Background

Pain medicine is the multidisciplinary subspecialty that concentrates on the management of patients suffering from acute or chronic pain, or pain in patients requiring palliative care, according to the Accreditation Council for Graduate Medical Education (ACGME).

The American Academy of Pain Medicine (AAPM) states that a pain medicine practitioner is a physician who, by academic medical degree and clinical postgraduate training, board certification, CME in pain medicine, and a license to practice medicine, is uniquely qualified to provide a comprehensive array of professional services related to the medical specialty of pain medicine.

According to AAPM, the practice of this specialty involves the identification, diagnosis, and treatment of persons with chronic pain symptoms and often complex, chronic pain conditions to which many diseases may contribute. Pain treated by the subspecialty of pain medicine includes that caused by postoperative pain or associated with a malignancy, or conditions in which pain constitutes the primary problem, such as neuropathic pains or headaches, according to the AAPM.

Further, the AAPM states that the evaluation of painful syndromes includes:

- Interpretation of historical data
- Review of previous laboratory, imaging, and electrodiagnostic studies
- Assessment of behavioral, social, occupational, and avocational issues
- Interviews and examinations of the patient by the pain specialist

Evaluations may also require specialized diagnostic procedures, including central and peripheral neural blockade or monitored drug infusions. Pain medicine physicians consider the special needs of the pediatric and geriatric populations and patients’ cultural contexts when formulating a comprehensive treatment plan.

The pain physician serves as a consultant to other physicians but is often the principal treating physician and may provide care at various levels, such as direct treatment, prescribing medication, prescribing rehabilitation services, performing pain-relieving procedures, counseling patients and families, directing a multidisciplinary team, coordinating care with other healthcare providers, and providing consultative services to public and private agencies, according to the AAPM.
Physicians training in pain medicine may originate from different disciplines and approach the field with varying backgrounds and experience, according to the ACGME. All pain specialists, regardless of their primary specialty, should be competent in pain assessment, formulation and coordination of a multiple-modality treatment plan, integration of pain treatment with primary disease management and palliative care, and interaction with other members of a multidisciplinary team.

Physicians specializing in pain medicine complete a 12-month fellowship in pain medicine following the successful completion of an ACGME-accredited residency program.

The American Board of Anesthesiology (ABA), in consultation with the American Board of Psychiatry and Neurology (ABPN) and the American Board of Physical Medicine and Rehabilitation (ABPMR), have agreed on a single standard of certification in pain medicine. The American Osteopathic College of Anesthesiologists (AOCA) is the only American Osteopathic Association (AOA) board to offer a certificate of added qualification in pain management. The medical subspecialty of pain medicine is currently recognized by the American Board of Pain Medicine (ABPM) and the American Board of Medical Specialties (ABMS) as a subspecialty of anesthesiology, physical medicine and rehabilitation, neurology, and psychiatry.

**Involved specialties**

Anesthesiologists, neurologists, surgeons, physiatrists, physical medicine and rehabilitation physicians, and other physicians who treat patients for pain

**Positions of specialty boards**

**ABA**

The ABA offers certification in the subspecialty of pain medication for anesthesiologists holding primary certificates in anesthesiology. According to ABA’s Booklet of Information, the ABMS has authorized the ABA to award subspecialty certification in pain medicine, though it is a multidisciplinary specialty. Physicians must understand the anatomical and physiological basis of pain perception, the psychological factors that modify the pain experience, and the basic principles of pain medicine.

To be eligible for a pain medicine certification by the ABA, the candidate must:

- Be a diplomate of the ABA
- Fulfill the licensure requirement for certification
- Have fulfilled the subspecialty training requirement as defined by the ABA
- Have satisfied the subspecialty examination requirement as defined by the ABA
- Be capable of performing independently the entire scope of subspecialty practice without accommodation or with reasonable accommodation

Successful exam scores do not guarantee certification by the ABA.
Candidates must be recertified every 10 years. Candidates cannot be certified in pain medicine by the ABA if they already hold a pain medicine subspecialty certification by another board. The continuum of education in an anesthesiology subspecialty consists of 12 months of full-time ACGME-accredited training. The credentialing requirements, examination, and passing standard are the same for certification and recertification.

The ABA began transitioning from subspecialty recertification to Maintenance of Certification in Anesthesiology for Subspecialties (MOCA-SUBS) in January 2010. The last subspecialty recertification examination will be administered in 2016 and the MOCA-SUBS examination will be administered in 2017. The MOCA-SUBS examination is the only option for holders of pain medicine certificates issued in 2010 or later. The MOCA-SUBS recertification differs from the original recertification practices in that some of the required CME must be related to the subspecialty certification being maintained and a separate cognitive examination needs to be completed for the subspecialty certification being maintained. The ABA will verify the diplomate’s clinical activity in the subspecialty.

Once both anesthesiology and subspecialty certification is maintained (for pain medicine, for example), a diplomate may chose to maintain the subspecialty certification only. However, the diplomate is no longer board certified in anesthesiology. Although it’s possible to only hold the subspecialty certification, the ABA strongly discourages it.

