MIEC

6250 Claremont Avenue • Oakland, California 94618-1324 • Phone: 510-428-9411 • Toll Free: 800-227-4527 • Fax: 510-654-4634 • www.miec.com

SUPPLEMENTAL KERATOREFRACTIVE PROCEDURE QUESTIONNAIRE

MIEC requires special underwriting review of physicians requesting coverage for the performance of keratorefractive surgical procedures. Please answer all questions and attach a copy of your protocol, if available. **Please complete a separate questionnaire for each keratorefractive surgical procedure you perform.**

NAME OF PROCEDURE:_____

Training and Experience

1. What training did you receive in the performance of this procedure? Please include residencies, fellowships, preceptorships and other hands-on training. (Continue on Continuation Page, if necessary.)

COURSE/PROGRAM TITLE	_____	_____	_____
DATES	_____	_____	_____
LOCATION	_____	_____	_____
SPONSOR	_____	_____	_____
INSTRUCTOR	_____	_____	_____

2. During your training, how many cases did you:

	Live	Human Cadaver Eyes
a. Observe?	_____	_____
b. Assist?	_____	_____
c. Perform?	_____	_____

3. How many procedures have you performed as primary surgeon (rough estimates are acceptable):
   a. Since completion of your training? _____
   b. In the past 12 months? _____
   c. Anticipated for the next 12 months? _____

4. If you have no experience as primary surgeon for this procedure, do you intend to be proctored for your first several cases? ❑ Yes ❑ No

Patient Selection

5. Please outline your patient criteria:

   a. Age: Minimum_____ Maximum_____

   b. Degree of astigmatism:

	Minimum	Maximum
for RK alone	_____	_____
for RK w/AK	_____	_____
for AK alone	_____	_____
for other procedure(s)	_____	_____

   c. Degree of myopia: Minimum_____ Maximum_____

   d. Refractions must be stable for _____ months

   Note: If refractive stability is considered, for what length of time must patients be contact lens free prior to exams:

   Soft lenses:_____ Gas permeable lenses:_____ Hard lenses:_____

   e. Patient motivation/expectations:_____

   f. Contraindications:_____

   g. Other:_____

6. List all exams you routinely perform pre-operatively when evaluating a patient's eligibility for undergoing this procedure and the acceptable findings for each with respect to candidates for the procedure. (Continue on Continuation Page, if necessary.)

Exam	Acceptable Findings
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Informed Consent

7. Explain, in detail, your informed consent procedures. Indicate who conducts the consent discussion and how, when and where consent is obtained. Also submit a copy of your informational video, if any, your patient education literature, and your consent form for this procedure. (Continue on Continuation Page, if necessary.)

8. Do you write a note in the patient's medical record that the risks, benefits and alternatives were discussed? ❑ Yes ❑ No

9. Do you offer each patient a copy of the consent form? ❑ Yes ❑ No

Operative Procedures and Location

10. Where do you perform these procedures?

11. Do your hospital staff privileges extend to the performance of this procedure? ❑ Yes ❑ No
If yes, at which hospitals?

12. Please explain your operative procedures, including guidelines for anesthetic agents, optical zone size, depth and number of incisions, and technique followed. Include a sample of your operative report. (Continue on Continuation Page, if necessary.)

13. What is the minimum time interval you require between treatment of the first and second eyes? _____

Operative Procedures and Location, cont'd.

14. Provide information regarding any other employees that may be working at the office surgery suite, i.e., surgical techs. Describe their duties and responsibilities.

15. Provide the names of all physicians who will be using the office surgical suite and a certificate of insurance as evidence of professional liability insurance carried by each.

16. Provide details regarding compliance with any federal, state, or local licensing laws governing the use of an office surgery suite.

17. Provide details regarding the hospital or surgery facility's quality control or review requirements. If procedure is performed in an office surgery suite, will a review committee monitor adherence to the protocol and results of procedure(s)? Provide names and specialties of each committee member, frequency of committee meetings and a copy of bylaws or guidelines describing formation, utilization, and continuation of committee's activities.

Post Operative Care

18. Who renders the postoperative care?_____

19. What postoperative instructions are provided to the patient?_____

20. What medications are routinely prescribed postoperatively?_____

21. At what frequency do postoperative visits occur?_____

22. What exams are routinely performed during postoperative visits?_____

Advertising

23. Do you advertise your availability to perform this procedure? ❑ Yes ❑ No

If yes, submit a copy of your advertisement (print or video). Forward to us any new advertisements or changes in your advertisements as they occur.

_____ _____

Signature of Applicant *Date*

_____

Name (Type or Print)

Continuation Page