



NGAOM

National Guild of Acupuncture & Oriental Medicine
OPEIU Guild Local 62, AFL-CIO



June 01, 2010

California Acupuncture Board
444 North 3rd Street, Suite 260
Sacramento, CA 95811

RE: Recognition of the Specialty and Board

Dear CAB members and Staff Council:

There is a tremendous underserved population of chronic pain patients and in California and the U.S. and severe shortage of appropriately trained integrative specialists in Multidisciplinary Functional Restoration & Pain Management. With this Recognition Licensed Acupuncturist's will be able to help fulfill this task.

We request the California Acupuncture Board impart and defer Accreditation and Recognition of the Specialty of **CHINESE ORTHOPEDICS (CO): PAIN MANAGEMENT & THERAPEUTICS** for Accreditation by the California DIVISION OF WORKERS' COMPENSATION, MEDICAL UNIT in support of this much needed Specialty.

With this Recognition Licensed Acupuncturist's will be able to help fulfill the State Labor Code requirements requiring completion of intensive study and extended clinical experiences in a specialized area of practice skills, knowledge, and expertise above and beyond those outlined as meeting minimal competency standards in service to the public need.

As approved and recognized the CO course is the prerequisite to existing Accredited CO Coursework (DWC Provider No. 1210) and approved Continuing Medical Education (CME) which has been developed in conjunction with and fulfills Medical Provider Network (MPN) regulatory requirements for a primary care role in pain management, i.e., Evaluation & Management, Diagnosis & Treatment, and Medical-Legal requirements, as required by the **Medical Treatment Utilization Schedule (MTUS) California Labor Code Section 9792.24.1—Acupuncture Medical Treatment Guidelines**.

This course meets the Criteria for Interdisciplinary sub-specialties of Medicine in Pain Management (also called pain medicine) and is the medical discipline concerned with the relief of pain, for recognition in compliance with the DIVISION OF WORKERS' COMPENSATION QUALIFIED MEDICAL EVALUATOR REGULATIONS LC 3209.3 Licensed Acupuncturists TITLE 8, under § 13. Physician's Specialty and TITLE 8, and under § 12. Recognition of Specialty Boards.

We suggest the following language for you consideration.



NGAOM

National Guild of Acupuncture & Oriental Medicine

OPEIU Guild Local 62, AFL-CIO



*The California Acupuncture Board wishes to impart and defer Accreditation and Recognition by the California DIVISION OF WORKERS' COMPENSATION, MEDICAL UNIT, the Specialty of **CHINESE ORTHOPEDICS (CO): PAIN MANAGEMENT & THERAPEUTICS** under the DIVISION OF WORKERS' COMPENSATION QUALIFIED MEDICAL EVALUATOR REGULATIONS LC 3209.3 Licensed Acupuncturists TITLE 8, under § 13. Physician's Specialty and TITLE 8, and under § 12. Recognition of Specialty Boards.*

Sponsorship and peer review oversight by the National Guild for Acupuncture and Oriental Medicine NGAOM; AFL-CIO No.62 www.ngaom.org and the National Board of Chinese Orthopedics (NBO), as a Sub-Specialty Board of the Guild.

Regards,

Ted Priebe, OMD

Doctor of Oriental Medicine

Lic. No AC-2184

Board Member, National Board of Chinese Medicine Orthopedics (NBCMO)

Appointed Member, Medical Evidence Evaluation Advisory Committee (MEEAC)

California Department of Worker's Compensation, Medical Unit

www.tedpriebe.com 310-801-1462

Attachments.

1. A Call to Revolutionize Chronic Pain Care in America: An Opportunity in Health Care Reform November 4, 2009 *Amended March 4, 2010 **The Mayday Fund**
2. AMERICAN ACADEMY OF PAIN MANAGEMENT Pain Issues Pain Is An Epidemic A Special Message from the Director – Kathryn Weiner, PhD
3. Key Messages for Pain Care Advocacy ~ 2010; American Pain Foundation Action Network *Updated March 2010*
4. The Pain Epidemic: Some proposed solutions; Journal of the New Zealand Medical Association, 26 August 2005, Vol. 118, No1221
5. Chronic Pain Medical Treatment Guidelines MTUS (Effective July 18, 2009) 8 C.C.R. §§9792.20 – 9792.26

AMERICAN ACADEMY OF PAIN MANAGEMENT

Pain Issues

Pain Is An Epidemic

A Special Message from the Director – Kathryn Weiner, PhD

“We certainly cannot succeed as a culture by continuing to deny and ignore pain, as if we could silence it beneath a mountain of pills.” David Morris