**ABPN**

According to the ABPN, candidates in the subspecialty of pain medicine are those in the field of psychiatry, neurology, or child neurology who are seeking ABPN board certification. ABPN defines pain medicine as a subspecialty that involves primary or consultative care for patients experiencing acute, chronic, or cancer pain in both hospital and ambulatory settings; patient needs may also be coordinated with other specialists.

Effective January 1, 2012, ABPN requires physicians to become board certified within seven years following successful completion of ACGME-accredited or ABPN-approved residency training in their primary specialty or ACGME-accredited subspecialty. Graduates can take the ABPN certification examination as many times as allowed during the seven-year period. Individuals who completed an accredited residency program prior to January 1, 2012, will have until January 1, 2019, to become board certified.

Individuals who do not become certified during the seven-year period (or before January 1, 2019, for those who completed residency training before January 1, 2012) will be required to repeat the required clinical skills evaluations and complete one stage of MOC (90 CME credits, 24 self-assessment CME credits,
and one Performance in Practice (PIP) Unit that includes a clinical and feedback module) in order to be credentialed to take the ABPN certification examination.

All candidates applying or reapplying for certification in pain medicine must complete 12 months of ACGME-accredited training in pain medicine. Training must be completed by June 30 of the year of the examination. Test items address, but are not limited to, chronic pain, acute pain, cancer pain, anesthesia, psychiatry, neurology, physical medicine and rehabilitation, neurosurgery, pediatrics, ethics, and decision-making.

The required one year of specialized training in pain medicine may be completed on a part-time basis as long as it is not less than half time; credit is not given for periods of training lasting less than one year except under special circumstances that must be approved by the ABPN Credentials Committee. In such cases, it is the responsibility of the applicant to provide detailed documentation from the respective training directors, including the exact dates, and outlining training content, duties, and responsibilities. Each case is considered on an individual basis.

**ABPMR**

According to the ABPMR’s 2012–2013 Booklet of Information, pain medicine certificants must also maintain certification in their primary specialty. In the event a certificant’s primary certificate lapses, is revoked, suspended, or expired, the ABPMR will revoke subspecialty certification as well. Also, the designation of subspecialty certification in pain medicine does not imply that each physician working in a pain clinic setting must be certified in pain medicine.

The ABPMR offers subspecialty certification in pain medicine in order to enhance the quality of care available to individuals within the entire range of painful disorders. According to the ABPMR, this is accomplished through training highly expert clinicians, teachers, and investigators to:

- Provide a high level of care for patients experiencing problems with acute or chronic pain in both hospital and ambulatory settings
- Demonstrate special expertise in clinical knowledge and skill in pain medicine resulting in improved rehabilitation and care of individuals with the entire range of painful disorders
- Gain the pain medicine skills necessary for the coordination and responsibility of activities such as quality assurance, meeting regulatory standards, participation in pain medicine–related committees, facilities planning, and budget formation
- Participate in the formulation and/or evaluation of policies, procedures, standing orders, standards of care, and special equipment as related to pain medicine
- Provide coordination, quality control, and education of ancillary services (e.g., medical, nursing, psychology, physical therapy, and occupational therapy)
- Participate in research for the advancement of the clinical science of pain medicine directed toward the problems of individuals with painful disorders
• Provide expert primary diagnostic and management services for complex and severe clinical problems related to pain medicine that require interspecialty management in pain centers, improving interspecialty and interdisciplinary communication and cooperation among specialists caring for persons with painful disorders
• Support principal care providers of persons with a variety of painful disorders who practice in non-pain centers, by rendering follow-up care to prevent and manage complications related to painful disorders
• Improve the quality of teaching of pain medicine in residency programs of related primary specialties by stimulating the availability of subspecialists with additional knowledge and skills in pain medicine

ABPMR's pain medicine subspecialty requirements include:
• ABMS certification
• A current, valid, and unrestricted license to practice medicine in at least one jurisdiction in the United States, its territories, or Canada
• Evidence of unrestricted licensure in the state or states in which the physician practices will be required prior to issuance of the certificate

The educational requirements in pain medicine can be fulfilled by satisfactory completion of 12 months in an ACGME-accredited pain medicine fellowship (the training program must occur after completing residency, and must be completed by August 31 preceding the examination date). The training curriculum must be compatible with the program requirements in PM&R, which are published annually in the AMA’s Graduate Medical Education Directory. With uniformity in training achieved through common standards, it can be expected that at the completion of pain medicine training, the physician should be able to:
• Perform a directed history and physical examination to identify the etiology of pain medicine problems
• Document the findings, discuss the differential diagnoses, and provide a comprehensive management plan for acute or chronic pain conditions
• Integrate and coordinate the multidisciplinary assessment of psychological, rehabilitative, behavioral, and diagnostic services
• Appreciate and assess the complex psychological and socioeconomic forces affecting both pain presentation and response to therapy

