CLINICAL GUIDELINES

Acupuncture Services

Version 1.0
Effective February 14, 2020

Clinical guidelines for medical necessity review of acupuncture services.
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ACU-1.0: Covered Services and Exclusions

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ACU-1.1: Acupuncture Covered Services

Covered Acupuncture Services are those within the scope of acupuncture care that are therapeutic or corrective to help members achieve the physical state exhibited before an injury or illness, and that are determined by eviCore to be Medically Necessary.

- Services include the following:
  - Acupuncture
  - Electro-acupuncture

ACU-1.2: Medically Necessary Acupuncture Services

- To be considered reasonable and necessary the following conditions must each be met:
  - The clinical documentation must establish the individual's current condition and medical need for services
  - Services are for the treatment of a covered injury, illness or disease.
  - There is strong evidence supporting the services as effective and appropriate treatment for the condition.
  - Treatments are expected to result in significant, measurable, progressive improvement in a reasonable and generally predictable period of time. The improvement potential must be significant in relation to the extent and duration of the therapy required.
  - The complexity of the patient's condition must require the judgment and knowledge of a licensed qualified clinician. Services for conditions that do not require care under a qualified clinician are not skilled and are not considered reasonable or necessary services, even if they are performed by a qualified professional.
  - The amount, frequency, and duration of the services must be reasonable under accepted standards of practice. For these purposes, "generally acceptable standards of practice" means standards that are based on credible scientific evidence published in the peer-reviewed literature generally recognized by the relevant healthcare community, specialty society evidence-based guidelines or recommendation.

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ACU-1.3: Care Classifications

Therapeutic Care
Therapeutic care is care provided to relieve the functional loss associated with an injury or condition and is necessary to return the patient to the functioning level required to perform their activities of daily living, instrumental activities of daily living and work activities. Therapeutic care generally occurs within a reasonable period of time and is guided by evidence based practice of acupuncture.

Corrective or Rehabilitative Care
Corrective or rehabilitative care is the stage of ongoing care beyond the sub-acute phase.

It may also refer to treatment of conditions that are chronic in nature and do not occur in conjunction with an acute or subacute phase. The therapeutic goals of this phase are reduction and management of symptoms with a goal of maximizing function over time. Means and methods include progression of exercise, continued patient education, and transition to self-management. Intensity of care is guided by functional status, focusing on home management, supplemented by acupuncture.

Palliative Care (Not medically necessary acupuncture service)
Palliative care is typically given to alleviate symptoms and does not provide corrective benefit to the condition treated. A patient receiving palliative care, in most instances, demonstrates varying lapses between treatments. If an exacerbation of a condition occurs, care becomes therapeutic rather than palliative, and documentation of the necessity for care (e.g., etiology of exacerbation, objective findings, and desired outcomes) must be obtained.

Maintenance Care (Not medically necessary acupuncture service)
Maintenance care is defined as services required to maintain the member's current condition or to prevent or slow deterioration of the member's condition.

Preventive Care (Not medically necessary acupuncture service)
Preventive care includes management of the asymptomatic patient.

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ACU-1.4: Acupuncture Coverage Exclusions

- The following are not covered under the plan:
  - Services not covered by the health plan (e.g. services provided by non-participating providers and services provided outside the health plan's service area)
  - Services incurred prior to the beginning or after the end of coverage
  - Services that exceed the combined maximum covered visits for the benefit year
  - Charges incurred for missed appointments
  - Educational programs
  - Pre-employment, school entrance, or athletic physical exams
  - Services for conditions arising out of employment, including self-employment or covered under any workers' compensation act or law
  - Services for any bodily injury arising from or sustained in an automobile accident that is covered under an automobile insurance policy
  - Charges for which the member is not legally required to pay
  - Services rendered by a person who ordinarily resides in the member's home or who is related to the member by marriage or blood

ACU-1.5: Specific Acupuncture Services that are Limited or Excluded

- The following are not covered under the plan:
  - Services for preventive, maintenance, palliative or wellness care
  - Experimental or investigational services
  - Services not medically necessary as determined by eviCore
  - Vocational, or long-term rehabilitation
  - Hypnotherapy, behavior training, sleep therapy, or biofeedback
  - Rental or purchase of Durable Medical Equipment (DME)
  - Treatment primarily for purposes of weight control
  - Lab services
  - Thermography, hair analysis, heavy metal screening, or mineral studies
  - Transportation costs, including ambulance charges
  - Inpatient services
  - Advanced diagnostic services, such as MRI, CT, EMG, SEMG, and NCV
  - Drugs, vitamins, nutritional supplements, or herbs
  - X-rays of any kind
  - Services related to menstrual cramps
  - Services related to addiction, including smoking cessation
  - Services related to the treatment of infertility
  - Services furnished primarily for the convenience of the member (e.g. improving athletic performance and improving ability to perform recreational activities)
  - Services related to a condition for which there is currently unclear or insufficient research to support the efficacy of acupuncture treatment, including but not limited to: ankle sprain, carpal tunnel syndrome, dysmenorrhea[3], fibromyalgia, hyperemesis gravidarum, nausea in pregnancy.

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References

1. Boelig RC, Barton SJ, Saccone G, Kelly AJ, Edwards SJ, Berghella V. Interventions for treating hyperemesis gravidarum. Cochrane Database Syst Rev. 2016(5):Cd010607. doi:10.1002/14651858.CD010607.pub2.
2. Balshem H, Helfand M, Schunemann HJ, Oxman AD, Kunz R, Brozek J, et al. GRADE guidelines: 3. Rating the quality of evidence. J Clin Epidemiol. 2011 Apr;64(4):401-6. doi:10.1016/j.jclinepi.2010.07.015.
3. Brown J, Farquhar C. Endometriosis: an overview of Cochrane Reviews. Cochrane Database Syst Rev. 2014 Mar 10;(3):CD009590. doi:10.1002/14651858.CD009590.pub2.
4. Cheng X, Deng L. Chinese Acupuncture and Moxibustion. Beijing: Foreign Language Press; 2010.
5. Deare JC, Zheng Z, Xue CC, Liu JP, Shang J, Scott SW, et al. Acupuncture for treating fibromyalgia. Cochrane Database Syst Rev. 2013(5):Cd007070. doi:10.1002/14651858.CD007070.pub2.
6. Hadianfard M, Bazrafshan E, Momeninejad H, Jahani N. Efficacies of Acupuncture and Anti-inflammatory Treatment for Carpal Tunnel Syndrome. J Acupunct Meridian Stud. 2015 Oct;8(5):229-35. doi:10.1016/j.jams.2014.11.005.
7. Hempel S, Taylor SL, Solloway MR, Miake-Lye IM, Beroes JM, Shanman R, et al. VA Evidence-based Synthesis Program Reports. Evidence Map of Acupuncture. Washington (DC): Department of Veterans Affairs; 2014.
8. Horn KK, Jennings S, Richardson G, Vliet DV, Hefford C, Abbott JH. The patient-specific functional scale: psychometrics, clinimetrics, and application as a clinical outcome measure. J Orthop Sports Phys Ther. 2012 Jan;42(1):30-42. doi:10.2519/jospt.2012.3727.
9. Kaptchuk T. The Web That Has No Weaver. Contemporary Books. 2000.
10. Kelly RB. Acupuncture for pain. Am Fam Physician. 2009 Sep 1;80(5):481-4.
11. Kim TH, Lee MS, Kim KH, Kang JW, Choi TY, Ernst E. Acupuncture for treating acute ankle sprains in adults. Cochrane Database Syst Rev. 2014(6):Cd009065. doi:10.1002/14651858.CD009065.pub2.
12. Lauche R, Cramer H, Hauser W, Dobos G, Langhorst J. A Systematic Overview of Reviews for Complementary and Alternative Therapies in the Treatment of the Fibromyalgia Syndrome. Evid Based Complement Alternat Med. 2015;2015:610615. doi:10.1155/2015/610615.
13. Maciocia, G; The Foundations of Chinese Medicine: A Comprehensive Text; Churchill Livingstone, 2005.
14. MacPherson H, Vertosick EA, Foster NE, Lewith G, Linde K, Sherman KJ, et al. The persistence of the effects of acupuncture after a course of treatment: A meta-analysis of patients with chronic pain. Pain. 2016 Oct 17. doi:10.1097/j.pain.0000000000000747.
15. Matthews A, Haas DM, O'Mathuna DP, Dowswell T. Interventions for nausea and vomiting in early pregnancy. Cochrane Database Syst Rev. 2015(9):Cd007575. doi:10.1002/14651858.CD007575.pub4.
16. McDonald J, Janz S. The Acupuncture Evidence Project: A Comparative Literature Review (Revised Edition). Brisbane: Australian Acupuncture and Chinese Medicine Association Ltd; 2017.
17. National Health and Medical Research Council. NHMRC additional levels of evidence and grades for recommendations for developers of guidelines. Table 3. NHMRC Evidence Hierarchy: designations of 'levels of evidence' according to type of research question (including explanatory notes). National Health and Medical Research Council; 2009.
18. O'Connor J, Bensky D. Acupuncture: A Comprehensive Text. Chicago: Eastland Press; 1981.
19. Park J, Hahn S, Park JY, Park HJ, Lee H. Acupuncture for ankle sprain: systematic review and meta-analysis. BMC Complement Altern Med. 2013;13:55. doi:10.1186/1472-6882-13-55.
20. Porter, R; The Merck Manual, Merck, 2011.
21. Smith CA, Armour M, Zhu X, Li X, Lu ZY, Song J. Acupuncture for dysmenorrhoea. Cochrane Database Syst Rev. 2016;4:Cd007854. doi:10.1002/14651858.CD007854.pub3.
22. Yang B, Yi G, Hong W, Bo C, Wang Z, Liu Y, et al. Efficacy of acupuncture on fibromyalgia syndrome: a meta-analysis. J Tradit Chin Med. 2014 Aug;34(4):381-91.

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ACU-2.0: Headaches

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ACU-2.1: Cervicocranial Syndrome

Synonyms

- Barre-Lieou syndrome
- Osteophytosis
- Posterior Cervical Sympathetic Syndrome
- Spondylosis

Definition

- Cervicocranial syndrome is a dysfunction in the posterior cervical sympathetic nervous system; also known as Barre-Lieou Syndrome and Posterior cervical sympathetic syndrome. Condition commonly arises from a trauma to the cervicocranial junction, and is associated with the following symptoms:
  - Vertigo and unsteadiness
  - Neck pain
  - Burning sensation in the face
  - Tinnitus
  - Dysphagia
  - Arm pain
- Diagnosis is commonly misused by some practitioners to describe a cervicogenic headache. In this case, refer to Headache guideline for a description of the Oriental Medicine Evaluation and Management of this condition.

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ACU-2.2: Headache, Cephalgia

Definition

Headache of musculoskeletal origin, such as referral from soft tissue and articular structures of the neck (cervicogenic). Pain may be acute or chronic.

Oriental Medicine Diagnoses

- Liver Qi Stagnation
  - Causation can be due to external pathogens, lifestyle choices, such as, irregular or “incorrect” food choice, irregular eating times, lack of sleep, or stress.
- Excessive Liver Yang
  - Leading to a rising of energy. Causation is disturbance of the liver energy due to either emotional or physical reasons, sometimes caused by heavy drinking.
- Qi and Blood Stagnation
  - Stagnation results in pain. May have numerous causations. Can be related to trauma or underlying syndromes.
- Heat in the Stomach, or Fire in the Liver/Gall Bladder Meridians
  - May be caused by inappropriate food choices either recently or over time. Other causations are inappropriate life style choices, such as, irregular or “incorrect” food or drink choice—particularly alcohol, irregular eating times, lack of sleep.

Note: While the above pathways represent classical causations for a headache within the paradigm of Oriental Medicine diagnoses, they are not necessarily eligible for authorization or coverage under eviCore acupuncture benefit plans. To be eligible for coverage and reimbursement, headache symptoms and/or a diagnosis of "Headache" must be the direct result of a primary neuromusculoskeletal injury or illness.

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History

Acute or gradual onset, generally recurrent.

Specific Aspects of History

- Rule out red flags (requires medical management).
- Identify co-morbidities requiring medical management, and those that affect acupuncture and Oriental Medicine management.

Red Flag	Possible Consequence or Cause	Action Required
Sudden onset of severe headache with no past history	Subarachnoid hemorrhage; meningitis	Immediate referral to emergency department
New headache in older patient	Tumor; temporal arteritis; glaucoma	Prompt referral to Primary Care Provider
Headache following head trauma	Subdural hematoma; epidural hematoma	Immediate referral to emergency department
Neurologic signs or symptoms	Tumor; vascular accident	Immediate referral to emergency department
Vomiting without nausea	Increased intracranial pressure	Immediate referral to emergency department
Suspicion of drug or alcohol dependence	Side effect or withdrawal phenomenon	Immediate referral to emergency department
Headache associated with diastolic blood pressure greater than 110 mmHg	Uncontrolled hypertension	Prompt referral to Primary Care Provider
Persistent or severe headache in a child	Tumor; encephalitis; meningitis	Immediate referral to emergency department
Cognitive changes, such as confusion, drowsiness or giddiness	Subdural hematoma; epidural hematoma	Immediate referral to emergency department
Persistent or progressive headache	Tumor; intracranial mass	Prompt referral to Primary Care Provider
Nuchal rigidity	Subarachnoid hemorrhage; meningitis	Immediate referral to emergency department

- The following symptoms reported by the patient require physician referral or co-management:
  - Neck pain with difficulty swallowing or extreme neck stiffness accompanied by pain or electric shocks in arms or legs when moving neck
  - Visual symptoms or “aura” preceding headache
  - Neurologic symptoms associated with headache
  - Leg pain that worsens with exercise but is relieved by resting
  - Loss of feeling in inner thighs
  - Back pain associated with urinary problems
  - Severe pain that interrupts sleep
  - Constant pain that does not improve by changing positions or lying down

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- Recent unexplained weight loss
- Recent progressive muscle weakness or shaking
- Recent or recurrent fever over 102 degrees
- Loss of bowel or bladder control
- Blurred or double vision, dizziness, nausea or faintness when neck is in certain positions
- Memory loss after injury or blow to the head that resulted in loss of consciousness or other neurological changes
- History of stroke, aneurysm, angina or heart disease
- Diabetes or other significant organic disease
- Associated psychological symptoms

Subjective Findings

- Frequent headaches without associated neurologic signs.
- Pain is localized to neck and occipital region, but may refer to the forehead, orbital region, temples, vertex or ears.
- Pain occurs, or is aggravated by particular movements of the neck or with sustained neck postures.
- Pain should be documented as a numeric pain scale 0-10.
- Headache frequency, duration and numeric pain scale should be documented.

Functional Assessment

- Documentation of a patient's level of function is an important aspect of patient care. This documentation is required in order to establish the medical necessity of ongoing acupuncture treatment. The Patient Specific Functional Scale (PSFS) is a patient reported outcome assessment that is easy and appropriate for acupuncturists to use. The PSFS has been studied in peer-reviewed scientific literature, and it has been proven to be a valid, reliable, and responsive measure for a variety of pain syndromes (neck, back, knee, etc.).

Objective Findings

- Measure blood pressure, pulse rate, temperature (if allowed by law)
- Inspection of posture (forward head carriage, rounded shoulders)
- Palpate temporal arteries
- Palpate cervical spine for muscle spasm, trigger points
- Perform cervical ROM
- Percussion of sinuses
- Neurological examination for focal signs or asymmetric reflexes. Test cranial nerves (if allowed by law)

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Goal of Examination
Examine the musculoskeletal system for possible causes or contributing factors to the headache, particularly in the following:

- Restricted and/or painful neck motion
- Tenderness of cervical musculature
- May demonstrate postural imbalance, such as forward head carriage and rounded shoulders

Oriental Medicine Management [11, 26, 28]

- Oriental Medicine management goals are to resolve pain, restore the highest level of function possible and educate the patient to prevent recurrent symptoms.
- In order to be considered medically necessary, patient's symptoms must be the direct result of a primary neuromusculoskeletal injury or illness.
- Confirmation of appropriate medical co-management is always required when treating children age 14 and under.
- Treatment frequency should be commensurate with severity of the chief complaint.
- When significant improvements in patient's subjective and objective findings are demonstrated—continued treatment with decreased frequency is appropriate.
- As treatment progresses, one should see an increase in the active regimen of care, a decrease in the passive regimen of care, and a fading of treatment frequency.
- If the condition has not progressed towards resolution, refer the patient to an appropriate health care provider to explore other treatment alternatives.
- eviCore's consideration of requests for continued acupuncture treatment depends on updated clinical information submitted regarding patient's progress.
- Adequate and legible patient progress information that contains a history and examination, and/or eviCore's Acupuncture Treatment Request Form is required to determine medical necessity.
- In addition to improvements in the table below, significant progress may also be documented by increases in functional capacity and increasingly longer durations of pain relief.
- If improvement following the initial two weeks is not at least 25-50%, reassess case for other possible causes or complicating factors and consider different interventions.
- Discharge occurs when reasonable functional goals and expected outcomes have been achieved.
- The patient is discharged when the patient/care-giver can continue management of symptoms with an independent home program.

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- Treatment is discontinued when the patient is unable to progress towards outcomes because of medical complications, psychosocial factors or other personal circumstances.
- If the member has been non-compliant with treatment as is evidenced by the clinical documentation, and/or the lack of demonstrated progress, treatment will be deemed to be not medically necessary and the member should be discharged from treatment.

Week	Progress
0-1	◆ Some reduction of pain severity and frequency ◆ Some reduction of muscle spasm
2-4	◆ 50% decrease in pain severity and frequency ◆ 50% improvement in function
5-8	◆ 75% decrease in pain severity and frequency ◆ 75% improvement in function
9-12	◆ Gradual improvement leading toward resolution ◆ Reinforce self-management techniques ◆ Discharge patient to elective care, or to their primary care provider for alternative treatment options when a plateau is reached, or by week 12, whichever occurs first

Referral Guidelines

- Refer patient to their primary care provider for evaluation of alternative treatment options if:
  - Articular derangements such as rheumatoid arthritis or similar autoimmune disease, joint instability or hypermobility particularly of the atlanto-axial joint
  - History of infection as indicated by a fever greater than 100, constant low-grade fever, joint infection
  - Circulatory or cardiovascular disorder such as stroke, angina or heart disease
  - Recent fracture, bone weakening or destructive disorders such as tumors or history of compression fractures or greater than 3 months of steroid use
  - Signs or symptoms of neurological disorders such as nuchal rigidity, positive Brudzinski's or Kernig's sign, myelopathy, acute cauda equina syndrome, saddle anesthesia, multiple sclerosis
  - Atrophy in the extremities
  - Abnormal deep tendon reflexes or motor weakness
  - Scoliosis greater than 20 degrees in an adult or greater than 10 degrees in a child
  - Congenital connective tissue disorders such as Marfan's
  - Abnormal bowel or bladder function associated with the onset of symptoms attributable to the spine
  - Signs or symptoms of vertebrobasilar insufficiency
  - Fever, localized redness and swelling or ankylosing spondylitis
  - Signs or symptoms of cancer, recent or current chemotherapy, organ transplant or other immunosuppressive therapies
  - Any other signs or symptoms of organic disease
  - Recent loss of consciousness or blow to the head

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- Positive cranial nerve exam
- Dysphasia or other positive CNS findings
- Recent onset of headache with no prior history of headache
- Signs or symptoms of substance abuse or withdrawal

Appropriate Procedures/Modalities

- Acupuncture
- Electro-acupuncture
- Cupping
- Moxibustion
- Gua Sha
- Myofascial release
- Acupressure
- Trigger point massage
- Tui Na (not to include osseous manipulation)
- Herbal formulas

Note: Not all of these modalities are covered by the patient's health-plan; review documentation regarding coverage. Acupuncture and herbs must be appropriate for covered diagnoses under the patient's insurance policy. Acupuncturist is responsible for determining which procedures/modalities that are most appropriate for the patient's condition.

Inappropriate Procedures/Modalities

- Scarring moxa
- Applied kinesiology techniques
- Electro-acupuncture using more than 9 volts
- Any technique outside the scope of practice in your state

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Self-Management Techniques

- Rest and reduce strenuous activities
- Ergonomics, Postural advice, postural exercises
- Appropriate exercises/stretching
- Tai Qi, Qi Gong, Yoga
- Stress management, meditation
- Joint protection
- Weight loss
- Self-massage, Self-acupressure
- Hot packs/cold packs, if needed, to relieve discomfort
- Sleep with cervical pillow, if found helpful

Home Care

- Avoid headache triggers such as eyestrain, alcohol, fatty foods, caffeine, chocolate, stress
- Exercise muscles of the upper back and neck to improve posture, strength and flexibility

Alternatives to Oriental Medicine Management

(listed in alphabetical order)

- Biofeedback
- Chiropractic
- Dietary/Nutritional Medicine Counseling
- Injection therapy/Pain management
- Massage therapy
- Medication
- Occupational therapy
- Osteopathic Manipulation
- Physical Therapy
- Psychological counseling
- Recommendations depend on causation—can relate to food choices, lifestyle choices, stress reduction

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References

1. Balshem H, Helfand M, Schunemann HJ, Oxman AD, Kunz R, Brozek J, et al. GRADE guidelines: 3. Rating the quality of evidence. J Clin Epidemiol. 2011 Apr;64(4):401-6.
2. Beinfield, H and Korngold, E; Between Heaven and Earth, The Ballantine Publishing Group, 1992.
3. Birch, S and Hammerschlag R: Acupuncture Efficacy - A Compendium of Controlled Clinical Studies, The National Academy of Acupuncture and Oriental Medicine, 1996.
4. Cheng X, Deng L. Chinese Acupuncture and Moxibustion. Beijing: Foreign Language Press; 2010.
5. Hempel S, Taylor SL, Solloway MR, Miake-Lye IM, Beroes JM, Shanman R, et al. VA Evidence-based Synthesis Program Reports. Evidence Map of Acupuncture. Washington (DC): Department of Veterans Affairs; 2014.
6. Hopton A, MacPherson H. Acupuncture for chronic pain: is acupuncture more than an effective placebo? A systematic review of pooled data from meta-analyses. Pain Pract. 2010;10(2):94-102. doi:10.1111/j.1533-2500.2009.00337.x.
7. Horn KK, Jennings S, Richardson G, Vliet DV, Hefford C, Abbott JH. The patient-specific functional scale: psychometrics, clinimetrics, and application as a clinical outcome measure. J Orthop Sports Phys Ther. 2012 Jan;42(1):30-42. doi:10.2519/jospt.2012.3727.
8. Kaptchuk T. The Web That Has No Weaver. Contemporary Books. 2000.
9. Kelly RB. Acupuncture for pain. Am Fam Physician. 2009 Sep 1;80(5):481-4.
10. Li X, Wang R, Xing X, et al. Acupuncture for Myofascial Pain Syndrome: A Network Meta-Analysis of 33 Randomized Controlled Trials. Pain Physician. 2017 Sep;20(6):E883-E902.
11. Maciocia, G; The Foundations of Chinese Medicine: A Comprehensive Text; Churchill Livingstone, 2005.
12. MacPherson H, Vertosick EA, Foster NE, Lewith G, Linde K, Sherman KJ, et al. The persistence of the effects of acupuncture after a course of treatment: A meta-analysis of patients with chronic pain. Pain. 2016 Oct 17. doi:10.1097/j.pain.0000000000000747.
13. Magee, David J., Orthopedic Physical Assessment, Second Edition, W.B. Saunders Company, 2007.
14. Marcus, Alon; Musculoskeletal Disorders - Healing Methods from Chinese Medicine, Orthopaedic Medicine, and Osteopathy, North Atlantic Books, 1998.
15. McDonald J, Janz S. The Acupuncture Evidence Project: A Comparative Literature Review (Revised Edition). Brisbane: Australian Acupuncture and Chinese Medicine Association Ltd; 2017.
16. Melchart D, Streng A, Hoppe A, Brinkhaus B, Witt C, Wagenpfeil S, Pfaffenrath V, Hammes M, Hummelsberger J, Irnich D, Weidenhammer W, Willich SN, Linde K. Acupuncture in patients with tension-type headache: randomised controlled trial. BMJ. 2005 Aug 13;331(7513):376-82. doi: 10.1136/bmj.38512.405440.8F.
17. National Health and Medical Research Council. NHMRC additional levels of evidence and grades for recommendations for developers of guidelines. Table 3. NHMRC Evidence Hierarchy: designations of 'levels of evidence' according to type of research question (including explanatory notes). National Health and Medical Research Council; 2009.
18. O'Connor J, Bensky D. Acupuncture: A Comprehensive Text. Chicago: Eastland Press; 1981.
19. Olson WH, Brumback RA, Gascon G, Iyer V; Handbook of Symptom Oriented Neurology; Year Book Medical Publishers, Inc.; 2002.
20. Plank S, Goodard J. The effectiveness of acupuncture for chronic daily headache: an outcomes study. Mil Med. 2009 Dec;174(12):1276-81. doi:10.7205/milmed-d-00-5709.
21. Porter, R; The Merck Manual, Merck, 2011.
22. Roy, S., Irvin, R., and Iverson, D; Sports Medicine, Prevention, Education, Management, and Rehabilitation, Benjamin Cummings, 1998.
23. Sun Y, Gan TJ. Acupuncture for the management of chronic headache: a systematic review. Anesth Analg. 2008 Dec;107(6):2038-47. doi:10.1213/ane.0b013e318187c76a.
24. Vickers AJ, Cronin AM, Maschino AC, et al. Acupuncture for chronic pain: individual patient data meta-analysis. Arch Intern Med. 2012;172(19):1444-1453. doi:10.1001/archinternmed.2012.3654.
25. Vickers AJ, Rees RW, Zollman CE, McCarney R, Smith CM, Ellis N, Fisher P, Van Haselen R. Acupuncture for chronic headache in primary care: large, pragmatic, randomised trial. BMJ. 2004 Mar 27;328(7442):744. doi:10.1136/bmj.38029.421863.EB.

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26. Wang R, Li X, Zhou S, Zhang X, Yang K, Li X. Manual acupuncture for myofascial pain syndrome: a systematic review and meta-analysis. Acupunct Med. 2017 Aug;35(4):241-250. doi:10.1136/acupmed-2016-011176.
27. Weinstein, S, and Buckwalter, J. Orthopaedics Principles and Their Applications. Lippincott, Williams, & Wilkins, 2005.
28. Xiang A, Cheng K, Shen X, Xu P, Liu S. The Immediate Analgesic Effect of Acupuncture for Pain: A Systematic Review and Meta-Analysis. Evid Based Complement Alternat Med. 2017;2017:3837194. doi:10.1155/2017/3837194.
29. Yuan J, Purepong N, Hunter RF, Kerr DP, Park J, Bradbury I, McDonough S. Different frequencies of acupuncture treatment for chronic low back pain: an assessor-blinded pilot randomised controlled trial. Complement Ther Med. 2009 Jun;17(3):131-40. doi:10.1016/j.ctim.2008.10.003.
30. Zhao HJ, Tan JY, Wang T, Jin L. Auricular therapy for chronic pain management in adults: A synthesis of evidence.Complement Ther Clin Pract. 2015 May;21(2):68-78. doi:10.1016/j.ctcp.2015.03.006.

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ACU-2.3: Migraine With Aura

Synonyms

- Classical Migraine

Definition

Classical Migraine Headache is a predominantly inherited disorder characterized by varying degrees of recurrent vascular-quality headache, photophobia, sleep disruption, depression, and is preceded by an aura.

Oriental Medicine Diagnoses

The following diagnoses can be the primary Oriental Medicine causation or a contributing factor:

- Liver Qi Stagnation
  - Causation can be due to external pathogens, lifestyle choices, such as, irregular or “incorrect” food choice, irregular eating times, lack of sleep, or stress.
- Kidney Qi Deficiency
  - Can lead to an accumulation of Phlegm, Dampness and Deficiency where one of the symptoms can be headache. Causation is from either congenital deficiency of Kidney Qi and/or lifestyle choices that lead to a depletion of Kidney Qi.
- Excessive Liver Yang
  - Leading to rising of energy. Causation is disturbance of the Liver energy due to either emotional or physical reasons, sometimes caused by heavy drinking.
- Qi and Blood Stagnation
  - Stagnation results in pain. May have numerous causations. Can be related to trauma or underlying syndromes.
- Heat in the Stomach, or Fire in the Liver/Gall Bladder Meridians
  - May be caused by inappropriate food choices either recently or over time. Other causations are inappropriate life style choices, such as, irregular or “incorrect” food or drink choice—particularly alcohol, irregular eating times, lack of sleep.

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History

- Attacks usually occur while awake.
- Nausea and vomiting usually occur later in the attack.
- Photophobia and/or phonophobia are also commonly associated with the headache.
- About 60% of people who experience Migraine Headaches report a prodrome; typical symptoms are:
  - Food cravings
  - Constipation or diarrhea
  - Mood changes, such as, depression, irritability
  - Muscle stiffness, especially in the neck
  - Fatigue
  - Increased frequency of urination
- A migraine aura is a complex of neurological symptoms that may precede or accompany the headache phase or may occur in isolation. Auras can have a wide range of symptoms, including:
  - Visual—flashing lights, wavy lines, spots, partial loss of sight, blurry vision
  - Olfactory hallucinations—smelling odors that are not there
  - Tingling or numbness of the face or extremities on the side where the headache develops
  - Difficult finding words and/or speaking
  - Confusion
  - Vertigo
  - Partial paralysis
  - Auditory hallucinations
  - Decrease in or loss of hearing
  - Reduced sensation
  - Hypersensitivity to feel and touch

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Specific Aspects of History

- Rule out red flags (requires medical management).
- Identify co-morbidities requiring medical management, and those that affect acupuncture and Oriental Medicine management.

Red Flag	Possible Consequence or Cause	Action Required
Sudden onset of severe headache with no past history	Subarachnoid hemorrhage; meningitis	Immediate referral to emergency department
New headache in older patient	Tumor; temporal arteritis; glaucoma	Prompt referral to Primary Care Provider
Headache following head trauma	Subdural hematoma; epidural hematoma	Immediate referral to emergency department
Neurologic signs or symptoms	Tumor; vascular accident	Immediate referral to emergency department
Vomiting without nausea	Increased intracranial pressure	Immediate referral to emergency department
Suspicion of drug or alcohol dependence	Side effect or withdrawal phenomenon	Immediate referral to emergency department
Headache associated with diastolic blood pressure greater than 110 mmHg	Uncontrolled hypertension	Prompt referral to Primary Care Provider
Persistent or severe headache in a child	Tumor; encephalitis; meningitis	Immediate referral to emergency department
Cognitive changes, such as confusion, drowsiness or giddiness	Subdural hematoma; epidural hematoma	Immediate referral to emergency department
Persistent or progressive headache	Tumor; intracranial mass	Prompt referral to Primary Care Provider
Nuchal rigidity	Subarachnoid hemorrhage; meningitis	Immediate referral to emergency department

- In addition to the above red flags, the following symptoms reported by patient, require physician referral or co-management:
  - Headaches that are:
    - Associated with other neurological signs or symptoms (e.g., diplopia, loss of sensation, weakness, ataxia) or those of unusually abrupt onset.
    - Persistent (especially beyond 72 hours), which first occur after the age of 55 years, or develop after head injury or major trauma.
    - Associated with stiff neck or fever.

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Subjective Findings

- Pain is throbbing or pulsating
- Initially unilateral and localized in the frontotemporal and ocular area builds up over a period of one to two hours, progressing posteriorly and becoming diffuse
- Lasts from several hours to an entire day
- Pain intensity is moderate to severe and it tends to intensify even with routine physical activity
- Pain should be documented as a numeric pain scale 0-10
- Headache frequency, duration and numeric pain scale should be documented

Functional Assessment

- Documentation of a patient's level of function is an important aspect of patient care. This documentation is required in order to establish the medical necessity of ongoing acupuncture treatment. The Patient Specific Functional Scale (PSFS) is a patient reported outcome assessment that is easy and appropriate for acupuncturists to use. The PSFS has been studied in peer-reviewed scientific literature, and it has been proven to be a valid, reliable, and responsive measure for a variety of pain syndromes (neck, back, knee, etc.).

Objective Findings

Scope of Musculoskeletal Exam

- Inspection including Oriental Medicine inspection techniques
- Inspection of posture (forward head carriage, rounded shoulders)
- Palpate temporal arteries
- Measure blood pressure, pulse rate, temperature
- Palpate cervical spine for muscle spasm, trigger points
- Perform cervical ROM
- Percussion of sinuses
- Neurological examination for focal signs or asymmetric reflexes, test cranial nerves

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Specific Aspects of Examination for Classical Migraine

- Rule out other possible causes.
- Most patients with headache have a normal neurological examination.
- Some abnormal findings suggest a secondary cause, which would necessitate a different diagnostic and treatment approach.
- Presence of papilledema suggests increased intercranial pressure and warrants an immediate referral to primary care provider for a diagnostic imaging study to rule out a mass lesion.
- Nuchal rigidity due to meningeal irritation is seen with meningitis and subarachnoid or intraparenchymal hemorrhage.

Findings of Migraine headache

- Increased need of sleep
- Foggy thinking
- Neck pain
- Loss of appetite
- Nausea, vomiting
- Sensitivity to light or sound
- Loss of appetite
- Fatigue
- Numbness, tingling, or weakness

Differential Diagnoses

- Sinus inflammation
- Brain mass
- TIA
- Temporal arteritis, Giant-cell arteritis
- Migraine-triggered seizures (migralepsy)
- Cerebral aneurysms
- Vertebrobasilar insufficiency

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Oriental Medicine Management [9, 12, 32, 34]

- Oriental Medicine Management goals are to resolve pain, restore the highest level of function possible and educate patient to prevent recurrent symptoms.
- To be considered medically necessary, patient's symptoms must be the direct result of a primary neuromusculoskeletal injury or illness.
- Confirmation of appropriate medical co-management is always required when treating children age 14 and under.
- Treatment frequency should be commensurate with the severity of the chief complaint.
- When significant improvements in patient's subjective findings and objective findings are demonstrated—continued treatment with decreased frequency is appropriate.
- As treatment progresses, one should see an increase in the active regimen of care, a decrease in the passive regimen of care, and a fading of treatment frequency.
- If the condition has not progressed towards resolution, refer the patient to an appropriate health care provider to explore other treatment alternatives.
- eviCore's consideration of requests for continued acupuncture treatment depends on updated clinical information submitted regarding patient's progress.
- Adequate and legible patient progress information that contains a history and examination, and/or eviCore's Acupuncture Treatment Request Form Acupuncture Treatment Request Form is required to determine medical necessity.
- In addition to improvements in the table below, significant progress may be documented by increases in functional capacity and increasingly longer durations of pain relief.
- Initiate two to four-week trial of treatment.
- If severity or frequency of headaches decreases following the initial trial—continue treatment at a reduced frequency for a one-month period.
- Recommendations depend on causation; can relate to food choices, lifestyle choices, stress reduction.
- If the patient does not improve with trial of Oriental Medicine treatment or has reached a plateau, refer patient back to referring physician to explore other alternatives.
- Discharge occurs when reasonable functional goals and expected outcomes have been achieved.
- The patient is discharged when the patient/care-giver can continue management of symptoms with an independent home program.
- Treatment is discontinued when the patient is unable to progress towards outcomes because of medical complications, psychosocial factors or other personal circumstances.

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- If the member has been non-compliant with treatment as is evidenced by the clinical documentation, and/or the lack of demonstrated progress, treatment will be deemed to be not medically necessary and the member should be discharged from treatment.

Week	Progress
0-1	◆ Some reduction of pain severity and frequency ◆ Some reduction of muscle spasm
2-4	◆ 50% improvement in pain severity and frequency ◆ 50% increase in function ◆ Pain distribution is centralizing ◆ Reinforce self-management techniques
5-8	◆ Continued reduction of pain severity and frequency ◆ Continued increase in function ◆ Pain distribution continues to centralize ◆ Reinforce self-management techniques
9-12	◆ 75% improvement in pain severity and frequency ◆ 75% improvement in function ◆ Pain distribution is centralized to back ◆ Reinforce self-management techniques
13-16	◆ Gradual improvement leading toward resolution ◆ Reinforce self-management techniques ◆ Discharge patient to elective care, or to their primary care provider for alternative treatment options when a plateau is reached, or by week 16, whichever occurs first

Referral Guidelines (or co-management)

- Refer patient to their primary care provider for evaluation of alternative treatment options if:
  - Articular derangements such as rheumatoid arthritis or similar autoimmune disease, joint instability or hypermobility particularly of the atlanto-axial joint.
  - History of infection as indicated by a fever greater than 100, constant low-grade fever, joint infection.
  - Circulatory or cardiovascular disorder such as stroke, angina or heart disease.
  - Recent fracture, bone weakening or destructive disorders such as tumors or history of compression fractures or greater than 3 months of steroid use.
  - Signs or symptoms of neurological disorders such as nuchal rigidity, positive Brudzinski's or Kernig's sign, myelopathy, acute cauda equina syndrome, saddle anesthesia, multiple sclerosis.
  - Atrophy in the extremities.
  - Abnormal deep tendon reflexes or motor weakness.
  - Congenital connective tissue disorders such as Marfan's.
  - Signs or symptoms of vertebrobasilar insufficiency.
  - Any other signs or symptoms of organic disease.
  - Recent loss of consciousness or blow to the head; positive cranial nerve exam.
  - Dysphasia or other positive CNS findings; recent onset of headache with no prior history of headache.
  - Signs or symptoms of substance abuse or withdrawal.

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Appropriate Procedures/Modalities

- Acupuncture
- Electro-acupuncture
- Cupping
- Moxibustion
- Gua Sha
- Myofascial release
- Acupressure
- Trigger point massage
- Tui Na (not to include osseous manipulation)
- Herbal formulas

Note: Not all of these modalities are covered by the patient's health-plan; review documentation regarding coverage. Acupuncture and herbs must be appropriate for covered diagnoses under the patient's insurance policy. Acupuncturist is responsible for determining which procedures/modalities are most appropriate for the patient's condition.