Pain is a silent epidemic in the United States. An estimated 50 million Americans live with chronic pain caused by disease, disorder or accident. An additional 25 million people suffer acute pain resulting from surgery or accident.¹ Approximately two thirds of these individuals in pain have been living with this pain for more than five years.² The most common types of pain include arthritis, lower back, bone/joint pain, muscle pain and fibromyalgia.¹ The loss of productivity and daily activity due to pain is substantial. In a study done in 2000 it was reported that 36 million Americans missed work in the previous year due to pain and that 83 million indicated that pain affected their participation in various activities.³

In 1986 Koch⁴ estimated that 70 million office visits to physicians were motivated by pain complaints. In 1994 Joranson & Lietman⁵ estimated that approximately one-fifth of the adult American population experienced chronic pain, and in 1999 Marketdata Enterprises⁶ estimated that approximately 4.9 million individuals saw a physician for chronic pain treatment. One can conclude from these statistics that pain and its under treatment represents a major problem confronting our modern culture. In 1998 the National Institutes of Health⁷ estimated that approximately 80% of nursing home residents suffering pain were under-treated. A survey done by the American Pain Society² in 1999 revealed that more than four out of ten people suffering moderate to severe pain were unable to find adequate pain relief.

Untreated pain has significant impact on the pain sufferer and their family. The *Chronic Pain in America: Roadblocks to Relief*² study, demonstrated clearly that pain has a negative impact on an individual's quality of life. Pain diminishes their ability to concentrate, do their job, exercise, socialize, perform daily tasks and sleep. All resulting in an unrelenting downward spiral of depression, isolation and loss of self esteem. Sternbach^{8,9} conducted extensive clinical studies that concluded that depression is the most frequent psychological reaction to chronic pain and that anxiety is the most frequent psychological reaction to acute pain.

People with chronic pain have difficulty finding doctors who can effectively treat their pain. The *Chronic Pain in America: Roadblocks to Relief*² study found that one out of four pain patients had changed doctors at least three times, reporting that the primary reason for change was that they still experienced pain. Other reasons given were that



their pain was not taken seriously; that doctors were unwilling to treat pain aggressively; and that doctors lacked knowledge about how to treat pain.

Pain is complex and defies our ability to establish a clear definition. Pain is far more than neural transmission and sensory transduction. Pain is a complex melange of emotions, culture, experience, spirit and sensation. In 1986, the International Association for the Study of Pain¹⁰ grappled with this pain conundrum by defining pain as “an unpleasant sensory and emotional experience associated with actual or potential tissue damage or described in terms of such damage.” This definition speaks to the inherent subjectivity of the pain experience. As Turk and Melzack¹¹ observed in 2001, “There does not appear to be a simple isomorphic relationship between the amount of pain and the extent of the tissue damage.” This is particularly true when referring to chronic pain, both moderate and intractable. Thus, it is reasonable to believe that the unique characteristics of each individual impact their experience of pain.

Because pain is a complex puzzle, no single health care profession holds the puzzle piece that solves this puzzle; rather, each health care profession holds a critical piece that contributes to the completion of the puzzle. Pain practitioners are trained to see their patients as multifaceted, whole systems requiring a multidisciplinary viewpoint. A vast panoply of therapeutic options are available to pain patients, ranging from allopathic medicine to various complementary disciplines. Today’s pain patients may select Western medicine, Chinese medicine, acupuncture, pharmaceuticals, chiropractic, nutrition, supplementation, body work, yoga and psychology, to name a few. What does this mean to the pain patient? The path to pain reduction lies in the power of applying many different healing therapies in a way that complements the patient’s needs, beliefs and personality. While each of these therapies offer healing, the patient remains the key component to pain reduction. Pain patients must believe and affirm that they can reduce their pain and then select those therapies that will assist in doing so.

Each therapeutic option for pain management is based on collective wisdom that has been handed down from generation to generation, as well as, modern innovation. Multidisciplinary pain practitioners celebrate this unique knowledge and respect what each therapeutic option offers the pain patient. Practitioners are learning appropriate referral patterns, joining together in multidisciplinary treatment teams and learning what therapies are efficacious for pain management. Pain patients are encouraged to become self-advocates, to be an integral part of their treatment plan and to have a voice in treatment decisions.

The *Pain in America: A Research Report*³ done in 2000 found that four out of five Americans believe that pain is a part of getting older, and approximately sixty four percent would see a doctor only if their pain became unbearable. Sixty percent of the respondents said that pain was just something that you have to live with. A surprising twenty eight percent indicated that they felt that there was no solution for their pain. In light of this information it is essential for us to help those in pain to understand that they need not suffer. There are many treatment options available for the management of pain. Please refer to the American Academy of Pain Management’s website, www.aapainmanage.org to learn more about multidisciplinary pain management.



