A Call for State Action:
Establish the Qualifications Needed to Serve as a Pain Medicine Specialist

In the interest of improving access to high quality, team-based medical care for the 100 million patients in the U.S. who suffer from pain, the American Board of Pain Medicine ("ABPM") calls on state policymakers to adopt policies clarifying the qualifications needed to serve as pain medicine specialists.

About the ABPM and our Mission

The mission of the American Board of Pain Medicine (ABPM) is to serve the public by improving access to comprehensive, high quality pain care in the U.S. through a rigorous certification process for Pain Medicine physician specialists. Since 1992, ABPM has offered qualified candidates an eight-hour, comprehensive, psychometrically valid examination in the field of Pain Medicine. Certified ABPM Diplomates now number over 2,200 physicians. ABPM believes in an integrated approach to comprehensive pain care that includes demonstrated clinical experience and substantive expertise in the full spectrum of pain treatment therapies, including pharmacologic, psychological, interventional and complementary therapies. Successfully passing our examination demands that applicants demonstrate thorough knowledge in all areas of Pain Medicine, including but in no way limited to expertise in safe and appropriate prescribing of opioids, which are often over-prescribed by practitioners who do not understand the additional modalities of effective pain treatment or underprescribed by those who are uncomfortable in using opioids when they are indicated.

Introduction

Over the last decade, state policymakers have grappled with how to best address the public health crisis stemming from escalating incidence of opioid addiction, availability of illegal sources of Fentanyl, and diversion of prescription medications. Policies enacted by states, health insurers, and pharmacy benefit managers, to limit opioid medications, combined with hours spent on obtaining prior authorization for non-opioid care, have significant negative health consequences for pain patients. Failure to recognize diplomates of the American Board of Pain Medicine deprives patients and the medical community of a group of competent trained physicians who could help provide appropriate care to complicated chronic pain patients.

Impact on Pain Patients

Although New York is facing a surge in opioid overdoses and deaths from illicit use, patients with chronic pain who have benefited from safe, monitored use of prescribed opioids as an element of their pain treatment protocol, have often been deprived of effective care. ABPM's 2022 survey of pain medicine specialists highlights the plight of patients with pain and barriers to providing multidisciplinary pain care. According to the survey, 73% of pain medicine specialists report that many patients who were effectively managing their pain on a well-established opioid regimen, have been forced to taper their medications because of policies that limit the duration of opioid prescriptions or set a maximum dose of morphine milligram equivalents per day. As a result of these restrictions, patients are experiencing withdrawal, anxiety, depression and uncontrolled pain. Comprehensive patient care is additionally compromised by onerous prior authorization policies that delay, and in some instances prevent access to non-opioid treatment modalities. 82% of pain medicine specialists report that they have been required to submit a prior authorization for non-opioid pain care resulting in physicians, or their staff, spending hours a day on such requests.

As government and physician leaders in this public policy debate, we are challenged to devise a better system to provide more comprehensive, effective pain care to the enormous population of patients suffering from pain. Toward that goal, this paper shares the ABPM's perspectives on one under-examined aspect of this discussion: the need for states to define "pain medicine specialist" as they consider a wide range of regulatory responses aimed at curtailing inappropriate prescribing, addressing diversion, and improving the overall approach to caring for patients with pain. Some may question why this topic – who possesses the credentials necessary to act as a pain specialist – is relevant in this debate?

This brief will discuss the following question: As states consider a wide range of policies aimed at curbing the opioid epidemic, why is the topic of who is a pain medicine specialist relevant?

To answer this question fully, this Brief:

- Identifies underlying shortcomings within the health care system and medical education system that contribute to substandard pain care and aggravate the opioid abuse crisis
- Discusses state policy responses
- Identifies how access to specialty level pain care is critically important to achieving high quality, team-based care for the enormous population of Americans who suffer from chronic pain

- Provides specific policy recommendations for states to ensure appropriate credentialing for pain specialists

I. Current system-wide problems

A. General Problems

There is insufficient research to inform best medical practices to treat chronic pain. The current health care system's approach to treating pain often produces uneven, fragmented and poorly coordinated delivery of care. The result has been abuse of opioid analgesics, over-use of expensive procedures, and an unacceptably wide variation in the quality and breadth of pain care. These problems are documented in the 2011 Institute of Medicine report "Pain in America: A Blueprint for Transforming Prevention, Care, Education and Research," which details how access to high quality, cost-effective care continues to prove elusive for many of the 116 million-plus Americans who suffer from chronic pain.

