Physician's Name: ______________________________

Pain Management Supplemental Application

Section I — General Information

		Yes	% of Practice	No
1.	Have you registered with the NJ Prescription Monitoring Program (NJPMP)?	☐		☐
2.	Do you treat patients for pain?	☐		☐
a.	Acute Pain – Narcotics/CDS? (i.e. ≤ 3 months)	☐		☐
b.	Chronic Pain – Narcotics/CDS? (i.e.> 3 months)	☐	____%	☐
c.	Interventional Pain Procedures?	☐	____%	☐
d.	Other?	☐	____%	☐

____

____

IF YOU **DO NOT** TREAT PATIENTS FOR PAIN OR IF YOU ONLY TREAT PATIENTS FOR ACUTE PAIN (< 3 months)
GO TO THE LAST PAGE TO SIGN AND DATE APPLICATION
IF YOU TREAT PATIENTS FOR CHRONIC PAIN (> 3 months), **YOU MUST COMPLETE THIS APPLICATION.**

Section II — Pain Management – Narcotics

Complete this section only if you prescribe medications for chronic pain and/or drug detoxification, otherwise continue to Section III.

		Yes	No
3.	Are you aware of the NJ BME regulations for prescribing controlled substances?	☐	☐

For your reference, they include the following components:

a. Initial exam and pain assessment with differential diagnosis and identification of comorbid conditions
b. Risk assessment for substance abuse disorders
c. Treatment goals
d. Review of treatment plan & progress towards goals at least every 3 months
e. For Schedule II controlled substances, limit the supply not to exceed a 30 days (or 120 dosage units) or 90 days for infusion pumps

As a Conventus member, if you would like assistance in developing tools &/or documentation templates to assist in meeting these regulatory requirements, **the direct link to our Pain Management Resources is** **http://www.conventusnj.com/members/tools/pain-management-resources/**

		Yes	No
4.	Do you utilize the following documents when prescribing:		
a.	Informed Consent/Patient Agreement for CDS	☐	☐
b.	Other: ______________________	☐	☐

(If "Yes" to any of the above, please attach a copy.)

As a Conventus member, if you would like samples of any of these documents, **the direct link to our Pain Management Resources is** **http://www.conventusnj.com/members/tools/pain-management-resources/**

		Yes	No
5.	If you are NOT a pain management specialist, do you refer patients to a pain management specialist when treatment objectives are not met?	☐	☐

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6. Do you Prescribe: **Yes** **No**

a. Suboxone? ☐ ☐

b. Methadone? ☐ ☐

c. Medications for Drug Detoxification? ☐ ☐

If "Yes" to any of the above, please explain your training in managing these patients:

____

____

7. Are you registered to prescribe in NJ's Medicinal Marijuana program? **Yes** ☐ **No** ☐

a. If Yes, as a Conventus member, if you would like a copy of the NJ Board of Medical Examiners regulations on the "Compassionate Use of Medical Marijuana?" (NJAC 13.35-7A.1) **the direct link to our Pain Management Resources is** **http://www.conventusnj.com/members/tools/pain-management-resources/**

8. As a Conventus Member, would you like to take a FREE CME Course on prescribing controlled substances? **Yes** ☐ **No** ☐

If yes, **the direct link to our Pain Management Resources is** **http://www.conventusnj.com/members/tools/pain-management-resources/**

Section III **Interventional Pain Management**

Complete this section only if you perform Interventional procedures including trigger point injections, otherwise skip to the last page to sign and date.