References:

1. *National Pain Survey*, conducted for Ortho-McNeil Pharmaceutical, 1999.
2. *Chronic Pain in America: Roadblocks to Relief*, survey conducted for the American Pain Society, The American Academy of Pain Medicine and Janssen Pharmaceutica, 1999.
3. *Pain in America: A Research Report*, Survey conducted for Merck by the Gallup Organization, 2000.
4. *The Management of Chronic Pain in Office-based Ambulatory Care: National Ambulatory Medical Care Survey*, Koch, H., 1986, (Advance Data from Vital and Health Statistics, No. 123; DHHS Publication No. PHS 86-1250), Hyattsville, MD: US Public Health Service.
5. *The McNeil National Pain Study*, Joranson, D. & Lietman, R., 1994, New York: Louis Harris and Associates.
6. *Pain Management Programs: A Market Analysis*, Marketdata Enterprises, 1999, Tampa, FL: Author.
7. *Gender and Pain: Future Directions*, National Institutes of Health, 1988, April, <http://www1.od.nih.gov/painresearch/genderandpain/future.htm>.
8. *Pain patients: Traits and treatment*, Sternbach, R.A., 1974, New York: Academic Press.
9. "Psychological Aspects of Chronic Pain", Sternbach, R.A., 1977, *Clinical Orthopaedics and Related Research*, 129, 150-155.
10. International Association for the Study of Pain Subcommittee on Taxonomy & Merskey, H. (Eds.). (1986). Classification of chronic pain syndromes and definitions of pain terms. *Pain* (Suppl.3), S1-S226.
11. *Handbook of Pain Assessment*, Turk, D & Melzack, R., 2001, New York: Guilford Press.

Excellent General Books About Pain:

The Culture of Pain, Morris, D. B., 1991, Berkeley, CA: University of California Press.

The Chronic Pain Management Sourcebook, Drum, D., 1999, Los Angeles: Lowell House.



Key Messages for Pain Care Advocacy ~ 2010

Finding Our United Voice, Conquering Pain Together

Pain is a national healthcare crisis. It is our nation's hidden epidemic.

- More than one-quarter of Americans (26%) age 20 years and over—or, an estimated 76.5 million people—report that they have had a problem with pain of any sort that persisted for more than 24 hours in duration. This number does not account for acute pain.¹

Undertreated pain has serious physiological, psychological, social, and economic consequences.

- Uncontrolled pain diminishes quality of life. It adversely impacts almost every aspect of a person's life including sleep, work, and relationships with family and friends.

When pain is treated properly, many people can resume their lives.

- Pain is best managed using a combination of treatment options. These options include medications, psychosocial support, rehabilitative approaches, complementary and alternative medicine, injection/infusion therapies and implantable devices or surgical interventions. This is referred to as a "multi-modality" approach to pain care.

Patient safety remains one of the most pressing health care challenges affecting people with acute and/or chronic pain.

- "No single treatment option for pain management is without risk, including the decision *not* to treat the pain" – *Scott Fishman, MD*

Many barriers including a lack of professional medical training in pain management and social stigma about pain prevent effective pain treatment.

A national movement is growing to raise awareness about the problems caused by the epidemic of undertreated pain and to transform pain care in America.

Join the American Pain Foundation Action Network!

We need your help to improve pain care for all. Together we can make a difference!

The Bottom Line: People in pain have a right to timely, appropriate pain care.

Key Messages for Pain Care Advocacy: Background and Supporting Information

Pain is a national healthcare crisis. It is our nation's hidden epidemic.

- Pain is undertreated in America.
- According to the National Center for Health Statistics, more than one-quarter of Americans (26%) age 20 years and over - or, an estimated 76.5 million Americans - report that they have had a problem with pain of any sort that persisted for more than 24 hours in duration. This number does not account for acute pain.ⁱⁱ
 - Research has also shown that about a third of people who report pain indicate that their pain is "disabling," defined as both severe and having a high impact on functions of daily life.ⁱⁱⁱ
- Pain is one of the main reasons people seek medical care.
- Pain doesn't discriminate, but treatment often does. Pain affects people of all races and economic status at all stages of life—from our very young to our elders.
 - This growing public health crisis will become even more relevant as the baby boomer population ages and life expectancy increases.

Undertreated pain has serious physiological, psychological, social, and economic consequences.

- According to data released in 1998, the annual total cost of pain from all causes was estimated to be more than \$100 billion.^{iv} However, more recent studies have indicated that costs associated with low back pain alone are an estimated \$85.9 billion.^v The total cost of arthritis - the nation's leading cause of disability - is estimated at \$128 billion.^{vi}
 - A major study found that lost productive time due to headache, arthritis, back pain and other musculoskeletal conditions is estimated to cost \$61.2 billion per year. Seventy-six percent of the pain-related lost productive time was in the form of reduced performance occurring while the employees were at work, rather than absenteeism.^{vii} These more recent findings illustrate the exponential growth in costs associated with pain over the past decade.
- Undertreated pain drives up the cost of healthcare, because it extends lengths of stay in hospitals, increases emergency room visits and leads to unplanned clinic visits.

