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Re: CRNAs and Interventional Pain Management

Honorable Secretary Sebelius and Acting Administrator Tavenner:

On behalf of the Board of Directors and the entire membership of American Society of Interventional Pain Physicians (ASIPP), we would like to thank you for your help and so much interest in health care issues and preserving access to all Americans.

Recently we have come across your correspondence with AANA and we are extremely concerned about this issue. Consequently we are writing for your help to avoid the disastrous changes.

ASIPP is a not-for-profit professional organization comprised of over 4,500 interventional pain physicians and other practitioners who are dedicated to ensuring safe, appropriate, and equal access to essential pain management services for patients across the country suffering with chronic and acute pain. There are approximately 7,000 appropriately trained and qualified physicians practicing interventional pain management in the United States.

Interventional pain management is defined as the discipline of medicine devoted to the diagnosis and treatment of pain related disorders principally with the application of interventional techniques in managing sub acute, chronic, persistent, and intractable pain, independently or in conjunction with other modalities of treatment.¹

¹ The National Uniform Claims Committee. Specialty Designation for Interventional Pain Management- 09.  
Interventional pain management techniques are minimally invasive procedures, including percutaneous precision needle placement, with placement of drugs in targeted areas or ablation of targeted nerves; and some surgical techniques such as laser or endoscopic diskectomy, intrathecal infusion pumps and spinal cord stimulators, for the diagnosis and management of chronic, persistent or intractable pain.  

Social Security Act

Section 1861 of the Social Security Act defines services of a Certified Registered Nurse Anesthetist (CRNA) to mean "anesthesia services and related care furnished by a certified registered nurse anesthetist, which the nurse anesthetist is legally authorized to perform as such by the State in which the services are furnished".  

MedPAC has defined Interventional pain management techniques as including minimally invasive procedures including, percutaneous precision needle placement, with placement of drugs in targeted areas or destruction of targeted nerves; and also surgical techniques such as laser or endoscopic diskectomy, percutaneous lumbar decompression and surgically implanted devices such as intrathecal infusion pumps and spinal cord stimulators, for the diagnosis and management of chronic, persistent or intractable pain. Interventional pain management is a minimally invasive specialty with maximum risks, even in qualified and experienced hands.  

CRNAs are trained to anesthetize a patient for surgery. IPM involves a clinic based approach to improve function and quality of life for a patient who suffers from a chronic condition. Most IPM practices are referral based, i.e., patients are sent for specialist consultation by other physicians for care that is beyond the scope of the referring physicians medical practice. A consultation requires a thorough musculoskeletal, neurological, physiological and psychological evaluation. Diagnostic studies must be ordered and interpreted when indicated. The treating physician often must prescribe complex medication management and coordinate long term physical therapy, oncology, rehabilitation, surgical consultations and psychology service. Complex procedures and surgeries may be performed. Complication management and follow-up care provided. All of these services must be provided and represents the quintessential definition of the practice of medicine. All aspects of this care lies fully outside the scope of perioperative "related care" as defined in the Social Security Act.  

CRNAs are now seeking an unprecedented expansion of their scope of practice to diagnose complex medical conditions, order expensive diagnostic testing, provide unsupervised treatments and to perform complicated and dangerous procedures and surgeries for which they have had no formal training or certification.  

Historical Perspective

Chronic pain management has become a field of immense complexity and - perhaps justifiably - is under intense regulatory scrutiny. Twenty years ago pain management was largely the province of anesthesiologists who performed simple "blind" spinal injections in the hospital as a side-line service while providing anesthetic services. More complicated interventional procedures such as spinal cord stimulation (a spinal implant to control pain) was usually performed by a select group of neurosurgeons.  

Opioid analgesics were used infrequently and with great caution. Board certification in pain management for physicians was not established.

Much has changed. In 2011 the Centers for Disease Control (CDC) released a policy impact statement characterizing prescription painkiller overdose deaths as a growing, deadly epidemic (CDC 2011). The report noted that overdose death rates in the U.S. had more than tripled since 1990. Opioid pain relievers (OPRs) were present in 74% (14,800 of 20,044) of the prescription drug overdose deaths that occurred in 2008, more than cocaine and heroin combined (CDC 2011). Prescription opioid analgesics have become among the most prescribed of all medications in the US and are now considered to be the leading public health problem in the country. The majority of pain prescriptions are written by primary care practitioners including nurse practitioners (Volkow et al. 2011).