Inappropriate Procedures/Modalities

- Scarring moxa
- Applied kinesiology techniques
- Electro-acupuncture using more than 9 volt
- Any techniques outside of the scope of practice in your state

Self-Management Techniques

- Rest and reduce strenuous activities
- Ergonomics, Postural advice, postural exercises
- Appropriate exercises/stretching
- Tai Qi, Qi Gong, Yoga
- Stress management, meditation
- Joint protection
- Weight loss
- Self-massage, Self-acupressure
- Hot packs/cold packs, if needed, to relieve discomfort
- Avoid suspected dietary triggers:
  - Chocolate
  - Aged cheeses and meats

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- Wine and beer (e.g., sulfites)
- Caffeine
- Onions
- Nuts and peanut butter
- Dairy products
- Baked goods
- Citrus fruits

- Other potential triggers include:
  - Allergic reactions
  - Bright lights
  - Loud noises
  - Physical or mental stress
  - Changes in sleep patterns
  - Smoking or exposure to tobacco smoke
  - Missed meals
  - Hormonal fluctuations
- Educate patients about the causes
- Use of cervical pillow while sleeping may be helpful

Alternatives to Oriental Medicine Management

(listed in alphabetical order)

- Biofeedback
- Chiropractic
- Dietary/Nutritional Medicine Counseling
- Injection therapy/Pain management
- Massage therapy
- Medication
- Occupational therapy
- Osteopathic Manipulation
- Physical Therapy
- Psychological counseling

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References

1. Balshem H, Helfand M, Schunemann HJ, Oxman AD, Kunz R, Brozek J, et al. GRADE guidelines: 3. Rating the quality of evidence. J Clin Epidemiol. 2011 Apr;64(4):401-6. doi:10.1016/j.jclinepi.2010.07.015.
2. Beinfield, H and Korngold, E; Between Heaven and Earth, The Ballantine Publishing Group, 1992.
3. Birch, S and Hammerschlag R: Acupuncture Efficacy - A Compendium of Controlled Clinical Studies, The National Academy of Acupuncture and Oriental Medicine, 1996.
4. Cheng X, Deng L. Chinese Acupuncture and Moxibustion. Beijing: Foreign Language Press; 2010.
5. Guirguis-Blake J. Effectiveness of acupuncture for migraine prophylaxis. Am Fam Physician. 2010 Jan 1;81(1):29.
6. Hempel S, Taylor SL, Solloway MR, Miake-Lye IM, Beroes JM, Shanman R, et al. VA Evidence-based Synthesis Program Reports. Evidence Map of Acupuncture. Washington (DC): Department of Veterans Affairs; 2014.
7. Hopton A, MacPherson H. Acupuncture for chronic pain: is acupuncture more than an effective placebo? A systematic review of pooled data from meta-analyses. Pain Pract. 2010;10(2):94-102. doi:10.1111/j.1533-2500.2009.00337.x.
8. Horn KK, Jennings S, Richardson G, Vliet DV, Hefford C, Abbott JH. The patient-specific functional scale: psychometrics, clinimetrics, and application as a clinical outcome measure. J Orthop Sports Phys Ther. 2012 Jan;42(1):30-42. doi:10.2519/jospt.2012.3727.
9. Jiang Y, Bai P, Chen H, et al. The Effect of Acupuncture on the Quality of Life in Patients With Migraine: A Systematic Review and Meta-Analysis. Front Pharmacol. 2018;9:1190. Published 2018 Oct 26. doi:10.3389/fphar.2018.01190.
10. Kaptchuk T. The Web That Has No Weaver. Contemporary Books. 2000.
11. Kelly RB. Acupuncture for pain. Am Fam Physician. 2009 Sep 1;80(5):481-4.
12. Li X, Wang R, Xing X, et al. Acupuncture for Myofascial Pain Syndrome: A Network Meta-Analysis of 33 Randomized Controlled Trials. Pain Physician. 2017 Sep;20(6):E883-E902.
13. Li Y, Liang F, Yang X, Tian X, Yan J, Sun G, Chang X, Tang Y, Ma T, Zhou L, Lan L, Yao W, Zou R. Acupuncture for treating acute attacks of migraine: a randomized controlled trial. Headache. 2009 Jun;49(6):805-16. doi:10.1111/j.1526-4610.2009.01424.x.
14. Linde K, Allais G, Brinkhaus B, Fei Y, Mehring M, Vertosick EA, et al. Acupuncture for the prevention of episodic migraine. Cochrane Database Syst Rev. 2016(6):Cd001218. doi:10.1002/14651858.CD001218.pub3.
15. Linde K, Allais G, Brinkhaus B, Manheimer E, Vickers A, White AR. Acupuncture for migraine prophylaxis. Cochrane Database Syst Rev. 2009 Jan 21;(1):CD001218. doi:10.1002/14651858.CD001218.pub2.
16. Linde K, Streng A, Jurgens S, Hoppe A, Brinkhaus B, Witt C, Wagenpfeil S, Pfaffenrath V, Hammes MG, Weidenhammer W, Willich SN, Melchart D. Acupuncture for patients with migraine: a randomized controlled trial. JAMA. 2005 May 4;293(17):2118-25. doi:10.1001/jama.293.17.2118.
17. Maciocia, G; The Foundations of Chinese Medicine: A Comprehensive Text; Churchill Livingstone, 2005.
18. MacPherson H, Vertosick EA, Foster NE, Lewith G, Linde K, Sherman KJ, et al. The persistence of the effects of acupuncture after a course of treatment: A meta-analysis of patients with chronic pain. Pain. 2016 Oct 17. doi:10.1097/j.pain.0000000000000747.
19. Magee, David J., Orthopedic Physical Assessment, Second Edition, W.B. Saunders Company, 2007.
20. Marcus, Alon; Musculoskeletal Disorders - Healing Methods from Chinese Medicine, Orthopaedic Medicine, and Osteopathy, North Atlantic Books, 1998.
21. McDonald J, Janz S. The Acupuncture Evidence Project: A Comparative Literature Review (Revised Edition). Brisbane: Australian Acupuncture and Chinese Medicine Association Ltd; 2017.
22. Melchart D, Streng A, Hoppe A, Brinkhaus B, Witt C, Wagenpfeil S, Pfaffenrath V, Hammes M, Hummelsberger J, Irnich D, Weidenhammer W, Willich SN, Linde K. Acupuncture in patients with tension-type headache: randomised controlled trial. BMJ. 2005 Aug 13;331(7513):376-82. doi:10.1136/bmj.38512.405440.8F.
23. National Health and Medical Research Council. NHMRC additional levels of evidence and grades for recommendations for developers of guidelines. Table 3. NHMRC Evidence Hierarchy:

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designations of 'levels of evidence' according to type of research question (including explanatory notes). National Health and Medical Research Council; 2009.
24. O'Connor J, Bensky D. Acupuncture: A Comprehensive Text. Chicago: Eastland Press; 1981.
25. Olson WH, Brumback RA, Gascon G, Iyer V; Handbook of Symptom Oriented Neurology; Year Book Medical Publishers, Inc.; 2002.
26. Plank S, Goodard J. The effectiveness of acupuncture for chronic daily headache: an outcomes study. Mil Med. 2009 Dec;174(12):1276-81. doi:10.7205/milmed-d-00-5709.
27. Porter, R; The Merck Manual, Merck, 2011.
28. Roy, S., Irvin, R., and Iverson, D; Sports Medicine, Prevention, Education, Management, and Rehabilitation, Benjamin Cummings, 1998.
29. Sun Y, Gan TJ. Acupuncture for the management of chronic headache: a systematic review. Anesth Analg. 2008 Dec;107(6):2038-47. doi:10.1213/ane.0b013e318187c76a.
30. Vickers AJ, Cronin AM, Maschino AC, et al. Acupuncture for chronic pain: individual patient data meta-analysis. Arch Intern Med. 2012;172(19):1444-1453. doi:10.1001/archinternmed.2012.3654.
31. Vickers AJ, Rees RW, Zollman CE, McCarney R, Smith CM, Ellis N, Fisher P, Van Haselen R. Acupuncture for chronic headache in primary care: large, pragmatic, randomised trial. BMJ. 2004 Mar 27;328(7442):744. doi:10.1136/bmj.38029.421863.EB.
32. Wang R, Li X, Zhou S, Zhang X, Yang K, Li X. Manual acupuncture for myofascial pain syndrome: a systematic review and meta-analysis. Acupunct Med. 2017 Aug;35(4):241-250. doi:10.1136/acupmed-2016-011176.
33. Weinstein, S, and Buckwalter, J. Orthopaedics Principles and Their Applications. Lippincott, Williams, & Wilkins, 2005.
34. Xiang A, Cheng K, Shen X, Xu P, Liu S. The Immediate Analgesic Effect of Acupuncture for Pain: A Systematic Review and Meta-Analysis. Evid Based Complement Alternat Med. 2017;2017:3837194. doi:10.1155/2017/3837194.
35. Yang Y, Que Q, Ye X, Zheng G. Verum versus sham manual acupuncture for migraine: a systematic review of randomised controlled trials. Acupunct Med. 2016 Apr;34(2):76-83. doi:10.1136/acupmed-2015-010903.
36. Yuan J, Purepong N, Hunter RF, Kerr DP, Park J, Bradbury I, McDonough S. Different frequencies of acupuncture treatment for chronic low back pain: an assessor-blinded pilot randomised controlled trial. Complement Ther Med. 2009 Jun;17(3):131-40.. doi:10.1016/j.ctim.2008.10.003.
37. Zhao HJ, Tan JY, Wang T, Jin L. Auricular therapy for chronic pain management in adults: A synthesis of evidence. Complement Ther Clin Pract. 2015 May;21(2):68-78. doi:10.1016/j.ctcp.2015.03.006.

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ACU-2.4: Migraine Without Aura

Synonyms

- Common Migraine

Definition

- Common Migraine Headache, a dominantly inherited disorder characterized by varying degrees of recurrent vascular-quality headache, photophobia, sleep disruption, depression, and is not preceded by an aura.

Oriental Medicine Diagnoses

- Liver Qi Stagnation
  - Causation can be due to external pathogens; lifestyle choices, such as, irregular or “incorrect” food choice, irregular eating times, lack of sleep, or stress.
- Kidney Qi Deficiency
  - May lead to an accumulation of Phlegm, Dampness and Deficiency where one of the symptoms can be headache. Causation is from either congenital deficiency of Kidney Qi and/or lifestyle choices that lead to a depletion of Kidney Qi.
- Excessive Liver Yang
  - Leading to rising of energy. Causation is disturbance of the Liver energy due to either emotional or physical reasons, sometimes caused by heavy drinking.
- Qi and Blood Stagnation
  - Stagnation results in pain. May have numerous causations. May be related to trauma or underlying syndromes.
- Heat in the Stomach, or Fire in the Liver/Gall Bladder Meridians
  - May be caused by inappropriate food choices either recently or over time. Other causations are inappropriate life style choices, such as, irregular or “incorrect” food or drink choice – particularly alcohol, irregular eating times, lack of sleep.

History

- Attacks usually occur while awake
- Nausea and vomiting usually occur later in the attack
- Photophobia and/or phonophobia also commonly are associated with the headache
- About 60% of people who experience Migraine Headaches report a prodrome; typical symptoms are:
  - Food cravings
  - Constipation or diarrhea
  - Mood changes—depression, irritability
  - Muscle stiffness, especially in the neck
  - Fatigue
  - Increased frequency of urination

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Specific Aspects of History

- Rule out red flags (requires medical management).
- Identify co-morbidities requiring medical management, and those that affect acupuncture and Oriental Medicine management.

Red Flag	Possible Consequence or Cause	Action Required
Sudden onset of severe headache with no past history	Subarachnoid hemorrhage; meningitis	Immediate referral to emergency department
New headache in older patient	Tumor; temporal arteritis; glaucoma	Immediate referral to emergency department
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Headache associated with diastolic blood pressure greater than 110 mmHg	Uncontrolled hypertension	Prompt referral to Primary Care Provider
Persistent or severe headache in a child	Tumor; encephalitis; meningitis	Immediate referral to emergency department
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- In addition to the above red flags, the following symptoms reported by the patient require physician referral or co-management:
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Oriental Medicine Management [9, 12, 32, 34, 35]

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- In order to be considered medically necessary, patient's symptoms must be the direct result of a primary neuromusculoskeletal injury or illness.
- Confirmation of appropriate medical co-management is always required when treating children age 14 and under.
- Treatment frequency should be commensurate with severity of the chief complaint.
- When significant improvement in subjective findings and objective findings are demonstrated—continued treatment with decreased frequency is appropriate.
- As treatment progresses, one should see an increase in the active regimen of care, a decrease in the passive regimen of care, and a fading of treatment frequency.
- If the condition has not progressed towards resolution, refer the patient to an appropriate health care provider to explore other treatment alternatives.
- eviCore's consideration of requests for continued acupuncture treatment depends on updated clinical information submitted regarding patient's progress.
- Adequate and legible patient progress information that contains a history and examination, and/or eviCore's Acupuncture Treatment Request Form Acupuncture Treatment Request Form is required to determine medical necessity.
- In addition to improvements in the table below, significant progress may be documented by increases in functional capacity and increasingly longer durations of pain relief.
- Initiate two to four week trial of treatment.
- If severity or frequency of headaches decreases following the initial trial—continue treatment at a reduced frequency for a one month period.
- Recommendations depend on causation can relate to food choices, lifestyle choices, stress reduction.
- Discharge occurs when reasonable functional goals and expected outcomes have been achieved.
- The patient is discharged when the patient/care-giver can continue management of symptoms with an independent home program.
- Treatment is discontinued when the patient is unable to progress towards outcomes because of medical complications, psychosocial factors or other personal circumstances.
- If the member has been non-compliant with treatment as is evidenced by the clinical documentation, and/or the lack of demonstrated progress, treatment will be deemed to be not medically necessary and the member should be discharged from treatment.

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Week	Progress
0-1	◆ Some reduction of pain severity and frequency ◆ Some reduction of muscle spasm
2-4	◆ 50% improvement in pain severity and frequency ◆ 50% increase in function ◆ Pain distribution is centralizing ◆ Reinforce self-management techniques
5-8	◆ Continued reduction of pain severity and frequency ◆ Continued increase in function ◆ Pain distribution continues to centralize ◆ Reinforce self-management techniques
9-12	◆ 75% improvement in pain severity and frequency ◆ 75% improvement in function ◆ Pain distribution is centralized to back ◆ Reinforce self-management techniques
13-16	◆ Gradual improvement leading toward resolution ◆ Reinforce self-management techniques ◆ Discharge patient to elective care, or to their primary care provider for alternative treatment options when a plateau is reached, or by week 16, whichever occurs first

Referral Guidelines (or co-management)

- Refer patient to their primary care provider for evaluation of alternative treatment options if:
  - Articular derangements such as rheumatoid arthritis or similar autoimmune disease, joint instability or hypermobility particularly of the atlanto-axial joint
  - History of infection as indicated by a fever greater than 100, constant low-grade fever, joint infection
  - Circulatory or cardiovascular disorder such as stroke, angina or heart disease
  - Recent fracture, bone weakening or destructive disorders such as tumors or history of compression fractures or greater than three (3) months of steroid use
  - Signs or symptoms of neurological disorders such as nuchal rigidity, positive Brudzinski's or Kernig's sign, myelopathy, acute cauda equina syndrome, saddle anesthesia, multiple sclerosis
  - Atrophy in the extremities
  - Abnormal deep tendon reflexes or motor weakness
  - Congenital connective tissue disorders such as Marfan's
  - Signs or symptoms of vertebrobasilar insufficiency
  - Any other signs or symptoms of organic disease
  - Recent loss of consciousness or blow to the head; positive cranial nerve exam
  - Dysphasia or other positive CNS findings; recent onset of headache with no prior history of headache
  - Signs or symptoms of substance abuse or withdrawal

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Appropriate Procedures/Modalities

- Acupuncture
- Electro-acupuncture
- Cupping
- Moxibustion
- Gua Sha
- Myofascial release
- Acupressure
- Trigger point massage
- Tui Na (not to include osseous manipulation)
- Herbal formulas

Note: Not all of these modalities are covered by patient's health-plan; review documentation regarding coverage. Acupuncture and herbs must be appropriate for covered diagnoses under the patient's insurance policy. Acupuncturist is responsible for determining which procedures/modalities are most appropriate for the patient's condition.

Inappropriate Procedures/Modalities

- Scarring moxa
- Applied kinesiology techniques
- Electro-acupuncture using more than 9 volt
- Any techniques outside of the scope of practice in your state

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Self-Management Techniques

- Rest and reduce strenuous activities
- Ergonomics, Postural advice, postural exercises
- Appropriate exercises/stretching
- Tai Qi, Qi Gong, Yoga
- Stress management, meditation
- Joint protection
- Weight loss
- Self-massage, Self-acupressure
- Hot packs/cold packs, if needed, to relieve discomfort
- Avoid suspected dietary triggers:
  - Chocolate
  - Aged cheeses and meats
  - Wine and beer (e.g., sulfites)
  - Caffeine
  - Onions
  - Nuts and peanut butter
  - Dairy products
  - Baked goods
  - Citrus fruits
- Other potential triggers include:
  - Allergic reactions
  - Bright lights
  - Loud noises
  - Physical or mental stress
  - Changes in sleep patterns
  - Smoking or exposure to tobacco smoke
  - Missed meals
  - Hormonal fluctuations
  - Rest and reduce strenuous activities
- Educate patients about the causes
- Use of cervical pillow while sleeping may be helpful

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Alternatives to Oriental Medicine Management

(listed in alphabetical order)

- Biofeedback
- Chiropractic
- Dietary/Nutritional Medicine Counseling
- Injection therapy/Pain management
- Massage therapy
- Medication
- Occupational therapy
- Osteopathic Manipulation
- Physical Therapy
- Psychological counseling

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References

1. Balshem H, Helfand M, Schunemann HJ, Oxman AD, Kunz R, Brozek J, et al. GRADE guidelines: 3. Rating the quality of evidence. J Clin Epidemiol. 2011 Apr;64(4):401-6. doi:10.1016/j.jclinepi.2010.07.015.
2. Beinfield, H and Korngold, E; Between Heaven and Earth, The Ballantine Publishing Group, 1992.
3. Birch, S and Hammerschlag R: Acupuncture Efficacy - A Compendium of Controlled Clinical Studies, The National Academy of Acupuncture and Oriental Medicine, 1996.
4. Cheng X, Deng L. Chinese Acupuncture and Moxibustion. Beijing: Foreign Language Press; 2010.
5. Guirguis-Blake J. Effectiveness of acupuncture for migraine prophylaxis. Am Fam Physician. 2010 Jan 1;81(1):29.
6. Hempel S, Taylor SL, Solloway MR, Miake-Lye IM, Beroes JM, Shanman R, et al. VA Evidence-based Synthesis Program Reports. Evidence Map of Acupuncture. Washington (DC): Department of Veterans Affairs; 2014.
7. Hopton A, MacPherson H. Acupuncture for chronic pain: is acupuncture more than an effective placebo? A systematic review of pooled data from meta-analyses. Pain Pract. 2010;10(2):94-102. doi:10.1111/j.1533-2500.2009.00337.x.
8. Horn KK, Jennings S, Richardson G, Vliet DV, Hefford C, Abbott JH. The patient-specific functional scale: psychometrics, clinimetrics, and application as a clinical outcome measure. J Orthop Sports Phys Ther. 2012 Jan;42(1):30-42. doi:10.2519/jospt.2012.3727.
9. Jiang Y, Bai P, Chen H, et al. The Effect of Acupuncture on the Quality of Life in Patients With Migraine: A Systematic Review and Meta-Analysis. Front Pharmacol. 2018;9:1190. Published 2018 Oct 26. doi:10.3389/fphar.2018.01190.
10. Kaptchuk T. The Web That Has No Weaver. Contemporary Books. 2000.
11. Kelly RB. Acupuncture for pain. Am Fam Physician. 2009 Sep 1;80(5):481-4.
12. Li X, Wang R, Xing X, et al. Acupuncture for Myofascial Pain Syndrome: A Network Meta-Analysis of 33 Randomized Controlled Trials. Pain Physician. 2017 Sep;20(6):E883-E902.
13. Li Y, Liang F, Yang X, Tian X, Yan J, Sun G, Chang X, Tang Y, Ma T, Zhou L, Lan L, Yao W, Zou R. Acupuncture for treating acute attacks of migraine: a randomized controlled trial. Headache. 2009 Jun;49(6):805-16. doi:10.1111/j.1526-4610.2009.01424.x.
14. Linde K, Allais G, Brinkhaus B, Fei Y, Mehring M, Vertosick EA, et al. Acupuncture for the prevention of episodic migraine. Cochrane Database Syst Rev. 2016(6):Cd001218. doi:10.1002/14651858.CD001218.pub3.
15. Linde K, Allais G, Brinkhaus B, Manheimer E, Vickers A, White AR. Acupuncture for migraine prophylaxis. Cochrane Database Syst Rev. 2009 Jan 21;(1):CD001218. doi:10.1002/14651858.CD001218.pub2.
16. Linde K, Streng A, Jurgens S, Hoppe A, Brinkhaus B, Witt C, Wagenpfeil S, Pfaffenrath V, Hammes MG, Weidenhammer W, Willich SN, Melchart D. Acupuncture for patients with migraine: a randomized controlled trial. JAMA. 2005 May 4;293(17):2118-25. ne: A Comprehensive Text; Churchill Livingstone, 2005. doi:10.1001/jama.293.17.2118.
17. Maciocia, G; The Foundations of Chinese Medicine: A Comprehensive Text; Churchill Livingstone, 2005.
18. MacPherson H, Vertosick EA, Foster NE, Lewith G, Linde K, Sherman KJ, et al. The persistence of the effects of acupuncture after a course of treatment: A meta-analysis of patients with chronic pain. Pain. 2016 Oct 17. doi:10.1097/j.pain.00000000000007.
19. Magee, David J., Orthopedic Physical Assessment, Second Edition, W.B. Saunders Company, 2007.
20. Marcus, Alon; Musculoskeletal Disorders - Healing Methods from Chinese Medicine, Orthopaedic Medicine, and Osteopathy, North Atlantic Books, 1998.
21. McDonald J, Janz S. The Acupuncture Evidence Project: A Comparative Literature Review (Revised Edition). Brisbane: Australian Acupuncture and Chinese Medicine Association Ltd; 2017.
22. Melchart D, Streng A, Hoppe A, Brinkhaus B, Witt C, Wagenpfeil S, Pfaffenrath V, Hammes M, Hummelsberger J, Irnich D, Weidenhammer W, Willich SN, Linde K. Acupuncture in patients with tension-type headache: randomised controlled trial. BMJ. 2005 Aug 13;331(7513):376-82.

© 2019 eviCore healthcare. All Rights Reserved.

23. National Health and Medical Research Council. NHMRC additional levels of evidence and grades for recommendations for developers of guidelines. Table 3. NHMRC Evidence Hierarchy: designations of 'levels of evidence' according to type of research question (including explanatory notes). National Health and Medical Research Council; 2009.
24. O'Connor J, Bensky D. Acupuncture: A Comprehensive Text. Chicago: Eastland Press; 1981.
25. Olson WH, Brumback RA, Gascon G, Iyer V; Handbook of Symptom Oriented Neurology; Year Book Medical Publishers, Inc.; 2002.
26. Plank S, Goodard J. The effectiveness of acupuncture for chronic daily headache: an outcomes study. Mil Med. 2009 Dec;174(12):1276-81. doi:10.7205/milmed-d-00-5709.
27. Porter, R; The Merck Manual, Merck, 2011.
28. Roy, S., Irvin, R., and Iverson, D; Sports Medicine, Prevention, Education, Management, and Rehabilitation, Benjamin Cummings, 1998.
29. Sun Y, Gan TJ. Acupuncture for the management of chronic headache: a systematic review. Anesth Analg. 2008 Dec;107(6):2038-47. doi:10.1213/ane.0b013e318187c76a.
30. Vickers AJ, Cronin AM, Maschino AC, et al. Acupuncture for chronic pain: individual patient data meta-analysis. Arch Intern Med. 2012;172(19):1444-1453. doi:10.1001/archinternmed.2012.3654.
31. Vickers AJ, Rees RW, Zollman CE, McCarney R, Smith CM, Ellis N, Fisher P, Van Haselen R. Acupuncture for chronic headache in primary care: large, pragmatic, randomised trial. BMJ. 2004 Mar 27;328(7442):744. doi:10.1136/bmj.38029.421863.EB.
32. Wang R, Li X, Zhou S, Zhang X, Yang K, Li X. Manual acupuncture for myofascial pain syndrome: a systematic review and meta-analysis. Acupunct Med. 2017 Aug;35(4):241-250. doi:10.1136/acupmed-2016-011176.
33. Weinstein, S, and Buckwalter, J. Orthopaedics Principles and Their Applications. Lippincott, Williams, & Wilkins, 2005.
34. Xiang A, Cheng K, Shen X, Xu P, Liu S. The Immediate Analgesic Effect of Acupuncture for Pain: A Systematic Review and Meta-Analysis. Evid Based Complement Alternat Med. 2017;2017:3837194. doi:10.1155/2017/3837194.
35. Xu J, Zhang FQ, Pei J, Ji J. Acupuncture for migraine without aura: a systematic review and meta-analysis. J Integr Med. 2018 Sep;16(5):312-321. doi:10.1016/j.joim.2018.06.002.
36. Yang Y, Que Q, Ye X, Zheng G. Verum versus sham manual acupuncture for migraine: a systematic review of randomised controlled trials. Acupunct Med. 2016 Apr;34(2):76-83. doi:10.1136/acupmed-2015-010903.
37. Yuan J, Purepong N, Hunter RF, Kerr DP, Park J, Bradbury I, McDonough S. Different frequencies of acupuncture treatment for chronic low back pain: an assessor-blinded pilot randomised controlled trial. Complement Ther Med. 2009 Jun;17(3):131-40. doi:10.1016/j.ctim.2008.10.003.
38. Zhao HJ, Tan JY, Wang T, Jin L. Auricular therapy for chronic pain management in adults: A synthesis of evidence. Complement Ther Clin Pract. 2015 May;21(2):68-78. doi:10.1016/j.ctcp.2015.03.006.

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ACU-2.5: Unspecified Migraine Headache

Synonyms

Migraine—Unspecified

Definition

Unspecified Migraine Headache, a dominantly inherited disorder characterized by varying degrees of recurrent vascular-quality headache, photophobia, sleep disruption, depression, and it may or may not be preceded by an aura.

Oriental Medicine Diagnoses

- Liver Qi Stagnation
  - Causation can be due to external pathogens, lifestyle choices, such as, irregular or “incorrect” food choice, irregular eating times, lack of sleep, or stress.
- Kidney Qi Deficiency
  - Can lead to an accumulation of Phlegm, Dampness and Deficiency where one of the symptoms can be headache. Causation is from either congenital deficiency of Kidney Qi and/or lifestyle choices that lead to a depletion of Kidney Qi.
- Excessive Liver Yang
  - Leading to a rising of energy. Causation is disturbance of the Liver energy due to either emotional or physical reasons, sometimes caused by heavy drinking.
- Qi and Blood Stagnation
  - Stagnation results in pain. May have numerous causes. Can be related to trauma or underlying syndromes.
- Heat in the Stomach, or Fire in the Liver/Gall Bladder Meridians
  - May be caused by inappropriate food choices either recently or over time. Other causations are inappropriate life style choices such as, irregular or “incorrect” food or drink choice—particularly alcohol, irregular eating times, lack of sleep.

History

- Attacks usually occur while awake.
- Nausea and vomiting usually occur later in the attack.
- Photophobia and/or phonophobia also commonly are associated with the headache.
- About 60% of people who experience Migraine Headaches report a prodrome. Symptoms typical of the prodrome are:
  - Food cravings
  - Constipation or diarrhea
  - Mood changes—depression, irritability
  - Muscle stiffness, especially in the neck
  - Fatigue
  - Increased frequency of urination

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- Migraine aura is a complex of neurological symptoms that may precede or accompany the headache phase or may occur in isolation. Auras can have a wide range of symptoms, including:
  - Visual—flashing lights, wavy lines, spots, partial loss of sight, blurry vision
  - Olfactory hallucinations—smelling odors that are not there
  - Tingling or numbness of the face or extremities on the side where the headache develops
  - Difficult finding words and/or speaking
  - Confusion
  - Vertigo
  - Partial paralysis
  - Auditory hallucinations
  - Decrease in or loss of hearing
  - Reduced sensation
  - Hypersensitivity to feel and touch

Specific Aspects of History

- Rule out red flags (requires medical management).
- Identify co-morbidities requiring medical management, and those that affect acupuncture and Oriental Medicine management.

Red Flag	Possible Consequence or Cause	Action Required
Sudden onset of severe headache with no past history	Subarachnoid hemorrhage; meningitis	Immediate referral to emergency department
New headache in older patient	Tumor; temporal arteritis; glaucoma	Prompt referral to Primary Care Provider
Headache following head trauma	Subdural hematoma; epidural hematoma	Immediate referral to emergency department
Neurologic signs or symptoms	Tumor; vascular accident	Immediate referral to emergency department
Vomiting without nausea	Increased intracranial pressure	Immediate referral to emergency department
Suspicion of drug or alcohol dependence	Side effect or withdrawal phenomenon	Immediate referral to emergency department
Headache associated with diastolic blood pressure greater than 110 mmHg	Uncontrolled hypertension	Prompt referral to Primary Care Provider
Persistent or severe headache in a child	Tumor; encephalitis; meningitis	Immediate referral to emergency department
Cognitive changes, such as confusion, drowsiness or giddiness	Subdural hematoma; epidural hematoma	Immediate referral to emergency department
Persistent or progressive headache	Tumor; intracranial mass	Prompt referral to Primary Care Provider
Nuchal rigidity	Subarachnoid hemorrhage; meningitis	Immediate referral to emergency department

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- In addition to the above red flags, the following symptoms reported by the patient require physician referral or co-management:
  - Headaches that are:
    - Associated with other neurological signs or symptoms (e.g., diplopia, loss of sensation, weakness, ataxia) or those of unusually abrupt onset.
    - Persistent (especially beyond 72 hours), which first occur after the age of 55 years, or that develop after head injury or major trauma.
    - Associated with stiff neck or fever.

Subjective Findings

- Pain is throbbing or pulsating.
- Initially, unilateral and localized in the fronto-temporal and ocular area builds up over a period of 1-2 hours, progressing posteriorly and becoming diffuse.
- Lasts from several hours to an entire day.
- Pain intensity is moderate to severe and tends to intensify even with routine physical activity.
- Pain should be documented as a numeric pain scale 0-10
- Headache frequency, duration and numeric pain scale should be documented

Functional Assessment

- Documentation of a patient's level of function is an important aspect of patient care. This documentation is required in order to establish the medical necessity of ongoing acupuncture treatment. The Patient Specific Functional Scale (PSFS) is a patient reported outcome assessment that is easy and appropriate for acupuncturists to use. The PSFS has been studied in peer-reviewed scientific literature, and it has been proven to be a valid, reliable, and responsive measure for a variety of pain syndromes (neck, back, knee, etc.).

Objective Findings

Scope of Musculoskeletal Exam

- Inspection including Oriental Medicine inspection techniques
- Inspection of posture (forward head carriage, rounded shoulders)
- Palpate temporal arteries
- Measure blood pressure, pulse rate, temperature
- Palpate cervical spine for muscle spasm, trigger points
- Perform cervical ROM
- Percussion of sinuses
- Neurological examination for focal signs or asymmetric reflexes; test cranial nerves

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Specific Aspects of Examination for Unspecified Migraine Headache

- Rule out other possible causes.
- Most patients with headache have a normal neurological examination.
- Some abnormal findings suggest a secondary cause, which would necessitate a different diagnostic and treatment approach.
- Presence of papilledema suggests increased intracranial pressure and warrants an immediate referral to primary care provider for a diagnostic imaging study to rule out a mass lesion.
- Nuchal rigidity due to meningeal irritation is seen with meningitis and subarachnoid or intraparenchymal hemorrhage.

Findings of Migraine Headache

- Increased need of sleep
- Foggy thinking
- Neck pain
- Loss of appetite
- Nausea, vomiting
- Sensitivity to light or sound
- Loss of appetite
- Fatigue
- Numbness, tingling, or weakness

Differential Diagnoses

- Sinus inflammation
- Brain mass
- TIA
- Cranial arteritis
- Migraine-triggered seizures (migralepsy)
- Cerebral aneurysms
- Vertebrobasilar insufficiency

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Oriental Medicine Management [9, 12, 32, 34]

- Oriental Medicine management goals are to resolve pain, restore the highest level of function possible and educate the patient to prevent recurrent symptoms.
- In order to be considered medically necessary, patient's symptoms must be the direct result of a primary neuromusculoskeletal injury or illness.
- Confirmation of appropriate medical co-management is always required when treating children age 14 and under.
- Treatment frequency should be commensurate with severity of the chief complaint.
- If at least 50% improvement in pain frequency and severity is reported by the patient—continued treatment with decreased frequency is appropriate.
- As treatment progresses, one should see an increase in the active regimen of care, a decrease in the passive regimen of care, and a fading of treatment frequency.
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- Adequate and legible patient progress information that contains a history and examination, and/or eviCore's Acupuncture Treatment Request Form Acupuncture Treatment Request Form is required to determine medical necessity.
- In addition to improvements in the table below, significant progress may be documented by increases in functional capacity and increasingly longer durations of pain relief.
- Initiate two to four week trial of treatment.
- If severity or frequency of headaches decreases following the initial trial—continue treatment at a reduced frequency for a one month period.
- Recommendations depend on causation—can relate to food choices, lifestyle choices, stress reduction.
- If the patient does not improve with trial of Oriental Medicine treatment or has reached a plateau, refer patient back to referring physician to explore other alternatives.
- Discharge occurs when reasonable functional goals and expected outcomes have been achieved.
- The patient is discharged when the patient/care-giver can continue management of symptoms with an independent home program.
- Treatment is discontinued when the patient is unable to progress towards outcomes because of medical complications, psychosocial factors or other personal circumstances.

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References

1. Balshem H, Helfand M, Schunemann HJ, Oxman AD, Kunz R, Brozek J, et al. GRADE guidelines: 3. Rating the quality of evidence. J Clin Epidemiol. 2011 Apr;64(4):401-6. doi:10.1016/j.jclinepi.2010.07.015.
2. Beinfield, H and Korngold, E; Between Heaven and Earth, The Ballantine Publishing Group, 1992.
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5. Guirguis-Blake J. Effectiveness of acupuncture for migraine prophylaxis. Am Fam Physician. 2010 Jan 1;81(1):29.
6. Hempel S, Taylor SL, Solloway MR, Miake-Lye IM, Beroes JM, Shanman R, et al. VA Evidence-based Synthesis Program Reports. Evidence Map of Acupuncture. Washington (DC): Department of Veterans Affairs; 2014.
7. Hopton A, MacPherson H. Acupuncture for chronic pain: is acupuncture more than an effective placebo? A systematic review of pooled data from meta-analyses. Pain Pract. 2010;10(2):94-102. doi:10.1111/j.1533-2500.2009.00337.x.
8. Horn KK, Jennings S, Richardson G, Vliet DV, Hefford C, Abbott JH. The patient-specific functional scale: psychometrics, clinimetrics, and application as a clinical outcome measure. J Orthop Sports Phys Ther. 2012 Jan;42(1):30-42. doi:10.2519/jospt.2012.3727.
9. Jiang Y, Bai P, Chen H, et al. The Effect of Acupuncture on the Quality of Life in Patients With Migraine: A Systematic Review and Meta-Analysis. Front Pharmacol. 2018;9:1190. Published 2018 Oct 26. doi:10.3389/fphar.2018.01190.
10. Kaptchuk T. The Web That Has No Weaver. Contemporary Books. 2000.
11. Kelly RB. Acupuncture for pain. Am Fam Physician. 2009 Sep 1;80(5):481-4.
12. Li X, Wang R, Xing X, et al. Acupuncture for Myofascial Pain Syndrome: A Network Meta-Analysis of 33 Randomized Controlled Trials. Pain Physician. 2017 Sep;20(6):E883-E902.
13. Li Y, Liang F, Yang X, Tian X, Yan J, Sun G, Chang X, Tang Y, Ma T, Zhou L, Lan L, Yao W, Zou R. Acupuncture for treating acute attacks of migraine: a randomized controlled trial. Headache. 2009 Jun;49(6):805-16. doi:10.1111/j.1526-4610.2009.01424.x.
14. Linde K, Allais G, Brinkhaus B, Fei Y, Mehring M, Vertosick EA, et al. Acupuncture for the prevention of episodic migraine. Cochrane Database Syst Rev. 2016(6):Cd001218. doi:10.1002/14651858.CD001218.pub3.
15. Linde K, Allais G, Brinkhaus B, Manheimer E, Vickers A, White AR. Acupuncture for migraine prophylaxis. Cochrane Database Syst Rev. 2009 Jan 21;(1):CD001218. doi:10.1002/14651858.CD001218.pub2.
16. Linde K, Streng A, Jurgens S, Hoppe A, Brinkhaus B, Witt C, Wagenpfeil S, Pfaffenrath V, Hammes MG, Weidenhammer W, Willich SN, Melchart D. Acupuncture for patients with migraine: a randomized controlled trial. JAMA. 2005 May 4;293(17):2118-25. doi:10.1001/jama.293.17.2118.
17. Maciocia, G; The Foundations of Chinese Medicine: A Comprehensive Text; Churchill Livingstone, 2005.
18. MacPherson H, Vertosick EA, Foster NE, Lewith G, Linde K, Sherman KJ, et al. The persistence of the effects of acupuncture after a course of treatment: A meta-analysis of patients with chronic pain. Pain. 2016 Oct 17. doi:10.1097/j.pain.0000000000000747.
19. Magee, David J., Orthopedic Physical Assessment, Second Edition, W.B. Saunders Company, 2007.
20. Marcus, Alon; Musculoskeletal Disorders - Healing Methods from Chinese Medicine, Orthopaedic Medicine, and Osteopathy, North Atlantic Books, 1998.
21. McDonald J, Janz S. The Acupuncture Evidence Project: A Comparative Literature Review (Revised Edition). Brisbane: Australian Acupuncture and Chinese Medicine Association Ltd; 2017.
22. Melchart D, Streng A, Hoppe A, Brinkhaus B, Witt C, Wagenpfeil S, Pfaffenrath V, Hammes M, Hummelsberger J, Irnich D, Weidenhammer W, Willich SN, Linde K. Acupuncture in patients with tension-type headache: randomised controlled trial. BMJ. 2005 Aug 13;331(7513):376-82. doi:10.1136/bmj.38512.405440.8F.

© 2019 eviCore healthcare. All Rights Reserved.

23. National Health and Medical Research Council. NHMRC additional levels of evidence and grades for recommendations for developers of guidelines. Table 3. NHMRC Evidence Hierarchy: designations of 'levels of evidence' according to type of research question (including explanatory notes). National Health and Medical Research Council; 2009.
24. O'Connor J, Bensky D. Acupuncture: A Comprehensive Text. Chicago: Eastland Press; 1981.
25. Olson WH, Brumback RA, Gascon G, Iyer V; Handbook of Symptom Oriented Neurology; Year Book Medical Publishers, Inc.; 2002.
26. Plank S, Goodard J. The effectiveness of acupuncture for chronic daily headache: an outcomes study. Mil Med. 2009 Dec;174(12):1276-81. doi:10.7205/milmed-d-00-5709.
27. Porter, R; The Merck Manual, Merck, 2011.
28. Roy, S., Irvin, R., and Iverson, D; Sports Medicine, Prevention, Education, Management, and Rehabilitation, Benjamin Cummings, 1998.
29. Sun Y, Gan TJ. Acupuncture for the management of chronic headache: a systematic review. Anesth Analg. 2008 Dec;107(6):2038-47. doi:10.1213/ane.0b013e318187c76a.
30. Vickers AJ, Cronin AM, Maschino AC, et al. Acupuncture for chronic pain: individual patient data meta-analysis. Arch Intern Med. 2012;172(19):1444-1453. doi:10.1001/archinternmed.2012.3654.
31. Vickers AJ, Rees RW, Zollman CE, McCarney R, Smith CM, Ellis N, Fisher P, Van Haselen R. Acupuncture for chronic headache in primary care: large, pragmatic, randomised trial. BMJ. 2004 Mar 27;328(7442):744. doi:10.1136/bmj.38029.421863.EB.
32. Wang R, Li X, Zhou S, Zhang X, Yang K, Li X. Manual acupuncture for myofascial pain syndrome: a systematic review and meta-analysis. Acupunct Med. 2017 Aug;35(4):241-250. doi:10.1136/acupmed-2016-011176.
33. Weinstein, S, and Buckwalter, J. Orthopaedics Principles and Their Applications. Lippincott, Williams, & Wilkins, 2005.
34. Xiang A, Cheng K, Shen X, Xu P, Liu S. The Immediate Analgesic Effect of Acupuncture for Pain: A Systematic Review and Meta-Analysis. Evid Based Complement Alternat Med. 2017;2017:3837194. doi:10.1155/2017/3837194.
35. Yang Y, Que Q, Ye X, Zheng G. Verum versus sham manual acupuncture for migraine: a systematic review of randomised controlled trials. Acupunct Med. 2016 Apr;34(2):76-83. doi:10.1136/acupmed-2015-010903.
36. Yuan J, Purepong N, Hunter RF, Kerr DP, Park J, Bradbury I, McDonough S. Different frequencies of acupuncture treatment for chronic low back pain: an assessor-blinded pilot randomised controlled trial. Complement Ther Med. 2009 Jun;17(3):131-40. doi:10.1016/j.ctim.2008.10.003.
37. Zhao HJ, Tan JY, Wang T, Jin L. Auricular therapy for chronic pain management in adults: A synthesis of evidence. Complement Ther Clin Pract. 2015 May;21(2):68-78. doi:10.1016/j.ctcp.2015.03.006.

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ACU-2.6: Jaw Pain, Unspecified

Background

Jaw pain can have different causations; the most common is Temporomandibular Joint (TMJ) Syndrome, which is a gliding joint, formed by the condyle of the mandible and the squamous portion of the temporal bone. Pain may be acute or chronic.

- Articular surface of the temporal bone
  - Consists of a convex articular eminence anteriorly and a concave articular fossa posteriorly.
- Articular surface of the mandible
  - Consists of the top of the condyle.
- Articular surface of the mandible and temporal bone
  - Separated by an articular disk, which divides the joint cavity into 2 small spaces.
- Articular disk, also known as the meniscus
  - A biconcave, fibrocartilaginous structure providing the gliding surface for the mandibular condyle, resulting in smooth joint movement.
- Meniscus has three (3) parts
  - A thick anterior band, a thin intermediate zone and a thick posterior band. In the closed position of the mouth, the condyle is separated from the articular fossa of the temporal bone by the thick posterior band, while in the mouth open position the condyle is separated from the articular eminence of the temporal bone by the thin intermediate zone.

Syndrome: TMJ or Temporomandibular Disorder (TMD)

Most common cause of facial pain after toothache. No unequivocal definition of the disease exists; discrepancies concerning the terminology, definitions, and practical treatment methods hinder uniform conception from becoming effective.

- Temporomandibular Disorder (TMD)
  - Can be classified broadly as:
    - TMD secondary to Myofascial Pain and Dysfunction (MPD); and
    - TMD secondary to true articular disease.
  - These two types can be present at the same time, making diagnosis and treatment more challenging.
- Myofascial Pain and Dysfunction (MPD)
  - Forms the majority of the cases of TMD. Associated with pain, without apparent destructive changes of TMJ on x-ray, it is characterized by its poly-etiological nature and is frequently associated with bruxism and daytime jaw clenching in a stressed and anxious person.
- True intra-articular disease
  - Can be further specified as disk displacement disorder, chronic recurrent dislocations, Degenerative Joint Disorders (DJDs), systemic arthritic conditions, ankylosis, infections, and neoplasia.

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Pathophysiology

- Myofascial Pain and Dysfunction (MPD)
  - Etiological basis of the symptomatology (e.g., pain, tenderness, and spasm of the mastication muscles) is muscular hyperactivity and dysfunction due to malocclusion of variable degree and duration. Significance of psychological factors has been recognized during the past few years.
- Temporomandibular Disorder (TMD of articular origin)
  - Disk displacement is the most common cause. Abnormal anterior displacement and interposition of the posterior band between the condyle and eminence cause pain, pops, and crepitus. If the anteriorly displaced posterior band spontaneously returns to the normal position before completion of jaw opening, it is called anterior displacement with reduction.
  - The sudden reduction of the posterior band is what causes the pop, or the click sound. If the posterior band remains anteriorly displaced at all times during jaw opening, it is called anterior displacement without reduction; full jaw opening may not be possible. Inability to attain a jaw opening of more than 10 mm is known as closed lock. In TMD of articular origin, the spasm of the mastication muscle is secondary in nature.
  - Other causes of TMD of articular origin are diseases, such as DJD, rheumatoid arthritis (RA), ankylosis, dislocations, infections, and neoplasiathe pathophysiology, which is self-explanatory.

Oriental Medicine Diagnoses

- Liver Qi Stagnation
  - Causation can be due to external pathogens, lifestyle choices, such as irregular or incorrect food choice, irregular eating times, lack of sleep, or stress.
- Excessive Liver Yang
  - Leading to a rising of energy causation is disturbance of the liver energy due to either emotional or physical reasons, sometimes caused by heavy drinking.
- Qi and Blood Stagnation
  - Stagnation results in pain; may have numerous causations; can be related to trauma or underlying syndromes.

Note: While the above pathways represent classical causations for a jaw pain within the paradigm of Oriental Medicine diagnoses, they are not necessarily eligible for authorization or coverage under eviCore's acupuncture benefit plans. To be eligible for coverage and reimbursement, jaw symptoms, and/or a diagnosis of "jaw pain" must be the direct result of a primary neuromusculoskeletal injury or illness.

History

A comprehensive, chronological history and physical examination of the patient, including dental history and examination, is essential to diagnose the specific condition to decide further investigations, if any, and to provide specific treatment.

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Specific Aspects of History

- Rule out red flags (require medical management).
- Identify co-morbidities requiring medical management, and those that affect acupuncture and Oriental Medicine management.
- Determine if trauma-related; determine nature and extent of traumatic event.

Red Flag	Possible Consequence or Cause	Action Required
Severe trauma	Fracture	Immediate referral to emergency department
Fever, severe pain	Possible infection	Immediate referral to emergency department
Unilateral edema	Extremity deep vein thrombosis	Immediate referral to emergency department
Immune-compromised state	Infection	Prompt referral to Primary Care Provider
Cancer history	Cause of symptoms (metastatic or primary)	Prompt referral to Primary Care Provider
Discoloration of hand/fingers	Vascular occlusion	Immediate referral to emergency department
Exertional symptoms, history of cardiac disease	Anginal equivalent	Immediate referral to emergency department

Subjective Findings

Pain

- Pain usually is periauricular, associated with chewing, and may radiate to the head but is not like a headache.
- May be unilateral or bilateral in MPD, and usually is unilateral in TMD of articular origin, except in RA.
- In MPD pain may be associated with history of bruxism, jaw clenching, stress, and anxiety. Pain may be more severe during periods of increased stress. Assessment of pain is based principally on subjective estimation by the examining practitioner.
- Pain should be documented as a numeric pain scale 0-10

Click, pop, and snap

- Sounds usually associated with pain in TMD.
- Click with pain in anterior disk displacement is due to sudden reduction of the posterior band to normal position.
- An isolated click is very common in the general population and is not a risk factor for development of TMD.