Development of these skills is dependent on appropriate exposure. Pain medicine faculty will represent multiple ABMS disciplines, enabling training programs to provide learning and experience in a wide range of areas, including:
• Anesthesia, providing exposure to anesthetic approaches to pain medicine and the use of nerve blocks
• Psychiatry and neurology, providing exposure to psychiatric etiologies of pain as differentiated from physical pain, and performing a thorough neurological evaluation with appropriate neurological testing
• Physical medicine and rehabilitation, providing exposure to applying PM&R techniques to pain problems
• Neurosurgery, providing exposure to application of techniques utilized by neurosurgeons in their management of pain problems
• Pediatrics, providing exposure to the multidimensional nature of children’s pain experiences, the methods of pain measurement and assessment in children, and the unique pediatric factors that distinguish the pain experience of pediatric patients from that of adults
• Cancer pain, providing exposure to oncologic therapies, such as endocrine, chemotherapy, radiation, and immunotherapy, relating to the control of painful cancer conditions both in the inpatient and outpatient settings
• Administrative and teaching experience, allowing opportunity to teach and supervise residents and/or medical students during their rotations in pain medicine, and providing exposure to the experience of day-to-day pain unit management
• Documentation, providing application of proper procedures relevant to a variety of forms and communications encountered for reimbursement, referral, disability, and legal purposes
• Research, providing opportunity for pain-related research of a basic and/or clinical nature, culminating in publication and/or presentation in a scientific forum; and also providing exposure to or an understanding of the principles of pain research involving animals

The original certificate is a 10-year, time-limited certificate. To participate in the pain medicine maintenance of certification (MOC) program, certificants must maintain primary certification and have a current, valid, and unrestricted license to practice medicine in at least one jurisdiction in the United States, its territories, or Canada. Evidence of unrestricted licensure in the state or states in which the physician practices will be required prior to issuance of the certificate (refer to the ABPMR policy regarding licensure).

MOC requirements include achieving a passing score on a computer-based, proctored pain medicine subspecialty examination prior to the certificate expiration date. The examination may be taken in years 7–10 of the pain medicine MOC cycle.

If a certificant’s subspecialty certificate expires, the physician has a maximum of three years to pass the subspecialty MOC examination, meet the licensure requirement, and become recertified. After the three-year period, the physician must meet the application requirements in effect at the time of application (i.e., complete an ACGME-accredited fellowship in pain medicine).

In the event a certificant’s primary certificate lapses, is revoked, suspended, or expired, the ABPMR will revoke subspecialty certification as well.

**ABPM**

According to the ABPM’s 2013 Bulletin of Information, applicants must have satisfactorily completed an ACGME-accredited residency training program that included identifiable training in the specialty of pain medicine.
Applicants must have satisfactorily completed an ACGME-accredited residency training program that included identifiable training in the specialty of pain medicine. In addition to a license to practice medicine, U.S. applicants, candidates, and examinees must have a current, valid, and unrestricted registration with the DEA to prescribe, dispense, or administer narcotic controlled substances and, if applicable, a current, valid, and unrestricted authorization to prescribe, dispense, or administer narcotic controlled substances with the controlled substances authority in every jurisdiction in which they are licensed to practice medicine. Canadian applicants, candidates, and examinees must have the corresponding authorization to prescribe, dispense, or administer controlled substances.

Applicants, candidates, and examinees must hold a current and valid certification by an ABMS member board.

Applicants must have been engaged in the clinical practice of pain medicine on a substantial basis for at least 18 months, of which at least six months must be contiguous, within the 24-month period ending April 2013. Experience during a primary residency training program or a fellowship or subspecialty training program that is not accredited by ACGME is not considered practice for the purposes of this requirement.

If an applicant has successfully completed an ACGME-accredited fellowship or subspecialty training program in pain management/medicine that lasted 12 months or longer following the completion of primary residency training (e.g., psychiatry, neurosurgery), the applicant may count that experience as up to 12 months of clinical practice of pain medicine toward the requisite 18 months of clinical practice of pain medicine, provided that the training is completed within a 24-month period ending April 2013. If an applicant is counting an ACGME-accredited fellowship toward time in the clinical practice of pain medicine, he or she must submit documentation of the fellowship in pain medicine.

Applicants who completed training within the period between September 2010 and September 2012 are required to provide evidence of a minimum of 50 hours of Category I CME relevant to pain medicine from an ACGME-accredited CME provider or Canadian-certified CME (MAINPRO, MOCOMP), which is recognized as equivalent to ACGME for this purpose by the ABPM Credentials Committee. Time in a primary residency training program cannot be counted toward the CME requirement.

AOBA

The American Osteopathic Board of Anesthesiology (AOBA) offers a certificate of added qualifications (CAQ) in pain management. To be eligible to receive a CAQ in pain management from the AOA through the AOBA, physicians must meet the following minimum requirements:

- Be a graduate of an AOA-accredited college of osteopathic medicine
- Hold an unrestricted license to practice in a state or territory
• Show evidence of conformity to the standards set forth in the AOA Code of Ethics
• Be a member in good standing of the AOA or the Canadian Osteopathic Association for the two years immediately prior to the date of certification
• Satisfactorily complete residency training in anesthesiology
• Be actively certified by the AOA through the AOBA in anesthesiology (primary certification)

A physician for initial certification or recertification who has a restricted license may petition the AOBA for the ability to enter the certification or recertification process based upon review of the reason for license restriction.