In response to its findings, CDC issued recommendations aimed primarily at stricter state control of prescription drugs, including patient review and restriction programs and health care provider accountability. For health care providers, education regarding appropriate prescribing for acute and chronic pain, and recognizing when to refer to a Pain Management Physician are recommended by the Food and Drug Administration (FDA) and Drug Enforcement Agency (DEA). Initiatives for formal CME requirements for prescribing even by physicians are under consideration by legislative and regulatory bodies. IPM procedures such as infusing opioid analgesics through implanted devices may offer another approach for reducing dependence ad limiting pain pill abuse and diversion.

At the same time, a stampede of practitioners has entered into the field of Interventional Pain Management (IPM). Untrained practitioners have disproportionately contributed to an explosion in utilization of IPM procedures. For example, the rate of increase for facet injections (2002 – 2006) performed in the Medicare population was reported at 100% annually for CRNAs (and nurse practitioners). The use of fluoroscopy to guide these injections (a skill not taught in CRNA curricula but a mandatory requirement for safe and efficacious performance) was less than 19% in the general practitioner and nurse group while near 90% in the IPM group. At the same time the OIG reports an error rate (procedures that did not meet Medicare reporting requirements) were an astounding 100% for the nursing group but less than 12% for IPM Doctors. It should not be a surprise then that facet injections, imaging guidance and other IPM techniques are not part of CRNA anesthesia training.

For all of these reasons, many states have now enacted legislation that requires any Pain Management Facility to be operated only by a Physician and treatment rendered by physicians who are Board certified in their primary specialty and also board certified in Pain Management. The usual 12 years or more of education and training is no longer adequate in these states – additional specific IPM post residency fellowship training and/or approved board certification requiring 1-3 years is necessary. No such training occurs in the two years of post college education limited to anesthesia techniques received by CRNAs.

Many insurance companies also require that a physician be board certified in pain management (IPM) to be reimbursed for performing these procedures. As incongruous as this seems, CRNAs - with two years of nursing anesthesia training and no training at all in clinic based medicine or IPM procedures - are demanding to be paid precisely the same as board certified IPM doctors for procedures that are disallowed by many national insurance companies if performed by board certified anesthesiologists who do not have additional board certification in pain management.

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3 http://www.cdc.gov/homeandrecreational/safety/rxbrief/


Assessing the need

The CRNA groups requesting independent medical privileging to diagnose and treat these complex disease states frame their argument in terms of patient access and reduction in costs. Both arguments are patently specious. Payors, including Medicare and Medicaid, pay CRNAs in most practice settings precisely the same amount as doctors. No cost savings are possible and over utilization in this group appear rampant. CRNA advocacy groups quote recent findings of the Institute of Medicine (IOM) to support access issues. This is a gross misstatement of the findings and inconsistent with all available data. While chronic pain is a pervasive and costly societal burden, access to spinal injections and complex interventional procedures is not lacking except as limited by payor denials. The need as articulated by the IOM is for patient education and conservative management.  

The plan should:

• heighten awareness about pain and its health consequences;
• emphasize the prevention of pain;
• improve pain assessment and management in the delivery of healthcare and financing programs of the federal government;
• use public health communication strategies to inform patients on how to manage their own pain; and
• address disparities in the experience of pain among subgroups of Americans.

We agree with this approach. In fact, while CRNA's have no training in clinic based medicine, other advance nurse practitioners do and we support their earnest and admirable efforts to relieve suffering consistent with the fundamental and historical goals of nursing. Primary care education for practitioners to identify and refer patients to tertiary centers for complex procedures is a well-studied and effective model of health care delivery. Proliferation of procedure driven centers does not accomplish this goal and exacerbates the problems of over utilization. Moreover, the opportunity to provide clinic based evaluative and management care to suffering patients by nurse practitioners is already an acknowledged and covered service and is reimbursed identically as for physicians within most payor systems and practice arrangements.

Education, certification and outcomes

CRNA curricula do not include training in chronic pain management. In fact, unlike other fields of advanced nurse training, clinic based chronic patient care is not required or offered. Some CRNAs receive instruction in "blind" regional anesthetic techniques such as obstetric epidurals. This is unrelated to procedures for chronic pain. CRNAs receive no training on indications, pathophysiology, physical examination, psychological and medical management, rehabilitation, vocational management, anatomical and radiographic diagnosis, MRI interpretation, CT, ultrasound and fluoroscopic guidance - all of which are required to practice Pain Medicine and are an integral part of all interventional pain fellowships and board examinations.

Unlike physicians, there are no required board certifications or accreditation programs in IPM for nurse anesthetists and other non-physicians. Many Boards of Nursing have taken the position that if a CRNA

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wants to start practicing Interventional Pain Medicine and performing these procedures then it is OK to do so and it is the responsibility of the CRNA to determine his or her own competency. Virtually all experience and documentation of competency is gained through participation in for-profit workshops and on-the-job observation and proctoring.

