authorize all individuals and entities to whom legal inquiry is made by PSIC to provide the company with all information and/or documentation within their possession or under their control that pertains to my professional background, competence and qualifications, and I hereby release the providers of such information or documentation from all legal liabilities that might otherwise be incurred in connection herewith.

I agree to notify PSIC of any changes in my practice of medicine within thirty (30) days of its occurrence, including but not limited to:

- Any changes in the professional services provided by me or someone for whom I am legally responsible;
- Any changes in my profession as described in any declarations issued as a result of this application;
- Any change in the location of my practice;
- Any investigation, restriction, suspension or surrender of a state medical license, DEA license or any hospital privileges;
- Any mental or physical condition, including treatment for alcohol or substance abuse;
- Any conviction, plea or agreement related to charges of a misdemeanor or a felony (other than a minor traffic offense).

C. SIGNATURE REQUIRED (continued)

Important Reminder: If the coverage for which you are applying is written on a CLAIMS MADE basis, only claims first made against you and reported to the company during the policy period are covered, subject to policy provisions. If you have any questions, please discuss them with your agent.

For residents of all states except Oklahoma:
Any person who knowingly and with intent to defraud any insurance company or other person, files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto or knowingly helps with intent to defraud, commits a fraudulent insurance act, which may be a crime and may subject the person to criminal and civil penalties.

Oklahoma residents: Warning: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing false, incomplete or misleading information is guilty of a felony.

Signature of Applicant	Date
Signature of Agent	Date

D. ADDITIONAL INFORMATION

IF ADDITIONAL SPACE IS NEEDED, ATTACH ANOTHER PAGE.

Professional SOLUTIONS | INSURANCE COMPANY

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Clive, Iowa 50325-8258

Questions:
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