CAQs are time-dated, with a 10-year duration from the initial certification date, as determined by the AOA.

Diplomates with one or more years of formal training in pain management, acceptable to the AOBA, shall have practiced as a specialist in pain management for a minimum of one year prior to filing an application to take the examination.

Following satisfactory compliance with the prescribed requirements for examination, the diplomate is required to pass a written examination, administered by the AOBA. The examination is to evaluate the diplomate’s understanding of the scientific basis of the problems involved in pain management, familiarity with current advances in pain management, and possession of sound judgment and a high degree of skill in the diagnostic and therapeutic procedures involved in the practice in pain management.

Positions of societies, academies, colleges, and associations

AAPM

The AAPM approved a statement on June 22, 2010, that ruled nonphysicians are not qualified to practice pain medicine.

According to the AAPM, the practice of pain medicine is multidisciplinary in approach, incorporating modalities from various specialties to ensure the comprehensive evaluation and treatment of the pain patient. Reflecting the diverse nature of the field of medicine, AAPM members come from a variety of practice areas, including anesthesiology, internal medicine, neurology, neurological surgery, orthopedic surgery, physiatry, and psychiatry. The AAPM does not publish guidelines concerning the delineation of privileges for pain medicine.

AOA

The AOA’s Basic Standards for Fellowship Training in Pain Medicine is approved by the following organizations:
• AOA
According to this document, the core competencies for education in pain medicine include:

- **Osteopathic philosophy and osteopathic manipulative medicine**: Integration and application of osteopathic principles into the diagnosis and management of patient clinical presentations.
- **Medical knowledge**: A thorough knowledge of the complex differential diagnoses and treatment options in pain medicine and the ability to integrate the applicable sciences with clinical experiences.
- **Patient care**: The ability to evaluate, initiate, and provide appropriate treatment for patients with acute and chronic conditions in both the inpatient and outpatient settings as well as promote health maintenance and disease prevention.
- **Interpersonal and communication skills**: Use of clear, sensitive, and respectful communication with patients, patients' families, and members of the healthcare team.
- **Professionalism**: Adherence to principles of ethical conduct and integrity in dealing with patients, patients' families, and members of the healthcare team.
- **Practice-based learning and improvement**: Commitment to lifelong learning and scholarly pursuit in pain medicine for the betterment of patient care.
- **Systems-based practice**: Skills to lead healthcare teams in the delivery of quality patient care.

Subspecialty training in pain medicine should consist of 12 months of full-time training, beginning after satisfactory completion of an AOA-approved residency program in a participating conjoint specialty.

The fellow must have access to the following clinical experiences:

- **Continuity of care (longitudinal outpatient experience)**, including the management of chronic cancer and non-cancer pain
- **Inpatient experience**, including the management of chronic cancer and non-cancer pain
- **Experience in managing acute pain**
- **Exposure to interventional pain procedures**
- **A palliative care experience** (longitudinal involvement with patients with pain who require palliative care)
- **Experience in osteopathic principles and practice as it relates to pain medicine**

According to the AOA, the curriculum must contain the following educational components:
Pain medicine

- Overall educational goals for the program, which the program must distribute to fellows and faculty annually.
- Competency-based goals and objectives for each assignment at each educational level, which the program must distribute to fellows and faculty annually, in either written or electronic form. These must be reviewed by the fellow at the start of each rotation.
- Regularly scheduled didactic sessions.
- Delineation of fellow responsibilities for patient care, progressive responsibility for patient management, and supervision of fellows over the continuum of the program.

The program must integrate the following Osteopathic Graduate Medical Education competencies into the curriculum:
- Patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health.
- Competency in the diagnosis and treatment of osteopathic somatic dysfunction.
- Competency in the following:
  - Obtaining IV access in a minimum of 15 patients
  - Basic airway management, including a minimum of mask ventilation in 15 patients, and successful completion of a course in basic life support and advanced cardiac life support offered by the base institution
  - Management of sedation, including direct administration of sedation to a minimum of 15 patients
- Obtain a thorough and relevant biopsychosocial history, including history of depression or psychiatric illness, physical or sexual abuse, drug misuse, or addictive behaviors; recognize the importance of medical comorbid conditions as potential generators of pain states; understand the role of patient family and external support for pain patients; and evaluate the effectiveness of adjunctive therapies (e.g., massage, nutraceuticals, exercise for relief of pain).
- Elicit a directed neurological history, performing a detailed neurological examination to include at least mental status, cranial nerves, motor, sensory, reflex, cerebellum examinations, and gait in 15 patients. Faculty shall verify this experience in a minimum of five observed patient examinations.
- Become familiar with basic neuro-imaging and identify significant findings to include at least MRI and CT of the spine and brain on a minimum of 15 CT and/or MRI studies drawn from the examples within the following areas: brain, cervical, thoracic, and lumbar spine.
- Gain an understanding of the natural history of various musculoskeletal pain disorders and be able to appropriately integrate therapeutic modalities and surgical intervention in the treatment algorithm.
- Gain significant hands-on experience in the musculoskeletal and neuromuscular assessment of 15 patients and demonstrate proficiency in the clinical evaluation and rehabilitation plan development of a minimum of five patients and the use of osteopathic manipulative treatment as an adjunct to the treatment plan.
- Involvement with a minimum of 15 new patients with chronic pain, includ-
ating cancer pain, assessed in a consultation team or designated inpatient pain medicine service setting.