When pain is treated properly, many people can resume their lives.

- Pain treatment options provide important benefits by reducing pain and suffering, improving physical function and restoring one's quality of life.
 - Successful pain management aims to 1) lessen the pain, 2) improve functioning and 3) enhance quality of life.
 - Pain is best managed using a combination of treatment options. These options include medications, psychosocial support, rehabilitative approaches, complementary and alternative medicine, injection/infusion therapies and implantable devices or surgical interventions. This is referred to as a "multi-modality" approach to pain care.

Patient safety remains one of the most pressing health care challenges affecting people with acute and/or chronic pain.

- There are inherent risks with all treatment options for pain that may cause unintended or undesirable effects, from minor to life-threatening. These risks can be managed by educating consumers and healthcare providers about different treatment modalities and their safe use.
- “No single treatment option for pain management is without risk, including the decision *not* to treat the pain” – *Scott Fishman, MD*

Many barriers including a lack of professional medical training in pain medicine and social stigma about pain prevent effective pain treatment.

- Most healthcare professionals have little or no training in pain management and are unable to effectively respond to patients' reports of pain.
- Many people living with pain and even some healthcare providers falsely believe opioids (strong pain medicines) are universally addictive. Studies have shown that the risk of addiction is very small when these medicines are properly prescribed and taken as directed. As with any medication, there are risks, but these risks can be managed.
- Pain carries a stigma. Many people with pain are fearful or embarrassed to let their families, friends and even their healthcare professionals know they are in pain—they don't want to appear weak, or be considered a bad patient.
- People often mistakenly believe that pain is something they “just have to live with.” They are often made to feel that the pain is “just in their heads.”
- Funding for pain research is woefully inadequate. Currently less than two percent of the NIH research budget is dedicated to pain.
- State, legal and regulatory barriers interfere with the medical use of opioids for pain relief. Efforts to prevent the diversion and abuse of pain medication must be balanced so they do not interfere with patient care.
 - Fear of scrutiny by regulators or law enforcement, and specific actions by some agencies, have had a “chilling effect” on the willingness of doctors, nurse practitioners and physicians' assistants to prescribe opioids. We must not let people with pain become casualties of the “War on Drugs.”

A national movement is growing to raise awareness about the problems caused by the epidemic of undertreated pain and to transform pain care in America.

Join the American Pain Foundation Action Network!

We need your help to improve pain care for all. Together we can make a difference!

Visit the American Pain Foundation at www.APFActionNetwork.org to join today!

The Bottom Line: People in pain have a right to timely, appropriate pain care.

REFERENCES:

-
- ⁱ National Center for Health Statistics. Health, United States, 2006 with Chartbook on Trends in the Health of Americans. Hyattsville, MD
- ⁱⁱ National Center for Health Statistics. Health, United States, 2006 with Chartbook on Trends in the Health of Americans. Hyattsville, MD
- ⁱⁱⁱ Portenoy, R, Ugarte C, Fuller I, Haas G. "Population-based Survey of Pain in the United States: Differences Among White, African American, and Hispanic Subjects" *Journal of Pain*, Vol 5, Issue 6, 2004; pp 317-318.
- ^{iv} National Institutes of Health. NIH Guide: New Directions in Pain Research I. September 4, 1998. Retrieved [date] from <http://grants.nih.gov/grants/guide/pa-files/PA-98-102.html>.
- ^v Brook I. Martin, MPH; Richard A. Deyo, MD, MPH; Sohail K. Mirza, MD, MPH; Judith A. Turner, PhD; Bryan A. Comstock, MS; William Hollingworth, PhD; Sean D. Sullivan, PhD. "Expenditures and Health Status Among Adults With Back and Neck Problems." *JAMA*. 2008;299(6):656-664.
- ^{vi} Centers for Disease Control and Prevention. "Targeting Arthritis: Improving Quality of Life for More than 46 Million Americans." At a Glance 2008. Retrieved March 6, 2008 from <http://www.cdc.gov/nccdphp/publications/aag/arthritis.htm>.
- ^{vii} Stewart, W.F., Ricci, J.A., Chee, E., Morganstein, D., & Lipton, R. (2003). Lost productive time and cost due to common pain conditions in the US workforce. *Journal of the American Medical Association*, 290(18), 2443-2454.