9. Have you completed an ACGME or AOA accredited residency or fellowship that included formal training in Pain Management or Musculoskeletal Medicine? **Yes** ☐ **No** ☐

a. If yes, where did you receive your training? ________________________

Completion Date? ________________________

Describe procedures/treatments performed ________________________

____

____

Number of months of pain management training________________________

b. If No, describe your training in chronic pain management and/or interventional procedures. Include each type and number of procedures in which you were supervised. **Please attach a copy of any training certification(s).**

____

____

10. Are you Board Certified in Pain Management or Board Qualified to sit for the Sub-Specialty board exam in pain management? **Yes** ☐ **No** ☐

a. ABA ☐ ☐

b. ABPM ☐ ☐

c. ABPMR ☐ ☐

d. Other: ________________________ ☐ ☐

11. If you are Board Qualified, when do you plan on taking the Exam?

a. Target Date: ________________________

b. Identify which Board: ________________________

12. Check all Interventional Procedures you perform:

	Yes	No	# of Annual Procedures		Yes	No	# of Annual Procedures
Intervertebral Procedures (Total)	☐	☐		Acupuncture	☐	☐	
Cervical	☐	☐		Hypnosis	☐	☐	
Thoracic	☐	☐		Epidural Interlaminar &/or Transforaminal Injections (Total)	☐	☐	
Lumbar	☐	☐		Cervical	☐	☐	
IDET	☐	☐		Thoracic	☐	☐	
Annuloplasty/Biacuplasty	☐	☐		Lumbar	☐	☐	
Percutaneous Vertebral Discectomy	☐	☐		Nerve Root Injections	☐	☐	
Discography (Total)	☐	☐		Facet Injection (Total)	☐	☐	
Cervical	☐	☐		Cervical	☐	☐	
Thoracic	☐	☐		Thoracic	☐	☐	
Lumbar	☐	☐		Lumbar	☐	☐	
Sympathetic Nerve Block (Total)	☐	☐		Radio frequency Ablation (RFA) (Total)	☐	☐	
Celiac Plexus	☐	☐		Cervical	☐	☐	
Cervical Plexus	☐	☐		Thoracic	☐	☐	
Lumbar	☐	☐		Lumbar	☐	☐	
Sacral Plexus	☐	☐		Peripheral Nerve Blocks (Total)	☐	☐	
Cervical Paravertebral	☐	☐		Joint Injections	☐	☐	
Neuromodulation (Total)	☐	☐		Bursa Injections	☐	☐	
Spinal Cord Stimulation	☐	☐		Trigger Point Injections (Total)	☐	☐	
Peripheral Nerve Stimulation	☐	☐		Cervical	☐	☐	
Sacral Root Stimulation	☐	☐		Botox Injections	☐	☐	
Vertebral Interventions (Total)	☐	☐		**Others:**	☐	☐	
Percutaneous Vertebroplasty	☐	☐			☐	☐	
Balloon Kyphoplasty	☐	☐			☐	☐	
	☐	☐			☐	☐	
	☐	☐			☐	☐	

13. Are there any interventional procedures for which you do NOT use Fluoroscopy? **Yes** ☐ **No** ☐

____

____

____

14. During stimulator or catheter insertion, do you:

	Yes	No
a. Go higher than T4 for spinal stimulator and epidural catheter for drug infusion?	☐	☐
b. Go higher than L2 for intrathecal catheter drug infusion?	☐	☐
c. Verify placement with Fluoroscopy?	☐	☐

15. Do you perform interventional pain procedures in the following locations? **Yes** **No**

a. Office ☐ ☐

i. List Procedures: ______________________________

____

____

Yes **No**

b. One Room Surgical Suite ☐ ☐

Facility Name: ______________________________

Address: ______________________________

i. List Procedures:

____

____

____

c. Accredited by: ______________________________

Yes **No**

d. Ambulatory Surgery Center ☐ ☐

Facility Name: ______________________________

Address: ______________________________

Accredited by: ______________________________

Yes **No**

e. Hospital ☐ ☐

f. Other: ☐ ☐

Explain:

____

____

____

16. What new techniques do you now perform that you did not do 2 years ago? **Please attach a copy of any training certification(s).**

____

____

____

Name/Title: ______________________________

Please Print

Signature: ______________________ Date: ______________________

Notice to New Jersey Applicants: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceal for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.