- Involvement with a minimum of 50 new patients with acute pain.
- Involvement with or direct observation of a minimum of 25 patients who undergo interventional procedures.
- Longitudinal involvement with a minimum of 20 cancer patients and a minimum of five patients who require palliative care.

The AOA states that, with regard to fellows’ medical knowledge, fellows must “demonstrate knowledge of established and evolving biomedical, clinical, epidemiological, and social-behavioral sciences” and apply this knowledge to patient care. Fellows should have exposure to the following areas:

- Assessment of pain
- Treatment of pain
- General topics, research, and ethics (e.g., epidemiology of pain, gender issues in pain, placebo response)
- Interventional pain treatment

Additional details on the specific aspects of each of the areas listed above can be found in the Basic Standards for Fellowship Training in Pain Medicine.

**ACGME**

According to the ACGME’s Program Requirements for Graduate Medical Education in Pain Medicine, physicians training in pain medicine may originate from different disciplines and approach the field with varying backgrounds and experience. All pain specialists, regardless of their primary specialty, should be competent in pain assessment, formulation, and coordination of a multimodality treatment plan, integration of pain treatment with primary disease management and palliative care, and interaction with other members of a multidisciplinary team. Therefore, the didactic and clinical curriculum of the pain program must address attainment of these competencies.

Subspecialty training in pain medicine shall consist of 12 months of full-time training, beginning after satisfactory completion of a residency program accredited by the ACGME. If a program elects to extend the training beyond 12 months, a clear educational rationale must be developed for the additional experience offered.

Fellows will enter the fellowship in pain medicine with a range of different experiences. The pain medicine program must demonstrate separate, identifiable clinical experiences that provide the elements from medical disciplines essential to the practice of pain medicine. The clinical experience within the four disciplines outlined below may take the form of discrete clinical rotations, or may occur concurrently with the core clinical curriculum. The principal multidisciplinary elements of pain medicine education from the disciplines relevant to pain medicine are as follows:

- Anesthesiology: The fellow will demonstrate competency in:
- Obtaining IV access in a minimum of 15 patients
- Basic airway management, including a minimum of mask ventilation in 15 patients and endotracheal intubation in 15 patients
- Basic life support and advanced cardiac life support
- Management of sedation, including direct administration of sedation to a minimum of 15 patients
- Administration of neuraxial analgesia, including placement of a minimum of 15 thoracic or lumbar epidural injections using an interlaminar technique

• Neurology: The fellow should meet the following requirements:
  - Ability to elicit a directed neurological history, performing a detailed neurological examination to include at least mental status, cranial nerves, motor, sensory, reflex, cerebellum examinations, and gait in 15 patients, with a minimum of five faculty-observed patient examinations
  - Familiarity with basic neuro-imaging and ability to identify significant findings to include at least MRI and CT of the spine and brain on a minimum of 15 CT and/or MRI studies drawn from the examples within the following areas: brain, cervical, thoracic, and lumbar spine
  - Understanding of the indicators and interpretation of electrodiagnostic studies

• Physical medicine & rehabilitation: Fellows should demonstrate the following:
  - Understanding of the natural history of various musculoskeletal pain disorders
  - Ability to appropriately integrate therapeutic modalities and surgical intervention in the treatment algorithm
  - Understanding of the indicators and interpretation of electrodiagnostic studies
  - Significant hands-on experience in the musculoskeletal and neuromuscular assessment of 15 patients
  - Proficiency in the clinical evaluation and rehabilitation plan development of a minimum of five patients

• Psychiatry: The fellow must meet the following requirements:
  - Carry out a complete psychiatric history with special attention to psychiatric and pain comorbidities
  - Conduct a complete mental status examination on a minimum of 15 patients and demonstrate this ability in five patients to a faculty observer
  - Understand the principles and techniques of the psychosocial therapies, with special attention to supportive and cognitive behavioral therapies, sufficient to explain to a patient and make a referral when indicated

Pain medicine fellows should also have experience in the following areas:
• Outpatient (continuity clinic): Fellows should attend a supervised outpatient clinic for a minimum of eight months and document primary responsibility for 50 different patients followed over at least two months each.
• Inpatient chronic pain: Fellows must document involvement with a minimum of 15 new patients assessed in an inpatient setting.
• Inpatient acute pain: Fellows must document involvement with a minimum of
50 new patients with acute pain.

- Interventional: Fellows must document involvement with a minimum of 25 patients who undergo interventional procedures; interventional experience must be supervised.
- Cancer pain: Fellows must document longitudinal involvement with a minimum of 20 patients in an ambulatory or inpatient population who require care for cancer pain.
- Palliative care: Fellows must document longitudinal involvement with a minimum of 10 patients who require palliative care.
- Pediatric: Experience with the assessment and treatment of pain in children is strongly encouraged.