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Limited jaw opening and locking episodes

- Lock can be open or closed.
- Open lock is the inability to close the mouth, and is seen when the mandibular condyle dislocates anteriorly in front of articular eminence. If not reduced immediately, it is very painful.
- Closed lock is an inability to open the mouth because of pain or disk displacement.

Headaches

- Pain of TMD is not like a usual headache. TMD may act as a trigger in patients prone to headaches, and when present in association with TMD, tend to be severe in nature.
- Some patients may have a history of headaches resistant to treatment.
- Diagnosis and treatment of TMD trigger should not be overlooked in such patients as it is essential for treating these headaches.
- Headache frequency, duration and numeric pain scale should be documented
- Other symptoms associated with TMD are otalgia, neck pain and/or stiffness, shoulder pain, and dizziness. About one third of these patients have a history of psychiatric problems. History of facial trauma, systemic arthritic disease, and recurrent dislocation also should be elicited.

Functional Assessment

- Documentation of a patient's level of function is an important aspect of patient care. This documentation is required in order to establish the medical necessity of ongoing acupuncture treatment. The Patient Specific Functional Scale (PSFS) is a patient reported outcome assessment that is easy and appropriate for acupuncturists to use. The PSFS has been studied in peer-reviewed scientific literature, and it has been proven to be a valid, reliable, and responsive measure for a variety of pain syndromes (neck, back, knee, etc.).

Objective Findings

Scope of Musculoskeletal Examination

- Inspection
- Palpation of bony and soft tissue
- Range of motion, active and passive
- Orthopedic testing
- Neurologic testing if neurologic signs are present
- Manual muscle testing

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Specific Aspects of Examination for TMJ

Examine the musculoskeletal system for possible causes or contributing factors to the complaint.

Findings of TMJ Syndrome

- Tender to palpation
- Manual muscle testing of affected muscle groups is weak and painful
- Observation
- Asymmetry, muscle hypertrophy, malocclusion of jaw, abnormal dental wear and missing teeth
- Limited range of motion: normal range of motion for vertical jaw opening, measured between the incisors, is 5 cm; protrusive and lateral mandibular movement is normally 1 cm.

Palpation

- TMJ is best palpated laterally as a depression just below the zygomatic arch, 1-2 cm anterior to the tragus. Posterior aspect of the joint is palpated through the external auditory canal. Joint should be palpated in both open and closed positions and both laterally and posteriorly. While palpating, examiner should feel for muscle spasm, muscle or joint tenderness, and joint sound. Muscles palpated as a part of complete TMJ exam are masseter, temporalis, medial pterygoid, lateral pterygoid, and sternocleidomastoid. Isolated MPD, joint tenderness and joint click are usually absent.
- Auscultation: In most patients, the joint movements causing sounds can be felt during palpation of the joint; in some cases, however, a less obvious sound can be auscultated.

Causes

- MPD
  - Etiology is multifactorial and includes malocclusion, jaw clenching, bruxism, personality disorders, increased pain sensitivity, and stress and anxiety. In most patients more than one factor is present.
  - Significance of psychological factors has been recognized during the past few years.
  - Patients also tend to score high on obsessive-compulsive scale, have increased levels of disease conviction, and are less likely to deny the existence of problems in their life.
- TMD
  - Disk displacement is the most common of TMD of articular origin
  - Other diseases such as DJD, RA, ankylosis, dislocation, infection, neoplasia, and congenital anomalies may contribute to pain.

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Differential Diagnoses

- Chronic Paroxysmal Hemicrania
- Cluster headache
- Migraine headache
- Migraine Headache Neuro-ophthalmic Perspective
- Migraine Headache Pediatric Perspective
- Migraine Variants
- Sialitis
- Pharyngeal abscess
- Postherpetic Neuralgia
- Temporal/Giant Cell Arteritis
- Trigeminal Neuralgia
- Carotidynia
- Dental infections
- Jaw myotonia
- Otic infections
- Styloid process syndrome
- Paratrigeminal syndrome

Occlusal Splints

- Occlusal splints are referred to as nightguards, bruxism appliances, or orthotics.
- Various kinds of splints are available; most of which, can be classified into 2 groups anterior repositioning splints and autorepositional splints.
- Physiologic basis of the pain relief provided by splints is not well understood. Factors such as alteration of occlusal relationships, redistribution of occlusal forces of bite, and alteration of structural relationship and forces in the TMJ seem to play some role.
- Autorepositional splints, also referred to as muscle splints, are used most frequently. Some sort of pain relief is seen in as many as 70-90% of patients using splints. In acute cases, the splint may be worn 24 hours a day for several months. Later, as the condition permits, they may be worn at nighttime only.

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Surgical Care

Treatment of chronic TMD is difficult, and at some time during the course of the disease, surgical options are discussed. Following are some of the surgical options:

Arthrocentesis

- Simple washing of the upper compartment of TMJ using arthrocentesis has been very effective in patients with a history of condylomeniscal incoordination; results have been comparable to those of arthroscopic surgery.
- Benefit of this treatment brings into question the significance of disk position in the etiology of TMD.
- A 22-gauge needle is inserted gently in the superior joint space and a small amount of saline is injected to distend the joint space, after which the fluid is withdrawn and evaluated. Joint is then redistended and a second needle is placed in the same joint space to lavage the joint.
- Steroids and/or local anesthetics can be injected into the joint space at the conclusion of the procedure.

Arthroscopic Surgery

- Indications include internal derangements, adhesions, fibrosis, and DJDs.
- Appears to be as efficient as open surgery, causes less surgical morbidity, and has few severe complications as compared to open surgical procedure. One retrospective short-term study found it to be safe, minimally invasive, and an effective treatment method, with 80% of patients reporting reduced pain and increased range of motion. In acute TMJ lock, arthroscopy and arthroscopic lysis and lavage of the upper compartment of TMJ produce comparable success rates.
- In one study, only 10.3% of 301 patients who underwent arthroscopic lysis and lavage had complications. More than 80% of complications were otological in nature; neurological complications were seen in five cases, of which three were fifth cranial nerve injury, and two were seventh cranial nerve injury.

Open Surgery

Main surgical option in the 1970s and 1980s. Most common procedure was disk repositioning and plication. In cases of severe disk damage, procedures such as disk repair and removal were done using artificial or autogenous material.

Arthroplasty

Surgical procedure of choice for bony intracapsular ankylosis.

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Oriental Medicine Management [8, 19, 21, 22]

- Oriental Medicine management goals are to resolve pain, restore the highest level of function possible, and educate patient to prevent recurrent symptoms.
- To be considered medically necessary, patient's symptoms must be the direct result of a primary neuromusculoskeletal injury or illness.
- Confirmation of appropriate medical co-management is always required when treating children age 14 and under.
- Treatment frequency should be commensurate with severity of the chief complaint.
- When significant improvements in patient's subjective findings and objective findings are demonstrated—continued treatment with decreased frequency is appropriate.
- As treatment progresses, one should see an increase in the active regimen of care, a decrease in the passive regimen of care, and a fading of treatment frequency.
- If the condition has not progressed towards resolution, refer the patient to an appropriate health care provider to explore other treatment alternatives.
- eviCore's consideration of requests for continued acupuncture treatment depends on updated clinical information submitted regarding patient's progress.
- Adequate and legible patient progress information that contains a history and examination, and/or eviCore's Acupuncture Treatment Request Form is required to determine medical necessity.
- In addition to improvements in the table below, significant progress may also be documented by increases in functional capacity and increasingly longer durations of pain relief.
- Discharge occurs when reasonable functional goals and expected outcomes have been achieved.
- The patient is discharged when the patient/care-giver can continue management of symptoms with an independent home program.
- Treatment is discontinued when the patient is unable to progress towards outcomes because of medical complications, psychosocial factors or other personal circumstances.
- If the member has been non-compliant with treatment as is evidenced by the clinical documentation, and/or the lack of demonstrated progress, treatment will be deemed to be not medically necessary and the member should be discharged from treatment.

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Week	Progress
0-1	◆ Some reduction of pain frequency and severity ◆ Some reduction of muscle spasm
2-4	◆ 50% decrease in pain severity and frequency ◆ 50% improvement in function
5-8	◆ 75% decrease in pain severity and frequency ◆ 75% improvement in function
9-12	◆ Gradual improvement leading toward resolution ◆ Reinforce self-management techniques ◆ Discharge patient to elective care, or to their primary care provider for alternative treatment options when a plateau is reached, or by week 12, whichever occurs first

Referral Guidelines

If improvement following the initial two weeks is not at least 25-50%, reassess case for other possible causes or complicating factors and consider different interventions. If patient is not asymptomatic, or at least 75% improved at the end of the second two week trial, or has reached a plateau, refer patient back to the referring physician to explore other treatment alternatives.

Appropriate Procedures/Modalities

- Acupuncture
- Electro-acupuncture
- Cupping
- Moxibustion
- Gua Sha
- Myofascial release
- Acupressure
- Trigger point massage
- Tui Na (not to include osseous manipulation)
- Herbal formulas

Note: Not all of these modalities are covered by the patient's health-plan; review documentation regarding coverage. Acupuncture and herbs must be appropriate for covered diagnoses under the patient's insurance policy. Acupuncturist is responsible for determining which procedures/modalities are most appropriate for the patient's condition.

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Inappropriate Procedures/Modalities

- Scarring moxa
- Applied kinesiology techniques
- Electro-acupuncture using more than 9 volts
- Any technique outside the scope of practice in your state

Self-Management Techniques

- Rest and reduce strenuous activities
- Ergonomics, Postural advice, postural exercises
- Appropriate exercises/stretching
- Tai Qi, Qi Gong, Yoga
- Stress management, meditation
- Joint protection
- Weight loss
- Self-massage, Self-acupressure
- Hot packs/cold packs, if needed, to relieve discomfort
- Instruction in use of orthosis

Alternatives to Oriental Medicine Management

(listed in alphabetical order)

- Chiropractic
- Dietary/Nutritional Medicine Counseling
- Injection therapy/Pain management
- Massage therapy
- Medication
- Occupational therapy
- Osteopathic Manipulation
- Physical Therapy
- Psychological counseling
- Surgery

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References

1. Balshem H, Helfand M, Schunemann HJ, Oxman AD, Kunz R, Brozek J, et al. GRADE guidelines: 3. Rating the quality of evidence. J Clin Epidemiol. 2011 Apr;64(4):401-6. doi:10.1016/j.jclinepi.2010.07.015.
2. Cheng X, Deng L. Chinese Acupuncture and Moxibustion. Beijing: Foreign Language Press; 2010.
3. Hempel S, Taylor SL, Solloway MR, Miake-Lye IM, Beroes JM, Shanman R, et al. VA Evidence-based Synthesis Program Reports. Evidence Map of Acupuncture. Washington (DC): Department of Veterans Affairs; 2014.
4. Horn KK, Jennings S, Richardson G, Vliet DV, Hefford C, Abbott JH. The patient-specific functional scale: psychometrics, clinimetrics, and application as a clinical outcome measure. J Orthop Sports Phys Ther. 2012 Jan;42(1):30-42. doi:10.2519/jospt.2012.3727.
5. Kaptchuk T. The Web That Has No Weaver. Contemporary Books. 2000.
6. Kelly RB. Acupuncture for pain. Am Fam Physician. 2009 Sep 1;80(5):481-4.
7. Kligler B, Nielsen A, Kohrrer C, Schmid T, Waltermaurer E, Perez E, Merrell W. Acupuncture Therapy in a Group Setting for Chronic Pain. Pain Med. 2017 Jun 8. doi:10.1093/pm/pnx134.
8. Li X, Wang R, Xing X, et al. Acupuncture for Myofascial Pain Syndrome: A Network Meta-Analysis of 33 Randomized Controlled Trials. Pain Physician. 2017 Sep;20(6):E883-E902.
9. Maciocia, G; The Foundations of Chinese Medicine: A Comprehensive Text; Churchill Livingstone, 2005.
10. MacPherson H, Vertosick EA, Foster NE, Lewith G, Linde K, Sherman KJ, et al. The persistence of the effects of acupuncture after a course of treatment: A meta-analysis of patients with chronic pain. Pain. 2016 Oct 17. doi:10.1097/j.pain.0000000000000747.
11. Magee, David J., Orthopedic Physical Assessment, Second Edition, W.B. Saunders Company, 2007.
12. McDonald J, Janz S. The Acupuncture Evidence Project: A Comparative Literature Review (Revised Edition). Brisbane: Australian Acupuncture and Chinese Medicine Association Ltd; 2017.
13. National Health and Medical Research Council. NHMRC additional levels of evidence and grades for recommendations for developers of guidelines. Table 3. NHMRC Evidence Hierarchy: designations of 'levels of evidence' according to type of research question (including explanatory notes). National Health and Medical Research Council; 2009.
14. O'Connor J, Bensky D. Acupuncture: A Comprehensive Text. Chicago: Eastland Press; 1981.
15. Olson WH, Brumback RA, Gascon G, Iyer V; Handbook of Symptom Oriented Neurology; Year Book Medical Publishers, Inc.; 2002.
16. Porter, R; The Merck Manual, Merck, 2011.
17. Roy, S., Irvin, R., and Iverson, D; Sports Medicine, Prevention, Education, Management, and Rehabilitation, Benjamin Cummings, 1998.
18. Shen YF, Younger J, Goddard G, Mackey S. Randomized clinical trial of acupuncture for myofascial pain of the jaw muscles. J Orofac Pain. 2009 Fall;23(4):353-9.
19. Wang R, Li X, Zhou S, Zhang X, Yang K, Li X. Manual acupuncture for myofascial pain syndrome: a systematic review and meta-analysis. Acupunct Med. 2017 Aug;35(4):241-250. doi:10.1136/acupmed-2016-011176.
20. Weinstein, S, and Buckwalter, J. Orthopaedics Principles and Their Application. Lippincott, Williams, & Wilkins, 2005.
21. Wu JY, Zhang C, Xu YP, et al. Acupuncture therapy in the management of the clinical outcomes for temporomandibular disorders: A PRISMA-compliant meta-analysis. Medicine (Baltimore). 2017;96(9):e6064. doi:10.1097/MD.0000000000006064.
22. Xiang A, Cheng K, Shen X, Xu P, Liu S. The Immediate Analgesic Effect of Acupuncture for Pain: A Systematic Review and Meta-Analysis. Evid Based Complement Alternat Med. 2017;2017:3837194. doi:10.1155/2017/3837194.
23. Yuan J, Purepong N, Hunter RF, Kerr DP, Park J, Bradbury I, McDonough S. Different frequencies of acupuncture treatment for chronic low back pain: an assessor-blinded pilot randomised controlled trial. Complement Ther Med. 2009 Jun;17(3):131-40. ,doi:10.1016/j.ctim.2008.10.003.
24. Zhao HJ, Tan JY, Wang T, Jin L. Auricular therapy for chronic pain management in adults: A synthesis of evidence.Complement Ther Clin Pract. 2015 May;21(2):68-78. doi:10.1016/j.ctcp.2015.03.006.

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25. Zotelli VL, Grillo CM, Gil ML, Wada RS, Sato JE, da Luz Rosário de Sousa M. Acupuncture Effect on Pain, Mouth Opening Limitation and on the Energy Meridians in Patients with Temporomandibular Dysfunction: A Randomized Controlled Trial. J Acupunct Meridian Stud. 2017 Oct;10(5):351-359. doi:10.1016/j.jams.2017.08.005.

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ACU-3.0: Cervical Conditions (Disc Radicular)

ACU-3.1: Brachial Neuritis	**66**
ACU-3.2: Cervical, Degeneration of Intervertebral Disc	**75**
ACU-3.3: Cervical, Post-Surgical Syndrome	**84**
ACU-3.4: Cervical Stenosis	**95**
ACU-3.5: Cervicobrachial Syndrome	**104**

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ACU-3.1: Brachial Neuritis

Synonyms

- Lateral recess entrapment of cervical nerve root
- Cervical radiculopathy due to spinal stenosis
- Neck pain, shoulder pain, arm pain

Definition

Neurogenic pain following the distribution of one, or less commonly, more than one of the cervical nerve root(s). Pain may be accompanied by upper extremity numbness, weakness, or hyporeflexia; and may be due to cervical disc herniation (younger patients) or foraminal encroachment or spinal stenosis (older patients). Pain may be acute or chronic.

Oriental Medicine Diagnoses

- Qi and Blood Stagnation
  - Stagnation results in this painful condition; may have numerous causations; can be related to trauma or underlying syndromes.
- Spleen Qi Deficiency resulting in Damp
  - Causation by external pathogens, inappropriate lifestyle choices that result in damp and Qi deficiency, stress.
- Bi Syndrome
  - In the case of cervical disc degeneration—it would be Damp Bi, Cold Bi, or Damp Cold Bi.

History

- Patient history may include:
  - General demographics
  - Occupation/employment
  - Hand dominance
  - Living environment
  - History of current condition
  - Functional status & activity level
  - Medications
  - Other tests and measurements (laboratory and diagnostic tests)
  - Past history (including history of prior Oriental Medicine treatment, and response to prior treatment)

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Specific Aspects of History

- Rule out red flags (require medical management).
- Identify co-morbidities requiring medical management, and those that affect acupuncture and Oriental Medicine management.
- Determine if trauma-related; determine nature and extent of traumatic event.

Red Flag	Possible Consequence or Cause	Action Required
Severe trauma	Fracture	Immediate referral to emergency department
Direct trauma to the head with loss of consciousness (LOC)	Direct trauma to the head with loss of consciousness (LOC)	Immediate referral to emergency department
Nuchal rigidity and/or positive Brudzinskis or Kernigs sign	Subarachnoid hemorrhage; meningitis	Immediate referral to emergency department
Bladder dysfunction associated with onset of neck pain	Myelopathy; spinal cord injury	Immediate referral to emergency department
Associated dysphasia		Immediate referral to emergency department
Associated cranial nerve or central nervous system (CNS) signs/symptoms	Tumor; intracranial hematoma	Immediate referral to emergency department
Onset of a new headache	Tumor; infection; vascular cause (older patients, also consider temporal arteritis; glaucoma)	Prompt referral to Primary Care Provider
Co-morbidities of rheumatoid arthritis, seronegative arthritides, Down's syndrome	Atlantoaxial instability due to associated transverse ligament laxity	Prompt referral to Primary Care Provider
Cancer	Cause of symptoms (metastatic or primary)	Prompt referral to Primary Care Provider
Alcoholism, drug abuse	Side effect or withdrawal phenomenon	Immediate referral to emergency department
Immune-compromised state	Infection	Prompt referral to Primary Care Provider

Presentation

Patient may report trauma or insidious onset. Incidence of disc herniation in patients over age of 40 decreases due to the dehydration of the nucleus pulposus.

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Subjective Findings

- Pain, numbness, tingling, paresthesias in the upper extremity following cervical nerve root distribution, particularly with hyperextension and rotation
- May complain of weakness in the upper extremity, such as with grip strength
- Lack of upper extremity coordination and difficulty with fine manipulation tasks, including handwriting, may be reported
- Midline disc protrusions may involve both extremities
- Better with rest
- Placing hand on top of head may provide relief by decreasing tension on irritated cervical nerve
- Headaches and neck pain may accompany upper extremity pain
- Pain should be documented as a numeric pain scale 0-10
- Headache and upper extremity symptom frequency, duration and numeric pain scale should be documented

Functional Assessment

- Documentation of a patient's level of function is an important aspect of patient care. This documentation is required in order to establish the medical necessity of ongoing acupuncture treatment. The Patient Specific Functional Scale (PSFS) is a patient reported outcome assessment that is easy and appropriate for acupuncturists to use. The PSFS has been studied in peer-reviewed scientific literature, and it has been proven to be a valid, reliable, and responsive measure for a variety of pain syndromes (neck, back, knee, etc.).

Objective Findings

Scope of Cervical and Upper Extremity Examination

- Inspection—spine, shoulder, elbow, wrist
- Palpation of bony and soft tissue—spine, shoulder, elbow, wrist
- Range of motion—spine, shoulder, elbow, wrist
- Motion palpation of spine
- Orthopedic testing—spine, shoulder, elbow, wrist
- Neurologic testing

Specific Aspects of Examination of Cervical Radiculitis

Examine the neuromusculoskeletal system for possible causes or contributing factors to the neck pain.

Note: Diseases that may refer pain to the cervical spine include: brain lesions, CAD, dental disease, esophageal disease, upper airway disease, lymphadenopathy.

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Findings of Cervical Radiculitis

- Cervical range of motion restrictions may be present, may be a loss of the cervical lordosis
- Muscle spasms in corresponding myotomes or paravertebral muscle
- Nerve root tension signs (shoulder depression) are positive but may be absent in cases involving a free fragment of disc tissue
- For a minal compression may cause radiating upper extremity pain
- Extension with rotation of cervical spine may cause shoulder or arm pain
- Dejerine's triad may be positive
- Dural tension signs
- Extremities symptoms and findings, if present, follow nerve root pattern
- Sensory abnormalities in dermatome
- Loss of reflex
- Motor power weakness of upper extremity
- Decreased upper extremity girth may be present

Differential Diagnoses

- Myocardial ischemia (refer for evaluation if suspected)
- Demyelinating conditions (symptoms, intensity and location vary)
- Myelopathy (trunk or leg dysfunction, gait disturbance, bowel or bladder dysfunction, signs of upper motor neuron involvement)
- Thoracic outlet syndrome (positive TOS orthopedic test)
- Peripheral nerve entrapment (Phalen's test, Tinel's test at elbow and wrist)
- Adhesive capsulitis of shoulder with referred cervical pain (restricted active and passive shoulder motion)
- Rotator cuff disorder with referred cervical pain (significant pain with shoulder circumduction motions)

Note: Signs of upper motor neuron involvement (clonus, hyperreflexia, Babinski reflex) may suggest compression of the spinal cord, which should be evaluated medically.

- Cervical nerve root compression
- Other myelopathies
- Multiple sclerosis
- Metastatic CA
- TIA/CVA

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Oriental Medicine Management [19, 35, 37, 40]

- Most patients with this diagnosis will already have consulted with their Primary Care Provider. If not, however, they should be directed to make an appointment with their MD at their earliest opportunity.
- Confirmation of appropriate medical co-management is always required when treating children age 14 and under.
- Oriental Medicine management goals are to resolve pain, restore the highest level of function possible, and educate patient to prevent recurrent symptoms.
- To be considered medically necessary, patient's symptoms must be the direct result of a primary neuromusculoskeletal injury or illness.
- Treatment frequency should be commensurate with the severity of the chief complaint.
- When significant improvements in patient's subjective findings and objective findings are demonstrated—continued treatment with decreased frequency is appropriate.
- As treatment progresses, one should see an increase in the active regimen of care, a decrease in the passive regimen of care, and a fading of treatment frequency.
- If the condition has not progressed towards resolution, refer the patient to an appropriate health care provider to explore other treatment alternatives.
- eviCore's consideration of requests for continued acupuncture treatment depends on updated clinical information submitted regarding patient's progress.
- Adequate and legible patient progress information that contains a history and examination, and/or eviCore's Acupuncture Treatment Request Form Acupuncture Treatment Request Form is required to determine medical necessity.
- In addition to the improvements in the table below, significant progress may also be documented by increases in functional capacity and increasingly longer durations of pain relief.
- Discharge occurs when reasonable functional goals and expected outcomes have been achieved.
- The patient is discharged when the patient/care-giver can continue management of symptoms with an independent home program.
- Treatment is discontinued when the patient is unable to progress towards outcomes because of medical complications, psychosocial factors or other personal circumstances.
- If the member has been non-compliant with treatment as is evidenced by the clinical documentation, and/or the lack of demonstrated progress, treatment will be deemed to be not medically necessary and the member should be discharged from treatment.

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Week	Progress
0-1	◆ Some reduction of pain severity and frequency ◆ Some reduction of muscle spasm
2-4	◆ 50% decrease in pain severity and frequency ◆ 50% improvement in function
5-8	◆ 75% decrease in pain severity and frequency ◆ 75% improvement in function
9-12	◆ Gradual improvement leading toward resolution ◆ Reinforce self-management techniques ◆ Discharge patient to elective care, or to their primary care provider for alternative ◆ Treatment options when a plateau is reached, or by week 12, whichever occurs first

Referral Guidelines

- Refer patient to their primary care provider for evaluation of alternative treatment options if:
  - Improvement does not meet the above guidelines or improvement has reached a plateau
  - Atrophy of upper extremity
  - Signs of demyelinating condition, tumor or infection
  - Increasing neurologic signs/symptoms: increasing UE numbness/tingling, increasing UE weakness, increasing UE pain, decreasing UE reflexes

Appropriate Procedures/ Modalities

- Acupuncture
- Electro-acupuncture
- Cupping
- Moxibustion
- Gua Sha
- Myofascial release
- Acupressure
- Trigger point massage
- Tui Na (not to include osseous manipulation)
- Herbal formulas

Note: Not all of these modalities are covered by patient's health-plan; review documentation regarding coverage. Acupuncture and herbs must be appropriate for covered diagnoses under the patient's insurance policy. Acupuncturist is responsible for determining which procedures/modalities are most appropriate for the patient's condition.

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Inappropriate Procedures/Modalities

- Scarring moxa
- Applied kinesiology techniques
- Electro-acupuncture using more than 9 volts
- Techniques outside the scope of practice in your state

Self-Management Techniques

- Rest and reduce strenuous activities
- Ergonomics, Postural advice, postural exercises
- Appropriate exercises/stretching
- Tai Qi, Qi Gong, Yoga
- Stress management, meditation
- Joint protection
- Weight loss
- Self-massage, Self-acupressure
- Hot packs/cold packs, if needed, to relieve discomfort
- Educate patients about the causes
- Cervical isometric exercises, cervical stabilization exercises, flexibility exercises
- Brief use of cervical collar, if necessary, in the acute stages to limit motion

Alternatives to Oriental Medicine Management

(listed in alphabetical order)

- Chiropractic
- Dietary/Nutritional Medicine Counseling
- Injection therapy/Pain management
- Massage therapy
- Medication
- Occupational therapy
- Osteopathic Manipulation
- Physical Therapy
- Psychological counseling

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References

1. Balshem H, Helfand M, Schunemann HJ, Oxman AD, Kunz R, Brozek J, et al. GRADE guidelines: 3. Rating the quality of evidence. J Clin Epidemiol. 2011 Apr;64(4):401-6. doi:10.1016/j.jclinepi.2010.07.015.
2. Blossfeldt P. Acupuncture for chronic neck pain--a cohort study in an NHS pain clinic. Acupunct Med. 2004 Sep;22(3):146-51.doi:10.1136/aim.22.3.146.
3. Ceccherelli F, Gioioso L, Casale R, Gagliardi G, Ori C. Neck pain treatment with acupuncture: does the number of needles matter? Clin J Pain. 2010 Nov-Dec;26(9):807-12.doi:10.1097/AJP.0b013e3181e375c9.
4. Chen W-T, Fu G-Q, Shen W-D. [Progresses of studies on acupuncture analgesia for postoperative reaction]. Zhen Ci Yan Jiu. 2013;38(1):83-87.
5. Cheng X, Deng L. Chinese Acupuncture and Moxibustion. Beijing: Foreign Language Press; 2010.
6. Cohen Steven P, Hooten W Michael. Advances in the diagnosis and management of neck pain BMJ 2017; 358 :j3221. doi:10.1136/bmj.j3221.
7. Deganello A, Battat N, Muratori E, Cristofaro G, Buongiorno A, Mannelli G, Picconi M, Giachetti R, Borsotti G, Gallo O. Acupuncture in shoulder pain and functional impairment after neck dissection: A prospective randomized pilot study. Laryngoscope. 2016 Aug;126(8):1790-5. doi: 10.1002/lary.25921.
8. Dong W, Goost H, Lin XB, Burger C, Paul C, Wang ZL, et al. Treatments for shoulder impingement syndrome: a PRISMA systematic review and network meta-analysis. Medicine (Baltimore). 2015 Mar;94(10):e510. doi:10.1097/MD.0000000000000510.
9. Ernst E, Lee MS, Choi TY. Acupuncture: does it alleviate pain and are there serious risks? A review of reviews. Pain. 2011 Apr;152(4):755-64. doi:10.1016/j.pain.2010.11.004.
10. França DL, Senna-Fernandes V, Cortez CM, Jackson MN, Bernardo-Filho M, Guimarães MA. Tension neck syndrome treated by acupuncture combined with physiotherapy: a comparative clinical trial (pilot study). Complement Ther Med. 2008 Oct;16(5):268-77. doi:10.1016/j.ctim.2008.02.006.
11. Fu LM, Li JT, Wu WS. Randomized controlled trials of acupuncture for neck pain: systematic review and meta-analysis. J Altern Complement Med. 2009 Feb;15(2):133-45. Review. doi:10.1089/acm.2008.0135.
12. Fuentealba Cargill F, Biagini Alarcón L. Acupuncture for postoperative pain, a literature review. Rev Med Chil. 2016;144(3):325-332. doi:10.4067/S0034-98872016000300007.
13. Hempel S, Taylor SL, Solloway MR, Miake-Lye IM, Beroes JM, Shanman R, et al. VA Evidence-based Synthesis Program Reports. Evidence Map of Acupuncture. Washington (DC): Department of Veterans Affairs; 2014.
14. Horn KK, Jennings S, Richardson G, Vliet DV, Hefford C, Abbott JH. The patient-specific functional scale: psychometrics, clinimetrics, and application as a clinical outcome measure. J Orthop Sports Phys Ther. 2012 Jan;42(1):30-42. doi:10.2519/jospt.2012.3727.
15. Kaptchuk T. The Web That Has No Weaver. Contemporary Books. 2000.
16. Kelly RB. Acupuncture for pain. Am Fam Physician. 2009 Sep 1;80(5):481-4.
17. Kligler B, Nielsen A, Kohrrer C, Schmid T, Waltermaurer E, Perez E, Merrell W. Acupuncture Therapy in a Group Setting for Chronic Pain. Pain Med. 2017 Jun 8. doi:10.1093/pm/pnx134.
18. Lee MS, Ernst E. Acupuncture for surgical conditions: an overview of systematic reviews. Int J Clin Pract. 2014 Jun;68(6):783-9. doi:10.1111/ijcp.12372.
19. Li X, Wang R, Xing X, et al. Acupuncture for Myofascial Pain Syndrome: A Network Meta-Analysis of 33 Randomized Controlled Trials. Pain Physician. 2017 Sep;20(6):E883-E902.
20. Linde K, Allais G, Brinkhaus B, Fei Y, Mehring M, Shin BC, et al. Acupuncture for the prevention of tension-type headache. Cochrane Database Syst Rev. 2016;4:Cd007587. doi:10.1002/14651858.CD007587.pub2.
21. Linde K, Allais G, Brinkhaus B, Manheimer E, Vickers A, White AR. Acupuncture for tension-type headache. Cochrane Database Syst Rev. 2009 Jan 21;(1):CD007587. doi:10.1002/14651858.CD007587.
22. Maciocia, G; The Foundations of Chinese Medicine: A Comprehensive Text; Churchill Livingstone, 2005.

© 2019 eviCore healthcare. All Rights Reserved.

23. MacPherson H, Tilbrook H, Richmond S, Woodman J, Ballard K, Atkin K, Bland M, Eldred J, Essex H, Hewitt C, Hopton A, Keding A, Lansdown H, Parrott S, Torgerson D, Wenham A, Watt I. Alexander Technique Lessons or Acupuncture Sessions for Persons With Chronic Neck Pain: A Randomized Trial. Ann Intern Med. 2015 Nov 3;163(9):653-62. doi:10.7326/M15-0667.
24. MacPherson H, Vertosick EA, Foster NE, Lewith G, Linde K, Sherman KJ, et al. The persistence of the effects of acupuncture after a course of treatment: A meta-analysis of patients with chronic pain. Pain. 2016 Oct 17. doi:10.1097/j.pain.0000000000000747.
25. Magee, David J., Orthopedic Physical Assessment, Second Edition, W.B. Saunders Company, 2007.
26. McDonald J, Janz S. The Acupuncture Evidence Project: A Comparative Literature Review (Revised Edition). Brisbane: Australian Acupuncture and Chinese Medicine Association Ltd; 2017.
27. National Health and Medical Research Council. NHMRC additional levels of evidence and grades for recommendations for developers of guidelines. Table 3. NHMRC Evidence Hierarchy: designations of 'levels of evidence' according to type of research question (including explanatory notes). National Health and Medical Research Council; 2009.
28. O'Connor J, Bensky D. Acupuncture: A Comprehensive Text. Chicago: Eastland Press; 1981.
29. Olson WH, Brumback RA, Gascon G, Iyer V; Handbook of Symptom Oriented Neurology; Year Book Medical Publishers, Inc.; 2002.
30. Porter, R; The Merck Manual, Merck, 2011.
31. Roy, S., Irvin, R., and Iverson, D; Sports Medicine, Prevention, Education, Management, and Rehabilitation, Benjamin Cummings, 1998.
32. Seo SY, Lee KB, Shin JS, et al. Effectiveness of Acupuncture and Electroacupuncture for Chronic Neck Pain: A Systematic Review and Meta-Analysis. Am J Chin Med. 2017;45(8):1573-1595. doi:10.1142/S0192415X17500859.
33. Sun Y, Gan TJ. Acupuncture for the management of chronic headache: a systematic review. Anesth Analg. 2008 Dec;107(6):2038-47. doi:10.1213/ane.0b013e318187c76a.
34. Trinh K, Graham N, Irnich D, Cameron ID, Forget M. Acupuncture for neck disorders. Cochrane Database Syst Rev. 2016(5):Cd004870. doi:10.1002/14651858.CD004870.pub4.
35. Wang R, Li X, Zhou S, Zhang X, Yang K, Li X. Manual acupuncture for myofascial pain syndrome: a systematic review and meta-analysis. Acupunct Med. 2017 Aug;35(4):241-250. doi:10.1136/acupmed-2016-011176.
36. Wei X, Wang S, Li J, et al. Complementary and Alternative Medicine for the Management of Cervical Radiculopathy: An Overview of Systematic Reviews. Evidence-Based Complementary and Alternative Medicine. 2015;2015:1-10. doi:10.1155/2015/793649.
37. Weinstein, S, and Buckwalter, J. Orthopaedics Principles and Their Applications. Lippincott, Williams, & Wilkins, 2005.
38. White P, Lewith G, Prescott P, Conway J. Acupuncture versus placebo for the treatment of chronic mechanical neck pain: a randomized, controlled trial. Ann Intern Med. 2004 Dec 21;141(12):911-9. doi:10.7326/0003-4819-141-12-200412210-00007.
39. Wu MS, Chen KH, Chen IF, Huang SK, Tzeng PC, Yeh ML, et al. The Efficacy of Acupuncture in Post-Operative Pain Management: A Systematic Review and Meta-Analysis. PLOS ONE. 2016;11(3):e0150367. doi:10.1371/journal.pone.0150367.
40. Xiang A, Cheng K, Shen X, Xu P, Liu S. The Immediate Analgesic Effect of Acupuncture for Pain: A Systematic Review and Meta-Analysis. Evid Based Complement Alternat Med. 2017;2017:3837194. doi:10.1155/2017/3837194.
41. Yuan J, Purepong N, Hunter RF, Kerr DP, Park J, Bradbury I, McDonough S. Different frequencies of acupuncture treatment for chronic low back pain: an assessor-blinded pilot randomised controlled trial. Complement Ther Med. 2009 Jun;17(3):131-40. doi:10.1016/j.ctim.2008.10.003.
42. Yuan Q-l, Guo T-m, Liu L, Sun F, Zhang Y-g (2015) Traditional Chinese Medicine for Neck Pain and Low Back Pain: A Systematic Review and Meta-Analysis. PLoS ONE 10(2): e0117146. doi:10.1371/ journal.pone.0117146.
43. Zhao HJ, Tan JY, Wang T, Jin L. Auricular therapy for chronic pain management in adults: A synthesis of evidence. Complement Ther Clin Pract. 2015 May;21(2):68-78. doi:10.1016/j.ctcp.2015.03.006.

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ACU-3.2: Cervical, Degeneration of Intervertebral Disc

Synonyms

- Cervical degenerative joint disease
- Neck pain

Definition

Either osteophyte formation or arthritic degeneration may encroach on the intervertebral foramen with narrowing of the intervertebral disc. This may occur as a late degenerative change from a preexisting disc lesion. Rupture of the cervical disc is almost always posterolateral with immediate compression, and 95% of cervical disc lesions occur at the fifth and sixth level. Pain may be acute or chronic. Radicular symptoms may or may not be present.

Oriental Medicine Diagnoses

- Qi and Blood Stagnation
  - Stagnation results in the painful condition; may have numerous causations; can be related to trauma or underlying syndromes.
- Spleen Qi Deficiency resulting in Damp
  - Causation by external pathogens. Inappropriate lifestyle choices that result in damp and Qi deficiency, stress.
- Bi Syndrome
  - Accumulation of Wind, Damp, Cold or Heat. In the case of cervical disc degeneration—it would be Damp Bi, Cold Bi, or Damp Cold Bi.

History

- Patient history may include:
  - General demographics
  - Occupation/employment
  - Hand dominance
  - Living environment
  - History of current condition
  - Functional status & activity level
  - Medications
  - Other tests and measurements (laboratory and diagnostic tests)
  - Past history (including history of prior Oriental Medicine treatment, and response to prior treatment)

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Specific Aspects of History

Red Flag	Possible Consequence or Cause	Action Required
Severe trauma	Fracture	Immediate referral to emergency department
Direct trauma to the head with loss of consciousness (LOC)	Subdural hematoma; epidural hematoma; fracture	Immediate referral to emergency department
Nuchal rigidity and/or positive Brudzinskis or Kernig's sign	Subarachnoid hemorrhage; meningitis	Immediate referral to emergency department
Bladder dysfunction associated with onset of neck pain	Myelopathy; spinal cord injury	Immediate referral to emergency department
Associated dysphasia	Cerebrovascular accident	Immediate referral to emergency department
Associated cranial nerve or central nervous system (CNS) signs/symptoms	Tumor; intracranial hematoma	Immediate referral to emergency department
Onset of a new headache	Tumor; infection; vascular cause (older patients, also consider temporal arteritis; glaucoma)	Prompt referral to Primary Care Provider
Co-morbidities of rheumatoid arthritis, sero-negative arthritides, Down's syndrome	Atlantoaxial instability due to associated transverse ligament laxity	Prompt referral to Primary Care Provider
Cancer	Cause of symptoms (metastatic or primary)	Prompt referral to Primary Care Provider
Alcoholism, drug abuse	Side effect or withdrawal phenomenon	Immediate referral to emergency department
Immune-compromised state	Infection	Prompt referral to Primary Care Provider

Presentation

Lesions tend to occur at the point of greatest mobility. While patient may have suffered a downward compression or hyperflexion injury, most have no history of trauma. Patient complains of neck pain radiating into one shoulder and arm; Paresthesias are common. Pain is increased with movement, Valsalva maneuver, and compression. Hypoesthesia and weakness may be present.

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Subjective Findings

- Pain and stiffness in the neck
- Pain typically worse with flexion, extension and lateral flexion towards the lesion
- May report crepitus with certain cervical motions, particularly circumduction
- Headaches may accompany pain
- Non-dermatomal upper extremity pain (unilateral or bilateral) may occur with lateral recess stenosis and nerve root entrapment
- Pain should be documented as a numeric pain scale 0-10
- Headache and upper extremity symptom frequency, duration and numeric pain scale should be documented

Functional Assessment

- Documentation of a patient's level of function is an important aspect of patient care. This documentation is required in order to establish the medical necessity of ongoing acupuncture treatment. The Patient Specific Functional Scale (PSFS) is a patient reported outcome assessment that is easy and appropriate for acupuncturists to use. The PSFS has been studied in peer-reviewed scientific literature, and it has been proven to be a valid, reliable, and responsive measure for a variety of pain syndromes (neck, back, knee, etc.).

Objective Findings

Scope of Cervical Examination

- Inspection (including postural evaluation)
- Palpation of bony and soft tissue
- Range of motion
- Motion palpation of spine
- Orthopedic testing
- Neurologic testing

Specific Aspects of Examination for Cervical Sprain/Strain

Examine the region for contributing factors to the complaint.

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Findings of Cervical Degenerative Disc

- May relate tenderness to palpation in the lateral portions of the neck and along spinous processes
- May demonstrate range of motion, range of motion restrictions in the cervical spine (electrical shock-like sensations down the arms and/or legs with cervical flexion may indicate myelopathy or a disorder of the central nervous system that requires medical evaluation)
- Nerve root tension signs (shoulder depression) may be positive
- Foraminal compression may cause radiating upper extremity pain
- Extension with rotation of cervical spine may cause shoulder or arm pain
- Dejerine's triad may be positive

Differential Diagnoses

- Metastatic tumor (awakened by constant and severe night pain that is not relieved by changing position, especially when there is a known or suspected history of cancer)
- Spinal cord tumor
- Syringomyelia (superficial abdominal reflexes absent, insensitive to pain)
- Cervical vertebral instability (due to rheumatoid arthritis or following significant recent trauma)

Note: Signs of upper motor neuron involvement may suggest compression of the spinal cord, which should be evaluated medically.

Oriental Medicine Management [19, 32, 35, 40]

- Most patients with this diagnosis will already have consulted with their Primary Care Provider. If not, however, they should be directed to make an appointment with their MD at their earliest opportunity.
- Confirmation of appropriate medical co-management is always required when treating children age 14 and under.
- Oriental Medicine management goals are to resolve pain, restore the highest level of function possible, and educate patient to prevent recurrent symptoms.
- To be considered medically necessary, patient's symptoms must be the direct result of a primary neuromusculoskeletal injury or illness.
- Treatment frequency should be commensurate with severity of the chief complaint.
- When significant improvement in patient's subjective findings and objective findings are demonstrated—continued treatment with decreased frequency is appropriate.