The pain epidemic: some proposed solutions

Edward Shipton, Elspeth Shipton

Musculoskeletal pain is a major health problem in surveys undertaken in both developed and developing countries.¹ The prevalence of musculoskeletal pain is much higher than that reported 40 years ago. In one recent large survey of 3498 routine primary care visits, musculoskeletal pain occurred in 65% of adults aged 60 years and older.² Furthermore, musculoskeletal disorders form the bulk of work-related consultations in general practice.

In an attempt to design a study to determine the prevalence and impact of musculoskeletal pain in the adult New Zealand population, Taylor has undertaken an initial pilot study in this issue of the *Journal* (www.nzma.org.nz/journal/118-1221/1629). This determined the response rate and feasibility of a postal survey measuring the population frequency of site-specific musculoskeletal pain and associated health related quality of life. The prevalence of musculoskeletal pain ranged from 40.0% (women aged less than 40 years) to 66.7% (women aged older than 65 years).

Back and shoulder were the sites most commonly affected. Quality of Life scores were significantly decreased for respondents with musculoskeletal pain (median 0.77 [no pain] to 0.41 [pain at 7 sites]), even when adjusted for psychological distress. This is a good start in trying to understand the epidemiology of the pain problem in New Zealand.

Back pain is among the most common conditions for which patients seek medical care. It has been estimated that over 80% of the population will report low back pain at some point in life.³ Of the arthritic diseases, osteoarthritis is the most common disease identified, particularly affecting the knees. In the United States, arthritis affects an estimated 43 million (20.8%) of adults and is the leading cause of disability.⁴

Pain is a multifactorial dynamic experience, not just a sensation. New onset musculoskeletal disorders therefore have a marked deleterious effect on the quality of life in the physical domain, with lesser effects on social and mental functioning. The under-treatment of acute pain associated with musculoskeletal conditions and surgical procedures remains a growing concern. In some patients, the hyperphenomena (primary and secondary hyperalgesia, mechanical allodynia) that are normal in the first days or weeks after injury, do not regress but persist beyond the usual course of an acute injury.⁵

Local inflammation in injured tissue increases the sensitisation of peripheral nociceptors, leading to central sensitisation and to chronic pain. Chronic (or persistent) pain with its biological, psychosocial, physical, and emotional dimensions comprises a disease entity in its own right.⁶ Continuing nociceptive inputs result in a multitude of consequences that impact on the individual, ranging from changes in receptor function to mood dysfunction, inappropriate cognitions, and to social disruption.⁶ Persistent pain shares many of the salient features of other chronic conditions such as diabetes and congestive heart failure.

Chronic pain, when not effectively treated and relieved, has a harmful effect on all aspects of health-related quality of life. In Taylor's study, musculoskeletal pain was associated with impaired health-related quality of life scores comparable with complicated diabetes mellitus, chronic liver disease prior to liver transplantation, and terminal cancer.

A strong association occurs between pain-related disability and the greater use of health services.⁷ Chronic pain creates a major public health problem impacting negatively on the quality-of-life issues and healthcare costs.⁵ The latest prevalence study of chronic pain was performed in the Norwegian population. It shows a prevalence of 24.4%,⁸ similar to the prevalence in the Australian population.⁹ In Germany, chronic pain results in direct and indirect costs totalling an estimated 38 billion euro annually.¹⁰

Risk factors in the development of chronic pain include unrelieved acute post-traumatic and postoperative pains, although psychological and environmental factors are at work as well.

Disabling chronic pain is relatively common in the working population, and in those of older age, and lower education and occupational class.¹¹ Indeed, pain is a strong predictor of reduced work ability and wellbeing.¹¹ As a result, employers face a nearly invisible but significant drain on productivity. The problem is of workers being at work, but not fully functional (presenteeism)—together with other chronic diseases, this phenomenon costs United States companies an estimated US150 billion dollars a year (much more than absenteeism does).

In addition to the suffering incurred, inadequate pain management increases the use of healthcare resources and augments healthcare costs. The evidence that pain has an early significant impact on the quality of life of sufferers reinforces the need for early treatment and primary prevention. Furthermore, adequate pain relief is being progressively regarded as a universal human right. Faced with the enormity of the pain problem, how do we as New Zealanders respond to prevent the prevalence of chronic pain and disability continuing to escalate in our society?

Tremendous progress has occurred in Pain Medicine (particularly interventional Pain Medicine) thus improving the outlook for those affected. Receptors, transmitters, second messenger systems, transcription factors, and signalling molecules underlying the neural plasticity observed in the spinal cord and brainstem after tissue or nerve injury, have been identified.