With regards to advanced education in interventional pain medicine, the ACGME recommends the following minimal experiences for interventional techniques:

- Image-guided spinal injection techniques, cervical spine (15 procedures)
- Image-guided spinal injection techniques, lumbar spine (25 procedures)
- Injection of major joint or bursa (10 procedures)
- Trigger point injections (20 procedures)
- Sympathetic blockade (10 procedures)
- Neurolytic techniques, including chemical and radiofrequency treatment for pain (5 procedures)
- Intradiscal procedures, including discography (10 procedures)
- Spinal cord stimulation (3 procedures)
- Placement of permanent spinal drug delivery system (3 procedures)

The ACGME recognizes that interventional pain medicine is an evolving discipline and notes that programs shall not be required to offer all techniques to their trainees.

**Positions of accreditation bodies**

**CMS**

CMS has no formal position concerning the delineation of privileges for pain medicine. However, the CMS *Conditions of Participation (CoP)* define a requirement for a criteria-based privileging process in §482.22(c)(6) stating, “The bylaws must include criteria for determining the privileges to be granted to individual practitioners and a procedure for applying the criteria to individuals requesting privileges.”

§482.12(a)(6) states, “The governing body must assure that the medical staff bylaws describe the privileging process. The process articulated in the bylaws, rules or regulations must include criteria for determining the privileges that may be granted to individual practitioners and a procedure for applying the criteria to individual practitioners that considers:

- Individual character
• Individual competence
• Individual training
• Individual experience
• Individual judgment

The governing body must ensure that the hospital’s bylaws governing medical staff membership or the granting of privileges apply equally to all practitioners in each professional category of practitioners."

Specific privileges must reflect activities that the majority of practitioners in that category can perform competently and that the hospital can support. Privileges are not granted for tasks, procedures, or activities that are not conducted within the hospital, regardless of the practitioner’s ability to perform them.

Each practitioner must be individually evaluated for requested privileges. It cannot be assumed that every practitioner can perform every task, activity, or privilege specific to a specialty, nor can it be assumed that the practitioner should be automatically granted the full range of privileges. The individual practitioner’s ability to perform each task, activity, or privilege must be individually assessed.

CMS also requires that the organization have a process to ensure that practitioners granted privileges are working within the scope of those privileges.

CMS’ CoPs include the need for a periodic appraisal of practitioners appointed to the medical staff/ granted medical staff privileges (§482.22[a][1]). In the absence of a state law that establishes a time frame for the periodic appraisal, CMS recommends that an appraisal be conducted at least every 24 months. The purpose of the periodic appraisal is to determine whether clinical privileges or membership should be continued, discontinued, revised, or otherwise changed.

**The Joint Commission**

The Joint Commission has no formal position concerning the delineation of privileges for pain medicine. However, in its *Comprehensive Accreditation Manual for Hospitals*, The Joint Commission states, “The hospital collects information regarding each practitioner’s current license status, training, experience, competence, and ability to perform the requested privilege” (MS.06.01.03).

In the introduction for MS.06.01.03, The Joint Commission states that there must be a reliable and consistent system in place to process applications and verify credentials. The organized medical staff must then review and evaluate the data collected. The resultant privilege recommendations to the governing body are based on the assessment of the data.

The Joint Commission introduces MS.06.01.05 by stating, “The organized medical staff is responsible for planning and implementing a privileging process.”
It goes on to state that this process typically includes:

- Developing and approving a procedures list
- Processing the application
- Evaluating applicant-specific information
- Submitting recommendations to the governing body for applicant-specific delineated privileges
- Notifying the applicant, relevant personnel, and, as required by law, external entities of the privileging decision
- Monitoring the use of privileges and quality-of-care issues

MS.06.01.05 further states, “The decision to grant or deny a privilege(s) and/or to renew an existing privilege(s) is an objective, evidence-based process.”

The EPs for standard MS.06.01.05 include several requirements as follows:

- The need for all licensed independent practitioners who provide care, treatment, and services to have a current license, certification, or registration, as required by law and regulation
- Established criteria as recommended by the organized medical staff and approved by the governing body with specific evaluation of current licensure and/or certification, specific relevant training, evidence of physical ability, professional practice review data from the applicant’s current organization, peer and/or faculty recommendation, and a review of the practitioner’s performance within the hospital (for renewal of privileges)
- Consistent application of criteria
- A clearly defined (documented) procedure for processing clinical privilege requests that is approved by the organized medical staff
- Documentation and confirmation of the applicant’s statement that no health problems exist that would affect his or her ability to perform privileges requested
- A query of the NPDB for initial privileges, renewal of privileges, and when a new privilege is requested
- Written peer recommendations that address the practitioner’s current medical/clinical knowledge, technical and clinical skills, clinical judgment, interpersonal skills, communication skills, and professionalism
- A list of specific challenges or concerns that the organized medical staff must evaluate prior to recommending privileges (MS.06.01.05, EP 9)
- A process to determine whether there is sufficient clinical performance information to make a decision related to privileges
- A decision (action) on the completed application for privileges that occurs within the time period specified in the organization’s medical staff bylaws
- Information regarding any changes to practitioners’ clinical privileges, updated as they occur

The Joint Commission further states, “The organized medical staff reviews and analyzes information regarding each requesting practitioner’s current licensure status, training, experience, current competence, and ability to perform the
requested privilege” (MS.06.01.07).