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- As treatment progresses, one should see an increase in the active regimen of care, a decrease in the passive regimen of care, and a fading of treatment frequency.
- If the condition has not progressed towards resolution, refer the patient to an appropriate health care provider to explore other treatment alternatives.
- eviCore's consideration of requests for continued acupuncture treatment depends on updated clinical information submitted regarding patient's progress.
- Adequate and legible patient progress information that contains a history and examination, and/or eviCore's Acupuncture Treatment Request Form is required to determine medical necessity.
- In addition to improvements in the table below, significant progress may also be documented by increases in functional capacity and increasingly longer durations of pain relief.
- Discharge occurs when reasonable functional goals and expected outcomes have been achieved.
- The patient is discharged when the patient/care-giver can continue management of symptoms with an independent home program.
- Treatment is discontinued when the patient is unable to progress towards outcomes because of medical complications, psychosocial factors or other personal circumstances.
- If the member has been non-compliant with treatment as is evidenced by the clinical documentation, and/or the lack of demonstrated progress, treatment will be deemed to be not medically necessary and the member should be discharged from treatment.

Week	Progress
0-1	◆ Some reduction of pain severity and frequency ◆ Some reduction of muscle spasm
2-4	◆ 50% improvement in pain severity and frequency ◆ 50% increase in function ◆ Pain distribution is centralizing ◆ Reinforce self-management techniques
5-8	◆ Continued reduction of pain severity and frequency ◆ Continued increase in function ◆ Pain distribution continues to centralize ◆ Reinforce self-management techniques
9-12	◆ 75% improvement in pain severity and frequency ◆ 75% improvement in function ◆ Pain distribution is centralized to back ◆ Reinforce self-management techniques
13-16	◆ Gradual improvement leading toward resolution ◆ Reinforce self-management techniques ◆ Discharge patient to elective care, or to their primary care provider for alternative treatment options when a plateau is reached, or by week 16, whichever occurs first

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Referral Guidelines

- Refer patient to their primary care provider for evaluation of alternative treatment options if:
  - Improvement does not meet the above guidelines or improvement has reached a plateau
  - Atrophy of upper extremity
  - Signs of demyelinating condition, tumor or infection
  - Progressive neurologic signs/symptoms: increasing UE numbness/tingling, increasing UE weakness, decreasing UE reflexes

Appropriate Procedures/ Modalities

- Acupuncture
- Electro-acupuncture
- Cupping
- Moxibustion
- Gua Sha
- Myofascial release
- Acupressure
- Trigger point massage
- Tui Na (not to include osseous manipulation)
- Herbal formulas

Note: Not all of these modalities are covered by patient's health-plan; review documentation regarding coverage. Acupuncture and herbs must be appropriate for covered diagnoses under the patient's insurance policy. Acupuncturist is responsible for determining which procedures/modalities are most appropriate for the patient's condition.

Inappropriate Procedures/Modalities

- Scarring moxa
- Applied kinesiology techniques
- Electro-acupuncture using more than 9 volts
- Any techniques outside the scope of practice in your state

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Self-Management Techniques

- Rest and reduce strenuous activities
- Ergonomics, Postural advice, postural exercises
- Appropriate exercises/stretching
- Tai Qi, Qi Gong, Yoga
- Stress management, meditation
- Joint protection
- Weight loss
- Self-massage, Self-acupressure
- Hot packs/cold packs, if needed, to relieve discomfort
- Use of cervical pillow, if helpful

Alternatives to Oriental Medicine Management

(listed in alphabetical order)

- Biofeedback
- Chiropractic
- Dietary/Nutritional Medicine Counseling
- Injection therapy/Pain management
- Massage therapy
- Medication
- Occupational therapy
- Osteopathic Manipulation
- Physical Therapy
- Psychological counseling

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References

1. Balshem H, Helfand M, Schunemann HJ, Oxman AD, Kunz R, Brozek J, et al. GRADE guidelines: 3. Rating the quality of evidence. J Clin Epidemiol. 2011 Apr;64(4):401-6. doi:10.1016/j.jclinepi.2010.07.015.
2. Blossfeldt P. Acupuncture for chronic neck pain--a cohort study in an NHS pain clinic. Acupunct Med. 2004 Sep;22(3):146-51. doi:10.1136/aim.22.3.146.
3. Ceccherelli F, Gioioso L, Casale R, Gagliardi G, Ori C. Neck pain treatment with acupuncture: does the number of needles matter? Clin J Pain. 2010 Nov-Dec;26(9):807-12. doi:10.1097/AJP.0b013e3181e375c9.
4. Chen W-T, Fu G-Q, Shen W-D. [Progresses of studies on acupuncture analgesia for postoperative reaction]. Zhen Ci Yan Jiu. 2013;38(1):83-87.
5. Cheng X, Deng L. Chinese Acupuncture and Moxibustion. Beijing: Foreign Language Press; 2010.
6. Cohen Steven P, Hooten W Michael. Advances in the diagnosis and management of neck pain BMJ 2017; 358 :j3221. doi:10.1136/bmj.j3221.
7. Deganello A, Battat N, Muratori E, Cristofaro G, Buongiorno A, Mannelli G, Picconi M, Giachetti R, Borsotti G, Gallo O. Acupuncture in shoulder pain and functional impairment after neck dissection: A prospective randomized pilot study. Laryngoscope. 2016 Aug;126(8):1790-5. doi:10.1002/lary.25921.
8. Dong W, Goost H, Lin XB, Burger C, Paul C, Wang ZL, et al. Treatments for shoulder impingement syndrome: a PRISMA systematic review and network meta-analysis. Medicine (Baltimore). 2015 Mar;94(10):e510. doi:10.1097/MD.0000000000000510.
9. Ernst E, Lee MS, Choi TY. Acupuncture: does it alleviate pain and are there serious risks? A review of reviews. Pain. 2011 Apr;152(4):755-64. doi:10.1016/j.pain.2010.11.004.
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11. Fu LM, Li JT, Wu WS. Randomized controlled trials of acupuncture for neck pain: systematic review and meta-analysis. J Altern Complement Med. 2009 Feb;15(2):133-45. doi:10.1089/acm.2008.0135.
12. Fuentealba Cargill F, Biagini Alarcón L. Acupuncture for postoperative pain, a literature review. Rev Med Chil. 2016;144(3):325-332. doi:10.4067/S0034-98872016000300007.
13. Hempel S, Taylor SL, Solloway MR, Miake-Lye IM, Beroes JM, Shanman R, et al. VA Evidence-based Synthesis Program Reports. Evidence Map of Acupuncture. Washington (DC): Department of Veterans Affairs; 2014.
14. Horn KK, Jennings S, Richardson G, Vliet DV, Hefford C, Abbott JH. The patient-specific functional scale: psychometrics, clinimetrics, and application as a clinical outcome measure. J Orthop Sports Phys Ther. 2012 Jan;42(1):30-42. doi:10.2519/jospt.2012.3727.
15. Kaptchuk T. The Web That Has No Weaver. Contemporary Books. 2000.
16. Kelly RB. Acupuncture for pain. Am Fam Physician. 2009 Sep 1;80(5):481-4.
17. Kligler B, Nielsen A, Kohrrer C, Schmid T, Waltermaurer E, Perez E, Merrell W. Acupuncture Therapy in a Group Setting for Chronic Pain. Pain Med. 2017 Jun 8. doi:10.1093/pm/pnx134.
18. Lee MS, Ernst E. Acupuncture for surgical conditions: an overview of systematic reviews. Int J Clin Pract. 2014 Jun;68(6):783-9. doi:10.1111/ijcp.12372.
19. Li X, Wang R, Xing X, et al. Acupuncture for Myofascial Pain Syndrome: A Network Meta-Analysis of 33 Randomized Controlled Trials. Pain Physician. 2017 Sep;20(6):E883-E902.
20. Linde K, Allais G, Brinkhaus B, Fei Y, Mehring M, Shin BC, et al. Acupuncture for the prevention of tension-type headache. Cochrane Database Syst Rev. 2016;4:Cd007587. doi:10.1002/14651858.CD007587.pub2.
21. Linde K, Allais G, Brinkhaus B, Manheimer E, Vickers A, White AR. Acupuncture for tension-type headache. Cochrane Database Syst Rev. 2009 Jan 21;(1):CD007587. doi:10.1002/14651858.CD007587.
22. Maciocia, G; The Foundations of Chinese Medicine: A Comprehensive Text; Churchill Livingstone, 2005.

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23. MacPherson H, Tilbrook H, Richmond S, Woodman J, Ballard K, Atkin K, Bland M, Eldred J, Essex H, Hewitt C, Hopton A, Keding A, Lansdown H, Parrott S, Torgerson D, Wenham A, Watt I. Alexander Technique Lessons or Acupuncture Sessions for Persons With Chronic Neck Pain: A Randomized Trial. Ann Intern Med. 2015 Nov 3;163(9):653-62. doi:10.7326/M15-0667.
24. MacPherson H, Vertosick EA, Foster NE, Lewith G, Linde K, Sherman KJ, et al. The persistence of the effects of acupuncture after a course of treatment: A meta-analysis of patients with chronic pain. Pain. 2016 Oct 17. doi:10.1097/j.pain.0000000000000747.
25. Magee, David J., Orthopedic Physical Assessment, Second Edition, W.B. Saunders Company, 2007.
26. McDonald J, Janz S. The Acupuncture Evidence Project: A Comparative Literature Review (Revised Edition). Brisbane: Australian Acupuncture and Chinese Medicine Association Ltd; 2017.
27. National Health and Medical Research Council. NHMRC additional levels of evidence and grades for recommendations for developers of guidelines. Table 3. NHMRC Evidence Hierarchy: designations of 'levels of evidence' according to type of research question (including explanatory notes). National Health and Medical Research Council; 2009.
28. O'Connor J, Bensky D. Acupuncture: A Comprehensive Text. Chicago: Eastland Press; 1981.
29. Olson WH, Brumback RA, Gascon G, Iyer V; Handbook of Symptom Oriented Neurology; Year Book Medical Publishers, Inc.; 2002.
30. Porter, R; The Merck Manual, Merck, 2011.
31. Roy, S., Irvin, R., and Iverson, D; Sports Medicine, Prevention, Education, Management, and Rehabilitation, Benjamin Cummings, 1998.
32. Seo SY, Lee KB, Shin JS, et al. Effectiveness of Acupuncture and Electroacupuncture for Chronic Neck Pain: A Systematic Review and Meta-Analysis. Am J Chin Med. 2017;45(8):1573-1595. doi:10.1142/S0192415X17500859.
33. Sun Y, Gan TJ. Acupuncture for the management of chronic headache: a systematic review. Anesth Analg. 2008 Dec;107(6):2038-47. doi:10.1213/ane.0b013e318187c76a.
34. Trinh K, Graham N, Irnich D, Cameron ID, Forget M. Acupuncture for neck disorders. Cochrane Database Syst Rev. 2016(5):Cd004870. doi:10.1002/14651858.CD004870.pub4.
35. Wang R, Li X, Zhou S, Zhang X, Yang K, Li X. Manual acupuncture for myofascial pain syndrome: a systematic review and meta-analysis. Acupunct Med. 2017 Aug;35(4):241-250. doi:10.1136/acupmed-2016-011176.
36. Wei X, Wang S, Li J, et al. Complementary and Alternative Medicine for the Management of Cervical Radiculopathy: An Overview of Systematic Reviews. Evidence-Based Complementary and Alternative Medicine. 2015;2015:1-10. doi:10.1155/2015/793649.
37. Weinstein, S, and Buckwalter, J. Orthopaedics Principles and Their Application. Lippincott, Williams, & Wilkins, 2005.
38. White P, Lewith G, Prescott P, Conway J. Acupuncture versus placebo for the treatment of chronic mechanical neck pain: a randomized, controlled trial. Ann Intern Med. 2004 Dec 21;141(12):911-9. doi:10.7326/0003-4819-141-12-200412210-00007.
39. Wu MS, Chen KH, Chen IF, Huang SK, Tzeng PC, Yeh ML, et al. The Efficacy of Acupuncture in Post-Operative Pain Management: A Systematic Review and Meta-Analysis. PLOS ONE. 2016;11(3):e0150367. doi:10.1371/journal.pone.0150367.
40. Xiang A, Cheng K, Shen X, Xu P, Liu S. The Immediate Analgesic Effect of Acupuncture for Pain: A Systematic Review and Meta-Analysis. Evid Based Complement Alternat Med. 2017;2017:3837194. doi:10.1155/2017/3837194.
41. Yuan J, Purepong N, Hunter RF, Kerr DP, Park J, Bradbury I, McDonough S. Different frequencies of acupuncture treatment for chronic low back pain: an assessor-blinded pilot randomised controlled trial. Complement Ther Med. 2009 Jun;17(3):131-40. doi:10.1016/j.ctim.2008.10.003.
42. Yuan Q-l, Guo T-m, Liu L, Sun F, Zhang Y-g (2015) Traditional Chinese Medicine for Neck Pain and Low Back Pain: A Systematic Review and Meta-Analysis. PLoS ONE 10(2): e0117146. doi:10.1371/ journal.pone.0117146.
43. Zhao HJ, Tan JY, Wang T, Jin L. Auricular therapy for chronic pain management in adults: A synthesis of evidence. Complement Ther Clin Pract. 2015 May;21(2):68-78. doi:10.1016/j.ctcp.2015.03.006.

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ACU-3.3: Cervical, Post-Surgical Syndrome

Synonyms

- Post Fusion Syndrome
- Post Discectomy Syndrome
- Post Laminectomy Syndrome
- Failed Spinal Surgery Syndrome
- Neck pain, upper back pain, arm pain, hand pain

Definition

Post-surgical course, in which patient continues to have abnormal findings for strength, range of motion, and pain with referral to upper back, shoulder, arm, and/or hand. There may be altered reflexes and sensation. Because multiple factors can contribute to this syndrome, patients are considered to be suffering from a chronic pain syndrome. It is recommended that patients be treated by a multidisciplinary team including at least an MD/anesthesiologist, physical therapist or occupational therapist to help manage the rehabilitation.

Oriental Medicine Diagnoses

- Qi and Blood Stagnation:
  - This stagnation results in a painful condition, may have numerous causation, but for this diagnosis trauma is the primary causation, perhaps with underlying Qi Deficiency Syndrome.
- Damp Bi, Stationary (Damp) Painful Obstruction:
  - Pain is localized and does not move.
- Cold Bi, Painful (Cold) Painful Obstruction:
  - Severe pain in one part, or over one half of the body, which becomes worse when patient encounters cold and diminishes when patient is warm.
- Heat Bi, Heat Painful Obstruction:
  - Flesh is hot, area of pain is red and swollen, pain increases upon contact.
- Bi syndrome:
  - Condition can be any combination of the above.

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History

- Patient history may include:
  - General demographics
  - Occupation/employment
  - Hand dominance
  - Living environment
  - History of current condition
  - Functional status & activity level
  - Medications
  - Other tests and measurements (laboratory and diagnostic tests)
  - Past history (including history of prior Oriental Medicine treatment, and response to prior treatment)
  - In addition to the standard information gathered, a complete understanding of the surgical procedure performed should be obtained from surgeon.

Specific Aspects of History

- Rule out red flags (require medical management).
- Identify co-morbidities requiring medical management, and those that affect acupuncture and Oriental Medicine management.
- Determine if trauma-related; determine nature and extent of traumatic event.
- Determine OPQRST (Onset, Provocative/Palliative factors, Quality, Radiation/Referral pattern, Site [location], Timing of complaint).

Red Flag	Possible Consequence or Cause	Action Required
Severe trauma	Fracture	Immediate referral to emergency department
Fracture	Infection	Immediate referral to emergency department
Direct trauma to the head with loss of consciousness (LOC)	Subdural hematoma; epidural hematoma; fracture	Immediate referral to emergency department
Nuchal rigidity and/or positive Brudzinskis or Kernigs sign	Subarachnoid hemorrhage; meningitis	Immediate referral to emergency department
Bladder dysfunction associated with onset of neck pain	Myelopathy; spinal cord injury	Immediate referral to emergency department
Associated dysphasia; unilateral weakness	Cerebrovascular accident	Immediate referral to emergency department
Associated cranial nerve or central nervous system (CNS) signs/symptoms	Tumor; intracranial hematoma	Immediate referral to emergency department

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Red Flag	Possible Consequence or Cause	Action Required
Onset of a new headache	Tumor; infection; vascular cause (older patients, also consider temporal arteritis; glaucoma)	Prompt referral to Primary Care Provider
Co-morbidities of rheumatoid arthritis, seronegative arthritides, Down's syndrome	Atlantoaxial instability due to associated transverse ligament laxity	Prompt referral to Primary Care Provider
Cancer	Cause of symptoms (metastatic or primary)	Prompt referral to Primary Care Provider
Alcoholism, drug abuse	Side effect or withdrawal phenomenon	Immediate referral to emergency department
Immune-compromised state	Infection	Prompt referral to Primary Care Provider

Presentation

Patient presents with continued signs and symptoms post operatively and may have surgery specific precautions that vary by surgeon.

Subjective Findings

- Pain, numbness, tingling, paresthesias in the upper extremity following cervical nerve root distribution
- May complain of weakness in the upper extremity, such as with grip strength
- Lack of upper extremity coordination and difficulty with fine manipulation tasks, including handwriting, may be reported
- Headaches and neck pain may accompany upper extremity pain
- Pain should be documented as a numeric pain scale 0-10
- Headache and upper extremity symptom frequency, duration and numeric pain scale should be documented

Functional Assessment

- Documentation of a patient's level of function is an important aspect of patient care. This documentation is required in order to establish the medical necessity of ongoing acupuncture treatment. The Patient Specific Functional Scale (PSFS) is a patient reported outcome assessment that is easy and appropriate for acupuncturists to use. The PSFS has been studied in peer-reviewed scientific literature, and it has been proven to be a valid, reliable, and responsive measure for a variety of pain syndromes (neck, back, knee, etc.).

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Objective Findings

- Pain at surgical site, particularly with movement
- Swelling
- Weakness
- Limited range of motion
- Impaired motor function
- Restrictions/precautions set by surgeon (bracing, weight bearing)

Scope of Cervical and Upper Extremity Examination

- All of the following objective tests may not be appropriate, but should be assessed according to the member's condition and surgery type:
  - Pain: Determine OPQRST (Onset, Provocative/Palliative factors, Quality, Radiation/Referral pattern, Site [location], Timing of complaint). Observe surgical precautions.
  - Skin/Wound Integrity: Skin characteristics (blistering, color, sensation, temperature, texture), Surgical wound (signs of infection, scar tissue characteristics, stage of healing). Observe surgical precautions.
  - Palpation of bony and soft tissue: Palpate involved muscles for tender nodule, taut band, tight ropiness, Observe pattern of referred pain, Provocation tests. Observe surgical precautions.
  - Edema (measure both sides for comparison): Girth measurements, Palpation, Volume measurements. Observe surgical precautions.
  - Postural assessment: Postural alignment and position. Observe surgical precautions.
  - Range of motion: Active and passive movement of affected area and joint above and below and contralateral joints, Functional range of motion (e.g. squat tests, toe touch tests). Observe surgical precautions.
  - Manual Muscle Testing: Test related joints. Observe surgical precautions.
  - Assistive, protective and supportive devices
  - Neurologic tests: Proprioception, Sensation. Observe surgical precautions.
  - Gait and Locomotion: Gait indexes, Mobility skills profiles, Functional assessment profiles. Observe surgical precautions.
  - Motor Function Tests: Use standardized tests appropriate to the affected area. Observe surgical precautions.

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Specific Aspects of Cervical Examination

- Examine the neuromusculoskeletal system for possible causes or contributing factors to the neck pain.
- Evaluate for potential of post-surgical complications or other red flags. Refer appropriately if signs or symptoms of post-surgical complications develop.

Note: Diseases that may refer pain to the cervical spine include: brain lesions, CAD, dental and oral diseases, esophageal disease, upper airway disease, lymphadenopathy.

Findings of Cervical Examination

- Cervical range of motion restrictions may be present
- Muscle spasms in corresponding myotomes
- Extension with rotation of cervical spine may cause shoulder or arm pain
- Dural tension signs
- Extremities symptoms and findings, if present, follow nerve root pattern
- Sensory abnormalities in dermatome
- Loss of reflex
- Motor power weakness of upper extremity
- Decreased upper extremity girth may be present

Differential Diagnoses

- Myocardial ischemia (refer for evaluation if suspected)
- Demyelinating conditions (symptoms, intensity and location vary)
- Myelopathy (trunk or leg dysfunction, gait disturbance, bowel or bladder dysfunction, signs of upper motor neuron involvement)
- Thoracic outlet syndrome (positive TOS orthopedic test)
- Peripheral nerve entrapment (Phalens test, Tinels test at elbow and wrist)
- Adhesive capsulitis of shoulder with referred cervical pain (restricted active and passive shoulder motion)
- Rotator cuff disorder with referred cervical pain (significant pain with shoulder circumduction motions)

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Oriental Medicine Management [19, 32, 35, 40]

- Post-surgical rehabilitation should be managed by a multidisciplinary team including at least an MD and a physical therapist. Active rehabilitation, including physical therapy and occupational therapy, is critical for optimal recovery. The goal is to transition the patient as quickly as possible to active care, self-management and functional independence.
- Confirmation of appropriate medical co-management is always required when treating children age 14 and under.
- Treatment frequency should be commensurate with the severity of the chief complaint.
- When significant improvements in patient's subjective findings and objective findings are demonstrated—continued treatment with decreased frequency is appropriate.
- As treatment progresses, one should see an increase in the active regimen of care, a decrease in the passive regimen of care, and a fading of treatment frequency.
- If the condition has not progressed towards resolution, refer the patient to an appropriate health care provider to explore other treatment alternatives.
- eviCore's consideration of requests for continued acupuncture treatment depends on updated clinical information submitted regarding patient's progress.
- Adequate and legible patient progress information that contains a history and examination, and/or eviCore's Acupuncture Treatment Request Form is required to determine medical necessity.
- In addition to the improvements in the table below, significant progress may also be documented by increases in functional capacity and increasingly longer durations of pain relief.
- Discharge occurs when reasonable functional goals and expected outcomes have been achieved.
- The patient is discharged when the patient/care-giver can continue management of symptoms with an independent home program.
- Treatment is discontinued when the patient is unable to progress towards outcomes because of medical complications, psychosocial factors or other personal circumstances.
- If the member has been non-compliant with treatment as is evidenced by the clinical documentation, and/or the lack of demonstrated progress, treatment will be deemed to be not medically necessary and the member should be discharged from treatment.

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Week	Progress
0-1	◆ Some reduction of pain severity and frequency ◆ Some reduction of muscle spasm ◆ Observation of post-surgical activity restrictions, if any
2-4	◆ 50% improvement in pain severity and frequency ◆ Meet functional goals set by MD, PT or OT Observation of post-surgical activity restrictions, if any ◆ Pain distribution is centralizing ◆ Reinforce self-management techniques
5-8	◆ Continued reduction of pain severity and frequency ◆ Meet functional goals set by MD, PT or OT Observation of post-surgical activity restrictions, if any ◆ Pain distribution continues to centralize ◆ Reinforce self-management techniques
9-12	◆ 75% improvement in pain severity and frequency ◆ Meet functional goals set by MD, PT or OT Observation of post-surgical activity restrictions, if any ◆ Pain distribution is centralized to neck ◆ Reinforce self-management techniques
13-16	◆ Gradual improvement leading toward resolution ◆ Meet functional goals set by MD, PT or OT ◆ Reinforce self-management techniques ◆ Discharge patient to elective care, active rehabilitation, or to their primary care provider for alternative treatment options when a plateau is reached, or by week 16, whichever occurs first

Referral Guidelines

- Refer patient to their primary care provider for evaluation of alternative treatment options if:
  - Improvement does not meet the above guidelines or improvement has reached a plateau
  - Atrophy of upper extremity
  - Signs of demyelinating condition, tumor or infection
  - Increasing neurologic signs/symptoms: increasing UE numbness/tingling, increasing UE weakness, increasing UE pain, decreasing UE reflexes
  - Signs or symptoms of post-surgical complication or red flag

Potential post-surgical complications include:

- Nerve entrapment
- Wound dehiscence (usually from infection)
- Intra-articular hemorrhage
- Degenerative joint disease
- Osteophytic proliferation
- Recurrence of instability
- Residual pain

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Appropriate Procedures/ Modalities

- Acupuncture
- Electro-acupuncture
- Cupping
- Moxibustion
- Gua Sha
- Myofascial release
- Acupressure
- Trigger point massage
- Tui Na (not to include osseous manipulation)
- Herbal formulas

Note: Not all of these modalities are covered by patient's health-plan; review documentation regarding coverage. Acupuncture and herbs must be appropriate for covered diagnoses under the patient's insurance policy. Acupuncturist is responsible for determining which procedures/modalities are most appropriate for the patient's condition.

Inappropriate Procedures/Modalities

- Scarring moxa
- Applied kinesiology techniques
- Electro-acupuncture using more than 9 volts
- Any techniques outside the scope of practice in your state

Self-Management Techniques

- Observation of surgical restrictions/precautions
- Rest and reduce strenuous activities
- Use of home medical equipment as advised by MD, DO or PT
- Gradual increase in activity
- Compliance with home exercise/stretching program as assigned by PT
- Cold packs after incision heals, or as directed by MD
- Ergonomics, Postural advice, postural exercises
- Appropriate exercises/stretching
- Tai Qi, Qi Gong, Yoga
- Stress management, meditation

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- Joint protection
- Weight loss
- Self-massage, Self-acupressure

Alternatives to Oriental Medicine Management

(listed in alphabetical order)

- Anesthesia/Pain Management
- Chiropractic
- Dietary/Nutritional Medicine Counseling
- Injection therapy/Pain management
- Massage therapy
- Medication
- Occupational therapy
- Osteopathic Manipulation
- Physical Therapy
- Psychological counseling

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References

1. Balshem H, Helfand M, Schunemann HJ, Oxman AD, Kunz R, Brozek J, et al. GRADE guidelines: 3. Rating the quality of evidence. J Clin Epidemiol. 2011 Apr;64(4):401-6. doi:10.1016/j.jclinepi.2010.07.015.
2. Blossfeldt P. Acupuncture for chronic neck pain--a cohort study in an NHS pain clinic. Acupunct Med. 2004 Sep;22(3):146-51. doi:10.1136/aim.22.3.146.
3. Ceccherelli F, Gioioso L, Casale R, Gagliardi G, Ori C. Neck pain treatment with acupuncture: does the number of needles matter? Clin J Pain. 2010 Nov-Dec;26(9):807-12. doi:10.1097/AJP.0b013e3181e375c9.
4. Chen W-T, Fu G-Q, Shen W-D. [Progresses of studies on acupuncture analgesia for postoperative reaction]. Zhen Ci Yan Jiu. 2013;38(1):83-87.
5. Cheng X, Deng L. Chinese Acupuncture and Moxibustion. Beijing: Foreign Language Press; 2010.
6. Cohen Steven P, Hooten W Michael. Advances in the diagnosis and management of neck pain BMJ 2017; 358 :j3221. doi:10.1136/bmj.j3221.
7. Deganello A, Battat N, Muratori E, Cristofaro G, Buongiorno A, Mannelli G, Picconi M, Giachetti R, Borsotti G, Gallo O. Acupuncture in shoulder pain and functional impairment after neck dissection: A prospective randomized pilot study. Laryngoscope. 2016 Aug;126(8):1790-5. doi:10.1002/lary.25921.
8. Dong W, Goost H, Lin XB, Burger C, Paul C, Wang ZL, et al. Treatments for shoulder impingement syndrome: a PRISMA systematic review and network meta-analysis. Medicine (Baltimore). 2015 Mar;94(10):e510. doi:10.1097/MD.0000000000000510.
9. Ernst E, Lee MS, Choi TY. Acupuncture: does it alleviate pain and are there serious risks? A review of reviews. Pain. 2011 Apr;152(4):755-64. Review. doi:10.1016/j.pain.2010.11.004.
10. França DL, Senna-Fernandes V, Cortez CM, Jackson MN, Bernardo-Filho M, Guimarães MA. Tension neck syndrome treated by acupuncture combined with physiotherapy: a comparative clinical trial (pilot study). Complement Ther Med. 2008 Oct;16(5):268-77. doi:10.1016/j.ctim.2008.02.006.
11. Fu LM, Li JT, Wu WS. Randomized controlled trials of acupuncture for neck pain: systematic review and meta-analysis. J Altern Complement Med. 2009 Feb;15(2):133-45. doi:10.1089/acm.2008.0135.
12. Fuentealba Cargill F, Biagini Alarcón L. Acupuncture for postoperative pain, a literature review. Rev Med Chil. 2016;144(3):325-332. doi:10.4067/S0034-98872016000300007.
13. Hempel S, Taylor SL, Solloway MR, Miake-Lye IM, Beroes JM, Shanman R, et al. VA Evidence-based Synthesis Program Reports. Evidence Map of Acupuncture. Washington (DC): Department of Veterans Affairs; 2014.
14. Horn KK, Jennings S, Richardson G, Vliet DV, Hefford C, Abbott JH. The patient-specific functional scale: psychometrics, clinimetrics, and application as a clinical outcome measure. J Orthop Sports Phys Ther. 2012 Jan;42(1):30-42. doi:10.2519/jospt.2012.3727.
15. Kaptchuk T. The Web That Has No Weaver. Contemporary Books. 2000.
16. Kelly RB. Acupuncture for pain. Am Fam Physician. 2009 Sep 1;80(5):481-4.
17. Kligler B, Nielsen A, Kohrrer C, Schmid T, Waltermaurer E, Perez E, Merrell W. Acupuncture Therapy in a Group Setting for Chronic Pain. Pain Med. 2017 Jun 8. doi:10.1093/pm/pnx134.
18. Lee MS, Ernst E. Acupuncture for surgical conditions: an overview of systematic reviews. Int J Clin Pract. 2014 Jun;68(6):783-9. doi:10.1111/ijcp.12372.
19. Li X, Wang R, Xing X, et al. Acupuncture for Myofascial Pain Syndrome: A Network Meta-Analysis of 33 Randomized Controlled Trials. Pain Physician. 2017 Sep;20(6):E883-E902.
20. Linde K, Allais G, Brinkhaus B, Fei Y, Mehring M, Shin BC, et al. Acupuncture for the prevention of tension-type headache. Cochrane Database Syst Rev. 2016;4:Cd007587.
21. Linde K, Allais G, Brinkhaus B, Manheimer E, Vickers A, White AR. Acupuncture for tension-type headache. Cochrane Database Syst Rev. 2009 Jan 21;(1):CD007587. doi:10.1002/14651858.CD007587.
22. Maciocia, G; The Foundations of Chinese Medicine: A Comprehensive Text; Churchill Livingstone, 2005.
23. MacPherson H, Tilbrook H, Richmond S, Woodman J, Ballard K, Atkin K, Bland M, Eldred J, Essex H, Hewitt C, Hopton A, Keding A, Lansdown H, Parrott S, Torgerson D, Wenham A, Watt I.

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Alexander Technique Lessons or Acupuncture Sessions for Persons With Chronic Neck Pain: A Randomized Trial. Ann Intern Med. 2015 Nov 3;163(9):653-62. doi:10.7326/M15-0667.
24. MacPherson H, Vertosick EA, Foster NE, Lewith G, Linde K, Sherman KJ, et al. The persistence of the effects of acupuncture after a course of treatment: A meta-analysis of patients with chronic pain. Pain. 2016 Oct 17. doi:10.1097/j.pain.0000000000000747.
25. Magee, David J., Orthopedic Physical Assessment, Second Edition, W.B. Saunders Company, 2007.
26. McDonald J, Janz S. The Acupuncture Evidence Project: A Comparative Literature Review (Revised Edition). Brisbane: Australian Acupuncture and Chinese Medicine Association Ltd; 2017.
27. National Health and Medical Research Council. NHMRC additional levels of evidence and grades for recommendations for developers of guidelines. Table 3. NHMRC Evidence Hierarchy: designations of 'levels of evidence' according to type of research question (including explanatory notes). National Health and Medical Research Council; 2009.
28. O'Connor J, Bensky D. Acupuncture: A Comprehensive Text. Chicago: Eastland Press; 1981.
29. Olson WH, Brumback RA, Gascon G, Iyer V; Handbook of Symptom Oriented Neurology; Year Book Medical Publishers, Inc.; 2002.
30. Porter, R; The Merck Manual, Merck, 2011.
31. Roy, S., Irvin, R., and Iverson, D; Sports Medicine, Prevention, Education, Management, and Rehabilitation, Benjamin Cummings, 1998.
32. Seo SY, Lee KB, Shin JS, et al. Effectiveness of Acupuncture and Electroacupuncture for Chronic Neck Pain: A Systematic Review and Meta-Analysis. Am J Chin Med. 2017;45(8):1573-1595. doi:10.1142/S0192415X17500859.
33. Sun Y, Gan TJ. Acupuncture for the management of chronic headache: a systematic review. Anesth Analg. 2008 Dec;107(6):2038-47. doi:10.1213/ane.0b013e318187c76a.
34. Trinh K, Graham N, Irnich D, Cameron ID, Forget M. Acupuncture for neck disorders. Cochrane Database Syst Rev. 2016(5):Cd004870. doi:10.1002/14651858.CD004870.pub4..
35. Wang R, Li X, Zhou S, Zhang X, Yang K, Li X. Manual acupuncture for myofascial pain syndrome: a systematic review and meta-analysis. Acupunct Med. 2017 Aug;35(4):241-250. doi:10.1136/acupmed-2016-011176.
36. Wei X, Wang S, Li J, et al. Complementary and Alternative Medicine for the Management of Cervical Radiculopathy: An Overview of Systematic Reviews. Evidence-Based Complementary and Alternative Medicine. 2015;2015:1-10. doi:10.1155/2015/793649.
37. Weinstein, S, and Buckwalter, J. Orthopaedics Principles and Their Applications. Lippincott, Williams, & Wilkins, 2005.
38. White P, Lewith G, Prescott P, Conway J. Acupuncture versus placebo for the treatment of chronic mechanical neck pain: a randomized, controlled trial. Ann Intern Med. 2004 Dec 21;141(12):911-9. doi:10.7326/0003-4819-141-12-200412210-00007.
39. Wu MS, Chen KH, Chen IF, Huang SK, Tzeng PC, Yeh ML, et al. The Efficacy of Acupuncture in Post-Operative Pain Management: A Systematic Review and Meta-Analysis. PLOS ONE. 2016;11(3):e0150367. doi:10.1371/journal.pone.0150367.
40. Xiang A, Cheng K, Shen X, Xu P, Liu S. The Immediate Analgesic Effect of Acupuncture for Pain: A Systematic Review and Meta-Analysis. Evid Based Complement Alternat Med. 2017;2017:3837194. doi:10.1155/2017/3837194.
41. Yuan J, Purepong N, Hunter RF, Kerr DP, Park J, Bradbury I, McDonough S. Different frequencies of acupuncture treatment for chronic low back pain: an assessor-blinded pilot randomised controlled trial. Complement Ther Med. 2009 Jun;17(3):131-40. doi:10.1016/j.ctim.2008.10.003.
42. Yuan Q-l, Guo T-m, Liu L, Sun F, Zhang Y-g (2015) Traditional Chinese Medicine for Neck Pain and Low Back Pain: A Systematic Review and Meta-Analysis. PLoS ONE 10(2): e0117146. doi:10.1371/ journal.pone.0117146.
43. Zhao HJ, Tan JY, Wang T, Jin L. Auricular therapy for chronic pain management in adults: A synthesis of evidence. Complement Ther Clin Pract. 2015 May;21(2):68-78. doi:10.1016/j.ctcp.2015.03.006.

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ACU-3.4: Cervical Stenosis

Synonyms

- Spinal canal narrowing
- Neck pain

Definition

Condition caused by a narrowing of the spinal canal, usually present with pain or weakness in the extremities on walking. Condition may be mistaken for intermittent claudication due to vascular disease. Size of canal may be small since birth due to some congenital or developmental factors in certain individuals. Later in life when degenerative changes occur, canal is further narrowed by osteophytes from facet joints and the vertebral body, thickening of the posterior longitudinal ligament or ligamentum flavum, or retrolisthesis of the vertebral body, secondary to narrowing of the disc space. Pain may be acute or chronic.

Oriental Medicine Diagnoses

- Qi and Blood Stagnation
  - Stagnation results in this painful condition; may have numerous causations; can be related to trauma or underlying syndromes.
- Spleen Qi Deficiency resulting in Damp
  - Causation by external pathogens. Inappropriate lifestyle choices that result in damp and Qi Deficiency, stress.
- Bi Syndrome
  - Accumulation of Wind, Damp, Cold or Heat. In the case of cervical disc degeneration—it would be Damp Bi, Cold Bi, or Damp Cold Bi.

History

- Patient history may include:
  - General demographics
  - Occupation/employment
  - Hand dominance
  - Living environment
  - History of current condition
  - Functional status & activity level
  - Medications
  - Other tests and measurements (laboratory and diagnostic tests)
  - Past history (including history of prior Oriental Medicine treatment, and response to prior treatment)

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Specific Aspects of History

- Rule out red flags (require medical management).
- Identify co-morbidities requiring medical management, and those that affect acupuncture and Oriental Medicine management.

Determine if trauma-related; determine nature and extent of traumatic event.Red Flag	Possible Consequence or Cause	Action Required
Severe trauma	Fracture	Immediate referral to emergency department
Direct trauma to the head with loss of consciousness (LOC)	Subdural hematoma; epidural hematoma; fracture	Immediate referral to emergency department
Nuchal rigidity and/or positive Brudzinskis or Kernigs sign	Subarachnoid hemorrhage; meningitis	Immediate referral to emergency department
Bladder dysfunction associated with onset of neck pain	Myelopathy; spinal cord injury	Immediate referral to emergency department
Associated dysphasia	Cerebrovascular accident	Immediate referral to emergency department
Associated cranial nerve or central nervous system (CNS) signs/symptoms	Tumor; intracranial hematoma	Immediate referral to emergency department
Onset of a new headache	Tumor; infection; vascular cause (older patients, also consider temporal arteritis; glaucoma)	Prompt referral to Primary Care Provider
Co-morbidities of rheumatoid arthritis, seronegative arthritides, Down's syndrome	Atlantoaxial instability due to associated transverse ligament laxity	Prompt referral to Primary Care Provider
Exertional pain, history of CAD	CAD	Immediate referral to emergency department
Pleuritic pain, chronic cough, dyspnea	Pulmonary diseases	Prompt referral to Primary Care Provider
Cancer	Cause of symptoms (metastatic or primary)	Prompt referral to Primary Care Provider
Alcoholism, drug abuse	Side effect or withdrawal phenomenon	Immediate referral to emergency department
Immune-compromised state	Infection	Prompt referral to Primary Care Provider

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Presentation

Lateral cervical stenosis (radiculopathy)—typical of lower motor neuron disorders: Signs include hyperflexia of affected upper extremity accompanied by motor weakness and sensory disturbances consistent with the level of compression of the nerve root.

Cervical range of motion is limited, and extension and ipsilateral side-bending may exacerbate upper extremity symptoms. Spurling's test is usually positive. Upper extremity symptoms may be reduced or relieved with manual cervical traction. Neck pain is not always present. Unsteadiness in gait or clumsiness is often an early symptom.

Central cervical stenosis (myelopathy)—those of upper motor neuron or long-tract disorders: Weakness with spasticity may be present, along with clonus and a positive Babinski sign. Vibratory sensation is diminished in lower extremities, and both upper and lower extremity reflexes may become hyperactive. Cervical range of motion is restricted in all planes. Lhermitte's sign may be present. Spurling's test is expected to be negative, and manual cervical traction has no effect on symptoms.

Treatment can be conservative or surgical. Modes of conservative therapy include: rest, physical therapy with strengthening exercises for paraspinal musculature, bracing, use of optimal postural biomechanics, nonsteroidal anti-inflammatory medications, analgesics, and muscle relaxants.

Surgical decompression is indicated in persons who experience incapacitating pain, claudication, neurologic deficit, or myelopathy. Concomitant fusion with, or without fixation is reserved for individuals in whom segmental instability is suspected.

Subjective Findings

- Pain should be documented as a numeric pain scale 0-10
- Headache and upper extremity symptom frequency, duration and numeric pain scale should be documented

Functional Assessment

- Documentation of a patient's level of function is an important aspect of patient care. This documentation is required in order to establish the medical necessity of ongoing acupuncture treatment. The Patient Specific Functional Scale (PSFS) is a patient reported outcome assessment that is easy and appropriate for acupuncturists to use. The PSFS has been studied in peer-reviewed scientific literature, and it has been proven to be a valid, reliable, and responsive measure for a variety of pain syndromes (neck, back, knee, etc.).

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Objective Findings

Scope of Musculoskeletal Examination

- Inspection
- Palpation of bony and soft tissue
- Range of motion, active and passive
- Orthopedic testing
- Neurologic testing
- Manual muscle testing
- Gait analysis

Specific Aspects of Examination for Cervical Spinal Stenosis

Examine the musculoskeletal system for possible causes or contributing factors to the complaint.

Differential Diagnoses

- Cervical nerve root compression
- Other myelopathies
- Multiple sclerosis
- Metastatic cancer
- Transient ischemic attack, Cerebrovascular incident

Oriental Medicine Management [16, 29, 32, 35]

- Most patients with this diagnosis will already have consulted with their Primary Care Provider. If not, however, they should be directed to make an appointment with their MD at their earliest opportunity.
- Confirmation of appropriate medical co-management is always required when treating children age 14 and under.
- Oriental Medicine management goals are to resolve pain, restore the highest level of function possible, and educate patient to prevent recurrent symptoms.
- To be considered medically necessary, patient's symptoms must be the direct result of a primary neuromusculoskeletal injury or illness.
- Treatment frequency should be commensurate with the severity of the chief complaint.
- When significant improvements in patient's subjective findings and objective findings are demonstrated—continued treatment with decreased frequency is appropriate.
- As treatment progresses, one should see an increase in the active regimen of care, a decrease in the passive regimen of care, and a fading of treatment frequency.

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- If the condition has not progressed towards resolution, refer the patient to an appropriate health care provider to explore other treatment alternatives.
- eviCore's consideration of requests for continued acupuncture treatment depends on updated clinical information submitted regarding patient's progress.
- Adequate and legible patient progress information that contains a history and examination, and/or eviCore's Acupuncture Treatment Request Form is required to determine medical necessity.
- In addition to the improvements in the table below, significant progress may also be documented by increases in functional capacity and increasingly longer durations of pain relief.
- Discharge occurs when reasonable functional goals and expected outcomes have been achieved.
- The patient is discharged when the patient/care-giver can continue management of symptoms with an independent home program.
- Treatment is discontinued when the patient is unable to progress towards outcomes because of medical complications, psychosocial factors or other personal circumstances.
- If the member has been non-compliant with treatment as is evidenced by the clinical documentation, and/or the lack of demonstrated progress, treatment will be deemed to be not medically necessary and the member should be discharged from treatment.

