April 1, 2019

Dear Dr. Singh:

On behalf of the undersigned organizations representing Advanced Practice Registered Nurses (APRNs), we are pleased to provide comments on the Department of Health and Human Service Pain Management Best Practices Inter-Agency Task Force’s Draft Report on Pain Management Best Practices: Updates, Gaps, Inconsistencies and Recommendations. APRNs include Certified Nurse-Midwives (CNMs), Certified Registered Nurse Anesthetists (CRNAs), Clinical Nurse Specialists (CNSs), and Nurse Practitioners (NPs). Totaling roughly 340,000 healthcare professionals, including two of the ten largest categories of Medicare Part B provider specialties according to Medicare claims data, our primary interests are patient wellness and improving access to safe and cost-effective healthcare services. In every setting and region, for every population, particularly among the rural and medically underserved, America’s growing numbers of highly educated APRNs advance healthcare access and quality improvement in the United States and promote cost-effective healthcare delivery.


We are pleased that there is APRN representation on the task force, however, we feel this report fails to properly recognize the full panoply of qualified providers who deliver pain management services across the country, including APRNs. The emphasis in this report is solely on physicians who provide pain management and ignores the critical role of other provider types in providing these critical services and could adversely impact the chronic pain workforce, severely limiting access to these services. This report also ignores the HHS’ December 2018 report “Reforming America’s Healthcare System through Choice and Competition” which stated that APRNs can safely and effectively provide some of the same healthcare services as physicians and that “government rules restrict competition if they keep healthcare providers from practicing to the top of their license— i.e., to the full extent of their abilities, given their education, training, skills, and experience, consistent with the relevant standards of care.”

APRNs are qualified pain practitioners who have the training and experience to provide access to excellent care in many practice settings to treat patients suffering from a wide range of acute and chronic pain conditions. The APRN coalition believes that patients are best served when healthcare professionals practice to their full scope of practice, education and licensure, without barriers, collaboratively on a team that promotes safe, high-quality, value-driven, patient centered care. This type of care is not a value held by one profession or the responsibility of one healthcare professional, but rather is the culture of care embraced by the interdisciplinary, patient-driven team. The APRN coalition strongly encourages interdisciplinary collaboration among the patient’s team utilizing effective communication and leveraging the unique roles and responsibilities of all interdisciplinary team members. Therefore, we advise that APRNs should not face professional discrimination based solely on licensure in these efforts and that the task force work to ensure that all pain providers are recognized in this report.

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II.  

2.2 Medication (Gap 3, Recommendation 3a)

The APRN coalition supports the task force’s recommendations that use of nonopioid medications should be used as first line therapy to treat pain and that all pain management providers should understand the use of non-opioid medication for managing different components of pain syndromes. Use of non-opioid alternatives, such as multi-modal pain management services do lead to a decrease in prescription opioid use and addiction and this especially holds true considering the increasing opioid crisis across the country. The APRN community shares the task force’s concerns about the increase in opioid drug use, abuse and deaths. We are committed to working collaboratively toward comprehensive solutions to curb the opioid epidemic in the United States with APRNs playing a key role in the process. APRNs provide access to safe and high-quality healthcare and support managing a holistic, multimodal approach to pain using alternative non-pharmacologic and pharmacologic modalities for pain management that minimize the use of opioids. However, we use caution to prevent providers with prescribing authority to stop or limit medications when they are providing care based on the best clinical guidelines available.

III.  

2.4 Interventional Procedures (Gap 3, Recommendations 3a- 3c)

While we appreciate that Recommendation 1c under Section 3.3.3 calls for expansion of the availability of nonphysician pain specialists, this recommendation becomes moot due to the report’s recommendations for credentialing and training requirements limiting the pathways available for non-physician practitioners, such as CRNAs, to be able to provide interventional pain procedures. Furthermore, these recommendations lack any evidentiary basis and appear to be merely an avenue for medical guild protection, which ignore the needs of patients across the country. We request these recommendations as drafted be amended to include APRN, including CRNA, education and training as an appropriate path to competence and request that the credentialing and training requirements be amended to be inclusive of APRNs, including CRNAs, and all types of qualified practitioners and their educational pathways.

We request that the report also recognize APRNs, including CRNAs, who specialize in pain management and recognize nurse anesthesia programs accredited by the Council on Accreditation of Nurse Anesthesia Educational Programs (COA) and certification and recertification by the National Board for Certification and Recertification of Nurse Anesthetists (NBCRNA).