In the EPs for standard MS.06.01.07, The Joint Commission states that the information review and analysis process is clearly defined and that the decision process must be timely. The organization, based on recommendations by the organized medical staff and approval by the governing body, develops criteria that will be considered in the decision to grant, limit, or deny a request for privileges. The criteria must be consistently applied and directly relate to the quality of care, treatment, and services. Ultimately, the governing body or delegated governing body has the final authority for granting, renewing, or denying clinical privileges. Privileges may not be granted for a period beyond two years.

Criteria that determine a practitioner’s ability to provide patient care, treatment, and services within the scope of the privilege(s) requested are consistently evaluated.

The Joint Commission further states, “Ongoing professional practice evaluation information is factored into the decision to maintain existing privilege(s), to revise existing privileges, or to revoke an existing privilege prior to or at the time of renewal” (MS.08.01.03).

In the EPs for MS.08.01.03, The Joint Commission says there is a clearly defined process facilitating the evaluation of each practitioner’s professional practice, in which the type of information collected is determined by individual departments and approved by the organized medical staff. Information resulting from the ongoing professional practice evaluation is used to determine whether to continue, limit, or revoke any existing privilege.

**HFAP**

The Healthcare Facilities Accreditation Program (HFAP) has no formal position concerning the delineation of privileges for pain medicine. The bylaws must include the criteria for determining the privileges to be granted to the individual practitioners and the procedure for applying the criteria to individuals requesting privileges (03.01.09). Privileges are granted based on the medical staff’s review of an individual practitioner’s qualifications and its recommendation regarding that individual practitioner to the governing body.

It is also required that the organization have a process to ensure that practitioners granted privileges are working within the scope of those privileges.

Privileges must be granted within the capabilities of the facility. For example, if an organization is not capable of performing open-heart surgery, no physician should be granted that privilege.

In the explanation for standard 03.01.13 related to membership selection criteria, HFAP states, “Basic criteria listed in the bylaws, or the credentials manual,
include the items listed in this standard. (Emphasis is placed on training and competence in the requested privileges.)”

The bylaws also define the mechanisms by which the clinical departments, if applicable, or the medical staff as a whole establish criteria for specific privilege delineation.

Periodic appraisals of the suitability for membership and clinical privileges is required to determine whether the individual practitioner's clinical privileges should be approved, continued, discontinued, revised, or otherwise changed (03.00.04). The appraisals are to be conducted at least every 24 months.

The medical staff is accountable to the governing body for the quality of medical care provided, and quality assessment and performance improvement (03.02.01) information must be used in the process of evaluating and acting on re-privileging and reappointment requests from members and other credentialled staff.

**DNV**

DNV has no formal position concerning the delineation of privileges for pain medicine. MS.12 Standard Requirement (SR) #1 states, “The medical staff bylaws shall include criteria for determining the privileges to be granted to individual practitioners and a procedure for applying the criteria to those individuals that request privileges.”

The governing body shall ensure that under no circumstances is medical staff membership or professional privileges in the organization dependent solely upon certification, fellowship, or membership in a specialty body or society.

Regarding the Medical Staff Standards related to Clinical Privileges (MS.12), DNV requires specific provisions within the medical staff bylaws for:

- The consideration of automatic suspension of clinical privileges in the following circumstances: revocation/restriction of licensure; revocation, suspension, or probation of a DEA license; failure to maintain professional liability insurance as specified; and noncompliance with written medical record delinquency/deficiency requirements
- Immediate and automatic suspension of clinical privileges due to the termination or revocation of the practitioner’s Medicare/Medicaid status
- Fair hearing and appeal

The Interpretive Guidelines also state that core privileges for general surgery and surgical subspecialties are acceptable as long as the core is properly defined.

DNV also requires a mechanism (outlined in the bylaws) to ensure that
all individuals provide services only within the scope of privileges granted (MS.12, SR.4).
Clinical privileges (and appointments or reappointments) are for a period as defined by state law or, if permitted by state law, not to exceed three years (MS.12, SR.2).

Individual practitioner performance data must be measured, utilized, and evaluated as a part of the decision-making for appointment and reappointment. Although not specifically stated, this would apply to the individual practitioner’s respective delineation of privilege requests.

**CRC draft criteria**

The following draft criteria are intended to serve solely as a starting point for the development of an institution’s policy regarding pain medicine. The core privileges and accompanying procedure list are not meant to be all-encompassing. They define the types of activities, procedures, and privileges that the majority of practitioners in this specialty perform. Additionally, it cannot be expected or required that practitioners perform every procedure listed. Instruct practitioners that they may strikethrough or delete any procedures they do not wish to request.