Week	Progress
0-1	◆ Some reduction of pain severity and frequency ◆ Some reduction of muscle spasm
2-4	◆ 50% improvement in pain severity and frequency ◆ 50% increase in function ◆ Pain distribution is centralizing ◆ Reinforce self-management techniques
5-8	◆ Continued reduction of pain severity and frequency ◆ Continued increase in function ◆ Pain distribution continues to centralize ◆ Reinforce self-management techniques
9-12	◆ 75% improvement in pain severity and frequency ◆ 75% improvement in function ◆ Pain distribution is centralized to back ◆ Reinforce self-management techniques
13-16	◆ Gradual improvement leading toward resolution ◆ Reinforce self-management techniques ◆ Discharge patient to elective care, or to their primary care provider for alternative treatment options when a plateau is reached, or by week 16, whichever occurs first

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Appropriate Procedures/ Modalities

- Acupuncture
- Electro-acupuncture
- Cupping
- Moxibustion
- Gua Sha
- Myofascial release
- Acupressure
- Trigger point massage
- Tui Na (not to include osseous manipulation)
- Herbal formulas

Note: Not all of these modalities are covered by patient's health-plan; review documentation regarding coverage. Acupuncture and herbs must be appropriate for covered diagnoses under the patient's insurance policy. Acupuncturist is responsible for determining which procedures/modalities are most appropriate for the patient's condition.

Inappropriate Procedures/Modalities

- Scarring moxa
- Applied kinesiology techniques
- Electro-acupuncture using more than 9 volts
- Any techniques outside the scope of practice in your state

Self-Management Techniques

- Rest and reduce strenuous activities
- Ergonomics, Postural advice, postural exercises
- Appropriate exercises/stretching
- Tai Qi, Qi Gong, Yoga
- Stress management, meditation
- Joint protection
- Weight loss
- Self-massage, Self-acupressure
- Hot packs/cold packs, if needed, to relieve discomfort

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Alternatives to Oriental Medicine Management

(listed in alphabetical order)

- Biofeedback
- Chiropractic
- Dietary/Nutritional Medicine Counseling
- Injection therapy/Pain management
- Massage therapy
- Medication
- Occupational therapy
- Osteopathic Manipulation
- Physical Therapy
- Psychological counseling

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References

1. Balshem H, Helfand M, Schunemann HJ, Oxman AD, Kunz R, Brozek J, et al. GRADE guidelines: 3. Rating the quality of evidence. J Clin Epidemiol. 2011 Apr;64(4):401-6. doi:10.1016/j.jclinepi.2010.07.015.
2. Blossfeldt P. Acupuncture for chronic neck pain--a cohort study in an NHS pain clinic. Acupunct Med. 2004 Sep;22(3):146-51. doi:10.1136/aim.22.3.146.
3. Ceccherelli F, Gioioso L, Casale R, Gagliardi G, Ori C. Neck pain treatment with acupuncture: does the number of needles matter? Clin J Pain. 2010 Nov-Dec;26(9):807-12. doi:10.1097/AJP.0b013e3181e375c9.
4. Cheng X, Deng L. Chinese Acupuncture and Moxibustion. Beijing: Foreign Language Press; 2010.
5. Cohen Steven P, Hooten W Michael. Advances in the diagnosis and management of neck pain BMJ 2017; 358 :j3221.doi:10.1136/bmj.j3221.
6. Deganello A, Battat N, Muratori E, Cristofaro G, Buongiorno A, Mannelli G, Picconi M, Giachetti R, Borsotti G, Gallo O. Acupuncture in shoulder pain and functional impairment after neck dissection: A prospective randomized pilot study. Laryngoscope. 2016 Aug;126(8):1790-5. doi:10.1002/lary.25921.
7. Dong W, Goost H, Lin XB, Burger C, Paul C, Wang ZL, et al. Treatments for shoulder impingement syndrome: a PRISMA systematic review and network meta-analysis. Medicine (Baltimore). 2015 Mar;94(10):e510. doi:10.1097/MD.0000000000000510.
8. Ernst E, Lee MS, Choi TY. Acupuncture: does it alleviate pain and are there serious risks? A review of reviews. Pain. 2011 Apr;152(4):755-64. doi:10.1016/j.pain.2010.11.004.
9. França DL, Senna-Fernandes V, Cortez CM, Jackson MN, Bernardo-Filho M, Guimarães MA. Tension neck syndrome treated by acupuncture combined with physiotherapy: a comparative clinical trial (pilot study). Complement Ther Med. 2008 Oct;16(5):268-77.doi:10.1016/j.ctim.2008.02.006.
10. Fu LM, Li JT, Wu WS. Randomized controlled trials of acupuncture for neck pain: systematic review and meta-analysis. J Altern Complement Med. 2009 Feb;15(2):133-45. doi:10.1089/acm.2008.0135
11. Hempel S, Taylor SL, Solloway MR, Miake-Lye IM, Beroes JM, Shanman R, et al. VA Evidence-based Synthesis Program Reports. Evidence Map of Acupuncture. Washington (DC): Department of Veterans Affairs; 2014.
12. Horn KK, Jennings S, Richardson G, Vliet DV, Hefford C, Abbott JH. The patient-specific functional scale: psychometrics, clinimetrics, and application as a clinical outcome measure. J Orthop Sports Phys Ther. 2012 Jan;42(1):30-42. doi:10.2519/jospt.2012.3727.
13. Kaptchuk T. The Web That Has No Weaver. Contemporary Books. 2000.
14. Kelly RB. Acupuncture for pain. Am Fam Physician. 2009 Sep 1;80(5):481-4.
15. Kligler B, Nielsen A, Kohrrer C, Schmid T, Waltermaurer E, Perez E, Merrell W. Acupuncture Therapy in a Group Setting for Chronic Pain. Pain Med. 2017 Jun 8. doi:10.1093/pm/pnx134.
16. Li X, Wang R, Xing X, et al. Acupuncture for Myofascial Pain Syndrome: A Network Meta-Analysis of 33 Randomized Controlled Trials. Pain Physician. 2017 Sep;20(6):E883-E902.
17. Linde K, Allais G, Brinkhaus B, Fei Y, Mehring M, Shin BC, et al. Acupuncture for the prevention of tension-type headache. Cochrane Database Syst Rev. 2016;4:Cd007587.
18. Linde K, Allais G, Brinkhaus B, Manheimer E, Vickers A, White AR. Acupuncture for tension-type headache. Cochrane Database Syst Rev. 2009 Jan 21;(1):CD007587. doi:10.1002/14651858.CD007587.
19. Maciocia, G; The Foundations of Chinese Medicine: A Comprehensive Text; Churchill Livingstone, 2005.
20. MacPherson H, Tilbrook H, Richmond S, Woodman J, Ballard K, Atkin K, Bland M, Eldred J, Essex H, Hewitt C, Hopton A, Keding A, Lansdown H, Parrott S, Torgerson D, Wenham A, Watt I. Alexander Technique Lessons or Acupuncture Sessions for Persons With Chronic Neck Pain: A Randomized Trial. Ann Intern Med. 2015 Nov 3;163(9):653-62. doi:10.7326/M15-0667.
21. MacPherson H, Vertosick EA, Foster NE, Lewith G, Linde K, Sherman KJ, et al. The persistence of the effects of acupuncture after a course of treatment: A meta-analysis of patients with chronic pain. Pain. 2016 Oct 17. doi:10.1097/j.pain.0000000000000747.

© 2019 eviCore healthcare. All Rights Reserved.

22. Magee, David J., Orthopedic Physical Assessment, Second Edition, W.B. Saunders Company, 2007.
23. McDonald J, Janz S. The Acupuncture Evidence Project: A Comparative Literature Review (Revised Edition). Brisbane: Australian Acupuncture and Chinese Medicine Association Ltd; 2017.
24. National Health and Medical Research Council. NHMRC additional levels of evidence and grades for recommendations for developers of guidelines. Table 3. NHMRC Evidence Hierarchy: designations of 'levels of evidence' according to type of research question (including explanatory notes). National Health and Medical Research Council; 2009.
25. O'Connor J, Bensky D. Acupuncture: A Comprehensive Text. Chicago: Eastland Press; 1981.
26. Olson WH, Brumback RA, Gascon G, Iyer V; Handbook of Symptom Oriented Neurology; Year Book Medical Publishers, Inc.; 2002.
27. Porter, R; The Merck Manual, Merck, 2011.
28. Roy, S., Irvin, R., and Iverson, D; Sports Medicine, Prevention, Education, Management, and Rehabilitation, Benjamin Cummings, 1998.
29. Seo SY, Lee KB, Shin JS, et al. Effectiveness of Acupuncture and Electroacupuncture for Chronic Neck Pain: A Systematic Review and Meta-Analysis. Am J Chin Med. 2017;45(8):1573-1595. doi:10.1142/S0192415X17500859.
30. Sun Y, Gan TJ. Acupuncture for the management of chronic headache: a systematic review. Anesth Analg. 2008 Dec;107(6):2038-47. doi:10.1213/ane.0b013e318187c76a.
31. Trinh K, Graham N, Irnich D, Cameron ID, Forget M. Acupuncture for neck disorders. Cochrane Database Syst Rev. 2016(5):Cd004870. doi:10.1002/14651858.CD004870.pub4.
32. Wang R, Li X, Zhou S, Zhang X, Yang K, Li X. Manual acupuncture for myofascial pain syndrome: a systematic review and meta-analysis. Acupunct Med. 2017 Aug;35(4):241-250. doi:10.1136/acupmed-2016-011176.
33. Weinstein, S, and Buckwalter, J. Orthopaedics Principles and Their Applications. Lippincott, Williams, & Wilkins, 2005.
34. White P, Lewith G, Prescott P, Conway J. Acupuncture versus placebo for the treatment of chronic mechanical neck pain: a randomized, controlled trial. Ann Intern Med. 2004 Dec 21;141(12):911-9. doi:10.7326/0003-4819-141-12-200412210-00007..
35. Xiang A, Cheng K, Shen X, Xu P, Liu S. The Immediate Analgesic Effect of Acupuncture for Pain: A Systematic Review and Meta-Analysis. Evid Based Complement Alternat Med. 2017;2017:3837194. doi:10.1155/2017/3837194.
36. Yuan J, Purepong N, Hunter RF, Kerr DP, Park J, Bradbury I, McDonough S. Different frequencies of acupuncture treatment for chronic low back pain: an assessor-blinded pilot randomised controlled trial. Complement Ther Med. 2009 Jun;17(3):131-40. doi:10.1016/j.ctim.2008.10.003.
37. Yuan Q-l, Guo T-m, Liu L, Sun F, Zhang Y-g (2015) Traditional Chinese Medicine for Neck Pain and Low Back Pain: A Systematic Review and Meta-Analysis. PLoS ONE 10(2): e0117146. doi:10.1371/ journal.pone.0117146.
38. Zhao HJ, Tan JY, Wang T, Jin L. Auricular therapy for chronic pain management in adults: A synthesis of evidence. Complement Ther Clin Pract. 2015 May;21(2):68-78. doi:10.1016/j.ctcp.2015.03.006.

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ACU-3.5: Cervicobrachial Syndrome

Synonyms

- Lateral recess entrapment of cervical nerve root
- Cervical radiculopathy due to spinal stenosis
- Neck pain

Definition

Neurogenic pain following the distribution of one or, less commonly, more cervical nerve root(s). May be accompanied by upper extremity numbness, weakness, or hyporeflexia; and may be due to cervical disc herniation (younger patients) or foraminal encroachment or spinal stenosis (older patients). Pain may be acute or chronic.

Oriental Medicine Diagnoses

- Qi and Blood Stagnation
  - Stagnation results in this painful condition. May have numerous causations; can be related to trauma or underlying syndromes.
- Spleen Qi Deficiency resulting in Damp
  - Causation by external pathogens. Inappropriate lifestyle choices that result in damp and Qi Deficiency, stress.
- Bi Syndrome
  - Accumulation of Wind, Damp, Cold or Heat. In the case of cervical disc degeneration—it would be Damp Bi, Cold Bi, or Damp Cold Bi.

History

- Patient history may include:
  - General demographics
  - Occupation/employment
  - Hand dominance
  - Living environment
  - History of current condition
  - Functional status & activity level
  - Medications
  - Other tests and measurements (laboratory and diagnostic tests)
  - Past history (including history of prior Oriental Medicine treatment, and response to prior treatment)

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Specific Aspects of History

- Rule out red flags (require medical management).
- Identify co-morbidities requiring medical management, and those that affect acupuncture and Oriental Medicine management.
- Determine if trauma-related; determine nature and extent of traumatic event.

Red Flag	Possible Consequence or Cause	Action Required
Severe trauma	Fracture	Immediate referral to emergency department
Direct trauma to the head with loss of consciousness (LOC)	Subdural hematoma; epidural hematoma; fracture	Immediate referral to emergency department
Nuchal rigidity and/or positive Brudzinskis or Kernigs sign	Subarachnoid hemorrhage; meningitis	Immediate referral to emergency department
Bladder dysfunction associated with onset of neck pain	Myelopathy; spinal cord injury	Immediate referral to emergency department
Associated dysphasia		Immediate referral to emergency department
Associated cranial nerve or central nervous system (CNS) signs/symptoms	Tumor; intracranial hematoma	Immediate referral to emergency department
Onset of a new headache	Tumor; infection; vascular cause (older patients, also consider temporal arteritis; glaucoma)	Prompt referral to Primary Care Provider
Co-morbidities of rheumatoid arthritis, seronegative arthritides, Down's syndrome	Atlantoaxial instability due to associated transverse ligament laxity	Prompt referral to Primary Care Provider
Cancer	Cause of symptoms (metastatic or primary)	Prompt referral to Primary Care Provider
Alcoholism, drug abuse	Side effect or withdrawal phenomenon	Immediate referral to emergency department
Immune-compromised state	Infection	Prompt referral to Primary Care Provider

Presentation

Patient may report trauma or insidious onset. Incidence of disc herniation in patients over the age of 40 decreases due to the dehydration of the nucleus pulposus.

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Subjective Findings

- Pain, numbness, tingling, paresthesias in the upper extremity following cervical nerve root distribution
- May complain of weakness in the upper extremity, such as with grip strength
- Lack of upper extremity coordination and difficulty with fine manipulation tasks, including handwriting, may be reported
- Midline disc protrusions may involve both extremities
- Better with rest
- Placing hand on top of head may provide relief by decreasing tension on irritated cervical nerve
- Headaches and neck pain may accompany upper extremity pain
- Pain should be documented as a numeric pain scale 0-10
- Headache and upper extremity symptom frequency, duration and numeric pain scale should be documented

Functional Assessment

- Documentation of a patient's level of function is an important aspect of patient care. This documentation is required in order to establish the medical necessity of ongoing acupuncture treatment. The Patient Specific Functional Scale (PSFS) is a patient reported outcome assessment that is easy and appropriate for acupuncturists to use. The PSFS has been studied in peer-reviewed scientific literature, and it has been proven to be a valid, reliable, and responsive measure for a variety of pain syndromes (neck, back, knee, etc.).

Objective Findings

Scope of Cervical and Upper Extremity Examination

- Inspection—spine, shoulder, elbow, wrist
- Palpation of bony and soft tissue—spine, shoulder, elbow, wrist
- Range of motion—spine, shoulder, elbow, wrist
- Motion palpation of spine
- Orthopedic testing—spine, shoulder, elbow, wrist
- Neurologic testing

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Specific Aspects of Cervical Examination
Rule out other possible causes.

Note: Diseases that may refer pain to the cervical spine include: brain lesions, CAD, dental disease, esophageal disease, upper airway disease, lymphadenopathy.

Findings of Cervicobrachial Syndrome

- Cervical range of motion restrictions may be present
- Muscle spasms in corresponding myotomes
- Nerve root tension signs (shoulder depression) are typically positive but may be absent in cases involving a free fragment of disc tissue
- Foraminal compression may cause radiating upper extremity pain
- Extension with rotation of cervical spine may cause shoulder or arm pain
- Dejerine's triad may be positive
- Dural tension signs
- Extremities symptoms and findings, if present, follow nerve root pattern
- Sensory abnormalities in dermatome
- Loss of reflex
- Motor power weakness of upper extremity
- Decreased upper extremity girth may be present

Differential Diagnoses

- Myocardial ischemia (refer for evaluation if suspected)
- Demyelinating conditions (symptoms, intensity and location vary)
- Myelopathy (trunk or leg dysfunction, gait disturbance, bowel or bladder dysfunction, signs of upper motor neuron involvement)
- Thoracic outlet syndrome (positive TOS orthopedic test)
- Peripheral nerve entrapment (Phalens test, Tinels test at elbow and wrist)
- Adhesive capsulitis of shoulder with referred cervical pain (restricted active and passive shoulder motion)
- Rotator cuff disorder with referred cervical pain (significant pain with shoulder circumduction motions)

Note: Signs of upper motor neuron involvement (clonus, hyperreflexia, Babinski reflex) may suggest compression of the spinal cord, which should be evaluated medically.

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Oriental Medicine Management [16, 29, 32, 35]

- Most patients with this diagnosis will already have consulted with their Primary Care Provider. If not, however, they should be directed to make an appointment with their MD at their earliest opportunity.
- Confirmation of appropriate medical co-management is always required when treating children age 14 and under.
- Oriental Medicine management goals are to resolve pain, restore the highest level of function possible, and educate patient to prevent recurrent symptoms.
- To be considered medically necessary, patient's symptoms must be the direct result of a primary neuromusculoskeletal injury or illness.
- Treatment frequency should be commensurate with the severity of the chief complaint.
- When significant improvements in patient's subjective findings and objective findings are demonstrated—continued treatment with decreased frequency is appropriate.
- As treatment progresses, one should see an increase in the active regimen of care, a decrease in the passive regimen of care, and a fading of treatment frequency.
- If the condition has not progressed towards resolution, refer the patient to an appropriate health care provider to explore other treatment alternatives.
- eviCore's consideration of requests for continued acupuncture treatment depends on updated clinical information submitted regarding patient's progress.
- Adequate and legible patient progress information that contains a history and examination, and/or eviCore's Acupuncture Treatment Request Form is required to determine medical necessity.
- In addition to the improvements in the table below, significant progress may be documented by increases in functional capacity and increasingly longer durations of pain relief.
- Discharge occurs when reasonable functional goals and expected outcomes have been achieved.
- The patient is discharged when the patient/care-giver can continue management of symptoms with an independent home program.
- Treatment is discontinued when the patient is unable to progress towards outcomes because of medical complications, psychosocial factors or other personal circumstances.
- If the member has been non-compliant with treatment as is evidenced by the clinical documentation, and/or the lack of demonstrated progress, treatment will be deemed to be not medically necessary and the member should be discharged from treatment.

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Week	Progress
0-1	◆ Some reduction of pain severity and frequency ◆ Some reduction of muscle spasm
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13-16	◆ Gradual improvement leading toward resolution ◆ Reinforce self-management techniques ◆ Discharge patient to elective care, or to their primary care provider for alternative treatment options when a plateau is reached, or by week 16, whichever occurs first

Appropriate Procedures/ Modalities

- Acupuncture
- Electro-acupuncture
- Cupping
- Moxibustion
- Gua Sha
- Myofascial release
- Acupressure
- Trigger point massage
- Tui Na (not to include osseous manipulation)
- Herbal formulas

Note: Not all of these modalities are covered by patient's health-plan; review documentation regarding coverage. Acupuncture and herbs must be appropriate for covered diagnoses under the patient's insurance policy. Acupuncturist is responsible for determining which procedures/modalities are most appropriate for patient's condition.

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- Scarring moxa
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- Any techniques outside the scope of practice in your state

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- Rest and reduce strenuous activities
- Ergonomics, Postural advice, postural exercises
- Appropriate exercises/stretching
- Tai Qi, Qi Gong, Yoga
- Stress management, meditation
- Joint protection
- Weight loss
- Self-massage, Self-acupressure
- Hot packs/cold packs, if needed, to relieve discomfort

Alternatives to Oriental Medicine Management

(listed in alphabetical order)

- Chiropractic
- Dietary/Nutritional Medicine Counseling
- Injection therapy/Pain management
- Massage therapy
- Medication
- Occupational therapy
- Osteopathic Manipulation
- Physical Therapy
- Psychological counseling

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References

1. Balshem H, Helfand M, Schunemann HJ, Oxman AD, Kunz R, Brozek J, et al. GRADE guidelines: 3. Rating the quality of evidence. J Clin Epidemiol. 2011 Apr;64(4):401-6. doi:10.1016/j.jclinepi.2010.07.015.
2. Blossfeldt P. Acupuncture for chronic neck pain--a cohort study in an NHS pain clinic. Acupunct Med. 2004 Sep;22(3):146-51. doi:10.1136/aim.22.3.146.
3. Ceccherelli F, Gioioso L, Casale R, Gagliardi G, Ori C. Neck pain treatment with acupuncture: does the number of needles matter? Clin J Pain. 2010 Nov-Dec;26(9):807-12. doi:10.1097/AJP.0b013e3181e375c9.
4. Cheng X, Deng L. Chinese Acupuncture and Moxibustion. Beijing: Foreign Language Press; 2010.
5. Cohen Steven P, Hooten W Michael. Advances in the diagnosis and management of neck pain BMJ 2017; 358 :j3221. doi:10.1136/bmj.j3221.
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7. Dong W, Goost H, Lin XB, Burger C, Paul C, Wang ZL, et al. Treatments for shoulder impingement syndrome: a PRISMA systematic review and network meta-analysis. Medicine (Baltimore). 2015 Mar;94(10):e510. doi:10.1097/MD.0000000000000510.
8. Ernst E, Lee MS, Choi TY. Acupuncture: does it alleviate pain and are there serious risks? A review of reviews. Pain. 2011 Apr;152(4):755-64. doi:10.1016/j.pain.2010.11.004.
9. França DL, Senna-Fernandes V, Cortez CM, Jackson MN, Bernardo-Filho M, Guimarães MA. Tension neck syndrome treated by acupuncture combined with physiotherapy: a comparative clinical trial (pilot study). Complement Ther Med. 2008 Oct;16(5):268-77. doi:10.1016/j.ctim.2008.02.006.
10. Fu LM, Li JT, Wu WS. Randomized controlled trials of acupuncture for neck pain: systematic review and meta-analysis. J Altern Complement Med. 2009 Feb;15(2):133-45. doi:10.1089/acm.2008.0135.
11. Hempel S, Taylor SL, Solloway MR, Miake-Lye IM, Beroes JM, Shanman R, et al. VA Evidence-based Synthesis Program Reports. Evidence Map of Acupuncture. Washington (DC): Department of Veterans Affairs; 2014.
12. Horn KK, Jennings S, Richardson G, Vliet DV, Hefford C, Abbott JH. The patient-specific functional scale: psychometrics, clinimetrics, and application as a clinical outcome measure. J Orthop Sports Phys Ther. 2012 Jan;42(1):30-42. doi:10.2519/jospt.2012.3727.
13. Kaptchuk T. The Web That Has No Weaver. Contemporary Books. 2000.
14. Kelly RB. Acupuncture for pain. Am Fam Physician. 2009 Sep 1;80(5):481-4.
15. Kligler B, Nielsen A, Kohrrer C, Schmid T, Waltermaurer E, Perez E, Merrell W. Acupuncture Therapy in a Group Setting for Chronic Pain. Pain Med. 2017 Jun 8. doi:10.1093/pm/pnx134.
16. Li X, Wang R, Xing X, et al. Acupuncture for Myofascial Pain Syndrome: A Network Meta-Analysis of 33 Randomized Controlled Trials. Pain Physician. 2017 Sep;20(6):E883-E902.
17. Linde K, Allais G, Brinkhaus B, Fei Y, Mehring M, Shin BC, et al. Acupuncture for the prevention of tension-type headache. Cochrane Database Syst Rev. 2016;4:Cd007587. doi:10.1002/14651858.CD007587.pub2.
18. Linde K, Allais G, Brinkhaus B, Manheimer E, Vickers A, White AR. Acupuncture for tension-type headache. Cochrane Database Syst Rev. 2009 Jan 21;(1):CD007587. doi:10.1002/14651858.CD007587..
19. Maciocia, G; The Foundations of Chinese Medicine: A Comprehensive Text; Churchill Livingstone, 2005.
20. MacPherson H, Tilbrook H, Richmond S, Woodman J, Ballard K, Atkin K, Bland M, Eldred J, Essex H, Hewitt C, Hopton A, Keding A, Lansdown H, Parrott S, Torgerson D, Wenham A, Watt I. Alexander Technique Lessons or Acupuncture Sessions for Persons With Chronic Neck Pain: A Randomized Trial. Ann Intern Med. 2015 Nov 3;163(9):653-62. doi:10.7326/M15-0667.
21. MacPherson H, Vertosick EA, Foster NE, Lewith G, Linde K, Sherman KJ, et al. The persistence of the effects of acupuncture after a course of treatment: A meta-analysis of patients with chronic pain. Pain. 2016 Oct 17. doi:10.1097/j.pain.0000000000000747.

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22. Magee, David J., Orthopedic Physical Assessment, Second Edition, W.B. Saunders Company, 2007.
23. McDonald J, Janz S. The Acupuncture Evidence Project: A Comparative Literature Review (Revised Edition). Brisbane: Australian Acupuncture and Chinese Medicine Association Ltd; 2017.
24. National Health and Medical Research Council. NHMRC additional levels of evidence and grades for recommendations for developers of guidelines. Table 3. NHMRC Evidence Hierarchy: designations of 'levels of evidence' according to type of research question (including explanatory notes). National Health and Medical Research Council; 2009.
25. O'Connor J, Bensky D. Acupuncture: A Comprehensive Text. Chicago: Eastland Press; 1981.
26. Olson WH, Brumback RA, Gascon G, Iyer V; Handbook of Symptom Oriented Neurology; Year Book Medical Publishers, Inc.; 2002.
27. Porter, R; The Merck Manual, Merck, 2011.
28. Roy, S., Irvin, R., and Iverson, D; Sports Medicine, Prevention, Education, Management, and Rehabilitation, Benjamin Cummings, 1998.
29. Seo SY, Lee KB, Shin JS, et al. Effectiveness of Acupuncture and Electroacupuncture for Chronic Neck Pain: A Systematic Review and Meta-Analysis. Am J Chin Med. 2017;45(8):1573-1595. doi:10.1142/S0192415X17500859.
30. Sun Y, Gan TJ. Acupuncture for the management of chronic headache: a systematic review. Anesth Analg. 2008 Dec;107(6):2038-47. doi:10.1213/ane.0b013e318187c76a.
31. Trinh K, Graham N, Irnich D, Cameron ID, Forget M. Acupuncture for neck disorders. Cochrane Database Syst Rev. 2016(5):Cd004870. doi:10.1002/14651858.CD004870.pub4.
32. Wang R, Li X, Zhou S, Zhang X, Yang K, Li X. Manual acupuncture for myofascial pain syndrome: a systematic review and meta-analysis. Acupunct Med. 2017 Aug;35(4):241-250. doi:10.1136/acupmed-2016-011176.
33. Wei X, Wang S, Li J, et al. Complementary and Alternative Medicine for the Management of Cervical Radiculopathy: An Overview of Systematic Reviews. Evidence-Based Complementary and Alternative Medicine. 2015;2015:1-10. doi:10.1155/2015/793649.
34. Weinstein, S, and Buckwalter, J. Orthopaedics Principles and Their Applications. Lippincott, Williams, & Wilkins, 2005.
35. White P, Lewith G, Prescott P, Conway J. Acupuncture versus placebo for the treatment of chronic mechanical neck pain: a randomized, controlled trial. Ann Intern Med. 2004 Dec 21;141(12):911-9. doi:10.7326/0003-4819-141-12-200412210-00007.
36. Xiang A, Cheng K, Shen X, Xu P, Liu S. The Immediate Analgesic Effect of Acupuncture for Pain: A Systematic Review and Meta-Analysis. Evid Based Complement Alternat Med. 2017;2017:3837194. doi:10.1155/2017/3837194.
37. Yuan J, Purepong N, Hunter RF, Kerr DP, Park J, Bradbury I, McDonough S. Different frequencies of acupuncture treatment for chronic low back pain: an assessor-blinded pilot randomised controlled trial. Complement Ther Med. 2009 Jun;17(3):131-40. doi:10.1016/j.ctim.2008.10.003.
38. Yuan Q-l, Guo T-m, Liu L, Sun F, Zhang Y-g (2015) Traditional Chinese Medicine for Neck Pain and Low Back Pain: A Systematic Review and Meta-Analysis. PLoS ONE 10(2): e0117146. doi:10.1371/ journal.pone.0117146.
39. Zhao HJ, Tan JY, Wang T, Jin L. Auricular therapy for chronic pain management in adults: A synthesis of evidence. Complement Ther Clin Pract. 2015 May;21(2):68-78. doi:10.1016/j.ctcp.2015.03.006.

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ACU-4.0: Cervical Conditions (Non-Specific)	
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ACU-4.1: Cervicalgia

Synonyms

- Neck pain

Definition

Cervicalgia—used to describe pain in the cervical area, nonspecific in origin and/or nature, can be acute or chronic in nature; and, generally not used to describe episodes that involve radicular symptoms.

Oriental Medicine Diagnoses

- Qi and Blood Stagnation
  - Stagnation results in pain. May have numerous causations; can be related to trauma or underlying syndromes.
- Liver Qi Stagnation
  - Causation can be due to external pathogens. Lifestyle choices, such as irregular or "incorrect" food choice, irregular eating times, lack of sleep, or stress.
- Cold Damp Bi, Cold Damp with Painful Obstruction
  - Accumulation of Cold Damp can result from lifestyle choices, such as, irregular or "incorrect" food choice, irregular eating times, lack of sleep, or external pathogens.

History

Specific Aspects of Cervical Complaint History

- Rule out red flags (require medical management).
- Determine if trauma-related; determine nature and extent of traumatic event.
- Identify co-morbidities requiring medical management, and those that affect acupuncture and Oriental Medicine management.

Red Flags	Possible Consequence or Cause	Action Required
Severe trauma	Fracture	Immediate referral to emergency department
Direct trauma to the head with loss of consciousness (LOC)	Subdural hematoma; epidural hematoma; fracture	Immediate referral to emergency department
Nuchal rigidity and/or positive Brudzinskis or Kernigs sign	Subarachnoid hemorrhage; meningitis	Immediate referral to emergency department
Bladder dysfunction associated with onset of neck pain	Myelopathy; spinal cord injury	Immediate referral to emergency department
Associated dysphasia	Cerebrovascular accident	Immediate referral to emergency department

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Red Flags	Possible Consequence or Cause	Action Required
Associated cranial nerve or central nervous system (CNS) signs/symptoms	Tumor; intracranial hematoma	Immediate referral to emergency department
Onset of a new headache	Tumor; infection; vascular cause (older patients, also consider temporal arteritis; glaucoma)	Prompt referral to Primary Care Provider
Co-morbidities of rheumatoid arthritis, seronegative arthritides, Down's syndrome	Atlantoaxial instability due to associated transverse ligament laxity	Prompt referral to Primary Care Provider
Cancer	Cause of symptoms (metastatic or primary)	Prompt referral to Primary Care Provider
Alcoholism, drug abuse	Side effect or withdrawal phenomenon	Immediate referral to emergency department
Immune-compromised state	Infection	Prompt referral to Primary Care Provider

Presentation

Pain may arise gradually through repetitive stress, or suddenly due to injury or trauma. Location of pain may involve any area from the base of the skull to the shoulders. Client may complain of a dull ache, stabbing pain, stiffness, or numbness.

Subjective Findings

- Pain and stiffness in neck; pain worse with motion
- Headaches may accompany the neck pain
- Essentially constant awareness of some level of neck discomfort or limitations in motion
- Pain should be documented as a numeric pain scale 0-10
- Headache frequency, duration and numeric pain scale should be documented

Functional Assessment

- Documentation of a patient's level of function is an important aspect of patient care. This documentation is required in order to establish the medical necessity of ongoing acupuncture treatment. The Patient Specific Functional Scale (PSFS) is a patient reported outcome assessment that is easy and appropriate for acupuncturists to use. The PSFS has been studied in peer-reviewed scientific literature, and it has been proven to be a valid, reliable, and responsive measure for a variety of pain syndromes (neck, back, knee, etc.).

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Objective Findings

Scope of Cervical Examination

- Inspection
- Palpation of bony and soft tissue
- Range of motion
- Motion palpation of spine
- Orthopedic testing
- Neurologic testing

Specific Aspects of Cervical Examination

Examine the musculoskeletal system for possible causes or contributing factors to the complaint.

Note: Diseases that may refer pain to the cervical spine include: brain lesions, CAD, dental disease, esophageal disease, upper airway disease, lymphadenopathy, TMJ dysfunction, ankylosing spondylitis.

Findings of Cervicalgia

- Limited active cervical range of motion
- Neck pain
- Tenderness to palpation
- Normal neurological findings

Differential Diagnoses

- Cervical disc herniation (neurologic abnormality and radicular pain)
- Dislocation of the cervical spine (significant trauma, greater than 3 mm. loss of contact between contiguous segments)
- Fracture of cervical spine (history, abnormal radiograph)
- Inflammatory arthritides, such as rheumatoid arthritis (history, radiographic findings)
- Cervical spine tumor or infection (night pain, weight loss, history of cancer, fever)
- Cervical nerve root compression
- Other myelopathies
- Multiple sclerosis
- Metastatic CA
- TIA/CVA

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Oriental Medicine Management [15, 28, 31, 34]

- Oriental Medicine management goals are to resolve pain, restore the highest level of function possible, and educate patient to prevent recurrent symptoms.
- To be considered medically necessary, patient's symptoms must be the direct result of a primary neuromusculoskeletal injury or illness.
- Confirmation of appropriate medical co-management is always required when treating children age 14 and under.
- Treatment frequency should be commensurate with severity of the chief complaint.
- When significant improvements in patient's subjective findings and objective findings are demonstrated—continued treatment with decreased frequency is appropriate.
- As treatment progresses, one should see an increase in the active regimen of care, a decrease in the passive regimen of care, and a fading of treatment frequency.
- If the condition has not progressed towards resolution, refer the patient to an appropriate health care provider to explore other treatment alternatives.
- eviCore's consideration of requests for continued acupuncture treatment depends on updated clinical information submitted regarding patient's progress.
- Adequate and legible patient progress information that contains a history and examination, and/or eviCore's Acupuncture Treatment Request Form is required to determine medical necessity.
- In addition to improvements in the table below, significant progress may also be documented by increases in functional capacity and increasingly longer durations of pain relief.
- Discharge occurs when reasonable functional goals and expected outcomes have been achieved.
- The patient is discharged when the patient/care-giver can continue management of symptoms with an independent home program.
- Treatment is discontinued when the patient is unable to progress towards outcomes because of medical complications, psychosocial factors or other personal circumstances.
- If the member has been non-compliant with treatment as is evidenced by the clinical documentation, and/or the lack of demonstrated progress, treatment will be deemed to be not medically necessary and the member should be discharged from treatment.

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Week	Progress
0-1	◆ Some reduction of pain severity and frequency ◆ Some reduction of muscle spasm
2-4	◆ 50% decrease in pain severity and frequency ◆ 50% improvement in function
5-8	◆ 75% decrease in pain severity and frequency ◆ 75% improvement in function
9-12	◆ Gradual improvement leading toward resolution ◆ Reinforce self-management techniques ◆ Discharge patient to elective care, or to their primary care provider for alternative treatment options when a plateau is reached, or by week 12, whichever occurs first

Referral Guidelines

Refer patient when—no benefit is attained from treatment, treatment is palliative in benefit, or patient's condition has reached a plateau but residual symptoms still exist.

Appropriate Procedures/ Modalities

- Acupuncture
- Electro-acupuncture
- Cupping
- Moxibustion
- Gua Sha
- Myofascial release
- Acupressure
- Trigger point massage
- Tui Na (not to include osseous manipulation)
- Herbal formulas

Note: Not all of these modalities are covered by patient's health-plan; review documentation regarding coverage. Acupuncture and herbs must be appropriate for covered diagnoses under the patient's insurance policy. Acupuncturist is responsible for determining which procedures/modalities are most appropriate for the patient's condition.

Inappropriate Procedures/Modalities

- Scarring moxa
- Applied kinesiology techniques
- Electro-acupuncture using more than 9 volts
- Any techniques outside the scope of practice in your state

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Self-Management Techniques

- Rest and reduce strenuous activities
- Ergonomics, Postural advice, postural exercises
- Appropriate exercises/stretching
- Tai Qi, Qi Gong, Yoga
- Stress management, meditation
- Joint protection
- Weight loss
- Self-massage, Self-acupressure
- Hot packs/cold packs, if needed, to relieve discomfort

Alternatives to Oriental Medicine Management

(listed in alphabetical order)

- Chiropractic
- Dietary/Nutritional Medicine Counseling
- Injection therapy/Pain management
- Massage therapy
- Medication
- Occupational therapy
- Osteopathic Manipulation
- Physical Therapy
- Psychological counseling

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References

1. Balshem H, Helfand M, Schunemann HJ, Oxman AD, Kunz R, Brozek J, et al. GRADE guidelines: 3. Rating the quality of evidence. J Clin Epidemiol. 2011 Apr;64(4):401-6. doi:10.1016/j.jclinepi.2010.07.015.
2. Blossfeldt P. Acupuncture for chronic neck pain--a cohort study in an NHS pain clinic. Acupunct Med. 2004 Sep;22(3):146-51. doi:10.1136/aim.22.3.146.
3. Ceccherelli F, Gioioso L, Casale R, Gagliardi G, Ori C. Neck pain treatment with acupuncture: does the number of needles matter? Clin J Pain. 2010 Nov-Dec;26(9):807-12. doi:10.1097/AJP.0b013e3181e375c9.
4. Cheng X, Deng L. Chinese Acupuncture and Moxibustion. Beijing: Foreign Language Press; 2010.
5. Cohen Steven P, Hooten W Michael. Advances in the diagnosis and management of neck pain BMJ 2017;358:j3221. doi:10.1136/bmj.j3221.
6. Deganello A, Battat N, Muratori E, Cristofaro G, Buongiorno A, Mannelli G, Picconi M, Giachetti R, Borsotti G, Gallo O. Acupuncture in shoulder pain and functional impairment after neck dissection: A prospective randomized pilot study. Laryngoscope. 2016 Aug;126(8):1790-5. doi:10.1002/lary.25921.
7. Ernst E, Lee MS, Choi TY. Acupuncture: does it alleviate pain and are there serious risks? A review of reviews. Pain. 2011 Apr;152(4):755-64. doi:10.1016/j.pain.2010.11.004.
8. França DL, Senna-Fernandes V, Cortez CM, Jackson MN, Bernardo-Filho M, Guimarães MA. Tension neck syndrome treated by acupuncture combined with physiotherapy: a comparative clinical trial (pilot study). Complement Ther Med. 2008 Oct;16(5):268-77. doi:10.1016/j.ctim.2008.02.006.
9. Fu LM, Li JT, Wu WS. Randomized controlled trials of acupuncture for neck pain: systematic review and meta-analysis. J Altern Complement Med. 2009 Feb;15(2):133-45. doi:10.1089/acm.2008.0135.
10. Hempel S, Taylor SL, Solloway MR, Miake-Lye IM, Beroes JM, Shanman R, et al. VA Evidence-based Synthesis Program Reports. Evidence Map of Acupuncture. Washington (DC): Department of Veterans Affairs; 2014.
11. Horn KK, Jennings S, Richardson G, Vliet DV, Hefford C, Abbott JH. The patient-specific functional scale: psychometrics, clinimetrics, and application as a clinical outcome measure. J Orthop Sports Phys Ther. 2012 Jan;42(1):30-42. doi:10.2519/jospt.2012.3727.
12. Kaptchuk T. The Web That Has No Weaver. Contemporary Books. 2000.
13. Kelly RB. Acupuncture for pain. Am Fam Physician. 2009 Sep 1;80(5):481-4.
14. Kligler B, Nielsen A, Kohrrer C, Schmid T, Waltermaurer E, Perez E, Merrell W. Acupuncture Therapy in a Group Setting for Chronic Pain. Pain Med. 2017 Jun 8. doi:10.1093/pm/pnx134.
15. Li X, Wang R, Xing X, et al. Acupuncture for Myofascial Pain Syndrome: A Network Meta-Analysis of 33 Randomized Controlled Trials. Pain Physician. 2017 Sep;20(6):E883-E902.
16. Linde K, Allais G, Brinkhaus B, Fei Y, Mehring M, Shin BC, et al. Acupuncture for the prevention of tension-type headache. Cochrane Database Syst Rev. 2016;4:Cd007587. doi:10.1002/14651858.CD007587.pub2.
17. Linde K, Allais G, Brinkhaus B, Manheimer E, Vickers A, White AR. Acupuncture for tension-type headache. Cochrane Database Syst Rev. 2009 Jan 21;(1):CD007587. doi:10.1002/14651858.CD007587.
18. Maciocia, G; The Foundations of Chinese Medicine: A Comprehensive Text; Churchill Livingstone, 2005.
19. MacPherson H, Tilbrook H, Richmond S, Woodman J, Ballard K, Atkin K, Bland M, Eldred J, Essex H, Hewitt C, Hopton A, Keding A, Lansdown H, Parrott S, Torgerson D, Wenham A, Watt I. Alexander Technique Lessons or Acupuncture Sessions for Persons With Chronic Neck Pain: A Randomized Trial. Ann Intern Med. 2015 Nov 3;163(9):653-62. doi:10.7326/M15-0667.
20. MacPherson H, Vertosick EA, Foster NE, Lewith G, Linde K, Sherman KJ, et al. The persistence of the effects of acupuncture after a course of treatment: A meta-analysis of patients with chronic pain. Pain. 2016 Oct 17. doi:10.1097/j.pain.0000000000000747.
21. Magee, David J., Orthopedic Physical Assessment, Second Edition, W.B. Saunders Company, 2007.
22. McDonald J, Janz S. The Acupuncture Evidence Project: A Comparative Literature Review (Revised Edition). Brisbane: Australian Acupuncture and Chinese Medicine Association Ltd; 2017.