In exaggerated pain, astrocytes and microglia are activated by neuronal signals leading to the release of mediators such as the 'pro-inflammatory cytokines.' In low back pain, these cytokines contribute to its development. Drugs are being developed to modulate these chemical mediators. For facet and sacroiliac arthropathy, high temperature and pulsed radiofrequency is being increasingly applied. The radiofrequency heating of annular tears can lead to an improvement in the pain of internal disc disruption. For osteoarthritis, injectable therapies, such as corticosteroids and viscosupplementation have elicited favourable short-term responses but no long-term structural modification.

Yet the slow-acting drugs, especially chondroitin and glucosamine sulphate, have shown promising results. Kyphoplasty is a minimally invasive technique that appears to improve both pain and function in patients with vertebral fractures due to osteoporosis.

Progress is being made in the ability to combine local anaesthetics with liposomes (bupivacaine, morphine) and polymer microspheres. New systems designed to transiently circumvent the barrier function of the stratum corneum (using iontophoresis and sonophoresis) will expand the range of drugs that can be delivered transdermally. Using medication, multiple lines of evidence indicate that endocannabinoids serve to naturally suppress nociceptive neurotransmission.

Pregabalin is a novel alpha (2)-delta ligand with analgesic activity—for treating neuropathic pain.

Ziconotide is a drug derived from a snail toxin that works on the calcium channels. It is effective in patients suffering from cancer- or AIDS-related pain. The reduced demand for healthcare resources by patients receiving neuromodulation (peripheral nerve stimulation, spinal cord stimulation) suggests substantial long-term economic benefits in patients with neuropathic pain and chronic refractory angina receiving these.

Advances in neuroimaging techniques (positron emission tomography, functional magnetic resonance imaging [MRI]), help identify brain mechanisms for more effective treatments for chronic pain. And rapid progress is being made towards the development of gene therapy.

One approach is the use of viral vector-mediated gene transfer to achieve focal production of short-lived analgesic peptides. Research using growth factors to promote chondrocyte regeneration shows potential. Gene therapy to both prevent disc degeneration and regenerate the disc may soon have clinical application. In acute pain after surgery, developments and improvements of multimodal interventions within the context of 'fast track' surgery programmes represent a major change to achieve a pain free perioperative course.⁵

Frequent pain assessment is essential to good pain management and to quality assurance. Pain is the 'fifth vital sign' and should be measured at regular intervals. The emergence of the biopsychosocial model for managing pain has focused attention on to the psychological and social factors of pain. Patients' understanding and interpretation of symptoms (beliefs and cognitions) can modulate their pain experience.

Risk factors in acute pain (yellow and red flags) need to be identified and managed. This is to avoid the transition from acute pain to acute persistent and then on to chronic pain.⁵ Yellow flags represent

the psychological and environmental factors at work, whilst red flags characterise the physical disorders that need treatment. Patients with psychological risk factors (fear avoidance, catastrophising, pain behaviour, depression) can be identified and early preventative measures instituted. Behavioural interventions (cognitive therapy) modify any behaviour that may increase pain or prolong disability. Indeed, a coordinated approach is necessary to manage pain-related disability.

Patients often require information regarding complex regimens and reasonable access to healthcare. In a recent study of hospital-based pain services offered within Anaesthesia Departments in Quebec (Canada), 67% of patients had been waiting to see a pain consultant for 9 months or more.¹²

Integrated referral and care pathways with ready access to rehabilitation programmes and vocational rehabilitation are essential for the efficient and optimal care of patients with pain.

More attention should be given to community-based strategies for improving awareness and uptake of active self-management strategies. There may be a need to look at the ergonomic requirements of patients. For example, correct techniques in manual lifting may need to be taught.

In 2004, to raise public awareness of the problem, the International Association for the Study of Pain together with the World Health Organization launched an annual 'Global Day Against Pain.'

Educating the public on this issue should pressurise politicians and health-care providers to adequately resource and expand acute and chronic pain management services in New Zealand.

Finally, there exists a paucity of training in Pain Medicine in the undergraduate health science programme. Yet, complicated pain problems have moved beyond the scope of the General Practitioner to the Pain Medicine Specialist. In Australia, there is an application before the Medical Council to recognise 'Pain Medicine' as a stand-alone specialty.

This is a very exciting time in the field of Pain Medicine. But, as Taylor suggests, Health and Education authorities need to act urgently to address the issues raised if we have any hope of controlling the increasing prevalence of chronic pain and disability in our society.

But, as Taylor suggests, Health and Education authorities need to act urgently to address the issues raised if we have any hope of controlling the increasing prevalence of chronic pain and disability in our society.