Despite a decade of policy reforms since the 2011 report, the problems still exist. From our perspective, primary system-wide shortcomings include:

- Fragmented, poorly coordinated delivery of pain care services to many patients with chronic and/or acute pain;
- Failure to adopt a multi-disciplinary, team-based approach to chronic pain care;
- Financial incentives for non-experts to present themselves as "pain specialists" and to establish pain clinics;
- Insufficient training of primary care physician in how to most effectively treat pain, including when they should refer patients with complex pain problems to Pain Medicine specialists;
- Lack of broadly accepted evidence-based treatment protocols for various chronic pain syndromes
- Failure to establish comprehensive, coherent, and accredited graduate medical education programs in pain medicine, which would increase the supply of Pain Medicine specialists and establish more consistent training and qualifications within this field.

B. Severe Shortage of Specialty Level Pain Care

In ABPM's view, the current medical education system's approach to training physicians – primary care and specialists alike – contributes to the problems:

1. Inadequate training for all physicians in pain care
2. Producing insufficient numbers of Pain Medicine specialists to provide advanced-level care for patients with complex pain presentations.

The IOM report reflects that there is only one certified Pain Medicine specialist for every 33,000 people with pain. This severe shortage of pain medicine specialists impedes efforts to develop efficient, cost-effective health care delivery models for treating the vast population of patients with chronic pain. With the undersupply of competent pain medicine consultation options, primary care physicians often have difficulty referring patients with complex pain problems to specialists.

Simple solutions for complex problems are generally wrong. Pain clinics that only provided opioid analgesics proliferated, offering opioids not only to pain patients but to those addicted to opioids as well. Other centers were developed that did not provide opioids, but only provided various nerve block procedures. Attempts to address a complex chronic pain problem with a single therapy is bound to produce suboptimal results at best and injury to patients at worst. These clinics have often been owned and operated by clinicians who have not been formally trained in evaluating and treating chronic pain. The problems associated with these entities are well-documented and difficult to address. Because people suffering with pain are particularly vulnerable to claims of easy or quick relief, there is a special need to protect these patients. States are stepping in to address this problem with "truth in advertising" regulations and stricter qualifications for pain clinic operators.

C. Insufficient Training in Pain Care

There is wide agreement among state policymakers and physician organizations, including ABPM, regarding the need for enhanced education and more consistent clinical guidance to inform patient care. In our view, it is important that physicians and physician organizations play a lead role in addressing system-wide shortcomings that contribute to substandard pain care and aggravate the prescription drug abuse problem. Indeed, physician organizations are discussing how to enhance the curricula in medical education and graduate medical education systems to improve training for all physicians, as well as how to best develop and implement effective clinical pain treatment protocols for specific medical conditions.

The current system affords insufficient training for primary care physicians in how to treat pain most effectively. To address this education gap, over the past several years, states have developed prescribing protocols and continuing medical education (CME) requirements to address this problem. Other states have adopted the Federation of State Medical Board (FSMB) and the Center for Disease Control (CDC) prescribing guidelines.
Despite efforts by physician organizations to ensure that these policy responses will serve the intended goals to improve outcomes for patients with pain, unintended consequences include a chilling effect on well trained clinicians to appropriately prescribe opioids for fear of sanction.

D. Confusion Surrounding the Term "Pain Medicine Specialist"

Currently, the term "pain medicine specialist," is confusing for all health system stakeholders, including:

- Policymakers seeking to:
    a. Protect the public from unqualified practitioners,
    b. Regulate pain clinics and
    c. Establish opioid prescribing protocols
- Patients seeking specialty-level care
- Treating physicians looking for pain consultations to help manage patients' pain
- Hospitals and payers seeking to credential pain physician specialists

Why the confusion? Unlike other medical specialties (e.g., pediatrics, cardiology and emergency medicine), there are no independent residency training programs for the specialty of Pain

Medicine. To become Board-certified in Pain Medicine, a physician must complete an ACGME-accredited residency training program in a different primary medical specialty whose core training varies considerably, typically Anesthesiology, Neurology, Neurosurgery, Psychiatry, or Physical Medicine & Rehabilitation. After completing this residency program, a physician must complete either a one-year fellowship in Pain Medicine (through the American Board of Anesthesiology or another ABMS board) or provide proof of substantial training in pain medicine related-topics, and actively practice comprehensive Pain Medicine for a significant amount of time to demonstrate competence to qualify to apply for Board certification (through the ABPM). The physician must then successfully pass an examination offered by either ABPM or an ABMS recognized Board.