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23. National Health and Medical Research Council. NHMRC additional levels of evidence and grades for recommendations for developers of guidelines. Table 3. NHMRC Evidence Hierarchy: designations of 'levels of evidence' according to type of research question (including explanatory notes). National Health and Medical Research Council; 2009.
24. O'Connor J, Bensky D. Acupuncture: A Comprehensive Text. Chicago: Eastland Press; 1981.
25. Olson WH, Brumback RA, Gascon G, Iyer V; Handbook of Symptom Oriented Neurology; Year Book Medical Publishers, Inc.; 2002.
26. Porter, R; The Merck Manual, Merck, 2011.
27. Roy, S, Irvin, R, and Iverson, D; Sports Medicine, Prevention, Education, Management, and Rehabilitation. Benjamin Cummings, 1998.
28. Seo SY, Lee KB, Shin JS, et al. Effectiveness of Acupuncture and Electroacupuncture for Chronic Neck Pain: A Systematic Review and Meta-Analysis. Am J Chin Med. 2017;45(8):1573-1595. doi:10.1142/S0192415X17500859.
29. Sun Y, Gan TJ. Acupuncture for the management of chronic headache: a systematic review. Anesth Analg. 2008 Dec;107(6):2038-47. doi:10.1213/ane.0b013e318187c76a.
30. Trinh K, Graham N, Irnich D, Cameron ID, Forget M. Acupuncture for neck disorders. Cochrane Database Syst Rev. 2016(5):Cd004870. doi:10.1002/14651858.CD004870.pub4.
31. Wang R, Li X, Zhou S, Zhang X, Yang K, Li X. Manual acupuncture for myofascial pain syndrome: a systematic review and meta-analysis. Acupunct Med. 2017 Aug;35(4):241-250. doi:10.1136/acupmed-2016-011176.
32. Weinstein, S, and Buckwalter, J. Orthopaedics Principles and Their Applications. Lippincott, Williams, & Wilkins, 2005.
33. White P, Lewith G, Prescott P, Conway J. Acupuncture versus placebo for the treatment of chronic mechanical neck pain: a randomized, controlled trial. Ann Intern Med. 2004 Dec 21;141(12):911-9.
34. Xiang A, Cheng K, Shen X, Xu P, Liu S. The Immediate Analgesic Effect of Acupuncture for Pain: A Systematic Review and Meta-Analysis. Evid Based Complement Alternat Med. 2017;2017:3837194. doi:10.1155/2017/3837194.
35. Yuan J, Purepong N, Hunter RF, Kerr DP, Park J, Bradbury I, McDonough S. Different frequencies of acupuncture treatment for chronic low back pain: an assessor-blinded pilot randomised controlled trial. Complement Ther Med. 2009 Jun;17(3):131-40. doi:10.1016/j.ctim.2008.10.003.
36. Yuan Q-l, Guo T-m, Liu L, Sun F, Zhang Y-g (2015) Traditional Chinese Medicine for Neck Pain and Low Back Pain: A Systematic Review and Meta- Analysis. PLoS ONE 10(2): e0117146. doi:10.1371/journal.pone.0117146.
37. Zhao HJ, Tan JY, Wang T, Jin L. Auricular therapy for chronic pain management in adults: A synthesis of evidence. Complement Ther Clin Pract. 2015 May;21(2):68-78. doi:10.1016/j.ctcp.2015.03.006.

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ACU-4.2: Cervical Spondylosis

Synonyms

- Cervical degenerative joint disease
- Cervical arthritis
- Neck pain

Definition

Chronic neck pain and stiffness, occasionally with radicular pain, due to narrowing or stenosis of the spinal canal or intervertebral foramen. Narrowing may be caused by osteophytes, buckling or protrusion of interlaminar ligaments, or cervical disc herniation.

Oriental Medicine Diagnoses

- Qi and Blood Stagnation
  - Stagnation results in the painful condition. May have numerous causation; can be related to trauma or underlying syndromes.
- Cold Damp Bi, Cold Damp with Painful Obstruction
  - Accumulation of Cold Damp can result from lifestyle choices that result in the underlying syndromes leading to this syndrome, external pathogens.
- Bi Syndromes; particularly Wind Damp Bi
  - Resulting from the invasion of wind and damp or internal wind and damp.
- Kidney Yin and Yang Deficiency
  - Underlying condition with additional symptoms caused by either illness, stress, lifestyle choices that result in depletion of this energy, or congenital insufficiency.
- Kidney Qi Deficiency
  - Can result from lifestyle choices that diminish Qi and Blood, chronic illness.

History

- Patient history may include:
  - General demographics
  - Occupation/employment
  - Hand dominance
  - Living environment
  - History of current condition
  - Functional status & activity level
  - Medications
  - Other tests and measurements (laboratory and diagnostic tests)
  - Past history (including history of prior Oriental Medicine treatment, and response to prior treatment)

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Specific Aspects of History

- Rule out red flags (require medical management).
- Determine if trauma-related; determine nature and extent of traumatic event.
- Identify co-morbidities requiring medical management, and those that affect acupuncture and Oriental Medicine management.

Red Flag	Possible Consequence or Cause	Action Required
Severe trauma	Fracture	Immediate referral to emergency department
Direct trauma to the head with loss of consciousness (LOC)	Subdural hematoma; epidural hematoma; fracture	Immediate referral to emergency department
Nuchal rigidity and/or positive Brudzinskis or Kernigs sign	Subarachnoid hemorrhage; meningitis	Immediate referral to emergency department
Bladder dysfunction associated with onset of neck pain	Myelopathy; spinal cord injury	Immediate referral to emergency department
Associated dysphasia	Cerebrovascular accident	Immediate referral to emergency department
Associated cranial nerve or central nervous system (CNS) signs/symptoms	Tumor; intracranial hematoma	Immediate referral to emergency department
Onset of a new headache	Tumor; infection; vascular cause (older patients, also consider temporal arteritis; glaucoma)	Prompt referral to Primary Care Provider
Co-morbidities of rheumatoid arthritis, seronegative arthritides, Down's syndrome	Atlantoaxial instability due to associated transverse ligament laxity	Prompt referral to Primary Care Provider
Cancer	Cause of symptoms (metastatic or primary)	Prompt referral to Primary Care Provider
Alcoholism, drug abuse	Side effect or withdrawal phenomenon	Immediate referral to emergency department
Immune-compromised state	Infection	Prompt referral to Primary Care Provider

Presentation

Usually an insidious onset of pain. Patient may have a history of head or neck trauma, or multiple episodes of neck and/or arm pain. Morning pain/stiffness that decreases with motion, but is aggravated by excessive motions or strenuous activity is common.

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Subjective Findings

- Pain and stiffness in the neck
- Pain typically worse with motion
- May report crepitus with certain cervical motions, particularly circumduction
- Headaches may accompany pain
- Non-dermatomal upper extremity pain (unilateral or bilateral) may occur with lateral recess stenosis and nerve root entrapment
- Pain should be documented as a numeric pain scale 0-10
- Headache and upper extremity symptom frequency, duration and numeric pain scale should be documented

Functional Assessment

- Documentation of a patient's level of function is an important aspect of patient care. This documentation is required in order to establish the medical necessity of ongoing acupuncture treatment. The Patient Specific Functional Scale (PSFS) is a patient reported outcome assessment that is easy and appropriate for acupuncturists to use. The PSFS has been studied in peer-reviewed scientific literature, and it has been proven to be a valid, reliable, and responsive measure for a variety of pain syndromes (neck, back, knee, etc.).

Objective Findings

Scope of Cervical Examination

- Inspection (including postural evaluation)
- Palpation of bony and soft tissue
- Range of motion
- Motion palpation of spine
- Orthopedic testing
- Neurologic testing

Specific Aspects of Examination for Cervical Spondylosis

Examine the region for contributing factors to the complaint.

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Findings of Cervical Spondylosis

- May relate tenderness to palpation in the lateral portions of the neck and along spinous processes.
- May demonstrate range of motion restrictions in the cervical spine (electrical shock-like sensations down the arms and/or legs with cervical flexion may indicate myelopathy or a disorder of the central nervous system that requires medical evaluation).
- Nerve root tension signs (shoulder depression) may be positive.
- Foraminal compression may cause radiating upper extremity pain.
- Extension with rotation of cervical spine may cause shoulder or arm pain.
- Dejerine's triad may be positive.

Differential Diagnoses

- Brown-Sequard Syndrome
- Carpal Tunnel Syndrome
- Central Cord Syndrome
- Cervical Disc Disease
- Cervical Myofascial Pain
- Cervical Sprain and Strain
- Chronic Pain Syndrome
- Diabetic Neuropathy
- Multiple Sclerosis
- Myofascial Pain
- Neoplastic Brachial Plexopathy
- Osteoporosis and Spinal Cord Injury
- Radiation-Induced Brachial Plexopathy
- Rheumatoid Arthritis
- Traumatic Brachial Plexopathy

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Oriental Medicine Management [7, 16, 29, 32, 35]

- Oriental Medicine management goals are to resolve pain, restore the highest level of function possible, and educate patient to prevent recurrent symptoms.
- To be considered medically necessary, the patient's symptoms must be the direct result of a primary neuromusculoskeletal injury or illness.
- Confirmation of appropriate medical co-management is always required when treating children age 14 and under.
- Treatment frequency should be commensurate with severity of the chief complaint.
- If at least 50% improvement in pain frequency, and severity is reported by patient—then
- Continued treatment with decreased frequency is appropriate.
- As treatment progresses, one should see an increase in the active regimen of care, a decrease in the passive regimen of care, and a fading of treatment frequency.
- If the condition has not progressed towards resolution, refer the patient to an appropriate health care provider to explore other treatment alternatives.
- eviCore's consideration of requests for continued acupuncture treatment depends on updated clinical information submitted regarding patient's progress.
- Adequate and legible patient progress information that contains a history and examination, and/or eviCore's Acupuncture Treatment Request Form is required to determine medical necessity.
- In addition to the improvements in the table below, significant progress may also be documented by increases in functional capacity and increasingly longer durations of pain relief.
- Discharge occurs when reasonable functional goals and expected outcomes have been achieved.
- The patient is discharged when the patient/care-giver can continue management of symptoms with an independent home program.
- Treatment is discontinued when the patient is unable to progress towards outcomes because of medical complications, psychosocial factors or other personal circumstances.
- If the member has been non-compliant with treatment as is evidenced by the clinical documentation, and/or the lack of demonstrated progress, treatment will be deemed to be not medically necessary and the member should be discharged from treatment.

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Week	Progress
0-1	◆ Some reduction of pain severity and frequency ◆ Some reduction of muscle spasm
2-4	◆ 50% decrease in pain severity and frequency ◆ 50% improvement in function
5-8	◆ 75% decrease in pain severity and frequency ◆ 75% improvement in function
9-12	◆ Gradual improvement leading toward resolution ◆ Reinforce self-management techniques ◆ Discharge patient to elective care, or to their primary care provider for alternative treatment options when a plateau is reached, or by week 12, whichever occurs first

Referral Guidelines

- Refer patient to their primary care provider for evaluation of alternative treatment options if:
  - Improvement does not meet the above guidelines or improvement has reached a plateau
  - Atrophy of upper extremity
  - Signs of myelopathy
  - Signs of demyelinating condition, tumor or infection
  - Increasing neurological signs: increasing upper extremities numbness/tingling, increasing upper extremities weakness, decreasing upper extremities reflexes

Appropriate Procedures/ Modalities

- Acupuncture
- Electro-acupuncture
- Cupping
- Moxibustion
- Gua Sha
- Myofascial release
- Acupressure
- Trigger point massage
- Tui Na (not to include osseous manipulation)
- Herbal formulas

Note: Not all of these modalities are covered by patient's health-plan; review documentation regarding coverage. Acupuncture and herbs must be appropriate for covered diagnoses under the patient's insurance policy. Acupuncturist is responsible for determining which procedures/modalities are most appropriate for the patient's condition.

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Inappropriate Procedures/Modalities

- Scarring moxa
- Applied kinesiology techniques
- Electro-acupuncture using more than 9 volts
- Any techniques outside the scope of practice in your state

Self-Management Techniques

- Rest and reduce strenuous activities
- Ergonomics, Postural advice, postural exercises
- Appropriate exercises/stretching
- Tai Qi, Qi Gong, Yoga
- Stress management, meditation
- Joint protection
- Weight loss
- Self-massage, Self-acupressure
- Hot packs/cold packs, if needed, to relieve discomfort
- Cervical pillow while sleeping, if helpful
- Aerobic conditioning, such as walking or swimming
- Use of tennis balls (or other appropriate device) for trigger point work such as suboccipitals, upper trapezius, rhomboids

Alternatives to Oriental Medicine Management

(listed in alphabetical order)

- Chiropractic
- Dietary/Nutritional Medicine Counseling
- Injection therapy/Pain management
- Massage therapy
- Medication
- Occupational therapy
- Osteopathic Manipulation
- Physical Therapy
- Psychological counseling

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References

1. Balshem H, Helfand M, Schunemann HJ, Oxman AD, Kunz R, Brozek J, et al. GRADE guidelines: 3. Rating the quality of evidence. J Clin Epidemiol. 2011 Apr;64(4):401-6. doi:10.1016/j.jclinepi.2010.07.015.
2. Blossfeldt P. Acupuncture for chronic neck pain--a cohort study in an NHS pain clinic. Acupunct Med. 2004 Sep;22(3):146-51. doi:10.1136/aim.22.3.146.
3. Ceccherelli F, Gioioso L, Casale R, Gagliardi G, Ori C. Neck pain treatment with acupuncture: does the number of needles matter? Clin J Pain. 2010 Nov-Dec;26(9):807-12. doi:10.1097/AJP.0b013e3181e375c9.
4. Cheng X, Deng L. Chinese Acupuncture and Moxibustion. Beijing: Foreign Language Press; 2010.
5. Cohen Steven P, Hooten W Michael. Advances in the diagnosis and management of neck pain BMJ 2017;358:j3221. doi:10.1136/bmj.j3221.
6. Deganello A, Battat N, Muratori E, Cristofaro G, Buongiorno A, Mannelli G, Picconi M, Giachetti R, Borsotti G, Gallo O. Acupuncture in shoulder pain and functional impairment after neck dissection: A prospective randomized pilot study. Laryngoscope. 2016 Aug;126(8):1790-5. doi:10.1002/lary.25921.
7. Deng YZ, Xu LG, Chen L, Zhou D, Liu Y. Effectiveness of acupuncture in the management of cervical spondylosis: a meta-analysis. J Biol Regul Homeost Agents. 2017 Oct-Dec;31(4):1017-1022.
8. Ernst E, Lee MS, Choi TY. Acupuncture: does it alleviate pain and are there serious risks? A review of reviews. Pain. 2011 Apr;152(4):755-64. doi:10.1016/j.pain.2010.11.004.
9. França DL, Senna-Fernandes V, Cortez CM, Jackson MN, Bernardo-Filho M, Guimarães MA. Tension neck syndrome treated by acupuncture combined with physiotherapy: a comparative clinical trial (pilot study). Complement Ther Med. 2008 Oct;16(5):268-77. doi:10.1016/j.ctim.2008.02.006.
10. Fu LM, Li JT, Wu WS. Randomized controlled trials of acupuncture for neck pain: systematic review and meta-analysis. J Altern Complement Med. 2009 Feb;15(2):133-45. doi:10.1089/acm.2008.0135.
11. Hempel S, Taylor SL, Solloway MR, Miake-Lye IM, Beroes JM, Shanman R, et al. VA Evidence-based Synthesis Program Reports. Evidence Map of Acupuncture. Washington (DC): Department of Veterans Affairs; 2014.
12. Horn KK, Jennings S, Richardson G, Vliet DV, Hefford C, Abbott JH. The patient-specific functional scale: psychometrics, clinimetrics, and application as a clinical outcome measure. J Orthop Sports Phys Ther. 2012 Jan;42(1):30-42. doi:10.2519/jospt.2012.3727.
13. Kaptchuk T. The Web That Has No Weaver. Contemporary Books. 2000.
14. Kelly RB. Acupuncture for pain. Am Fam Physician. 2009 Sep 1;80(5):481-4.
15. Kligler B, Nielsen A, Kohrrer C, Schmid T, Waltermaurer E, Perez E, Merrell W. Acupuncture Therapy in a Group Setting for Chronic Pain. Pain Med. 2017 Jun 8. doi:10.1093/pm/pnx134.
16. Li X, Wang R, Xing X, et al. Acupuncture for Myofascial Pain Syndrome: A Network Meta-Analysis of 33 Randomized Controlled Trials. Pain Physician. 2017 Sep;20(6):E883-E902.
17. Linde K, Allais G, Brinkhaus B, Fei Y, Mehring M, Shin BC, et al. Acupuncture for the prevention of tension-type headache. Cochrane Database Syst Rev. 2016;4:Cd007587. doi:10.1002/14651858.CD007587.pub2.
18. Linde K, Allais G, Brinkhaus B, Manheimer E, Vickers A, White AR. Acupuncture for tension-type headache. Cochrane Database Syst Rev. 2009 Jan 21;(1):CD007587. doi:10.1002/14651858.CD007587.
19. Maciocia, G; The Foundations of Chinese Medicine: A Comprehensive Text; Churchill Livingstone, 2005.
20. MacPherson H, Tilbrook H, Richmond S, Woodman J, Ballard K, Atkin K, Bland M, Eldred J, Essex H, Hewitt C, Hopton A, Keding A, Lansdown H, Parrott S, Torgerson D, Wenham A, Watt I. Alexander Technique Lessons or Acupuncture Sessions for Persons With Chronic Neck Pain: A Randomized Trial. Ann Intern Med. 2015 Nov 3;163(9):653-62. doi:10.7326/M15-0667.
21. MacPherson H, Vertosick EA, Foster NE, Lewith G, Linde K, Sherman KJ, et al. The persistence of the effects of acupuncture after a course of treatment: A meta-analysis of patients with chronic pain. Pain. 2016 Oct 17. doi:10.1097/j.pain.0000000000000747.

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22. Magee, David J., Orthopedic Physical Assessment, Second Edition, W.B. Saunders Company, 2007.
23. McDonald J, Janz S. The Acupuncture Evidence Project: A Comparative Literature Review (Revised Edition). Brisbane: Australian Acupuncture and Chinese Medicine Association Ltd; 2017.
24. National Health and Medical Research Council. NHMRC additional levels of evidence and grades for recommendations for developers of guidelines. Table 3. NHMRC Evidence Hierarchy: designations of 'levels of evidence' according to type of research question (including explanatory notes). National Health and Medical Research Council; 2009.
25. O'Connor J, Bensky D. Acupuncture: A Comprehensive Text. Chicago: Eastland Press; 1981.
26. Olson WH, Brumback RA, Gascon G, Iyer V; Handbook of Symptom Oriented Neurology; Year Book Medical Publishers, Inc.; 2002.
27. Porter, R; The Merck Manual, Merck, 2011.
28. Roy, S., Irvin, R., and Iverson, D; Sports Medicine, Prevention, Education, Management, and Rehabilitation, Benjamin Cummings, 1998.
29. Seo SY, Lee KB, Shin JS, et al. Effectiveness of Acupuncture and Electroacupuncture for Chronic Neck Pain: A Systematic Review and Meta-Analysis. Am J Chin Med. 2017;45(8):1573-1595. doi:10.1142/S0192415X17500859.
30. Sun Y, Gan TJ. Acupuncture for the management of chronic headache: a systematic review. Anesth Analg. 2008 Dec;107(6):2038-47. doi:10.1213/ane.0b013e318187c76a.
31. Trinh K, Graham N, Irnich D, Cameron ID, Forget M. Acupuncture for neck disorders. Cochrane Database Syst Rev. 2016(5):Cd004870. doi:10.1002/14651858.CD004870.pub4.
32. Wang R, Li X, Zhou S, Zhang X, Yang K, Li X. Manual acupuncture for myofascial pain syndrome: a systematic review and meta-analysis. Acupunct Med. 2017 Aug;35(4):241-250. doi:10.1136/acupmed-2016-011176.
33. Weinstein, S, and Buckwalter, J. Orthopaedics Principles and Their Applications. Lippincott, Williams, & Wilkins, 2005.
34. White P, Lewith G, Prescott P, Conway J. Acupuncture versus placebo for the treatment of chronic mechanical neck pain: a randomized, controlled trial. Ann Intern Med. 2004 Dec 21;141(12):911-9. doi:10.7326/0003-4819-141-12-200412210-00007.
35. Xiang A, Cheng K, Shen X, Xu P, Liu S. The Immediate Analgesic Effect of Acupuncture for Pain: A Systematic Review and Meta-Analysis. Evid Based Complement Alternat Med. 2017;2017:3837194. doi:10.1155/2017/3837194.
36. Yuan J, Purepong N, Hunter RF, Kerr DP, Park J, Bradbury I, McDonough S. Different frequencies of acupuncture treatment for chronic low back pain: an assessor-blinded pilot randomised controlled trial. Complement Ther Med. 2009 Jun;17(3):131-40. doi:10.1016/j.ctim.2008.10.003
37. Yuan Q-l, Guo T-m, Liu L, Sun F, Zhang Y-g(2015) Traditional Chinese Medicine for Neck Pain and Low Back Pain: A Systematic Review and Meta- Analysis. PLoS ONE 10(2): e0117146. doi:10.1371/ journal.pone.0117146.
38. Zhao HJ, Tan JY, Wang T, Jin L. Auricular therapy for chronic pain management in adults: A synthesis of evidence. Complement Ther Clin Pract. 2015 May;21(2):68-78. doi:10.1016/j.ctcp.2015.03.006.

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ACU-4.3: Cervical Sprain/Strain

Synonyms

- Whiplash
- Cervical acceleration/deceleration syndrome
- Cervical ligamentous sprain
- Neck strain, neck pain

Definition

Non-radicular neck pain that may extend into the trapezius region and occurs either suddenly or following a trauma, which may be either instantaneous or repetitive.

Strain

Overstretching or tearing of a muscle or tendon.

Sprain

Overstretching or tearing of ligamentous tissue.

Oriental Medicine Diagnoses

- Qi and Blood Stagnation
  - Stagnation results in painful condition; may have numerous causations; can be related to trauma or underlying syndromes.
- Kidney Yang Deficiency
  - Underlying condition with additional symptoms caused by illness, stress, lifestyle choices that result in depletion of this energy, or congenital insufficiency.
- Cold Damp Bi, Cold Damp with Painful Obstruction
  - Accumulation of cold damp can result from lifestyle that results in the underlying imbalance leading to this syndrome.

History

- Patient history may include:
  - General demographics
  - Occupation/employment
  - Living environment
  - History of current condition
  - Functional status & activity level
  - Medications
  - Other tests and measurements (laboratory and diagnostic tests)
  - Past history (including history of prior Oriental Medicine treatment, and response to prior treatment)

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Specific Aspects of History

- Determine if trauma-related; determine nature and extent of traumatic event.
- Identify co-morbidities requiring medical management, and those that affect acupuncture and Oriental Medicine management.
- Determine opqrst (onset, provocative/palliative factors, quality, radiation/referral pattern, site [location], timing of complaint).

Red Flag	Possible Consequence or Cause	Action Required
Severe trauma	Fracture	Immediate referral to emergency department
Direct trauma to the head with loss of consciousness (LOC)	Subdural hematoma; epidural hematoma; fracture	Immediate referral to emergency department
Nuchal rigidity and/or positive Brudzinskis or Kernigs sign	Subarachnoid hemorrhage; meningitis	Immediate referral to emergency department
Bladder dysfunction associated with onset of neck pain	Myelopathy; spinal cord injury	Immediate referral to emergency department
Associated dysphasia	Cerebrovascular accident	Immediate referral to emergency department
Associated cranial nerve or central nervous system (CNS) signs/symptoms	Tumor; intracranial hematoma	Immediate referral to emergency department
Onset of a new headache	Tumor; infection; vascular cause (older patients, also consider temporal arteritis; glaucoma)	Prompt referral to Primary Care Provider
Co-morbidities of rheumatoid arthritis, seronegative arthritides, Down's syndrome	Atlantoaxial instability due to associated transverse ligament laxity	Prompt referral to Primary Care Provider
Cancer	Cause of symptoms (metastatic or primary)	Prompt referral to Primary Care Provider
Alcoholism, drug abuse	Side effect or withdrawal phenomenon	Immediate referral to emergency department
Immune-compromised state	Infection	Prompt referral to Primary Care Provider

Presentation

Strain

Overexertion in some static or dynamic activity; over stretching; or contusion. Pain is worse with initial activity and rest typically relieves the pain.

Sprain

Chronic manifestations typically involves prolonged periods of postural abuse. Acute onset typically involves a sudden motion or poor body mechanics while performing an activity.

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Subjective Findings

Strain

- Pain and stiffness in a muscle/tendon group.

Sprain

- Pain and stiffness in the affected area.
- Neck pain located anywhere from the occiput to cervico-thoracic junction and towards the shoulders along the distribution of the trapezii. Motion of the head and neck is painful. Headaches originating from the cervical region or occiput may accompany the neck pain.
  - Pain should be documented as a numeric pain scale 0-10
  - Headache frequency, duration and numeric pain scale should be documented

Functional Assessment

- Documentation of a patient's level of function is an important aspect of patient care. This documentation is required in order to establish the medical necessity of ongoing acupuncture treatment. The Patient Specific Functional Scale (PSFS) is a patient reported outcome assessment that is easy and appropriate for acupuncturists to use. The PSFS has been studied in peer-reviewed scientific literature, and it has been proven to be a valid, reliable, and responsive measure for a variety of pain syndromes (neck, back, knee, etc.).

Objective Findings

Scope of Cervical Examination

- Inspection
- Palpation of bony and soft tissue
- Range of motion
- Motion palpation of spine
- Orthopedic and neurologic testing

Specific Aspects of Examination for Cervical Sprain/Strain

Examine the region for contributing factors to the complaint.

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Findings of Cervical Sprain/Strain

Strain

- Inspection negative for visible deformity
- Tenderness, spasm, and possible swelling in the muscle or tendon upon palpation
- Limited cervical motion is common
- Pain on isometric contraction or active motion of the involved muscle
- Neurological exam is usually normal

Sprain

- Inspection negative for visible deformity
- Tenderness +2 or greater in the immediate area of the involved joint(s)
- Localized spasm and/or swelling in the tissues directly adjacent to the region
- Limited cervical motion is common
- Pain intensified by passive motion of the involved joint(s)
- Neurological exam is usually normal

Differential Diagnoses

- Cervical herniated disc
- Cervical myelopathy
- Cervical osteoarthritis
- Factitious disorder
- Infection or osteomyelitis
- Polymyalgia rheumatica
- Vascular abnormality of cervical structures

Oriental Medicine Management [15, 28, 31, 34]

- Oriental Medicine management goals are to resolve pain, restore the highest level of function possible, and educate patient to prevent recurrent symptoms.
- To be considered medically necessary, patient's symptoms must be the direct result of a primary neuromusculoskeletal injury or illness.
- Confirmation of appropriate medical co-management is always required when treating children age 14 and under.
- Treatment frequency should be commensurate with severity of the chief complaint.
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- As treatment progresses, one should see an increase in the active regimen of care, a decrease in the passive regimen of care, and a fading of treatment frequency.
- If the condition has not progressed towards resolution, refer the patient to an appropriate health care provider to explore other treatment alternatives.
- eviCore's consideration of requests for continued acupuncture treatment depends on updated clinical information submitted regarding patient's progress.
- Adequate and legible patient progress information that contains a history and examination, and/or eviCore's Acupuncture Treatment Request Form is required to determine medical necessity.
- In addition to the improvements in the table below, significant progress may also be documented by increases in functional capacity and increasingly longer durations of pain relief.
- Discharge occurs when reasonable functional goals and expected outcomes have been achieved.
- The patient is discharged when the patient/care-giver can continue management of symptoms with an independent home program.
- Treatment is discontinued when the patient is unable to progress towards outcomes because of medical complications, psychosocial factors or other personal circumstances.
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Referral Guidelines

- Refer patient to their primary care provider for evaluation of alternative treatment options if:
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  - Signs of myelopathy
  - Signs of demyelinating condition, tumor or infection
  - Increasing neurological signs: increasing UE numbness/tingling, increasing UE weakness, decreasing UE reflexes

Appropriate Procedures/ Modalities

- Acupuncture
- Electro-acupuncture
- Cupping
- Moxibustion
- Gua Sha
- Myofascial release
- Acupressure
- Trigger point massage
- Tui Na (not to include osseous manipulation)
- Herbal formulas

Note: Not all of these modalities are covered by patient's health-plan; review documentation regarding coverage. Acupuncture and herbs must be appropriate for covered diagnoses under the patient's insurance policy. Acupuncturist is responsible for determining which procedures/modalities are most appropriate for the patient's condition.

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- Electro-acupuncture using more than 9 volts
- Any techniques outside the scope of practice in your state

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Self-Management Techniques

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- Tai Qi, Qi Gong, Yoga
- Stress management, meditation
- Joint protection
- Weight loss
- Self-massage, Self-acupressure
- Hot packs/cold packs, if needed, to relieve discomfort
- Cervical pillow while sleeping, if helpful
- Aerobic conditioning, such as walking or swimming
- Use of tennis balls (or other appropriate device) for trigger point work such as suboccipitals, upper trapezius, rhomboids

Alternatives to Oriental Medicine Management

(listed in alphabetical order)

- Chiropractic
- Dietary/Nutritional Medicine Counseling
- Injection therapy/Pain management
- Massage therapy
- Medication
- Occupational therapy
- Osteopathic Manipulation
- Physical Therapy
- Psychological counseling

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References

1. Balshem H, Helfand M, Schunemann HJ, Oxman AD, Kunz R, Brozek J, et al. GRADE guidelines: 3. Rating the quality of evidence. J Clin Epidemiol. 2011 Apr;64(4):401-6. doi:10.1016/j.jclinepi.2010.07.015.
2. Blossfeldt P. Acupuncture for chronic neck pain--a cohort study in an NHS pain clinic. Acupunct Med. 2004 Sep;22(3):146-51. doi:10.1136/aim.22.3.146.
3. Ceccherelli F, Gioioso L, Casale R, Gagliardi G, Ori C. Neck pain treatment with acupuncture: does the number of needles matter? Clin J Pain. 2010 Nov-Dec;26(9):807-12. doi:10.1097/AJP.0b013e3181e375c9.
4. Cheng X, Deng L. Chinese Acupuncture and Moxibustion. Beijing: Foreign Language Press; 2010.
5. Cohen Steven P, Hooten W Michael. Advances in the diagnosis and management of neck pain BMJ 2017; 358:j3221. doi:10.1136/bmj.j3221.
6. Deganello A, Battat N, Muratori E, Cristofaro G, Buongiorno A, Mannelli G, Picconi M, Giachetti R, Borsotti G, Gallo O. Acupuncture in shoulder pain and functional impairment after neck dissection: A prospective randomized pilot study. Laryngoscope. 2016 Aug;126(8):1790-5. doi:10.1002/lary.25921.
7. Ernst E, Lee MS, Choi TY. Acupuncture: does it alleviate pain and are there serious risks? A review of reviews. Pain. 2011 Apr;152(4):755-64. doi:10.1016/j.pain.2010.11.004.
8. França DL, Senna-Fernandes V, Cortez CM, Jackson MN, Bernardo-Filho M, Guimarães MA. Tension neck syndrome treated by acupuncture combined with physiotherapy: a comparative clinical trial (pilot study). Complement Ther Med. 2008 Oct;16(5):268-77. doi:10.1016/j.ctim.2008.02.006.
9. Fu LM, Li JT, Wu WS. Randomized controlled trials of acupuncture for neck pain: systematic review and meta-analysis. J Altern Complement Med. 2009 Feb;15(2):133-45. doi:10.1089/acm.2008.0135.
10. Hempel S, Taylor SL, Solloway MR, Miake-Lye IM, Beroes JM, Shanman R, et al. VA Evidence-based Synthesis Program Reports. Evidence Map of Acupuncture. Washington (DC): Department of Veterans Affairs; 2014.
11. Horn KK, Jennings S, Richardson G, Vliet DV, Hefford C, Abbott JH. The patient-specific functional scale: psychometrics, clinimetrics, and application as a clinical outcome measure. J Orthop Sports Phys Ther. 2012 Jan;42(1):30-42. doi:10.2519/jospt.2012.3727.
12. Kaptchuk T. The Web That Has No Weaver. Contemporary Books. 2000.
13. Kelly RB. Acupuncture for pain. Am Fam Physician. 2009 Sep 1;80(5):481-4.
14. Kligler B, Nielsen A, Kohrrer C, Schmid T, Waltermaurer E, Perez E, Merrell W. Acupuncture Therapy in a Group Setting for Chronic Pain. Pain Med. 2017 Jun 8. doi:10.1093/pm/pnx134.
15. Li X, Wang R, Xing X, et al. Acupuncture for Myofascial Pain Syndrome: A Network Meta-Analysis of 33 Randomized Controlled Trials. Pain Physician. 2017 Sep;20(6):E883-E902.
16. Linde K, Allais G, Brinkhaus B, Fei Y, Mehring M, Shin BC, et al. Acupuncture for the prevention of tension-type headache. Cochrane Database Syst Rev. 2016;4:Cd007587. doi:10.1002/14651858.CD007587.pub2.
17. Linde K, Allais G, Brinkhaus B, Manheimer E, Vickers A, White AR. Acupuncture for tension-type headache. Cochrane Database Syst Rev. 2009 Jan 21;(1):CD007587. doi:10.1002/14651858.CD007587.
18. Maciocia, G; The Foundations of Chinese Medicine: A Comprehensive Text; Churchill Livingstone, 2005.
19. MacPherson H, Tilbrook H, Richmond S, Woodman J, Ballard K, Atkin K, Bland M, Eldred J, Essex H, Hewitt C, Hopton A, Keding A, Lansdown H, Parrott S, Torgerson D, Wenham A, Watt I. Alexander Technique Lessons or Acupuncture Sessions for Persons With Chronic Neck Pain: A Randomized Trial. Ann Intern Med. 2015 Nov 3;163(9):653-62. doi:10.7326/M15-0667.
20. MacPherson H, Vertosick EA, Foster NE, Lewith G, Linde K, Sherman KJ, et al. The persistence of the effects of acupuncture after a course of treatment: A meta-analysis of patients with chronic pain. Pain. 2016 Oct 17. doi:10.1097/j.pain.0000000000000747.
21. Magee, David J., Orthopedic Physical Assessment, Second Edition, W.B. Saunders Company, 2007.
22. McDonald J, Janz S. The Acupuncture Evidence Project: A Comparative Literature Review (Revised Edition). Brisbane: Australian Acupuncture and Chinese Medicine Association Ltd; 2017.

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23. National Health and Medical Research Council. NHMRC additional levels of evidence and grades for recommendations for developers of guidelines. Table 3. NHMRC Evidence Hierarchy: designations of 'levels of evidence' according to type of research question (including explanatory notes). National Health and Medical Research Council; 2009.
24. O'Connor J, Bensky D. Acupuncture: A Comprehensive Text. Chicago: Eastland Press; 1981.
25. Olson WH, Brumback RA, Gascon G, Iyer V; Handbook of Symptom Oriented Neurology; Year Book Medical Publishers, Inc.; 2002.
26. Porter, R; The Merck Manual, Merck, 2011.
27. Roy, S., Irvin, R., and Iverson, D; Sports Medicine, Prevention, Education, Management, and Rehabilitation, Benjamin Cummings, 1998.
28. Seo SY, Lee KB, Shin JS, et al. Effectiveness of Acupuncture and Electroacupuncture for Chronic Neck Pain: A Systematic Review and Meta-Analysis. Am J Chin Med. 2017;45(8):1573-1595. doi:10.1142/S0192415X17500859.
29. Sun Y, Gan TJ. Acupuncture for the management of chronic headache: a systematic review. Anesth Analg. 2008 Dec;107(6):2038-47. doi:10.1213/ane.0b013e318187c76a.
30. Trinh K, Graham N, Irnich D, Cameron ID, Forget M. Acupuncture for neck disorders. Cochrane Database Syst Rev. 2016(5):Cd004870. doi:10.1002/14651858.CD004870.pub4.
31. Wang R, Li X, Zhou S, Zhang X, Yang K, Li X. Manual acupuncture for myofascial pain syndrome: a systematic review and meta-analysis. Acupunct Med. 2017 Aug;35(4):241-250. doi:10.1136/acupmed-2016-011176.
32. Weinstein, S, and Buckwalter, J. Orthopaedics Principles and Their Applications. Lippincott, Williams, & Wilkins, 2005.
33. White P, Lewith G, Prescott P, Conway J. Acupuncture versus placebo for the treatment of chronic mechanical neck pain: a randomized, controlled trial. Ann Intern Med. 2004 Dec 21;141(12):911-9.
34. Xiang A, Cheng K, Shen X, Xu P, Liu S. The Immediate Analgesic Effect of Acupuncture for Pain: A Systematic Review and Meta-Analysis. Evid Based Complement Alternat Med. 2017;2017:3837194. doi:10.1155/2017/3837194.
35. Yuan J, Purepong N, Hunter RF, Kerr DP, Park J, Bradbury I, McDonough S. Different frequencies of acupuncture treatment for chronic low back pain: an assessor-blinded pilot randomised controlled trial. Complement Ther Med. 2009 Jun;17(3):131-40. doi:10.1016/j.ctim.2008.10.003.
36. Yuan Q-l, Guo T-m, Liu L, Sun F, Zhang Y-g (2015) Traditional Chinese Medicine for Neck Pain and Low Back Pain: A Systematic Review and Meta-Analysis. PLoS ONE 10(2): e0117146. doi:10.1371/journal.pone.0117146.
37. Zhao HJ, Tan JY, Wang T, Jin L. Auricular therapy for chronic pain management in adults: A synthesis of evidence. Complement Ther Clin Pract. 2015 May;21(2):68-78. doi:10.1016/j.ctcp.2015.03.006.

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ACU-5.0: Thoracic Conditions

ACU-5.1: Dorsalgia, Non-specific	**141**
ACU-5.2: Dorsalgia, Disc radicular	**149**

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ACU-5.1: Dorsalgia, Non-specific

Synonyms

- Upper back pain, mid back pain
- Rib pain

Definition

Dorsalgia—used to describe pain in the thoracic area, nonspecific in origin and/or nature, can be acute or chronic in nature; and, generally not used to describe episodes that involve radicular symptoms.

Oriental Medicine Diagnoses

- Qi and Blood Stagnation
  - Stagnation results in the painful condition; may have numerous causation; can be related to trauma or underlying syndromes.
- Bi Syndromes—particularly Wind Damp Bi
  - Resulting from the invasion of wind and damp or internal wind and damp.
- Kidney Yin and Yang Deficiency or Jing Deficiency
  - Underlying condition with additional symptoms caused by either illness, stress, and/or lifestyle choices that result in depletion of this energy, or congenital insufficiency.
- Kidney Qi Deficiency
  - Can result from lifestyle choices that diminish Qi and Blood, chronic illness.

History

Goals of Thoracic History

- Rule out red flags (require medical management).
- Identify co-morbidities requiring medical management, and those that affect acupuncture and Oriental Medicine management.
- Determine if trauma-related; determine nature and extent of traumatic event.
- Determine OPQRST (Onset, Provocative/Palliative factors, Quality, Radiation/Referral pattern, Site [location], Timing of complaint).

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Red Flag	Possible Consequence or Cause	Action Required
Severe trauma	Fracture	Immediate referral to emergency department
Onset following minor fall or heavy lifting in elderly or osteoporotic patient	Fracture	Immediate referral to emergency department
Direct blow to the back in young adult	Fracture	Immediate referral to emergency department
Saddle anesthesia	Cauda equina syndrome	Immediate referral to emergency department
Severe or progressive neurologic complaints	Cauda equina syndrome	Immediate referral to emergency department
Unexplained weight loss	Malignancy	Prompt referral to Primary Care Provider
Prior history of cancer	Malignancy	Prompt referral to Primary Care Provider
Pain that is worse with recumbency or worse at night	Malignancy	Prompt referral to Primary Care Provider
Fever or recent bacterial infection	Infection	Prompt referral to Primary Care Provider
Intravenous drug abuse or immunosupression	Infection	Prompt referral to Primary Care Provider
Prolonged steroid use	Infection	Prompt referral to Primary Care Provider

Presentation

Axial pain may be the predominant complaint. Axial pain is usually localized to the middle-to-lower thoracic region, but may radiate to the middle lumbar region as well. Patient usually describes pain as being of mild to moderate intensity.

Subjective Findings

- Pain and stiffness in the mid back
- Symptoms are often vague and generalized
- Neck pain and headaches are often reported concomitantly
- Pain should be documented as a numeric pain scale 0-10
- Headache and upper extremity symptom frequency, duration and numeric pain scale should be documented

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Functional Assessment

- Documentation of a patient's level of function is an important aspect of patient care. This documentation is required in order to establish the medical necessity of ongoing acupuncture treatment. The Patient Specific Functional Scale (PSFS) is a patient reported outcome assessment that is easy and appropriate for acupuncturists to use. The PSFS has been studied in peer-reviewed scientific literature, and it has been proven to be a valid, reliable, and responsive measure for a variety of pain syndromes (neck, back, knee, etc.).

Objective Findings

Scope of Musculoskeletal Examination

- Inspection
- Palpation of bony and soft tissue
- Range of motion
- Motion palpation of spine
- Orthopedic testing
- Neurologic testing

Specific Aspects of Thoracic Examination

Examine the musculoskeletal system for possible causes or contributing factors to the complaint.

Note: Extra spinal diseases that may refer pain to the back include: aortic aneurysm, colon cancer, pancreatitis, renal disease.

The most serious cause of back pain is malignant tumor. Most malignant tumors are metastatic and some may cause bony collapse and paralysis. Cancers that most commonly metastasize to bone consist of adrenal, breast, kidney, lung, prostate, and thyroid.