In this context, it is useful to examine a typical interventional pain procedure such as spinal cord stimulation (SCS). This is a procedure that involves almost exactly the same level of diagnostic skills medical judgment and surgical acumen as exercised by an interventional cardiologist or cardiovascular surgeon performing pace maker implantation. First, the physician must diagnose the condition based on careful; history taking and physical examination. Complex diagnostic studies must be performed and interpreted. Alternative therapies must be investigated and offered. Medication trials are usually pursued and evaluated for efficacy prior to moving towards surgery. Psychological factors are evaluated and treated. Once surgical implantation has been decided the patient is brought to an operating room and placed under anesthesia by an anesthesia provider. Leads are placed directly into the spinal column through a surgical incision and introducer under fluoroscopic guidance to avoid severe neurological damage of the spinal cord. Just as a cardiovascular surgeon would place cardiac leads precise positioning is critical. Likewise, testing is performed similar to testing pacemaker function. Subsequently, a surgical pocket is fashioned and leads are tunneled from one part of the body to another and connected to a generator and retested. Hemostasis is achieved using electrocautery, incisions are then closed surgically and the patient managed post-operatively for complications.

There is no aspect of the above vignette, although typical in daily practice for an IPM doctor that is consistent with CRNA scope of practice - any more than placing a pacemaker or defibrillator.

The art of Medicine is defined by two pillars of clinical practice:

1. Diagnosis: figuring out what is wrong with the patient, and
2. Treatment: deciding what to do for the patient, and then carrying out the plan.

While legal definitions vary somewhat from state to state, correctly diagnosing what is wrong with a given patient then providing only necessary and appropriate treatment is the *sine qua non* of practicing medicine. The Federation of State Medical Boards (FSMB) recommends that every state’s medical practice act provide a definition of the “Practice of Medicine” and that the definition includes “rendering a determination of medical necessity or appropriateness of proposed treatment.”

The American Medical Association rightly introduced at the November 2006 House of Delegates meeting language included in Resolution 902 that, "state medical boards have full authority to regulate the practice of medicine by all persons within a state, notwithstanding claims to the contrary by boards of nursing, mid-level practitioners or other entities."

Public safety requires that interventional pain management in statute and regulation is clearly recognized as the practice of medicine and the interventional treatment of pain is provided only by well-qualified and well-trained physicians. Due to the complexities involved in the treatment of pain, pain medicine is recognized as a separate medical subspecialty by the American Board of Medical Specialties.

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Case Precedence

The inclusion of interventional pain management procedures in CRNA’s scope of practice was successfully challenged in Louisiana and affirmed by the courts. In Spine Diagnostics Center of Baton Rouge, Inc. v. Louisiana State Board of Nursing et al, the Appellate Court affirmed the trial court’s grant of a permanent injunction that limited the scope of practice for CRNAs by restricting them from performing Interventional Pain Management procedures. During the lengthy process these issues were fully examined after numerous national experts testified at trial and amicus briefs were filed by several entities from across the nation.

After reviewing all the evidence, the Supreme Court upheld the trial court’s decision that ensured pain management patients in Louisiana would receive the highest quality of care from licensed medical physicians. The ruling shows that the scope of practice issue and public health and welfare issues are inseparable.

Additionally, Noridian the Medicare Contractor for most of the Western United States issued an opinion on March 17, 2011, that leads to the conclusion that CRNAs cannot independently practice Interventional Pain Medicine. Noridian determined that since CRNAs are not trained in curriculums which teach assessment skills for chronic pain therapies, they do not possess the skills to assess and evaluate chronic pain.

ASIPP Position

The paramount responsibility of medical regulation is to ensure safety and efficacy for patients who seek care but may not understand the vast differences in training and skill among health care providers and medical treatments. The US medical education system and credentialing process seeks to ensure that even the least of physician providers possesses an acceptable level of competency and safety through an arduous course of extensive medical training, broad based patient care responsibilities, mentored specialty training, critical oral, written and hands-on specialty board certification as well as ongoing medical education and specialty re-certification.

Current requests by CRNAs to enter into the practice of medicine, specifically the complex field of Interventional Pain Medicine circumvents the goal of medical education, mentored specialty training and nationally validated competency certifications that are the underpinnings of our health care system.

ASIPP strongly objects to any consideration of CRNA’s request to practice outside the field of anesthesia services, specifically in the field of medicine defined as Interventional Pain Management.
Thank you again. If you need further information, please contact us.

Thank you,

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