Author information: Edward A Shipton, Academic Head and Chair; Elspeth E Shipton, Registered Nurse; Department of Anaesthesia, Christchurch School of Medicine, University of Otago, Christchurch

Correspondence: Professor Edward Shipton, Department of Anaesthesia, Christchurch School of Medicine, University of Otago, PO Box 4345, Christchurch. Fax: (03) 357 2594; email: ted.shipton@cdhb.govt.nz

References:

1. Muirden KD. Community Oriented Program for the Control of Rheumatic Diseases: studies of rheumatic diseases in the developing world. *Curr Opin Rheumatol.* 2005;17:153–6.
2. Sha MC, Callahan CM, Counsell SR, et al. Physical symptoms as a predictor of health care use and mortality among older adults. *Am J Med.* 2005;118:301–6.
3. Jones GT, Macfarlane GJ. Epidemiology of low back pain in children and adolescents. *Arch Dis Child.* 2005;90:312–6.
4. Centers for Disease Control and Prevention (CDC). Monitoring progress in arthritis management – United States and 25 states; 2003.
5. Shipton EA, Tait B. Flagging the pain: preventing the burden of pain by identifying and treating risk factors in acute pain. *Eur J Anaesthesiol.* 2005;22:405–12.
6. Siddall PJ, Cousins MJ. Persistent pain as a disease entity: implications for clinical management. *Anesth Analg.* 2004;99:510–20.
7. Blyth FM, March LM, Cousins MJ. Chronic pain-related disability and use of analgesia and health services in a Sydney community. *Med J Aust.* 2003;179:84–7.
8. Rustoen T, Wahl AK, Hanestad BR, et al. Prevalence and characteristics of chronic pain in the general Norwegian population. *Eur J Pain.* 2004;8:555–65.
9. Blyth FM, March LM, Brnabic AJ, Cousins MJ. Chronic pain and frequent use of health care. *Pain.* 2004;111:51–8.
10. Zimmermann M. Chronic pain. Epidemiology and management in Germany. *Orthopade.* 2004;33:508–14.
11. Saastamoinen P, Leino-Arjas P, Laaksonen M, Lahelma E. Socio-economic differences in the prevalence of acute, chronic and disabling chronic pain among ageing employees. *Pain.* 2005;114:364–71.

12. Veillette Y, Dion D, Altier N, Choiniere M. The treatment of chronic pain in Quebec: a study of hospital-based services offered within anesthesia departments: *Can J Anesth.* 2005;52:600-6.



Labor Code section 5307.27 requires the Administrative Director to adopt a medical treatment utilization schedule (MTUS) that is “scientific and evidence-based, peer-reviewed, and nationally recognized.” (See, also Lab. Code, § 4604.5(b).) Labor Code section 5307.27 further provides that the MTUS shall address, at a minimum, “the frequency, duration, intensity, and appropriateness of all treatment procedures and modalities commonly performed in workers’ compensation cases.”

A patient suffering from severe intractable pain who does not qualify for participation in a chronic pain program or who has failed a chronic pain program “should have access to proper treatment of his or her pain.” California Health and Safety Code section 124960

CHRONIC PAIN MEDICAL TREATMENT GUIDELINES

Chronic Pain Medical Treatment Guidelines 8 C.C.R. §§9792.20 – 9792.26

MTUS (Effective July 18, 2009) Page 5 of 127

The following chart contrasts these two pain models (Hanson and Gerber 1993):

Pain Models

Biomedical model Biopsychosocial model

Most appropriate for acute pain conditions More useful for those with chronic pain conditions

Emphasizes peripheral nociception Recognizes the role that central mechanisms play in modulating peripheral nociception or generating the experience of pain in the absence of nociception

Focus on physical disease mechanisms Recognizes the importance of illness behavior including cognitive and emotional responses to pain

Reductionistic approach to understanding and treating pain

Multidimensional systems approach to understanding and treating pain

Reliance on medical management approaches Utilization of self-management approaches

Linton identified strong evidence that psychosocial variables are strongly linked to the transition from

acute to chronic pain disability and that psychosocial variables generally have more impact than

biomedical or biomechanical factors on back pain disability. (Linton 2000) Thus, when clinical progress

is insufficient, the clinician should always be prepared to address confounding psychosocial variables, in a coordinated, multidisciplinary manner.

§ 9792.20. Medical Treatment Utilization Schedule—Definitions

As used in this Article:

(a) “American College of Occupational and Environmental Medicine (ACOEM)” is a medical society of physicians and other health care professionals specializing in the field of occupational and environmental medicine, dedicated to promoting the health of workers through preventive medicine, clinical care, research, and education.

(b) “ACOEM Practice Guidelines” means the American College of Occupational and Environmental Medicine’s Occupational Medicine Practice Guidelines, 2nd Edition (2004). A copy may be obtained from the American College of Occupational and Environmental Medicine, 25 Northwest Point Blvd., Suite 700, Elk Grove Village, Illinois, 60007-1030 (www.acoem.org).