Findings of Thoracic Dorsalgia

- Limited active thoracic range of motion
- Back pain
- Tenderness to palpation
- Normal neurological findings

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Differential Diagnoses

- Multiple sclerosis
- Metastatic CA
- Aortic aneurysm
- CAD
- CHF
- Gall Bladder Disease
- Herpes zoster
- Hiatal hernia
- Kidney disease
- Lung disease
- Pancreatic disease
- Peptic ulcer disease
- Rib lesions
- Spinal cord tumor
- Thoracic vertebral body fracture (major trauma, minor trauma in elderly or osteoporotic patient, pathological fracture)
- Herpetic neuralgia (vesicles present following nerve root path)
- Thoracic disc rupture (long tract signs, such as clonus, spasticity, gait disturbance, or numbness of both legs
- Ankylosing spondylitis
- Tumor (intense constant pain, severe night time pain)
- Extra spinal causes, such as from disease/disorder of the pancreas, heart or kidney

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Oriental Medicine Management [10, 20, 22]

- Most patients with this diagnosis will already have consulted with their Primary Care Provider. If not, however, they should be directed to make an appointment with their MD at their earliest opportunity.
- Confirmation of appropriate medical co-management is always required when treating children age 14 and under.
- Oriental Medicine management goals are to resolve pain, restore the highest level of function possible, and educate patient to prevent recurrent symptoms.
- To be considered medically necessary, patient's symptoms must be the direct result of a primary neuromusculoskeletal injury or illness.
- Treatment frequency should be commensurate with severity of the chief complaint.
- When significant improvements in patient's subjective findings and objective findings are demonstrated—continued treatment with decreased frequency is appropriate.
- As treatment progresses, one should see an increase in the active regimen of care, a decrease in the passive regimen of care, and a fading of treatment frequency.
- If the condition has not progressed towards resolution, refer the patient to an appropriate health care provider to explore other treatment alternatives.
- eviCore's consideration of requests for continued acupuncture treatment depends on updated clinical information submitted regarding patient's progress.
- Adequate and legible patient progress information that contains a history and examination, and/or eviCore's Acupuncture Treatment Request Form is required to determine medical necessity.
- In addition to the improvements in the table below, significant progress may be documented by increases in functional capacity and increasingly longer durations of pain relief.
- Discharge occurs when reasonable functional goals and expected outcomes have been achieved.
- The patient is discharged when the patient/care-giver can continue management of symptoms with an independent home program.
- Treatment is discontinued when the patient is unable to progress towards outcomes because of medical complications, psychosocial factors or other personal circumstances.
- If the member has been non-compliant with treatment as is evidenced by the clinical documentation, and/or the lack of demonstrated progress, treatment will be deemed to be not medically necessary and the member should be discharged from treatment.

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Week	Progress
0-1	◆ Some reduction of pain severity and frequency ◆ Some reduction of muscle spasm
2-4	◆ 50% decrease in pain severity and frequency ◆ 50% improvement in function
5-8	◆ 75% decrease in pain severity and frequency ◆ 75% improvement in function
9-12	◆ Gradual improvement leading toward resolution ◆ Reinforce self-management techniques ◆ Discharge patient to elective care, or to their primary care provider for alternative treatment options when a plateau is reached, or by week 12, whichever occurs first

Referral Guidelines

- Refer patient when—no benefit is attained from treatment, treatment is palliative in benefit, or patient's condition has reached a plateau but residual symptoms still exist.

Appropriate Procedures/ Modalities

- Acupuncture
- Electro-acupuncture
- Cupping
- Moxibustion
- Gua Sha
- Myofascial release
- Acupressure
- Trigger point massage
- Tui Na (not to include osseous manipulation)
- Herbal formulas

Note: Not all of these modalities are covered by the patient's health-plan; review documentation regarding coverage. Acupuncture and herbs must be appropriate for covered diagnoses under the patient's insurance policy. Acupuncturist is responsible for determining which procedures/modalities are most appropriate for the patient's condition.

Inappropriate Procedures/Modalities

- Scarring moxa
- Applied kinesiology techniques
- Electro-acupuncture using more than 9 volts
- Any technique outside the scope of practice in your state

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Self-Management Techniques

- Rest and reduce strenuous activities
- Ergonomics, Postural advice, postural exercises
- Appropriate exercises/stretching
- Tai Qi, Qi Gong, Yoga
- Stress management, meditation
- Joint protection
- Weight loss
- Self-massage, Self-acupressure
- Hot packs/cold packs, if needed, to relieve discomfort
- Lumbar stabilization exercises
- Aerobic conditioning, such as walking or swimming

Alternatives to Oriental Medicine Management

(listed in alphabetical order)

- Chiropractic
- Dietary/Nutritional Medicine Counseling
- Injection therapy/Pain management
- Massage therapy
- Medication
- Occupational therapy
- Osteopathic Manipulation
- Physical Therapy
- Psychological counseling

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References

1. Balshem H, Helfand M, Schunemann HJ, Oxman AD, Kunz R, Brozek J, et al. GRADE guidelines: 3. Rating the quality of evidence. J Clin Epidemiol. 2011 Apr;64(4):401-6. doi:10.1016/j.jclinepi.2010.07.015.
2. Cheng X, Deng L. Chinese Acupuncture and Moxibustion. Beijing: Foreign Language Press; 2010.
3. Dong W, Goost H, Lin XB, Burger C, Paul C, Wang ZL, et al. Treatments for shoulder impingement syndrome: a PRISMA systematic review and network meta-analysis. Medicine (Baltimore). 2015 Mar;94(10):e510. doi:10.1097/MD.0000000000000510.
4. Hempel S, Taylor SL, Solloway MR, Miake-Lye IM, Beroes JM, Shanman R, et al. VA Evidence-based Synthesis Program Reports. Evidence Map of Acupuncture. Washington (DC): Department of Veterans Affairs; 2014.
5. Hopton A, MacPherson H. Acupuncture for chronic pain: is acupuncture more than an effective placebo? A systematic review of pooled data from meta-analyses. Pain Pract. 2010;10(2):94-102. doi:10.1111/j.1533-2500.2009.00337.x.
6. Horn KK, Jennings S, Richardson G, Vliet DV, Hefford C, Abbott JH. The patient-specific functional scale: psychometrics, clinimetrics, and application as a clinical outcome measure. J Orthop Sports Phys Ther. 2012 Jan;42(1):30-42. doi:10.2519/jospt.2012.3727.
7. Kaptchuk T. The Web That Has No Weaver. Contemporary Books. 2000.
8. Kelly RB. Acupuncture for pain. Am Fam Physician. 2009 Sep 1;80(5):481-4.
9. Kligler B, Nielsen A, Kohrrer C, Schmid T, Waltermaurer E, Perez E, Merrell W. Acupuncture Therapy in a Group Setting for Chronic Pain. Pain Med. 2017 Jun 8. doi:10.1093/pm/pnx134.
10. Li X, Wang R, Xing X, et al. Acupuncture for Myofascial Pain Syndrome: A Network Meta-Analysis of 33 Randomized Controlled Trials. Pain Physician. 2017 Sep;20(6):E883-E902.
11. Maciocia, G; The Foundations of Chinese Medicine: A Comprehensive Text; Churchill Livingstone, 2005.
12. MacPherson H, Vertosick EA, Foster NE, Lewith G, Linde K, Sherman KJ, et al. The persistence of the effects of acupuncture after a course of treatment: A meta-analysis of patients with chronic pain. Pain. 2016 Oct 17. doi:10.1097/j.pain.0000000000000747.
13. Magee, David J. Orthopedic Physical Assessment, Second Edition, W.B. Saunders Company, 2007.
14. McDonald J, Janz S. The Acupuncture Evidence Project: A Comparative Literature Review (Revised Edition). Brisbane: Australian Acupuncture and Chinese Medicine Association Ltd; 2017.
15. National Health and Medical Research Council. NHMRC additional levels of evidence and grades for recommendations for developers of guidelines. Table 3. NHMRC Evidence Hierarchy: designations of 'levels of evidence' according to type of research question (including explanatory notes). National Health and Medical Research Council; 2009.
16. O'Connor J, Bensky D. Acupuncture: A Comprehensive Text. Chicago: Eastland Press; 1981.
17. Olson WH, Brumback RA, Gascon G, Iyer V; Handbook of Symptom Oriented Neurology; Year Book Medical Publishers, Inc.; 2002.
18. Porter R. The Merck Manual, Merck, 2011.
19. Roy S., Irvin R., and Iverson D. Sports Medicine, Prevention, Education, Management, and Rehabilitation, Benjamin Cummings, 1998.
20. Wang R, Li X, Zhou S, Zhang X, Yang K, Li X. Manual acupuncture for myofascial pain syndrome: a systematic review and meta-analysis. Acupunct Med. 2017 Aug;35(4):241-250. doi:10.1136/acupmed-2016-011176.
21. Weinstein S, and Buckwalter J. Orthopaedics Principles and Their Applications. Lippincott, Williams, & Wilkins, 2005.
22. Xiang A, Cheng K, Shen X, Xu P, Liu S. The Immediate Analgesic Effect of Acupuncture for Pain: A Systematic Review and Meta-Analysis. Evid Based Complement Alternat Med. 2017;2017:3837194. doi:10.1155/2017/3837194.
23. Yuan J, Purepong N, Hunter RF, Kerr DP, Park J, Bradbury I, McDonough S. Different frequencies of acupuncture treatment for chronic low back pain: an assessor-blinded pilot randomised controlled trial. Complement Ther Med. 2009 Jun;17(3):131-40. doi:10.1016/j.ctim.2008.10.003.
24. Zhao HJ, Tan JY, Wang T, Jin L. Auricular therapy for chronic pain management in adults: A synthesis of evidence. Complement Ther Clin Pract. 2015 May;21(2):68-78. doi:10.1016/j.ctcp.2015.03.006.

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ACU-5.2: Dorsalgia, Disc radicular

Synonyms

- Thoracic, herniated disc
- Thoracic, disc displacement
- Thoracic outlet syndrome
- Brachial plexopathy
- Upper back pain, mid back pain, shoulder pain, clavicular pain, arm pain, rib pain

Definition

Condition that involves nerve root irritation, as a result of thoracic disc pathology. Or, compression, injury, or irritation to the neurovascular structures at the root of the neck or upper thoracic region, bounded by the anterior and middle scalenes; between the clavicle and first rib (with possible enlargement/hypertrophy of the subclavius); or beneath the pectoralis minor muscle. This area of involvement has also been described as an opening bordered by the first rib laterally, the vertebral column medially, and the claviculomanubrial complex anteriorly. The syndrome of compression at this site could be primarily neurologic, involving the brachial plexus, most often the lower trunk or medial cord; alternatively, it could involve compression of the subclavian artery, vein, or both. Pain may be acute or chronic.

Oriental Medicine Diagnoses

- Qi and Blood Stagnation
  - Stagnation results in the painful condition; may have numerous causation; can be related to trauma or underlying syndromes.
- Bi Syndromes—particularly Wind Damp Bi
  - Resulting from the invasion of wind and damp or internal wind and damp.
- Kidney Yin and Yang Deficiency or Jing Deficiency
  - Underlying condition with additional symptoms caused by either illness, stress, and/or lifestyle choices that result in depletion of this energy, or congenital insufficiency.
- Kidney Qi Deficiency
  - Can result from lifestyle choices that diminish Qi and Blood, chronic illness.

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History

Patient's symptoms may begin insidiously after repetitive or stressful activity, such as prolonged computer keyboard use or mechanical and overhead work. Trauma, such as a traction injury of the arm or an automobile accident with occurrence of a whiplash injury also has been associated with the onset of herniated thoracic discs and TOS respectively with a frequency of up to 23%. Sports activities, especially throwing and swimming, have been implicated as well; symptoms may be similar to those of a clavicular fracture, with a delayed onset from hours to weeks.

Autonomic phenomena (e.g., cold hands, blanching, and swelling) also may be reported. Proximity of the stellate ganglion to the first rib articulation, which is often dysfunctional or restricted in TOS, has been postulated as a cause. Primary vascular lesions, such as thrombus or aneurysm, may be present as well as secondary problems such as emboli. Tumors, such as upper lobe lung lesions (Pancoast tumor), are also a possible cause.

Pain and stiffness will often be the patient's main complaint. Patients may also complain of radicular pain, often band-like, frequently spaning across the anterior chest wall. Patients with radicular symptoms often complain of sensory changes, including dysesthesias and paresthesias, which usually occur in a dermatomal or radicular distribution. Patients with central protrusions may present with myelopathic symptoms, such as increased muscle tone, hyperreflexia, abnormal gait, and urinary incontinence.

Specific Aspects of History

- Rule out red flags (require medical management).
- Identify co-morbidities requiring medical management, and those that affect acupuncture and Oriental Medicine management.
- Determine if trauma-related; determine nature and extent of traumatic event.

Red Flag	Possible Consequence or Cause	Action Required
Severe trauma	Fracture, ligament tear, tendon rupture	Immediate referral to emergency department
Unilateral edema	Upper extremity deep vein thrombosis	Immediate referral to emergency department
Immune-compromised state	Infection	Prompt referral to Primary Care Provider
Cancer history	Cause of symptoms (metastatic or primary)	Prompt referral to Primary Care Provider
Discoloration of hand/fingers	Vascular occlusion, shunt emboli (dialysis patients)	Immediate referral to emergency department
Exertional symptoms, history of cardiac disease	Anginal equivalent (Acute heart disease)	Immediate referral to emergency department
Onset following minor fall or heavy lifting in elderly or osteoporotic patient	Fracture	Immediate referral to emergency department
Direct blow to the back in young adult	Fracture	Immediate referral to emergency department

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Red Flag	Possible Consequence or Cause	Action Required
Unexplained weight loss	Malignancy	Prompt referral to Primary Care Provider
Prior history of cancer	Malignancy	Prompt referral to Primary Care Provider
Pain that is worse with recumbency or worse at night	Malignancy	Prompt referral to Primary Care Provider
Fever or recent bacterial infection	Infection	Prompt referral to Primary Care Provider
Intravenous drug abuse or immunosuppression	Infection	Prompt referral to Primary Care Provider
Prolonged steroid use	Infection	Prompt referral to Primary Care Provider

Subjective Findings

- Pain, numbness and/or tingling, and heaviness of the involved upper extremity
- Symptoms are often vague and generalized
- Neck pain and headaches are often reported concomitantly
- Headache and upper extremity symptom frequency, duration and numeric pain scale should be documented
- Pain and stiffness in the mid back
- Patient may complain of radicular pain, which is often band-like and spans across the anterior chest wall. T10 dermatomal region most often is described as the focus of pain, irrespective of the level involved. Upper thoracic and lateral disc herniations most often precipitate radicular pain, and may even cause concomitant axial pain. Patients with radicular symptoms often complain of sensory changes, including dysesthesias and paresthesias, which usually occur in a dermatomal or radicular distribution.
- Patients with central protrusions may present with myelopathic symptoms, such as increased muscle tone, hyperreflexia, abnormal gait, and urinary incontinence.
- Those with lateral herniation may have symptoms of radiculopathy.
  - Other presentations must be considered in ruling out Displacement of thoracic intervertebral disc:
    - Patients with a large acute midline or paramedian disc herniation may cause classic spinal cord syndromes such as Brown-Sequard syndrome.
    - Presentation may also mimic that of degenerative hip disease or renal disease. Chest and abdominal pain suggests a mid-thoracic herniation.
    - Patients with an upper thoracic lesion could present with neck pain, upper extremity pain, or symptoms of Horner syndrome.
    - Patients with thoracic intervertebral disc conditions pain may present with symptoms that could be confused with those of cervical degenerative disease, particularly if a T1 or T2 disc herniation is present.

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- Pain should be documented as a numeric pain scale 0-10
- Radicular symptom frequency, duration and numeric pain scale should be documented

Functional Assessment

- Documentation of a patient's level of function is an important aspect of patient care. This documentation is required in order to establish the medical necessity of ongoing acupuncture treatment. The Patient Specific Functional Scale (PSFS) is a patient reported outcome assessment that is easy and appropriate for acupuncturists to use. The PSFS has been studied in peer-reviewed scientific literature, and it has been proven to be a valid, reliable, and responsive measure for a variety of pain syndromes (neck, back, knee, etc.).

Objective Findings

Scope of Musculoskeletal Examination

- Inspection including Oriental Medicine inspection techniques
- Palpation of bony and soft tissue including Oriental Medicine palpation techniques
- Range of motion, active and passive
- Orthopedic and neurologic testing if neurologic signs are present (where allowed by law)

Specific Aspects of Thoracic Examination

Examine the musculoskeletal system for possible causes or contributing factors to the complaint.

Note: Extra spinal diseases that may refer pain to the back include: aortic aneurysm, colon cancer, pancreatitis, renal disease.

The most serious cause of back pain is malignant tumor. Most malignant tumors are metastatic and some may cause bony collapse and paralysis. Cancers that most commonly metastasize to bone consist of adrenal, breast, kidney, lung, prostate, and thyroid.

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Findings of Thoracic Dorsalgia, Disc radicular

- Patient with radicular symptoms may demonstrate decreased or altered sensation to light touch or pinprick in the dermatomes distal to the lesion. Clinician must establish a sensory level by testing sensory dermatomes and by correlating results with the patient's complaints of dysesthesias and paresthesias.
- Spinal cord compression caused by a herniated disc may elicit upper motor neuron signs such as spasticity, hyperreflexia, positive Babinski sign (i.e., extension of the big toe at the metatarsophalangeal joint elicited by stroking lateral aspect of foot), and gait disturbances.
- Patient may also have weakness caused by compression of the spinal cord. Presence of a Hoffmann sign is demonstrated with the flicking of the terminal phalanx of middle finger, which results in reflex flexion of the distal phalanx of thumb, index, ring, and little fingers. This sign is not expected unless concomitant cervical pathology is present.
- Palpation or percussion of the spine may reproduce radicular symptoms. Although one cannot examine the function of muscles innervated by thoracic nerve roots because of their low specificity, having the patient sit upright and observing for any asymmetric contractions of the rectus abdominis may be helpful.
- One may test superficial abdominal reflexes to isolate an upper motor neuron lesion from this region. Superficial cremasteric reflex could be used to test the efferent T12 level and the afferent L1-L2 levels.
- If ankle clonus is present or if the plantar reflex is found to be positive, one must be wary of an upper motor lesion, and the thoracic and thoracolumbar regions should be examined.
- In high thoracic disc herniations (T2 through T5), discerning thoracic disease from cervical disease may be difficult. A positive result with the Spurling's compression test suggests a cervical pathology. Spurling's test is a maneuver designed to exacerbate encroachment on a cervical nerve root by extending and rotating the patient's head toward the symptomatic side, followed by axial compression.
- Many tests have been developed to assess patient with thoracic outlet syndrome. They may be helpful in determining the cause and location of the compression, thus, assist in proper therapy treatment.
- Due to the high false positive rate for TOS tests, perform at least three tests to reduce this possibility:
  - Adson's maneuver
    - Performed in the sitting or standing position with the examiner palpating the radial pulse in the patient's abducted and extended arm.
    - Examiner extends and externally rotates the arm as the patient rotates his or her head toward the examiner and takes a deep breath.
    - Diminished or absent radial pulse suggests compression of the subclavian artery by the scalene muscles.

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- Allen test
  - Test the involved side by having the patient make a fist and elevate their hand above their head for 30 seconds.
  - Occlude the Ulnar and Radial arteries by placing direct pressure over each artery at the wrist.
  - Ask the patient to open their hand (it should appear blanched).
  - Return their hand to waist level and release the pressure on the ulnar artery. Watch for color to return.
  - Repeat procedure, this time release pressure on the Radial artery. Watch for color to return.
- Roos test/EAST test (elevated arm stress test)
  - Patient holds both arms in the 90/90 position of the Allen test and then rapidly opens and closes the fingers for 3 minutes.
  - Inability to maintain the test position, diminished motor function of the hands, or decreased sensation or paresthesias are suggestive of TOS secondary to neurovascular compromise. In one study, over 80% of patients with carpal tunnel syndrome (CTS) presenting to an electrodiagnostic medicine laboratory had a positive EAST.
- Wright test
  - Arm is hyper-abducted so that the hand is brought over the head with the elbow and arm in the coronal plane.
  - Wright advocated performing the test in the sitting, then supine positions.
  - Taking a breath or rotating or extending the head and neck may have an additional effect.
  - Pulse is palpated for differences.
  - Test is used to detect compression in the costoclavicular space.
- Costoclavicular syndrome test or military brace
  - Accomplished by palpating the radial pulse and drawing the patient's shoulder down and back.
  - Positive test is indicated by the absence of the pulse.
- Provocation elevation test
  - Patient elevates both arms above the horizontal and rapidly opens and closes the hands 15 times. If fatigue, cramping, or tingling occurs, the test is positive for vascular insufficiency and TOS.
- Shoulder girdle passive elevation test
  - Patient crosses one arm on the chest. Examiner stands behind patient and passively elevates shoulder girdle upward and forward (passive shoulder shrug). Position is held for 30 seconds. Positive test is reported if the pulse becomes stronger, skin color improves, or hand temperature increases. Patient also may report a "relief phenomenon," which can range from numbness, pins and needles, or pain as the ischemia to the nerve is released.
- Halstead maneuver
  - The radial pulse is palpated and examiner applies a downward traction on the arm while patient's neck is hyperextended and the head is rotated to the opposite side. Absence or decrease pulse indicates a positive test for TOS.

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Differential Diagnoses

- Thoracic nerve root compression
- Other myelopathies
- Multiple sclerosis
- Metastatic CA
- Aortic aneurysm
- CAD
- CHF
- Gall Bladder Disease
- Herpes zoster
- Hiatal hernia
- Kidney disease
- Lung disease
- Pancreatic disease
- Peptic ulcer disease
- Rib lesions
- Spinal cord tumor
- Thoracic vertebral body fracture (major trauma, minor trauma in elderly or osteoporotic patient, pathological fracture)
- Herpetic neuralgia (vesicles present following nerve root path)
- Thoracic disc rupture (long tract signs, such as clonus, spasticity, gait disturbance, or numbness of both legs
- Ankylosing spondylitis
- Tumor (intense constant pain, severe night time pain)
- Extra spinal causes, such as from disease/disorder of the pancreas, heart or kidney
- Shoulder tendonitis, bursitis, impingement
- Shoulder (glenohumeral) instability
- Raynaud syndrome
- Ulnar neuropathy (cubital tunnel syndrome, Guyon canal syndrome)

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Oriental Medicine Management [10, 20, 22]

- Oriental Medicine management goals are to resolve pain, restore the highest level of function possible, and educate patient to prevent recurrent symptoms.
- To be considered medically necessary, patient's symptoms must be the direct result of a primary neuromusculoskeletal injury or illness.
- Confirmation of appropriate medical co-management is always required when treating children age 14 and under.
- Treatment frequency should be commensurate with severity of the chief complaint.
- If at least 50% improvement in pain frequency and severity is reported by patient—continued treatment with decreased frequency is appropriate.
- As treatment progresses, one should see an increase in the active regimen of care, a decrease in the passive regimen of care, and a fading of treatment frequency.
- If the condition has not progressed towards resolution, refer the patient to an appropriate health care provider to explore other treatment alternatives.
- eviCore's consideration of requests for continued acupuncture treatment depends on updated clinical information submitted regarding patient's progress.
- Adequate and legible patient progress information that contains a history and examination, and/or eviCore's Acupuncture Treatment Request Form is required to determine medical necessity.
- In addition to improvements in the table below, significant progress may be documented by increases in functional capacity and increasingly longer durations of pain relief.
- Discharge occurs when reasonable functional goals and expected outcomes have been achieved.
- The patient is discharged when the patient/care-giver can continue management of symptoms with an independent home program.
- Treatment is discontinued when the patient is unable to progress towards outcomes because of medical complications, psychosocial factors or other personal circumstances.
- If the member has been non-compliant with treatment as is evidenced by the clinical documentation, and/or the lack of demonstrated progress, treatment will be deemed to be not medically necessary and the member should be discharged from treatment.

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Week	Progress
0-1	◆ Some reduction of pain frequency and severity ◆ Some reduction of muscle spasm
2-4	◆ 50% decrease in pain severity and frequency ◆ 50% improvement in function ◆ Pain distribution is centralizing
5-8	◆ Continued reduction of pain frequency and severity ◆ Continued increase in function ◆ Pain distribution continues to centralize
9-12	◆ 75% improvement in pain severity and frequency ◆ 75% improvement in function ◆ Pain distribution is centralized to back ◆ Reinforce self-management techniques
13-16	◆ Gradual improvement leading toward resolution ◆ Reinforce self-management techniques ◆ Discharge patient to elective care, or to their primary care provider for alternative treatment options when a plateau is reached, or by week 16, whichever occurs first

Referral Guidelines

- Improvement has reached a plateau
- Fever, chills, unexplained weight loss, significant night time pain
- Presence of pathological fracture
- Obvious deformity
- Saddle anesthesia
- Loss of major motor function
- Bowel or bladder dysfunction
- Abdominal pain
- Visceral dysfunction
- Increasing neurologic signs/symptoms: increasing lower extremity weakness, increasing lower extremity pain, increasing lower extremity numbness/tingling, and decreasing lower extremity reflexes

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Appropriate Procedures/ Modalities

- Acupuncture
- Electro-acupuncture
- Cupping
- Moxibustion
- Gua Sha
- Myofascial release
- Acupressure
- Trigger point massage
- Tui Na (not to include osseous manipulation)
- Herbal formulas

Note: Not all of these modalities are covered by the patient's health-plan; review documentation regarding coverage. Acupuncture and herbs must be appropriate for covered diagnoses under the patient's insurance policy. Acupuncturist is responsible for determining which procedures/modalities are most appropriate for the patient's condition.

Inappropriate Procedures/Modalities

- Scarring moxa
- Applied kinesiology techniques
- Electro-acupuncture using more than 9 volts
- Any technique outside the scope of practice in your state

Self-Management Techniques

- Rest and reduce strenuous activities
- Ergonomics, Postural advice, postural exercises
- Appropriate exercises/stretching
- Tai Qi, Qi Gong, Yoga
- Stress management, meditation
- Joint protection
- Weight loss
- Self-massage, Self-acupressure
- Hot packs/cold packs, if needed, to relieve discomfort
- Use of cervical pillow while sleeping may be helpful

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Alternatives to Oriental Medicine Management

(listed in alphabetical order)

- Chiropractic
- Dietary/Nutritional Medicine Counseling
- Injection therapy/Pain management
- Massage therapy
- Medication
- Occupational therapy
- Osteopathic Manipulation
- Physical Therapy
- Psychological counseling
- Physiatry

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References

1. Balshem H, Helfand M, Schunemann HJ, Oxman AD, Kunz R, Brozek J, et al. GRADE guidelines: 3. Rating the quality of evidence. J Clin Epidemiol. 2011 Apr;64(4):401-6. doi:10.1016/j.jclinepi.2010.07.015.
2. Cheng X, Deng L. Chinese Acupuncture and Moxibustion. Beijing: Foreign Language Press; 2010.
3. Dong W, Goost H, Lin XB, Burger C, Paul C, Wang ZL, et al. Treatments for shoulder impingement syndrome: a PRISMA systematic review and network meta-analysis. Medicine (Baltimore). 2015 Mar;94(10):e510. doi:10.1097/MD.0000000000000510.
4. Hempel S, Taylor SL, Solloway MR, Miake-Lye IM, Beroes JM, Shanman R, et al. VA Evidence-based Synthesis Program Reports. Evidence Map of Acupuncture. Washington (DC): Department of Veterans Affairs; 2014.
5. Hopton A, MacPherson H. Acupuncture for chronic pain: is acupuncture more than an effective placebo? A systematic review of pooled data from meta-analyses. Pain Pract. 2010;10(2):94-102. doi:10.1111/j.1533-2500.2009.00337.x.
6. Horn KK, Jennings S, Richardson G, Vliet DV, Hefford C, Abbott JH. The patient-specific functional scale: psychometrics, clinimetrics, and application as a clinical outcome measure. J Orthop Sports Phys Ther. 2012 Jan;42(1):30-42. doi:10.2519/jospt.2012.3727.
7. Kaptchuk T. The Web That Has No Weaver. Contemporary Books. 2000.
8. Kelly RB. Acupuncture for pain. Am Fam Physician. 2009 Sep 1;80(5):481-4.
9. Kligler B, Nielsen A, Kohrrer C, Schmid T, Waltermaurer E, Perez E, Merrell W. Acupuncture Therapy in a Group Setting for Chronic Pain. Pain Med. 2017 Jun 8. doi:10.1093/pm/pnx134.
10. Li X, Wang R, Xing X, et al. Acupuncture for Myofascial Pain Syndrome: A Network Meta-Analysis of 33 Randomized Controlled Trials. Pain Physician. 2017 Sep;20(6):E883-E902.
11. Maciocia G. The Foundations of Chinese Medicine: A Comprehensive Text; Churchill Livingstone, 2005.
12. MacPherson H, Vertosick EA, Foster NE, Lewith G, Linde K, Sherman KJ, et al. The persistence of the effects of acupuncture after a course of treatment: A meta-analysis of patients with chronic pain. Pain. 2016 Oct 17. doi:10.1097/j.pain.0000000000000747.
13. Magee, David J. Orthopedic Physical Assessment, Second Edition, W.B. Saunders Company, 2007.
14. McDonald J, Janz S. The Acupuncture Evidence Project: A Comparative Literature Review (Revised Edition). Brisbane: Australian Acupuncture and Chinese Medicine Association Ltd; 2017. Date last accessed 01/15/18.
15. National Health and Medical Research Council. NHMRC additional levels of evidence and grades for recommendations for developers of guidelines. Table 3. NHMRC Evidence Hierarchy: designations of 'levels of evidence' according to type of research question (including explanatory notes). National Health and Medical Research Council; 2009.
16. O'Connor J, Bensky D. Acupuncture: A Comprehensive Text. Chicago: Eastland Press; 1981.
17. Olson WH, Brumback RA, Gascon G, Iyer V; Handbook of Symptom Oriented Neurology; Year Book Medical Publishers, Inc.; 2002.
18. Porter R. The Merck Manual, Merck, 2011.
19. Roy S., Irvin R., Iverson D. Sports Medicine, Prevention, Education, Management, and Rehabilitation, Benjamin Cummings, 1998.
20. Wang R, Li X, Zhou S, Zhang X, Yang K, Li X. Manual acupuncture for myofascial pain syndrome: a systematic review and meta-analysis. Acupunct Med. 2017 Aug;35(4):241-250. doi:10.1136/acupmed-2016-011176.
21. Weinstein S, Buckwalter J. Orthopaedics Principles and Their Applications. Lippincott, Williams, & Wilkins, 2005.
22. Xiang A, Cheng K, Shen X, Xu P, Liu S. The Immediate Analgesic Effect of Acupuncture for Pain: A Systematic Review and Meta-Analysis. Evid Based Complement Alternat Med. 2017;2017:3837194. doi:10.1155/2017/3837194.
23. Yuan J, Purepong N, Hunter RF, Kerr DP, Park J, Bradbury I, McDonough S. Different frequencies of acupuncture treatment for chronic low back pain: an assessor-blinded pilot randomised controlled trial. Complement Ther Med. 2009 Jun;17(3):131-40. doi:10.1016/j.ctim.2008.10.003.

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24. Zhao HJ, Tan JY, Wang T, Jin L. Auricular therapy for chronic pain management in adults: A synthesis of evidence. Complement Ther Clin Pract. 2015 May;21(2):68-78. doi:10.1016/j.ctcp.2015.03.006.

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ACU-6.0: Lumbosacral Conditions (Disc Radicular)

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ACU-6.1: Lumbar Degenerative Disc Disease

Synonyms

- Low back pain, sciatic pain, leg pain

Definition

Recurrent, episodic, chronic low back pain and stiffness, occasionally accompanied by sciatica that has been present for greater than three months. Disc degeneration is a function of the aging process, but can be accelerated by factors such as trauma, heredity, infection and use of tobacco. It is believed that loss of disc height loosens formerly tight ligaments, allowing tears to occur in the annulus with sliding and twisting motions that occur due to the loosened ligaments. These tears contribute to chronic, recurrent low back pain.

Oriental Medicine Diagnoses

- Qi and Blood Stagnation
  - Stagnation results in the painful condition; may have numerous causations; can be related to trauma or underlying syndromes.
- Bi Syndromes—particularly Wind Damp Bi
  - Resulting from the invasion of wind and damp or internal wind and damp.
- Kidney Yin and Yang Deficiency
  - Underlying condition with additional symptoms caused by either illness, stress, or lifestyle choices that result in depletion of this energy, or congenital insufficiency.
- Kidney Qi and Liver Blood Deficiency
  - Can result from lifestyle choices that diminish Qi and Blood, chronic illness.

History

- Patient history may include:
  - General demographics
  - Occupation/employment
  - Hand dominance
  - Living environment
  - History of current condition
  - Functional status & activity level
  - Medications
  - Other tests and measurements (laboratory and diagnostic tests)
  - Past history (including history of Oriental Medicine treatment, and response to prior treatment)

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Specific Aspects of History

- Rule out red flags (require medical management).
- Determine if trauma-related; determine nature and extent of traumatic event.
- Identify co-morbidities requiring medical management, and those that affect acupuncture and Oriental Medicine management.

Red Flag	Possible Consequence or Cause	Action Required
Severe trauma	Fracture	Immediate referral to emergency department
Onset following minor fall or heavy lifting in elderly or osteoporotic patient	Fracture	Immediate referral to emergency department
Direct Blow to the back in young adult	Fracture	Immediate referral to emergency department
Saddle anesthesia	Cauda equina syndrome	Immediate referral to emergency department
Severe or progressive neurologic complaints	Cauda equina syndrome	Immediate referral to emergency department
Global or progressive motor weakness in the lower extremities	Cauda equina syndrome	Immediate referral to emergency department
Recent onset of bowel dysfunction or acute onset of bladder dysfunction in association with low back pain	Cauda equina syndrome	Immediate referral to emergency department
Unexplained weight loss	Malignancy	Prompt referral to Primary Care Provider
Prior history of cancer	Malignancy	Prompt referral to Primary Care Provider
Pain that is worse with recumbency or worse at night	Malignancy	Prompt referral to Primary Care Provider
Fever or recent bacterial infection	Infection	Prompt referral to Primary Care Provider
Intravenous drug abuse or immunosuppression	Infection	Prompt referral to Primary Care Provider
Prolonged steroid use	Osteoporosis	Prompt referral to Primary Care Provider
Pain that does not change with change in position	Kidney disease	Prompt referral to Primary Care Provider

Presentation

Usually insidious onset of pain. May report prior history of episodic low back pain, which may have been occasionally accompanied by sciatica. May begin between the 3rd and 6th decades of life and persist for years.

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Subjective Findings

- Pain and stiffness in the low back lasting over a period of time greater than three months
- Pain typically worse with motion
- Stiffness upon arising from a seated position
- May report history of occasional sciatica, but low back symptoms predominate
- Essentially constant awareness of some level of back discomfort or limitations in motion
- Pain should be documented as a numeric pain scale 0-10
- Lower extremity symptom frequency, duration and numeric pain scale should be documented

Functional Assessment

- Documentation of a patient's level of function is an important aspect of patient care. This documentation is required in order to establish the medical necessity of ongoing acupuncture treatment. The Patient Specific Functional Scale (PSFS) is a patient reported outcome assessment that is easy and appropriate for acupuncturists to use. The PSFS has been studied in peer-reviewed scientific literature, and it has been proven to be a valid, reliable, and responsive measure for a variety of pain syndromes (neck, back, knee, etc.).

Objective Findings

Scope of Lumbar Examination

- Inspection including Oriental Medicine techniques of inspection
- Palpation of bony and soft tissue including Oriental Medicine techniques of inspection
- Range of motion (where allowed by law)
- Orthopedic testing (where allowed by law)
- Neurologic testing if complaints radiate to lower extremities or signs/symptoms of cauda equina syndrome are present (where allowed by law)

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Specific Aspects of Lumbar Examination

- Rule out other possible causes.

Notes: Extra spinal diseases that may refer pain to the back include: aortic aneurysm, colon cancer, endometriosis, hip disease, kidney disease, kidney stones, ovarian disease, pancreatitis, pelvic infections, tumors or cysts of the reproductive tract, uterine cancer

The most serious cause of low back pain is malignant tumor. Most malignant tumors are metastatic and some may cause bony collapse and paralysis. Cancers that most commonly metastasize to bone consist of adrenal, breast, kidney, lung, prostate, and thyroid.

Findings of Lumbar Degenerative Disc Disease

- May relate tenderness to palpation in the lumbar spine and sacroiliac joints
- May demonstrate range of motion restrictions in the lumbar spine
- Neurological exam is generally negative

Differential Diagnoses

- Extra spinal causes (ovarian cyst, kidney stone, pancreatitis, ulcer)
- Osteoporosis and compression fractures (major trauma, or minor trauma in elderly/osteoporotic patient)
- Infection in disc or bone (fever, history of IV drug use, history of severe pain)
- Inflammatory arthritides (family history, patient age/sex, morning stiffness)
- Metastatic disease, myeloma, lymphoma (pathologic fracture, severe night pain)
- Spinal tuberculosis (lower socioeconomic groups, AIDS)
- Depression

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Oriental Medicine Management [18, 31, 34, 36]

- Most patients with this diagnosis will already have consulted with their Primary Care Provider. If not, however, they should be directed to make an appointment with their MD at their earliest opportunity.
- Confirmation of appropriate medical co-management is always required when treating children age 14 and under.
- Oriental Medicine management goals are to resolve pain, restore the highest level of function possible, and educate patient to prevent recurrent symptoms.
- In order to be considered medically necessary, patient's symptoms must be the direct result of a primary neuromusculoskeletal injury or illness.
- Treatment frequency should be commensurate with the severity of the chief complaint.
- When significant improvements in patient's subjective findings and objective findings are demonstrated—continued treatment with decreased frequency is appropriate.
- As treatment progresses, one should see an increase in the active regimen of care, a decrease in the passive regimen of care, and a fading of treatment frequency.
- If the condition has not progressed towards resolution, refer the patient to an appropriate health care provider to explore other treatment alternatives.
- eviCore's consideration of requests for continued acupuncture treatment depends on updated clinical information submitted regarding patient's progress.
- Adequate and legible patient progress information that contains a history and examination, and/or eviCore's Acupuncture Treatment Request Form is required to determine medical necessity.
- In addition to improvements in the table below, significant progress may also be documented by increases in functional capacity and increasingly longer durations of pain relief.
- Discharge occurs when reasonable functional goals and expected outcomes have been achieved.
- The patient is discharged when the patient/care-giver can continue management of symptoms with an independent home program.
- Treatment is discontinued when the patient is unable to progress towards outcomes because of medical complications, psychosocial factors or other personal circumstances.
- If the member has been non-compliant with treatment as is evidenced by the clinical documentation, and/or the lack of demonstrated progress, treatment will be deemed to be not medically necessary and the member should be discharged from treatment.

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Week	Progress
0-1	◆ Some reduction of pain severity and frequency ◆ Some reduction of muscle spasm
2-4	◆ 50% improvement in pain severity and frequency ◆ 50% increase in function ◆ Pain distribution is centralizing ◆ Reinforce self-management techniques
5-8	◆ Continued reduction of pain severity and frequency ◆ Continued increase in function ◆ Pain distribution continues to centralize ◆ Reinforce self-management techniques
9-12	◆ 75% improvement in pain severity and frequency ◆ 75% improvement in function ◆ Pain distribution is centralized to back ◆ Reinforce self-management techniques
13-16	◆ Gradual improvement leading toward resolution ◆ Reinforce self-management techniques ◆ Discharge patient to elective care, or to their primary care provider for alternative treatment options when a plateau is reached, or by week 16, whichever occurs first

Referral Guidelines

- Improvement has reached a plateau
- Fever, chills, unexplained weight loss, significant night time pain
- Presence of pathological fracture
- Obvious deformity
- Saddle anesthesia
- Loss of major motor function
- Bowel or bladder dysfunction
- Abdominal pain
- Visceral dysfunction
- Increasing neurologic signs/symptoms: increasing lower extremity weakness, increasing lower extremity pain, increasing lower extremity numbness/tingling, and decreasing lower extremity reflexes

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Appropriate Procedures/ Modalities

- Acupuncture
- Electro-acupuncture
- Cupping
- Moxibustion
- Gua Sha
- Myofascial release
- Acupressure
- Trigger point massage
- Tui Na (not to include osseous manipulation)
- Herbal formulas

Note: Not all of these modalities are covered by the patient's health-plan; review documentation regarding coverage. Acupuncture and herbs must be appropriate for covered diagnoses under the patient's insurance policy. Acupuncturist is responsible for determining which procedures/modalities are most appropriate for the patient's condition.