As part of their educational preparation, CRNAs are required to learn and demonstrate competence in the management of pain, a critical component in the delivery of anesthesia care. All CRNAs are certified and recertified to practice by the NBCRNA, an accredited nationally recognized organization. By virtue of education and individual clinical experience, a CRNA possesses the necessary knowledge and skills to employ therapeutic, physiological, pharmacological, interventional, and psychological modalities in the management and treatment of acute and chronic pain. Nurse anesthesia education, experience, and skill development to practice pain management are core elements of nurse anesthesia education programs. The standards issued by the COA mandate that nurse anesthesia programs provide content in, but not limited to, anatomy, physiology, pathophysiology, pharmacology, and acute and chronic pain management, and the standards require that SRNAs obtain clinical experiences in regional anesthetic techniques (i.e., spinal, epidural, and peripheral nerve blocks).

As professionals, APRNs, including CRNAs, engage in life-long learning and quality improvement activities for safety and excellence in all aspects of patient-centered anesthesia care, including procedures for chronic pain management practice. APRNs, including CRNAs, who provide pain management do so in accordance with their professional scope of practice, federal and state law, and facility policy. As providers integrate new technologies and techniques into their practices, they acquire and demonstrate the necessary knowledge, skills, and abilities. Fellowship training, although not required for either CRNAs or anesthesiologists, is available to those who would like further recognition in the field of pain management. It is incumbent upon each individual health care professional to assure his or her competency when providing patient care, including pain management and treatment.

The long-held position is that it is within a CRNA’s scope of practice to provide "acute, chronic and interventional pain management services..." and CRNA scope of practice includes "the use of ultrasound, fluoroscopy, and other technologies for diagnosis and care delivery, and to improve patient safety and comfort."8 In addition, “[b]y virtue of education and individual clinical experience and competency, a CRNA may practice chronic pain management

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8 AANA, Scope of Nurse Anesthesia Practice, at http://www.aana.com/resources2/professionalpractice/Pages/Scope-of-Nurse-Anesthesia-Practice.aspx
utilizing a variety of therapeutic, physiological, pharmacological, interventional, and psychological modalities in the management and treatment of pain.” Interventional pain management is not exclusively the practice of medicine. When performed by a nurse anesthetist, interventional pain management is the practice of nursing. State legislatures, through licensing laws, determine what is and is not the practice of medicine and what is and is not in the public’s best interest. Licensing laws, however, do not create monopolies for professions. Many professions are authorized to practice in the same, related, or similar fields and as a result have overlapping practice areas. Because of this overlap, many areas of practice are not the exclusive province of one healthcare profession or solely the practice of “medicine.”

Furthermore, the Medicare agency in its 2013 final rule covering all Medicare services provided by CRNAs within their state scope of practice. Medicare regulations state: “Medicare Part B pays for anesthesia and related care furnished by a certified registered nurse anesthetist or an anesthesiologist’s assistant who is legally authorized to perform the services by the State in which the services are furnished.” "Anesthesia and related care" are defined as “those services that a certified registered nurse anesthetist is legally authorized to perform in the state in which the services are furnished.” In the preamble to the CY 2013 Medicare Physician Fee Schedule Final Rule, the Centers for Medicare & Medicaid Services (CMS) said that it would defer to a state regarding what services are within a CRNA’s scope of practice. CMS does not defer to any particular medical society’s guidelines, nor are any such medical society’s guidelines mentioned in the preamble language. CMS concluded, “Anesthesia and related care means those services that a certified registered nurse anesthetist is legally authorized to provide in the state in which the services are furnished.” CMS has instituted this policy at Section 140.4.3 – Payment for Medical or Surgical Services Furnished by CRNAs. The policy states “Payment is determined under the physician fee schedule on the basis of the national physician fee schedule conversion factor, the geographic adjustment factor, and the resource-based relative value units for the medical or surgical service.” Nowhere in this policy does it state that CRNAs must be medically directed.

Regarding the credentialing requirements contained in Recommendation 3a and 3b, we also request background information to understand the requirements that credentialing criteria must be established to participate in pain management and that only clinicians who are credentialed in pain procedures can perform interventional procedures. Absent compelling evidence supporting the recommendation for its patient safety benefits, and we are not aware of the existence of such evidence, we recommend this proposed requirement be stricken from the report.

We appreciate your consideration of our views on these important issues. APRNs play a significant role in ensuring patient access to high quality healthcare that is cost-effective, and practice without physician supervision in many states. At the bedside, in the operating room, on the hospital units, and in the community, APRNs are crucial to access to care and patient safety. Should you have any questions, please feel free to contact the AANA Senior Director of Federal Government Affairs, Ralph Kohl, at 202-741-9080 or rkohl@aanadc.com.

Sincerely,

American Association of Nurse Anesthetists
American College of Nurse Midwives
National League for Nursing
National Organization of Nurse Practitioner Faculties