(c) “Chronic pain” means any pain that persists beyond the anticipated time of healing.

(d) “Claims administrator” is a self-administered workers' compensation insurer, a self-administered self-insured employer, a self-administered legally uninsured employer, a self-administered joint powers authority, a third-party claims administrator, or the California Insurance Guarantee Association.

(e) “Evidence-based” means based, at a minimum, on a systematic review of literature published in medical journals included in MEDLINE.

(f) “Functional improvement” means either a clinically significant improvement in activities of daily living or a reduction in work restrictions as measured during the history and physical exam, performed and documented as part of the evaluation and management visit billed under the Official Medical Fee Schedule (OMFS) pursuant to sections 9789.10-9789.111; and a reduction in the dependency on continued medical treatment.

(g) “Medical treatment” is care which is reasonably required to cure or relieve the employee from the effects of the industrial injury consistent with the requirements of sections 9792.20-9792.26.

(h) “Medical treatment guidelines” means the most current version of written recommendations revised within the last five years which are systematically developed by a multidisciplinary process through a comprehensive literature search to assist in decision-making about the appropriate medical treatment for specific clinical circumstances.

Title 8, California Code of Regulations, section 9792.20 et seq.

Effective July 18, 2009

(Final Version)

2

(i) “MEDLINE” is the largest component of PubMed, the U.S. National Library of Medicine’s database of biomedical citations and abstracts that is searchable on the Web. Its website address is www.pubmed.gov.

(j) “Nationally recognized” means published in a peer-reviewed medical journal; or developed, endorsed and disseminated by a national organization with affiliates based in two or more U.S. states; or currently adopted for use by one or more U.S. state governments or by the U.S. federal government; and is the most current version.

(k) "Peer reviewed" means that a medical study's content, methodology and results have been evaluated and approved prior to publication by an editorial board of qualified experts.

(l) "Scientifically based" means based on scientific literature, wherein the body of literature is identified through performance of a literature search in MEDLINE, the identified literature is evaluated, and then used as the basis for the guidelines.

(m) "Strength of Evidence" establishes the relative weight that shall be given to scientifically based evidence.

Authority: Sections 133, 4603.5, 5307.3, and 5307.27, Labor Code.

Reference: Sections 77.5, 4600, 4604.5, and 5307.27, Labor Code.

§ 9792.24.1. Acupuncture Medical Treatment Guidelines

(a) As used in this section, the following definitions apply:

(1) "Acupuncture" is used as an option when pain medication is reduced or not tolerated, it may be used as an adjunct to physical rehabilitation and/or surgical intervention to hasten functional recovery. It is the insertion and removal of filiform needles to stimulate acupoints (acupuncture points). Needles may be inserted, manipulated, and retained for a period of time. Acupuncture can be used to reduce pain, reduce inflammation, increase

Title 8, California Code of Regulations, section 9792.20 et seq.

Effective July 18, 2009

(Final Version)

9

blood flow, increase range of motion, decrease the side effect of medication-induced

nausea, promote relaxation in an anxious patient, and reduce muscle spasm.

(2) "Acupuncture with electrical stimulation" is the use of electrical current (microamperage or milli-amperage) on the needles at the acupuncture site. It is used to increase effectiveness of the needles by continuous stimulation of the acupoint. Physiological effects (depending on location and settings) can include endorphin release for pain relief, reduction of inflammation, increased blood circulation, analgesia through interruption of pain stimulus, and muscle relaxation. It is indicated to treat chronic pain conditions, radiating pain along a nerve pathway, muscle spasm, inflammation, scar tissue pain, and pain located in multiple sites.

(3) "Chronic pain for purposes of acupuncture" means chronic pain as defined in section 9792.20(c).

(b) Application

(1) These guidelines apply to acupuncture or acupuncture with electrical stimulation when referenced in the clinical topic medical treatment guidelines in the series of sections commencing with 9792.23.1 et seq., or in the chronic pain medical treatment guidelines contained in section 9792.24.2.

(c) Frequency and duration of acupuncture or acupuncture with electrical stimulation may be performed as follows:

(1) Time to produce functional improvement: 3 to 6 treatments.

(2) Frequency: 1 to 3 times per week.

(3) Optimum duration: 1 to 2 months.

(d) Acupuncture treatments may be extended if functional improvement is documented as defined in Section 9792.20(c).

(e) It is beyond the scope of the Acupuncture Medical Treatment Guidelines to state the

precautions, limitations, contraindications or adverse events resulting from acupuncture or acupuncture with electrical stimulations. These decisions are left up to the acupuncturist.

Authority: Sections 133, 4603.5, 5307.3, and 5307.27, Labor Code.

Reference: Sections 77.5, 4600, 4604.5, and 5307.27, Labor Code.