The ABPM has endeavored for more than 20 years to be recognized by the American Board of Medical Specialties (ABMS) to endorse Pain Medicine as a primary medical specialty, which would include developing ACGME-accredited pain residency programs to provide four years of concentrated, comprehensive training in Pain Medicine. Currently, the ABMS's policies support Pain Medicine only as a subspecialty of other primary medical specialties, not as a primary and independent medical specialty. While the subspecialty pathway is appropriate and should be preserved, in our view, this approach does not fully meet the demands of this patient population.

II. State Efforts to Address Problems and ABPM Recommendations

A. Opioid Prescribing Protocols

We support state efforts to address these problems by encouraging best treatment practices for patients with pain and discouraging inappropriate or ineffective practices of some health care practitioners. For instance, several states have adopted medical practice guidelines for physicians and other health care providers to follow when prescribing opioid analgesics. These protocols typically include requirements for consultation or referral to Pain Medicine specialists as needed for patients with complex pain conditions. Suggestions to lower doses of opioids when possible have been helpful with many patients, however, many states have misinterpreted CDC guidelines as hard and fast rules, negatively impacting patient care and forcing patients who had been successfully treated with opioids to inappropriately lower or discontinue medication, with recorded cases of suicide because of patient despair.

The recent updates to the CDC's Clinical Guidance for Prescribing Opioids[1] and the FSMB's *Draft* Strategies for Prescribing Opioids for the Management[2] contain strategies and recommendations intended as helpful resources to provide overall guidance on patient care. Neither Guideline is

[1] Dowell D, Ragan KR, Jones CM, Baldwin GT, Chou R. CDC Clinical Practice Guideline for Prescribing Opioids for Pain — United States, 2022. MMWR Recomm Rep 2022;71(No. RR-3):1–95. DOI: http://dx.doi.org/10.15585/mmwr.rr7103a1.

[2] https://www.fsmb.org/siteassets/communications/strategies-for-prescribing-opioids-for-the-management-of-pain-022123-draft.pdf

meant to establish strict standards of care for all patients but rather to encourage a responsible, patient-centered, and compassionate approach to caring for patients' pain. Notably, both guidelines discuss pain specialist consultations without providing a definition of pain medicine specialist.

Defining "pain specialist" will clarify for treating physicians whom they should turn to for the purpose of consultation and referrals for patients with complex cases who are most in need of the comprehensive, advanced pain management expertise demonstrated by board certification.

Florida, Kentucky, Georgia, Tennessee, Ohio, Washington and Alabama have adopted definitions of "pain specialist" or "pain management specialist" that recognize ABPM certification as well as ABMS and AOA Board certification. Similarly, the Boards of Medicine in California, Florida and Texas specifically recognize ABPM certification along with ABMS certification in specialty board advertising regulations. The U.S. Veterans Health Administration also recognizes ABPM specialty certification and ABMS subspecialty certification for Pain Medicine specialists.

Including definitional language for "pain specialist" will help address confusion caused by the growing trend among various types of practitioners to declare pain management expertise without having the credentials, education, or training to support their assertions. Patients with pain are particularly susceptible to representations that their pain can be alleviated quickly and easily. These patients often will spend considerable resources and subject themselves to untested treatments in a quest for relief. Although there is no silver bullet to this problem, states that clearly define "pain specialist" will help establish a standard for identifying physicians who are qualified to provide comprehensive, advanced pain management care to patients with persistent pain.

