PHYSICIANS' RECIPROCAL INSURERS
CHRONIC PAIN MANAGEMENT ADDENDUM

DO YOU PERFORM ANY OF THE FOLLOWING PROCEDURES?

					# of Procedures Done Annually
1.	**Epidural Injections**				
	a.	Cervical	Yes ☐	No ☐	_____
	b.	Thoracic	Yes ☐	No ☐	_____
	c.	Lumbar	Yes ☐	No ☐	_____
	d.	Caudal	Yes ☐	No ☐	_____
	e.	Selective nerve root block (transforaminal)	Yes ☐	No ☐	_____
2.	**Facet Injections**				
	a.	Cervical	Yes ☐	No ☐	_____
	b.	Lumbar	Yes ☐	No ☐	_____
3.	**Joint Injections**				
	a.	Sacroiliac	Yes ☐	No ☐	_____
	b.	Gleno-humeral	Yes ☐	No ☐	_____
	c.	Knee	Yes ☐	No ☐	_____
	d.	Hip	Yes ☐	No ☐	_____
		If yes, explain _____			
		_____			
4.	**Celiac Plexus Blocks**		Yes ☐	No ☐	_____
5.	**Spinal Endoscopy**				
	a.	Percutaneous laser discectomy	Yes ☐	No ☐	_____
	b.	Epiduroscopy	Yes ☐	No ☐	_____
	c.	Intradiscal electrothermal treatment (IDET)	Yes ☐	No ☐	_____
	d.	Racz catheter epidurolysis	Yes ☐	No ☐	_____
6.	**Neurolysis Procedures**				
	a.	Radiofrequency	Yes ☐	No ☐	_____
	b.	Cryoablation	Yes ☐	No ☐	_____
	c.	Intrathecal neurolytic solutions	Yes ☐	No ☐	_____
	d.	Other (Please specify below)	Yes ☐	No ☐	
		_____			_____
		_____			_____
7.	**Insertion of spinal cord stimulators**		Yes ☐	No ☐	_____
	a.	Do you go higher than vertebral level T4?	Yes ☐	No ☐	
	b.	Is placement verified with fluoroscopy?	Yes ☐	No ☐	
8.	**Insertion of epidural catheter for drug infusion**		Yes ☐	No ☐	_____
	(Do not include post-op epidural for acute pain management.)				
	a.	Do you go higher than vertebral level T4?	Yes ☐	No ☐	
	b.	Is placement verified with fluoroscopy?	Yes ☐	No ☐	
9.	**Insertion of intrathecal catheter for drug infusion**		Yes ☐	No ☐	_____
	a.	Do you insert the catheter at a level higher than vertebral level L2?	Yes ☐	No ☐	
	b.	Is placement verified by flouroscopy?	Yes ☐	No ☐	
10.	**Minimally invasive lumbar decompression (M.I.L.D.)?**		Yes ☐	No ☐	_____
11.	**Kyphoplasty?**		Yes ☐	No ☐	_____

12. **Are you prescribing opiate analgesics?** Yes ☐ No ☐

a. If yes, are you contacting the primary physician to learn about drug habits? Yes ☐ No ☐

b. Do you discuss with the patient and document in the patient's chart, the conditions and limitations under which opiates will be prescribed? Yes ☐ No ☐

c. Do you require the patient to sign a document specifying the conditions and limitations under which opiates will be prescribed? Yes ☐ No ☐

13. **What new techniques do you now use which you did not use 3 years ago?**

_____
_____

14. **Are you certified in Pain Medicine?** Yes ☐ No ☐

a. By the ABA? Yes ☐ No ☐

b. By the American Board of Pain Medicine? Yes ☐ No ☐

c. Other? (Please specify below) Yes ☐ No ☐

_____
_____

15. **Any other pain procedures?** Yes ☐ No ☐

If yes, please list below:

_____
_____
_____
_____

16. **Please list any training and fellowship programs.**

_____
_____
_____
_____

17. **Please list any hospitals/surgi-centers that you are credentialed to perform these procedures.**

_____
_____
_____
_____

18. **What percentage of your practice is devoted to chronic pain management?** _____

_____
Signature

_____ _____
Date Policy Number