**Minimum threshold criteria for requesting privileges in pain medicine**

**Basic education**: MD or DO

**Minimal formal training**: Successful completion of an ACGME- or AOA-accredited residency in a relevant medical specialty, followed by successful completion of an ACGME- or AOA-accredited fellowship in pain medicine of at least a 12-month duration and/or current subspecialty certification or active participation in the examination process (with achievement of certification within [n] years) leading to subspecialty certification in pain medicine by the ABA, the ABPN, or the ABPR, or current certification or active participation in the examination process (with achievement of certification within [n] years) leading to certification by the ABPM.

**Required current experience**: Inpatient, outpatient, or consultative pain medicine services for at least 50 patients, reflective of the scope of privileges requested, during the past 12 months or successful completion of an accredited residency or clinical fellowship within the past 12 months.

**References**

If the applicant is recently trained, a letter of reference should come from the director of the applicant’s training program. Alternatively, a letter of reference may come from the applicable department chair and/or clinical service chief at the facility where the applicant most recently practiced.
Core privileges in pain medicine

Core privileges in pain medicine include the ability to evaluate, diagnose, treat, and provide consultation to patients of all ages with acute and chronic pain or pain requiring palliative care, which includes invasive pain medicine procedures beyond basic pain medicine. Practitioners may provide care to patients in the intensive care setting in conformance with unit policies. Core privileges also include the ability to assess, stabilize, and determine the disposition of patients with emergent conditions consistent with medical staff policy regarding emergency and consultative call services. The core privileges in advanced pain medicine include the basic pain medicine core and the procedures on the following procedures list and such other procedures that are extensions of the same techniques and skills:

- Performance of history and physical exam
- Behavioral modification and feedback techniques
- Chemical neuromuscular denervation (e.g., Botox® injection)
- Diagnosis and treatment of chronic and cancer-related pain
- Discography and intradiscal/percutaneous disc treatments
- Epidural and intrathecal medication management
- Epidural, subarachnoid, or peripheral neurolysis
- Fluoroscopically guided facet blocks
- Implantation of subcutaneous, epidural, and intrathecal catheters
- Infusion port and pump implantation
- Injection of joint and bursa, including sacroiliac, hip, knee, and shoulder joint injections
- Management of chronic headache
- Modality therapy and physical therapy
- Neuroablation with cryo, chemical, and radiofrequency modalities
- Nucleoplasty
- Percutaneous and subcutaneous implantation of neurostimulator electrodes
- Peripheral, cranial, costal, plexus, and ganglion nerve blocks
- Prevention, recognition, and management of local anesthetic overdose, including airway management and resuscitation
- Recognition and management of therapies, side effects, and complications of pharmacologic agents used in the management of pain
- Rehabilitative and restorative therapy
- Stress management and relaxation techniques
- Spinal injections, including epidural injections: interlaminar, transforaminal, nerve root sheath injections, and zygapophysial joint injections
- Superficial electrical stimulation techniques (e.g., transcutaneous electrical neural stimulation)
- Trigger point injections
**Special noncore privileges in pain medicine**

If desired, noncore privileges are requested individually in addition to requesting the core. Each individual requesting noncore privileges must meet the specific threshold criteria governing the exercise of the privilege requested, including training, required previous experience, and maintenance of clinical competence. Noncore privileges include:
- Acupuncture for pain management
- Hypnotherapy for pain management
- Percutaneous vertebroplasty
- Balloon kyphoplasty
- Administration of sedation and analgesia

**Reappointment**

Reappointment should be based on unbiased, objective results of care according to a hospital’s quality assurance mechanism. To be eligible to renew privileges in advanced pain medicine, the applicant must demonstrate current competence and an adequate volume of experience ([n] inpatient, outpatient, or consultative pain medicine services) with acceptable results, reflective of the scope of privileges requested, for the past 24 months based on results of ongoing professional practice evaluation and outcomes. Evidence of current physical and mental ability to perform privileges requested is required of all applicants for renewal of privileges. In addition, at least 10 hours of continuing education related to pain management is required.

**For more information**

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Chicago, IL 60654
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Fax: 312-755-7498
Website: [www.acgme.org](http://www.acgme.org)

**American Academy of Pain Medicine**
4700 West Lake Avenue
Glenview, IL 60025
Telephone: 847-375-4731
Fax: 847-375-6429
Website: [www.painmed.org](http://www.painmed.org)

1. Healthcare organizations should define the minimum case/patient volume (the “[n]”) required to maintain clinical competence as recommended by the applicable department chair and the medical executive committee and subject to approval by the governing body.
American Academy of Physical Medicine and Rehabilitation
9700 W. Bryn Mawr Avenue, Suite 200
Rosemont, IL 60018
Telephone: 847-737-6000
Fax: 547-737-6001
Website: www.aapmr.org

The American Board of Anesthesiology
4208 Six Forks Road, Suite 900
Raleigh, NC 27609-5735
Telephone: 866-999-7501
Fax: 866-999-7503
Website: www.theaba.org

American Board of Medical Specialties
222 North LaSalle Street, Suite 1500
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Website: www.abms.org

American Board of Psychiatry and Neurology
2150 East Lake Cook Road, Suite 900
Buffalo Grove, IL 60089
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Website: www.abpn.com

American Osteopathic Association
142 East Ontario Street
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Website: www.jointcommission.org

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