> *RECOMMENDATION: When adopting a protocol for prescribing opioids (either based on the FSMB model or CDC Guideline, or a state-developed protocol), include language that defines "Pain Medicine/Management specialist" to include:*
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> *…Physicians who are certified in Pain Medicine by a member Board of the American Board of Medical Specialties (ABMS) or American Osteopathic Association (AOA) or by the American Board of Pain Medicine (ABPM).*
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> *Alternative approach: …Physicians who are certified by a medical specialty board whose certification standards for pain medicine specialists are deemed ABMS equivalent by this state medical board.*

B. Pain Clinic Regulations

Several states have established regulations that establish restrictions over the ownership/operation of pain clinics. These regulations are intended to combat the prevalence of so-called "pill mills." Developing standards for the establishment of new Pain Clinics and policies for their continued operation will also help states better guard against truly unscrupulous actors. Patients with addiction problems often will "physician shop" to secure prescriptions when their treating physicians decline. This has been the source of considerable concern in states that have experienced an influx of so-called "pill mills," which serve primarily as ready sources for opioid

prescriptions rather than centers that provide comprehensive pain care to patients. Pill mill operators thrive off the problems of patients suffering from pain and/or addiction and do not provide anything akin to specialty level pain care.

The Model Policy addresses this practice by establishing a detailed standard of care for patients in pain. Including a clear definition of "pain specialists" in the Model Policy will provide another weapon in states' arsenal in the battle against improper opioid dispensing.

> RECOMMENDATION: Restrict ownership/operation to definition of board certified pain medicine/management specialist by an ABMS or AOA approved board in pain medicine, or by the ABPM or a medical specialty board deemed substantially equivalent to ABMS by a state medical board.

C. Advertising Restrictions

State medical boards in some states have restricted the ability of health care practitioners from advertising themselves as "board-certified" unless the state recognizes the medical specialty board that issued the practitioner's certification. In the context of Pain Medicine specialists, ABPM supports this approach to combat sham practitioners claiming expertise.

> *RECOMMENDATION: Adopt language within the state medical practice act that no physician shall hold oneself out as a "Board-certified pain medicine/management specialist," or a "pain medicine/management specialist" unless certified by an ABMS or AOA-approved board in pain medicine, or by the ABPM or a medical specialty board deemed substantially equivalent to ABMS by the state medical board.*

D. Federal and State Recognition of ABPM in Definitions of Pain Specialists

A growing number of states have adopted definitions of "pain specialist" or "pain management specialist" that recognize ABPM certification in addition to certification by an ABMS and AOA Board. We are confident that a thorough review of ABPM's certification process will support recognition of ABPM certification by additional states, in keeping with the following federal and state policies:

- The U.S. Veterans Health Administration recognizes ABPM specialty certification along with ABMS subspecialty certification when defining qualified Pain Medicine specialists.

- The Boards of Medicine in California, Florida, and Texas specifically recognize ABPM as having "equivalent" certification requirements as ABMS Boards, allowing ABPM Diplomates to advertise as board-certified Pain Medicine specialists.

- Several states, including Alabama, Florida, Georgia, Kentucky, Michigan, Mississippi, Ohio, Tennessee, Rhode Island, West Virginia and Washington specifically recognize ABPM along with ABMS certification in state regulations to establish a prescribing protocol or define standards for pain clinics.

It is important to note that while New York's Board of Medicine does not recognize ABPM's credential for purposes of naming physician practices, the VA facilities throughout the state **accept** ABPM as an ABMS equivalent Board.

Conclusion

The Board of Medicine's 2014 decision to reject ABPM's credential, has had a detrimental impact on the medical practices of ABPM Diplomates, who through ABPM's rigorous credentialing process, have demonstrated specialist–level expertise in the field of pain medicine. In addition to unnecessarily restricting their right to advertise or otherwise publicly represent their ABPM-certification, hospitals, health carriers and other entities that "credential" physicians on behalf of these entities cite this policy as grounds for denying ABPM Diplomates credentials and/or refusing to contract with them as pain medicine physicians.

In today's health care system, a physician's ability to practice is directly incumbent on his or her ability to secure credentials and network contracts. The sum effect is that this policy often limits competition and undermines the ability of ABPM's Diplomates to practice in the field that they have trained.

An even greater concern is how the policy impacts patients seeking access to high quality, specialist-level pain management services as well as primary care providers in search of competent and qualified specialist referrals or consultations. Denying the public access to information regarding the credentials of ABPM Diplomates further exacerbates the severe shortage of high quality pain medicine specialists available to patients and providers.

New York would greatly benefit from a re-evaluation of the Board of Medicine's 2014 decision and recognize ABPM Diplomates. Doing so will expand the pool of truly qualified pain medicine specialists to properly treat patients suffering with intractable pain who cannot get adequate treatment in the current system.

The ABPM welcomes the opportunity to work with state policymakers as they address the issues outlined in this paper. For more information, please contact ABPM staff at info@abpm.org