AMERICAN OSTEOPATHIC ASSOCIATION

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Testimony of Jon F. Wills, Executive Director, Ohio Osteopathic Association
On Behalf of the
American Osteopathic Association

Thank you for the opportunity to testify today on 4731-29-01 "Standards and Procedures for the Operation of a Pain Management Clinic." I am speaking today on behalf of the American Osteopathic Association (AOA), which has reviewed the emergency rules in respect to current certification classifications available through the AOA as well as requirements and pain management regulations recently adopted in Florida and the state of Washington.

Misuse and diversion of controlled substances is a significant and growing public health problem that must be addressed through a multi-pronged public health approach. While working to minimize the misuse and diversion of prescription drugs, it is important to remember that physicians have an equally compelling ethical obligation to preserve access to effective pain management options for patients.

It is the AOA's position that, "[i]t is a right of all patients to have access to medically appropriate intervention and/or treatment of acute and chronic pain. It is the right of all physicians, to provide medically appropriate intervention and treatment modalities that will achieve safe and effective pain control for all their patients." Furthermore, it is in the best interest of patients not to confine, or seek to regulate opioid/opiate medications by limiting their use to a small number of specialties of medicine. (H-250/A-05 Long-Acting Opioid/Opiate Medication).

The emergency rule could significantly limit patient access to care. "[P]ain management clinic," is broadly defined as a facility in which "the primary component of the practice is the treatment of pain or chronic pain" and "the majority of patients of the prescribers at the facility are provided treatment for pain or chronic pain that includes the use of controlled substances… or other drugs specified in rules." While there are exceptions, many physician offices seem to fall under this definition, ranging from family physicians to orthopedic surgeons and other specialists.

The Ohio Osteopathic Association is receiving calls from physicians who have already started discharging "pain" patients to make sure their practice percentage falls below the 50 percent threshold to be considered a pain clinic. In one case, the physician has referred a number of patients to a Pain Clinic, which in turn has referred the patients back to the FP to continue to manage them based on current treatment plans. In other cases, patients are being told that there is up to a three-month waiting period to be seen, leaving them without access to care. There is also widespread confusion as to how this rule interfaces with the Intractable Pain Rule that is already in place.

The AOA and the OOA supports the current exemption in (A) (5) (c) for excluding patients from the calculation who are being treated for a condition that is expected to last less than 30 days. **However, we would also recommend including exceptions for end of life care and certain other Bureau of Workers Compensation patients**, which will be addressed in separate testimony by OOA Legal Counsel, Eric Jones.

The AOA is particularly concerned about the board certification requirements for the physician owner of a pain clinic contained in subsection (B(2)(a-d). In terms of AOA board certification, only Certificates of Added Qualifications (CAQs) in pain management and hospice and palliative medicine are recognized. We find these qualifications to be very limited thereby preventing qualified physicians from providing care. It is worth noting that other state medical and osteopathic boards that have adopted rules on this issue have not limited recognition to sub-specialty certification and also include pathways for non-board certified physicians to be recognized.

For example, Florida recognizes AOA CAQs in hospice and palliative medicine, pain management and geriatric medicine. Other pathways for meeting the definition include: (1) successful completion of a residency program in physical medicine and rehabilitation, anesthesiology, neurology, neurosurgery, or psychiatry approved by the ACGME or the AOA; (2) successful completion of a residency program in family practice, internal medicine, or orthopedics approved by the AOA; (3) current staff privileges at a Florida-licensed hospital to practice pain medicine or perform pain medicine procedures; (4) or three years of documented full-time practice, which is defined as an average of 20 hours per week each year, in pain-management and attendance and successful completion of 40 hours of in-person, live-participatory AMA Category I or AOA Category IA CME courses in pain management.

Washington state recognizes the following as meeting the definition of a "pain management specialist": (1) ABMS or AOA board certification or board eligibility in physical medicine and rehabilitation, rehabilitation medicine, neurology, rheumatology, or anesthesiology; (2) a subspecialty certificate in pain medicine by an ABMS-approved board; or (3) an AOA CAQ in pain management. Exemptions are provided for osteopathic physicians that complete 18 hours of CME in pain management every 3 years.

The AOA recommends recognizing primary specialty board certification in: physical medicine and rehabilitation, neurology and psychiatry, and neuromusculoskeletal medicine. According to their respective specialty colleges, these residency programs contain core competencies related to pain. In addition to their training, physicians in these specialties have passed examinations testing their competency in this area.

The National Board of Osteopathic Medical Examiners has designed the COMLEX-USA series to assess the osteopathic medical knowledge and clinical skills considered essential for osteopathic generalist physicians to practice medicine without supervision. The COMLEX-USA blueprint indicates the expansive coverage of pain related concepts in the examination series. For example, patients with presentations related to cognition, behavior, sensory and central nervous systems, substance abuse and visceral and sensory pain accounts for 28-38% of the COMLEX-USA series. Patients with presentations related to the musculoskeletal system, including somatic pain accounts for 6-12% of the COMEX-USA series.

The AOA had reached out to the member boards of the AOA-Bureau of Osteopathic Specialists to identify the percentage of questions on their exams that relate to pain.

- The American Osteopathic Board of Physical Medicine and Rehabilitation has indicated that 16% of their written exam is dedicated to pain and 32% of the oral portion of the exam is devoted to pain.

- The American Osteopathic Board of Neurology and Psychiatry noted that questions related to pain are found in the following board certification exams: Neurology; Psychiatry; Child Neurology; Child Psychiatry; CAQ Addiction Medicine; CAQ Neurophysiology; CAQ Geriatric Psychiatry; and CAQ Hospice and Palliative Medicine. The percentage of questions ranges from 2% to 15%, dependent on the exam.

Osteopathic family physician offices, in particular, constitute a particular dilemma, due to the profession's unique modality of osteopathic manipulative treatment (OMT). OMT is effective in treating pain that may or may not be related to the other chronic diseases being managed in the family physician's office on a long-term basis.

- The American Osteopathic Board of Neuromusculoskeletal Medicine (AOBNMM) has indicated that 29.34% of their primary certification exam questions address the issue of pain.

It is also worth noting that the AOA is in the process of developing a CAQ in pain medicine, which we hope to have available in the near future. **We would therefore suggest adding a subsection recognizing the subspecialty of pain medicine, including recognition of the AOA's CAQ in pain medicine.**

As of January 13, 2013, osteopathic continuous certification (OCC) will go into effect for AOA certifying boards. OCC is a process by which board certified osteopathic physicians will be required to maintain currency and demonstrate competency in their specialty area.

In addition to recognizing these additional specialty and sub-specialty certifications, we would also suggest a permanent pathway for non-board certified physicians consisting of mandatory continuing education requirements in pain management, similar to those outlined in (D).

We appreciate your willingness to consider our concerns. The AOA applauds the Ohio State Medical Board's efforts to address the problem of prescription drug addiction and abuse and for working with the professional associations to help solve these problems. We believe that these proposed amendments would help ensure that legitimate patients have access to appropriate care.

Sincerely,

Karen J. Nichols, DO
President, AOA