Inappropriate Procedures/Modalities

- Scarring moxa
- Applied kinesiology techniques
- Electro-acupuncture using more than 9 volts
- Any techniques outside of the scope of practice in your state

Self-Management Techniques

- Rest and reduce strenuous activities
- Ergonomics, Postural advice, postural exercises
- Appropriate exercises/stretching
- Tai Qi, Qi Gong, Yoga
- Stress management, meditation
- Joint protection
- Weight loss
- Self-massage, Self-acupressure
- Hot packs/cold packs, if needed, to relieve discomfort
- Lumbar stabilization exercises
- Aerobic conditioning, such as walking or swimming

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Alternatives to Oriental Medicine Management

(listed in alphabetical order)

- Chiropractic
- Dietary/Nutritional Medicine Counseling
- Injection therapy/Pain management
- Massage therapy
- Medication
- Occupational therapy
- Osteopathic Manipulation
- Physical Therapy
- Psychological counseling
- Physiatry

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References

1. Balshem H, Helfand M, Schunemann HJ, Oxman AD, Kunz R, Brozek J, et al. GRADE guidelines: 3. Rating the quality of evidence. J Clin Epidemiol. 2011 Apr;64(4):401-6. doi:10.1016/j.jclinepi.2010.07.015.
2. Brinkhaus B, Witt CM, Jena S, Linde K, Streng A, Wagenpfeil S, Irnich D, Walther HU, Melchart D, Willich SN. Acupuncture in patients with chronic low back pain: a randomized controlled trial. Arch Intern Med. 2006 Feb 27;166(4):450-7. doi:10.1001/archinte.166.4.450.
3. Cheng X, Deng L. Chinese Acupuncture and Moxibustion. Beijing: Foreign Language Press; 2010.
4. Cherkin DC, Sherman KJ, Avins AL, Erro JH, Ichikawa L, Barlow WE, Delaney K, Hawkes R, Hamilton L, Pressman A, Khalsa PS, Deyo RA. A randomized trial comparing acupuncture, simulated acupuncture, and usual care for chronic low back pain. Arch Intern Med. 2009 May 11;169(9):858-66. doi:10.1001/archinternmed.2009.65.
5. Chou R, Deyo R, Friedly J, Skelly A, Hashimoto R, Weimer M, et al. AHRQ Comparative Effectiveness Reviews. Noninvasive Treatments for Low Back Pain. Rockville (MD): Agency for Healthcare Research and Quality (US); 2016.
6. Chou R, Deyo R, Friedly J, Skelly A, Hashimoto R, Weimer M, et al. Nonpharmacologic Therapies for Low Back Pain: A Systematic Review for an American College of Physicians Clinical Practice Guideline. Ann Intern Med. 2017;166:493–505. doi:10.7326/M16-2459.
7. Furlan A, Tulder M, Cherkin D, Tsukayama H, Lao L, Koes B, Berman B. Acupuncture and dry-needling for low back pain. Cochrane Database Syst Rev. 2005 Jan 25; (1): CD001351. doi:10.1002/14651858.CD001351.pub2.
8. Haake M, Müller HH, Schade-Brittinger C, Basler HD, Schäfer H, Maier C, Endres HG, Trampisch HJ, Molsberger A. German Acupuncture Trials (GERAC) for chronic low back pain: randomized, multicenter, blinded, parallel-group trial with 3 groups. Arch Intern Med. 2007 Sep 24;167(17):1892-8. doi:10.1001/archinte.167.17.1892.
9. Hempel S, Taylor SL, Solloway MR, Miake-Lye IM, Beroes JM, Shanman R, et al. VA Evidence-based Synthesis Program Reports. Evidence Map of Acupuncture. Washington (DC): Department of Veterans Affairs; 2014.
10. Horn KK, Jennings S, Richardson G, Vliet DV, Hefford C, Abbott JH. The patient-specific functional scale: psychometrics, clinimetrics, and application as a clinical outcome measure. J Orthop Sports Phys Ther. 2012 Jan;42(1):30-42. doi:10.2519/jospt.2012.3727.
11. Kaptchuk T. The Web That Has No Weaver. Contemporary Books. 2000.
12. Kelly RB. Acupuncture for pain. Am Fam Physician. 2009 Sep 1;80(5):481-4.
13. Kligler B, Nielsen A, Kohrrer C, Schmid T, Waltermaurer E, Perez E, Merrell W. Acupuncture Therapy in a Group Setting for Chronic Pain. Pain Med. 2017 Jun 8. doi:10.1093/pm/pnx134.
14. Lam M, Galvin R, Curry P. Effectiveness of acupuncture for nonspecific chronic low back pain: a systematic review and meta-analysis. Spine (Phila Pa 1976). 2013 Nov 15;38(24):2124-38. doi:10.1097/01.brs.0000435025.65564.b7.
15. Lee JH, Choi TY, Lee MS, Lee H, Shin BC, Lee H. Acupuncture for acute low back pain: a systematic review. Clin J Pain. 2013 Feb;29(2):172-85. doi:10.1097/AJP.0b013e31824909f9.
16. Lewis K, Abdi S. Acupuncture for lower back pain: a review. Clin J Pain. 2010 Jan;26(1):60-9. doi:10.1097/AJP.0b013e3181bad71e.
17. Lewis RA, Williams NH, Sutton AJ, Burton K, Din NU, Matar HE, et al. Comparative clinical effectiveness of management strategies for sciatica: systematic review and network meta-analyses. Spine J. 2015 Jun 1;15(6):1461-77. doi:10.1016/j.spinee.2013.08.049.
18. Li X, Wang R, Xing X, et al. Acupuncture for Myofascial Pain Syndrome: A Network Meta-Analysis of 33 Randomized Controlled Trials. Pain Physician. 2017 Sep;20(6):E883-E902.
19. Liu L, Skinner M, McDonough S, Mabire L, Baxter GD. Acupuncture for low back pain: an overview of systematic reviews. Evid Based Complement Alternat Med. 2015;2015:328196. doi:10.1155/2015/328196.
20. Maciocia G. The Foundations of Chinese Medicine: A Comprehensive Text; Churchill Livingstone, 2005.
21. MacPherson H, Vertosick EA, Foster NE, Lewith G, Linde K, Sherman KJ, et al. The persistence of the effects of acupuncture after a course of treatment: A meta-analysis of patients with chronic pain. Pain. 2016 Oct 17. doi:10.1097/j.pain.0000000000000747
22. Magee DJ. Orthopedic Physical Assessment, Second Edition, W.B. Saunders Company, 2007

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23. Manheimer E, White A, Berman B, Forys K, Ernst E. Meta-analysis: acupuncture for low back pain. Ann Intern Med. 2005 Apr 19;142(8):651-63. doi:10.7326/0003-4819-142-8-200504190-00014.
24. McDonald J, Janz S. The Acupuncture Evidence Project: A Comparative Literature Review (Revised Edition). Brisbane: Australian Acupuncture and Chinese Medicine Association Ltd; 2017. Date last accessed 01/15/18.
25. National Health and Medical Research Council. NHMRC additional levels of evidence and grades for recommendations for developers of guidelines. Table 3. NHMRC Evidence Hierarchy: designations of 'levels of evidence' according to type of research question (including explanatory notes). National Health and Medical Research Council; 2009.
26. O'Connor J, Bensky D. Acupuncture: A Comprehensive Text. Chicago: Eastland Press; 1981.
27. Olson WH, Brumback RA, Gascon G, Iyer V; Handbook of Symptom Oriented Neurology; Year Book Medical Publishers, Inc.; 2002.
28. Porter R. The Merck Manual, Merck, 2011.
29. Roy S, Irvin R, Iverson D. Sports Medicine, Prevention, Education, Management, and Rehabilitation, Benjamin Cummings, 1998.
30. Rubinstein SM, van Middelkoop M, Kuijpers T, Ostelo R, Verhagen AP, de Boer MR, Koes BW, van Tulder MW. A systematic review on the effectiveness of complementary and alternative medicine for chronic non-specific low-back pain. Eur Spine J. 2010 Aug;19(8):1213-28. doi:10.1007/s00586-010-1356-3.
31. Tang S, Mo Z, Zhang R. Acupuncture for lumbar disc herniation: a systematic review and meta-analysis. Acupunct Med. 2018 Apr;36(2):62-70. doi:10.1136/acupmed-2016-011332.
32. Thomas KJ, Macpherson H, Thorpe L, Brazier J, Fitter M, Campbell MJ, Roman M, Walters SJ, Nicholl J. Randomised controlled trial of a short course of traditional acupuncture compared with usual care for persistent non-specific low back pain. BMJ. 2006 Sep 15.
33. Trigkilidas D. Acupuncture therapy for chronic lower back pain: a systematic review. Annals of The Royal College of Surgeons of England. 2010;92(7):595-598. doi:10.1308/003588410X12699663904196.
34. Wang R, Li X, Zhou S, Zhang X, Yang K, Li X. Manual acupuncture for myofascial pain syndrome: a systematic review and meta-analysis. Acupunct Med. 2017 Aug;35(4):241-250. doi:10.1136/acupmed-2016-011176.
35. Weinstein S Buckwalter J. Orthopaedics Principles and Their Applications. Lippincott, Williams, & Wilkins, 2005.
36. Xiang A, Cheng K, Shen X, Xu P, Liu S. The Immediate Analgesic Effect of Acupuncture for Pain: A Systematic Review and Meta-Analysis. Evid Based Complement Alternat Med. 2017;2017:3837194. doi:10.1155/2017/3837194.
37. Yuan J, Purepong N, Hunter RF, Kerr DP, Park J, Bradbury I, McDonough S. Different frequencies of acupuncture treatment for chronic low back pain: an assessor-blinded pilot randomised controlled trial. Complement Ther Med. 2009 Jun;17(3):131-40. doi:10.1016/j.ctim.2008.10.003.
38. Yuan Q-l, Guo T-m, Liu L, Sun F, Zhang Y-g. Traditional Chinese Medicine for Neck Pain and Low Back Pain: A Systematic Review and Meta-Analysis. PLoS ONE 2015:10(2); e0117146. doi:10.1371/ journal.pone.0117146.
39. Zhao HJ, Tan JY, Wang T, Jin L. Auricular therapy for chronic pain management in adults: A synthesis of evidence. Complement Ther Clin Pract. 2015 May;21(2):68-78. doi:10.1016/j.ctcp.2015.03.006.

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ACU-6.2: Lumbar, Post-Surgical Syndrome

Synonyms

- Post Fusion Syndrome
- Post Discectomy Syndrome
- Post Laminectomy Syndrome
- Failed Spinal Surgery Syndrome
- Low back pain, leg pain

Definition

Condition that results following a laminectomy procedure in the lumbar spine region, in which the patient continues to present with abnormal findings in strength, range of motion, and pain referred to the sacro-iliac and/or the lower extremity. Patient may also have altered reflexes and sensations.

Because multiple factors can contribute to this syndrome, patients are considered to be suffering from a chronic pain syndrome. It is recommended that patients be treated by a multidisciplinary team including at least an MD/anesthesiologist, physical therapist or occupational therapist to help manage the rehabilitation.

Oriental Medicine Diagnoses

- Qi and Blood Stagnation:
  - This stagnation results in a painful condition, may have numerous causation, but for this diagnosis trauma is the primary causation, perhaps with underlying Qi deficiency syndrome.
- Damp Bi, Stationary (Damp) Painful Obstruction:
  - Pain is localized and does not move.
- Cold Bi, Painful (Cold) Painful Obstruction:
  - Severe pain in one part, or over one half of the body, which becomes worse when patient encounters cold and diminishes when patient is warm.
- Heat Bi, Heat Painful Obstruction:
  - Flesh is hot, area of pain is red and swollen, pain increases upon contact.
- Bi Syndrome:
  - Condition can be any combination of the above.
- Kidney Yin and Yang Deficiency: Underlying condition with additional symptoms caused by either illness, stress, and/or lifestyle choices that result in depletion of this energy, or congenital insufficiency.
- Kidney Qi and Liver Blood Deficiency: Can result from lifestyle choices that diminish Qi and blood, chronic illness.

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History

- Patient history may include:
  - General demographics
  - Occupation/employment
  - Hand dominance
  - Living environment
  - History of current condition
  - Functional status & activity level
  - Medications
  - Other tests and measurements (laboratory and diagnostic tests)
  - Past history (including history of prior Oriental Medicine treatment, and response to prior treatment)
  - In addition to the standard information gathered, a complete understanding of the surgical procedure performed should be obtained from surgeon.

Specific Aspects of History

- Rule out red flags (require medical management).
- Identify co-morbidities requiring medical management, and those that affect acupuncture and Oriental Medicine management.
- Determine if trauma-related; determine nature and extent of traumatic event.
- Determine OPQRST (Onset, Provocative/Palliative factors, Quality, Radiation/Referral pattern, Site [location], Timing of complaint).

Red Flag	Possible Consequence or Cause	Action Required
Severe trauma	Fracture	Immediate referral to emergency department
Onset following minor fall or heavy lifting in elderly or osteoporotic patient	Fracture	Immediate referral to emergency department
Direct blow to the back in young adult	Fracture	Immediate referral to emergency department
Saddle anesthesia	Cauda equina syndrome	Immediate referral to emergency department
Severe or progressive neurologic complaints	Cauda equina syndrome	Immediate referral to emergency department
Global or progressive motor weakness in the lower extremities	Cauda equina syndrome	Immediate referral to emergency department
Recent onset of bowel dysfunction or acute onset of bladder dysfunction in association with low back pain	Cauda equina syndrome	Immediate referral to emergency department
Fever, recent bacterial infection or recent surgery	Infection	Prompt referral to Primary Care Provider
Intravenous drug abuse or immunosuppression	Infection	Prompt referral to Primary Care Provider
Prolonged steroid use	Osteoporosis	Prompt referral to Primary Care Provider

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Presentation

Patients presenting with altered sensation, diminished reflexes, or changes in bowel or bladder function should be cleared for treatment by medical/surgical physician. Patient may have post-surgical precautions that vary by surgeon.

Subjective Findings

- Pain, numbness, tingling, paresthesias in the lower extremity following lumbar nerve root distribution
- Complains of weakness in the lower extremity
- Midline disc protrusions may involve both extremities
- Better with rest
- Flexing knee may provide relief by decreasing tension on irritated lumbar nerve
- Complains of pain and stiffness in the low back
- Worse with prolonged sitting, standing, bending, stooping, lifting
- Pain should be documented as a numeric pain scale 0-10
- Lower extremity symptom frequency, duration and numeric pain scale should be documented

Functional Assessment

- Documentation of a patient's level of function is an important aspect of patient care. This documentation is required in order to establish the medical necessity of ongoing acupuncture treatment. The Patient Specific Functional Scale (PSFS) is a patient reported outcome assessment that is easy and appropriate for acupuncturists to use. The PSFS has been studied in peer-reviewed scientific literature, and it has been proven to be a valid, reliable, and responsive measure for a variety of pain syndromes (neck, back, knee, etc.).

Objective Findings

- Pain at surgical site, particularly with movement
- Swelling
- Weakness
- Limited range of motion
- Impaired motor function
- Restrictions/precautions set by surgeon (bracing, weight bearing)

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Scope of Lumbar and Lower Extremity Examination

- All of the following objective tests may not be appropriate, but should be assessed according to the member's condition and surgery type:
  - Pain: Determine OPQRST (Onset, Provocative/Palliative factors, Quality, Radiation/Referral pattern, Site [location], Timing of complaint). Observe surgical precautions.
  - Skin/Wound Integrity: Skin characteristics (blistering, color, sensation, temperature, texture), Surgical wound (signs of infection, scar tissue characteristics, stage of healing). Observe surgical precautions.
  - Palpation of bony and soft tissue: Palpate involved muscles for tender nodule, taut band, tight ropiness, Observe pattern of referred pain, Provocation tests. Observe surgical precautions.
  - Edema (measure both sides for comparison): Girth measurements, Palpation, Volume measurements. Observe surgical precautions.
  - Postural assessment: Postural alignment and position. Observe surgical precautions.
  - Range of motion: Active and passive movement of affected area and joint above and below and contralateral joints, Functional range of motion (e.g. squat tests, toe touch tests). Observe surgical precautions.
  - Manual Muscle Testing: Test related joints. Observe surgical precautions.
  - Assistive, protective and supportive devices
  - Neurologic tests: Proprioception, Sensation. Observe surgical precautions.
  - Gait and Locomotion: Gait indexes, Mobility skills profiles, Functional assessment profiles. Observe surgical precautions.
  - Motor Function Tests: Use standardized tests appropriate to the affected area. Observe surgical precautions.

Specific Aspects of Lumbar, Post Laminectomy Syndrome

- Examine the musculoskeletal system for possible causes or contributing factors to the complaint.
- Evaluate for potential of post-surgical complications or other red flags. Refer appropriately if signs or symptoms of post-surgical complications develop.

Notes: Extra spinal diseases that may refer pain to the back include: aortic aneurysm, colon cancer, pancreatic cancer, endometriosis, hip disease, kidney disease (especially Pyelonephritis), kidney stones, ovarian disease, pancreatitis, pelvic infections, tumors or cysts of the reproductive tract, uterine cancer.

The most serious cause of low back pain is malignant tumor. Most malignant tumors are metastatic and some may cause bony collapse and paralysis. Cancers that most commonly metastasize to bone consist of adrenal, breast, kidney, lung, prostate, and thyroid.

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Findings of Lumbar Examination

- Posture may be antalgic
- Lumbar range of motion restrictions may be present by pain or precaution
- Muscle spasms in corresponding myotomes
- Nerve root tension signs (SLR, Braggards) are typically positive but may be absent in cases involving a free fragment of disc tissue
- Positive flip sign (leaning back when the knee is extended from seated position combined with positive SLR (leg pain below knee) at less than 45 degrees is highly indicative of lumbar disc herniation
- Dejerine's triad may be positive
- Dural tension signs
- Extremities symptoms and findings, if present, follow nerve root pattern:
  - Sensory abnormalities in dermatome
  - Loss of reflex
  - Motor power weakness of upper extremity
  - Decreased upper extremity girth may be present

Differential Diagnoses

- Extra spinal nerve entrapment (due to abdominal or pelvic mass)
- Cauda equina syndrome (saddle anesthesia, bladder or bowel dysfunction, bilateral involvement)
- Myelopathy due to thoracic disc herniation
- Demyelinating disease
- Lateral femoral cutaneous nerve entrapment (lateral thigh, sensory only, reverse SLR or femoral nerve stretch test)
- Trochanteric bursitis (no nerve root tension signs, pain on lateral thigh/leg, exquisite tenderness to palpation over trochanter)
- Symptoms may arise from lesions or pathology other than the surgical level

Note: Approximately 5% of lumbar radiculopathies involve L4 nerve root; 67%, L5 nerve root; and 28%, S1 nerve root.

- Signs of upper motor neuron involvement (clonus, hyperreflexia, Babinski reflex) may suggest compression of the spinal cord, which should be evaluated medically.

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Oriental Medicine Management [22, 35, 38, 41]

- Post-surgical rehabilitation should be managed by a multidisciplinary team including at least an MD and a physical therapist. Active rehabilitation, including physical therapy and occupational therapy, is critical for optimal recovery. The goal is to transition the patient as quickly as possible to active care, self-management and functional independence.
- Confirmation of appropriate medical co-management is always required when treating children age 14 and under.
- Treatment frequency should be commensurate with severity of the chief complaint.
- When significant improvements in patient's subjective findings and objective findings are demonstrated—continued treatment with decreased frequency is appropriate.
- As treatment progresses, one should see an increase in the active regimen of care, a decrease in the passive regimen of care, and a fading of treatment frequency.
- If the condition has not progressed towards resolution, refer the patient to an appropriate health care provider to explore other treatment alternatives.
- eviCore's consideration of requests for continued acupuncture treatment depends on updated clinical information submitted regarding patient's progress.
- Adequate and legible patient progress information that contains a history and examination, and/or eviCore's Acupuncture Treatment Request Form is required to determine medical necessity.
- In addition to improvements in the table below, significant progress may also be documented by increases in functional capacity and increasingly longer durations of pain relief.
- Discharge occurs when reasonable functional goals and expected outcomes have been achieved.
- The patient is discharged when the patient/care-giver can continue management of symptoms with an independent home program.
- Treatment is discontinued when the patient is unable to progress towards outcomes because of medical complications, psychosocial factors or other personal circumstances.
- If the member has been non-compliant with treatment as is evidenced by the clinical documentation, and/or the lack of demonstrated progress, treatment will be deemed to be not medically necessary and the member should be discharged from treatment.

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Week	Progress
0-1	◆ Some reduction of pain severity and frequency ◆ Some reduction of muscle spasm ◆ Observation of post-surgical activity restrictions, if any
2-4	◆ 50% improvement in pain severity and frequency ◆ Meet functional goals set by MD, PT or OT Observation of post-surgical activity restrictions, if any ◆ Pain distribution is centralizing ◆ Reinforce self-management techniques
5-8	◆ Continued reduction of pain severity and frequency ◆ Meet functional goals set by MD, PT or OT Observation of post-surgical activity restrictions, if any ◆ Pain distribution continues to centralize ◆ Reinforce self-management techniques
9-12	◆ 75% improvement in pain severity and frequency ◆ Meet functional goals set by MD, PT or OT Observation of post-surgical activity restrictions, if any ◆ Pain distribution is centralized to back ◆ Reinforce self-management techniques
13-16	◆ Gradual improvement leading toward resolution of pain ◆ Meet functional goals set by MD, PT or OT ◆ Reinforce self-management techniques ◆ Discharge patient to elective care, active rehabilitation, or to their primary care provider for alternative treatment options when a plateau is reached, or by week 16, whichever occurs first

Referral Guidelines

- Atrophy of lower extremity
- Signs of demyelinating condition, tumor or infection
- Increasing neurologic signs/symptoms: increasing LE numbness/tingling, increasing LE weakness, increasing LE pain, and/or decreasing LE reflexes.
- Improvement has reached a plateau
- Signs or symptoms of any post-surgical complication or red flag

Appropriate Procedures/ Modalities

- Acupuncture
- Electro-acupuncture
- Cupping
- Moxibustion
- Gua Sha
- Myofascial release
- Acupressure
- Trigger point massage

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- Tui Na (not to include osseous manipulation)
- Herbal formulas

Note: Not all of these modalities are covered by the patient's health-plan; review documentation regarding coverage. Acupuncture and herbs must be appropriate for covered diagnoses under the patient's insurance policy. Acupuncturist is responsible for determining which procedures/modalities are most appropriate for the patient's condition.

Inappropriate Procedures/Modalities

- Scarring moxa
- Applied kinesiology techniques
- Electro-acupuncture using more than 9 volts
- Any technique outside the scope of practice in your state

Self-Management Techniques

- Observation of surgical restrictions/precautions
- Rest and reduce strenuous activities
- Use of home medical equipment as advised by MD or PT
- Gradual increase in activity
- Compliance with home exercise/stretching program as assigned by PT
- Cold packs after incision heals, or as directed by MD
- Ergonomics, Postural advice, postural exercises
- Appropriate exercises/stretching
- Tai Qi, Qi Gong, Yoga
- Stress management, meditation
- Joint protection
- Weight loss
- Self-massage, Self-acupressure

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Alternatives to Oriental Medicine Management

(listed in alphabetical order)

- Chiropractic
- Dietary/Nutritional Medicine Counseling
- Injection therapy/Pain management
- Massage therapy
- Medication
- Occupational therapy
- Osteopathic Manipulation
- Physical Therapy
- Psychological counseling

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References

1. Balshem H, Helfand M, Schunemann HJ, Oxman AD, Kunz R, Brozek J, et al. GRADE guidelines: 3. Rating the quality of evidence. J Clin Epidemiol. 2011 Apr;64(4):401-6. doi:10.1016/j.jclinepi.2010.07.015.
2. Brinkhaus B, Witt CM, Jena S, Linde K, Streng A, Wagenpfeil S, Irnich D, Walther HU, Melchart D, Willich SN. Acupuncture in patients with chronic low back pain: a randomized controlled trial. Arch Intern Med. 2006 Feb 27;166(4):450-7. doi:10.1001/archinte.166.4.450.
3. Chen W-T, Fu G-Q, Shen W-D. [Progresses of studies on acupuncture analgesia for postoperative reaction]. Zhen Ci Yan Jiu. 2013;38(1):83-87.
4. Cheng X, Deng L. Chinese Acupuncture and Moxibustion. Beijing: Foreign Language Press; 2010.
5. Cherkin DC, Sherman KJ, Avins AL, Erro JH, Ichikawa L, Barlow WE, Delaney K, Hawkes R, Hamilton L, Pressman A, Khalsa PS, Deyo RA. A randomized trial comparing acupuncture, simulated acupuncture, and usual care for chronic low back pain. Arch Intern Med. 2009 May 11;169(9):858-66. doi:10.1001/archinternmed.2009.65.
6. Cho YH, Kim CK, Heo KH, Lee MS, Ha IH, Son DW, et al. Acupuncture for acute postoperative pain after back surgery: a systematic review and meta-analysis of randomized controlled trials. Pain Pract. 2015 Mar;15(3):279-91. doi:10.1111/papr.12208.
7. Chou R, Deyo R, Friedly J, Skelly A, Hashimoto R, Weimer M, et al. AHRQ Comparative Effectiveness Reviews. Noninvasive Treatments for Low Back Pain. Rockville (MD): Agency for Healthcare Research and Quality (US); 2016.
8. Chou R, Deyo R, Friedly J, Skelly A, Hashimoto R, Weimer M, et al. Nonpharmacologic Therapies for Low Back Pain: A Systematic Review for an American College of Physicians Clinical Practice Guideline. Ann Intern Med. 2017;166:493–505. doi:10.7326/M16-2459.
9. Fuentealba Cargill F, Biagini Alarcón L. Acupuncture for postoperative pain, a literature review. Rev Med Chil. 2016;144(3):325-332. doi:10.4067/S0034-98872016000300007.
10. Furlan A, Tulder M, Cherkin D, Tsukayama H, Lao L, Koes B, Berman B. Acupuncture and dry-needling for low back pain. Cochrane Database Syst Rev. 2005 Jan 25; (1): CD001351. doi:10.1002/14651858.CD001351.pub2.
11. Haake M, Müller HH, Schade-Brittinger C, Basler HD, Schäfer H, Maier C, Endres HG, Trampisch HJ, Molsberger A. German Acupuncture Trials (GERAC) for chronic low back pain: randomized, multicenter, blinded, parallel-group trial with 3 groups. Arch Intern Med. 2007 Sep 24;167(17):1892-8. doi:10.1001/archinte.167.17.1892.
12. Hempel S, Taylor SL, Solloway MR, Miake-Lye IM, Beroes JM, Shanman R, et al. VA Evidence-based Synthesis Program Reports. Evidence Map of Acupuncture. Washington (DC): Department of Veterans Affairs; 2014.
13. Horn KK, Jennings S, Richardson G, Vliet DV, Hefford C, Abbott JH. The patient-specific functional scale: psychometrics, clinimetrics, and application as a clinical outcome measure. J Orthop Sports Phys Ther. 2012 Jan;42(1):30-42. doi:10.2519/jospt.2012.3727.
14. Kaptchuk T. The Web That Has No Weaver. Contemporary Books. 2000.
15. Kelly RB. Acupuncture for pain. Am Fam Physician. 2009 Sep 1;80(5):481-4.
16. Kligler B, Nielsen A, Kohrrer C, Schmid T, Waltermaurer E, Perez E, Merrell W. Acupuncture Therapy in a Group Setting for Chronic Pain. Pain Med. 2017 Jun 8. doi:10.1093/pm/pnx134.
17. Lam M, Galvin R, Curry P. Effectiveness of acupuncture for nonspecific chronic low back pain: a systematic review and meta-analysis. Spine (Phila Pa 1976). 2013 Nov 15;38(24):2124-38. doi:10.1097/01.brs.0000435025.65564.b7.
18. Lee JH, Choi TY, Lee MS, Lee H, Shin BC, Lee H. Acupuncture for acute low back pain: a systematic review. Clin J Pain. 2013 Feb;29(2):172-85. doi:10.1097/AJP.0b013e31824909f9.
19. Lee MS, Ernst E. Acupuncture for surgical conditions: an overview of systematic reviews. Int J Clin Pract. 2014 Jun;68(6):783-9. doi:10.1111/ijcp.12372.
20. Lewis K, Abdi S. Acupuncture for lower back pain: a review. Clin J Pain. 2010 Jan;26(1):60-9. doi:10.1097/AJP.0b013e3181bad71e.
21. Lewis RA, Williams NH, Sutton AJ, Burton K, Din NU, Matar HE, et al. Comparative clinical effectiveness of management strategies for sciatica: systematic review and network meta-analyses. Spine J. 2015 Jun 1;15(6):1461-77. doi:10.1016/j.spinee.2013.08.049.
22. Li X, Wang R, Xing X, et al. Acupuncture for Myofascial Pain Syndrome: A Network Meta-Analysis of 33 Randomized Controlled Trials. Pain Physician. 2017 Sep;20(6):E883-E902.

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23. Liu L, Skinner M, McDonough S, Mabire L, Baxter GD. Acupuncture for low back pain: an overview of systematic reviews. Evid Based Complement Alternat Med. 2015;2015:328196. doi:10.1155/2015/328196.
24. Maciocia G. The Foundations of Chinese Medicine: A Comprehensive Text; Churchill Livingstone, 2005.
25. MacPherson H, Vertosick EA, Foster NE, Lewith G, Linde K, Sherman KJ, et al. The persistence of the effects of acupuncture after a course of treatment: A meta-analysis of patients with chronic pain. Pain. 2016 Oct 17. doi:10.1097/j.pain.0000000000000747
26. Magee, David J., Orthopedic Physical Assessment, Second Edition, W.B. Saunders Company, 2007.
27. Manheimer E, White A, Berman B, Forys K, Ernst E. Meta-analysis: acupuncture for low back pain. Ann Intern Med. 2005 Apr 19;142(8):651-63.doi:10.7326/0003-4819-142-8-200504190-00014.
28. McDonald J, Janz S. The Acupuncture Evidence Project: A Comparative Literature Review (Revised Edition). Brisbane: Australian Acupuncture and Chinese Medicine Association Ltd; 2017.
29. National Health and Medical Research Council. NHMRC additional levels of evidence and grades for recommendations for developers of guidelines. Table 3. NHMRC Evidence Hierarchy: designations of 'levels of evidence' according to type of research question (including explanatory notes). National Health and Medical Research Council; 2009.
30. O'Connor J, Bensky D. Acupuncture: A Comprehensive Text. Chicago: Eastland Press; 1981.
31. Olson WH, Brumback RA, Gascon G, Iyer V. Handbook of Symptom Oriented Neurology; Year Book Medical Publishers, Inc.; 2002.
32. Porter R. The Merck Manual, Merck, 2011.
33. Roy S, Irvin R, Iverson D; Sports Medicine, Prevention, Education, Management, and Rehabilitation, Benjamin Cummings, 1998.
34. Rubinstein SM, van Middelkoop M, Kuijpers T, Ostelo R, Verhagen AP, de Boer MR, Koes BW, van Tulder MW. A systematic review on the effectiveness of complementary and alternative medicine for chronic non-specific low-back pain. Eur Spine J. 2010 Aug;19(8):1213-28. doi:10.1007/s00586-010-1356-3.
35. Tang S, Mo Z, Zhang R. Acupuncture for lumbar disc herniation: a systematic review and meta-analysis. Acupunct Med. 2018 Apr;36(2):62-70. doi:10.1136/acupmed-2016-011332.
36. Thomas KJ, Macpherson H, Thorpe L, Brazier J, Fitter M, Campbell MJ, Roman M, Walters SJ, Nicholl J. Randomised controlled trial of a short course of traditional acupuncture compared with usual care for persistent non-specific low back pain. BMJ. 2006 Sep 15. doi:10.1136/bmj.38878.907361.7C.
37. Trigkilidas D. Acupuncture therapy for chronic lower back pain: a systematic review. Annals of The Royal College of Surgeons of England. 2010;92(7):595-598. doi:10.1308/003588410X12699663904196.
38. Wang R, Li X, Zhou S, Zhang X, Yang K, Li X. Manual acupuncture for myofascial pain syndrome: a systematic review and meta-analysis. Acupunct Med. 2017 Aug;35(4):241-250. doi:10.1136/acupmed-2016-011176.
39. Weinstein S, Buckwalter J. Orthopaedics Principles and Their Applications. Lippincott, Williams, & Wilkins, 2005.
40. Wu MS, Chen KH, Chen IF, Huang SK, Tzeng PC, Yeh ML, et al. The Efficacy of Acupuncture in Post-Operative Pain Management: A Systematic Review and Meta-Analysis. PLOS ONE. 2016;11(3):e0150367. doi:10.1371/journal.pone.0150367.
41. Xiang A, Cheng K, Shen X, Xu P, Liu S. The Immediate Analgesic Effect of Acupuncture for Pain: A Systematic Review and Meta-Analysis. Evid Based Complement Alternat Med. 2017;2017:3837194. doi:10.1155/2017/3837194.
42. Yuan J, Purepong N, Hunter RF, Kerr DP, Park J, Bradbury I, McDonough S. Different frequencies of acupuncture treatment for chronic low back pain: an assessor-blinded pilot randomised controlled trial. Complement Ther Med. 2009 Jun;17(3):131-40. doi:10.1016/j.ctim.2008.10.003.
43. Yuan Q-l, Guo T-m, Liu L, Sun F, Zhang Y-g (2015) Traditional Chinese Medicine for Neck Pain and Low Back Pain: A Systematic Review and Meta-Analysis. PLoS ONE, 10(2): e0117146. doi:10.1371/ journal.pone.0117146.

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44. Zhao HJ, Tan JY, Wang T, Jin L. Auricular therapy for chronic pain management in adults: A synthesis of evidence. Complement Ther Clin Pract. 2015 May;21(2):68-78. doi:10.1016/j.ctcp.2015.03.006.

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ACU-6.3: Lumbar Radiculopathy and Sciatica

Synonyms

- Lumbar root compression syndrome
- Neurogenic leg pain
- Lumbosacral Neuritis NOS
- Low back pain, leg pain

Definition

Neurogenic pain following the distribution of one, or less commonly, more lumbar nerve root(s) due to mechanical pressure and inflammation of the lower lumbar nerve roots. Pain may be acute or chronic. May be accompanied by lower extremity numbness, weakness, and/or hyporeflexia. May be due to lumbar disc herniation (younger patients) or bony mechanical pressure of lower lumbar nerve root(s) (older patients).

Oriental Medicine Diagnoses

- Qi and Blood Stagnation
  - Stagnation results in the painful condition; may have numerous causes; can be related to trauma or underlying syndromes.
- Kidney Qi and Liver Blood Deficiency
  - Can result from lifestyle choices that diminish Qi and Blood, chronic illness.

Bi Syndrome, Cold Damp with painful obstruction

Accumulation of Cold Damp can result from lifestyle choices that result in the underlying syndromes leading to this syndrome, external pathogens.

Note: While the above pathways represent classical causations for sciatica within the paradigm of Oriental Medicine diagnoses, they are not necessarily eligible for authorization or coverage under eviCore's acupuncture benefit plans. To be eligible for coverage and reimbursement, sciatica symptoms and/or a diagnosis of "sciatica" must be the direct result of a primary neuromusculoskeletal injury or illness.

History

- Patient history may include:
  - General demographics
  - Occupation/employment
  - Hand dominance
  - Living environment
  - History of current condition
  - Functional status & activity level
  - Medications
  - Other tests and measurements (laboratory and diagnostic tests)

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- Past history (including history of prior Oriental Medicine treatment, and response to prior treatment)

Specific Aspects of History

- Rule out red flags (require medical management).
- Identify co-morbidities requiring medical management, and those that affect acupuncture and Oriental Medicine management.
- Determine if trauma-related; determine nature and extent of traumatic event.
- Determine OPQRST (Onset, Provocative/Palliative factors, Quality, Radiation/Referral pattern, Site [location], Timing of complaint).
- Determine Oriental Medicine diagnosis.

Red Flag	Possible Consequence or Cause	Action Required
Severe trauma	Fracture	Immediate referral to emergency department
Onset following minor fall or heavy lifting in elderly or osteoporotic patient	Fracture	Immediate referral to emergency department
Direct Blow to the back in young adult	Fracture	Immediate referral to emergency department
Saddle anesthesia	Cauda equina syndrome	Immediate referral to emergency department
Severe or progressive neurologic complaints	Cauda equina syndrome	Immediate referral to emergency department
Global or progressive motor weakness in the lower extremities	Cauda equina syndrome	Immediate referral to emergency department
Recent onset of bowel dysfunction or acute onset of bladder dysfunction in association with low back pain	Cauda equina syndrome	Immediate referral to emergency department
Unexplained weight loss	Malignancy	Prompt referral to Primary Care Provider
Prior history of cancer	Malignancy	Prompt referral to Primary Care Provider
Pain that is worse with recumbency or worse at night	Malignancy	Prompt referral to Primary Care Provider
Fever or recent bacterial infection	Infection	Prompt referral to Primary Care Provider
Intravenous drug abuse or immunosuppression	Infection	Prompt referral to Primary Care Provider
Prolonged steroid use	Osteoporosis	Prompt referral to Primary Care Provider

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Presentation

Patient may report trauma or insidious onset. Incidence of disc herniation in patients over the age of 40 decreases due to dehydration of the nucleus pulposus.

Subjective Findings

- Pain, numbness, tingling, paresthesias in the lower extremity following lumbar nerve root distribution
- May complain of weakness in the lower extremity
- Midline disc protrusions may involve both extremities
- Better with rest
- Flexing knee may provide relief by decreasing tension on irritated lumbar nerve
- Pain should be documented as a numeric pain scale 0-10
- Lower extremity symptom frequency, duration and numeric pain scale should be documented

Functional Assessment

- Documentation of a patient's level of function is an important aspect of patient care. This documentation is required in order to establish the medical necessity of ongoing acupuncture treatment. The Patient Specific Functional Scale (PSFS) is a patient reported outcome assessment that is easy and appropriate for acupuncturists to use. The PSFS has been studied in peer-reviewed scientific literature, and it has been proven to be a valid, reliable, and responsive measure for a variety of pain syndromes (neck, back, knee, etc.).

Objective Findings

Scope of Lumbar Examination

- Inspection including Oriental Medicine inspection techniques
- Palpation of bony and soft tissue including Oriental Medicine inspection techniques
- Range of motion (when allowed by law)
- Orthopedic testing (when allowed by law)
- Neurologic testing (when allowed by law)

Specific Aspects of Examination

Examine the musculoskeletal system for possible causes or contributing factors to the complaint.

Notes: Extra spinal diseases that may refer pain to the back include: aortic aneurysm, colon cancer, endometriosis, hip disease, kidney disease, kidney stones, ovarian disease, pancreatitis, pelvic infections, tumors or cysts of the reproductive tract, uterine cancer.

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The most serious cause of low back pain is malignant tumor. Most malignant tumors are metastatic and some may cause bony collapse and paralysis. Cancers that most commonly metastasize to bone consist of adrenal, breast, kidney, lung, prostate, and thyroid.

Findings of Lumbar Radiculopathy or Sciatica

- Posture may be antalgic
- Lumbar range of motion restrictions may be present
- Muscle spasms in corresponding myotomes
- Nerve root tension signs (slr, braggards) are typically positive but may be absent in cases involving a free fragment of disc tissue
- Positive Kemp's test

Differential Diagnoses

- Extra spinal nerve entrapment (due to abdominal or pelvic mass)
- Cauda equina syndrome (saddle anesthesia, bladder or bowel dysfunction, bilateral involvement)
- Myelopathy due to thoracic disc herniation
- Demyelinating disease
- Lateral femoral cutaneous nerve entrapment (lateral thigh, sensory only, reverse SLR or femoral nerve stretch test).
- Trochanteric bursitis (no nerve root tension signs, pain on lateral thigh/leg, exquisite tenderness to palpation over trochanter).

Oriental Medicine Management [19, 33, 36, 38]

- Most patients with this diagnosis will already have consulted with their Primary Care Provider. If not, however, they should be directed to make an appointment with their MD at their earliest opportunity.
- Confirmation of appropriate medical co-management is always required when treating children age 14 and under.
- Oriental Medicine management goals are to resolve pain, restore the highest level of function possible, and educate the patient to prevent recurrent symptoms.
- To be considered medically necessary, patient’s symptoms must be the direct result of a primary neuromusculoskeletal injury or illness.
- Treatment frequency should be commensurate with severity of the chief complaint.
- When significant improvements in patient’s subjective findings and objective findings are demonstrated—continued treatment with decreased frequency is appropriate.

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- As treatment progresses, one should see an increase in the active regimen of care, a decrease in the passive regimen of care, and a fading of treatment frequency.
- If the condition has not progressed towards resolution, refer the patient to an appropriate health care provider to explore other treatment alternatives.
- eviCore's consideration of requests for continued acupuncture treatment depends on updated clinical information submitted regarding patient's progress.
- Adequate and legible patient progress information that contains a history and examination, and/or eviCore's Acupuncture Treatment Request Form is required to determine medical necessity.
- In addition to improvements in the table below, significant progress may also be documented by increases in functional capacity and increasingly longer durations of pain relief.
- Discharge occurs when reasonable functional goals and expected outcomes have been achieved.
- The patient is discharged when the patient/care-giver can continue management of symptoms with an independent home program.
- Treatment is discontinued when the patient is unable to progress towards outcomes because of medical complications, psychosocial factors or other personal circumstances.
- If the member has been non-compliant with treatment as is evidenced by the clinical documentation, and/or the lack of demonstrated progress, treatment will be deemed to be not medically necessary and the member should be discharged from treatment.

Week	Progress
0-1	◆ Some reduction of pain severity and frequency ◆ Some reduction of muscle spasm
2-4	◆ 50% improvement in pain severity and frequency ◆ 50% increase in function ◆ Pain distribution is centralizing ◆ Reinforce self-management techniques
5-8	◆ Continued reduction of pain severity and frequency ◆ Continued increase in function ◆ Pain distribution continues to centralize ◆ Reinforce self-management techniques
9-12	◆ 75% improvement in pain severity and frequency ◆ 75% improvement in function ◆ Pain distribution is centralized to back ◆ Reinforce self-management techniques
13-16	◆ Gradual improvement leading toward resolution ◆ Reinforce self-management techniques ◆ Discharge patient to elective care, or to their primary care provider for alternative treatment options when a plateau is reached, or by week 16, whichever occurs first

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Refer to PCP (HMO) or an orthopedic or neurosurgeon (PPO)—if there are increasing neurologic signs/symptoms: increasing LE numbness/tingling, increasing LE weakness, increasing LE pain, and/or decreasing LE reflexes, atrophy of extremity. Refer to primary care provider if patient is not progressing during treatment, and is only experiencing palliative relief from treatment or no benefit from treatment to rule out underlying conditions.

Appropriate Procedures/ Modalities

- Acupuncture
- Electro-acupuncture
- Cupping
- Moxibustion
- Gua Sha
- Myofascial release
- Acupressure
- Trigger point massage
- Tui Na (not to include osseous manipulation)
- Herbal formulas

Note: Not all of these modalities are covered by the patient's health-plan; review documentation regarding coverage. Acupuncture and herbs must be appropriate for covered diagnoses under the patient's insurance policy. Acupuncturist is responsible for determining which procedures/modalities are most appropriate for the patient's condition.

Inappropriate Procedures/Modalities

- Scarring moxa
- Applied kinesiology techniques
- Electro-acupuncture using more than 9 volts
- Any technique outside the scope of practice in your state

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Self-Management Techniques

- Rest and reduce strenuous activities
- Ergonomics, Postural advice, postural exercises
- Appropriate exercises/stretching
- Tai Qi, Qi Gong, Yoga
- Stress management, meditation
- Joint protection
- Weight loss
- Self-massage, Self-acupressure
- Hot packs/cold packs, if needed, to relieve discomfort
- Aerobic conditioning, swimming

Alternatives to Oriental Medicine Management

(listed in alphabetical order)

- Chiropractic
- Dietary/Nutritional Medicine Counseling
- Injection therapy/Pain management
- Massage therapy
- Medication
- Occupational therapy
- Osteopathic Manipulation
- Physical Therapy
- Psychological counseling
- Physiatry

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References

1. Balshem H, Helfand M, Schunemann HJ, Oxman AD, Kunz R, Brozek J, et al. GRADE guidelines: 3. Rating the quality of evidence. J Clin Epidemiol. 2011 Apr;64(4):401-6. doi:10.1016/j.jclinepi.2010.07.015.
2. Brinkhaus B, Witt CM, Jena S, Linde K, Streng A, Wagenpfeil S, Irnich D, Walther HU, Melchart D, Willich SN. Acupuncture in patients with chronic low back pain: a randomized controlled trial. Arch Intern Med. 2006 Feb 27;166(4):450-7. doi:10.1001/archinte.166.4.450.
3. Cheng X, Deng L. Chinese Acupuncture and Moxibustion. Beijing: Foreign Language Press; 2010.
4. Cherkin DC, Sherman KJ, Avins AL, Erro JH, Ichikawa L, Barlow WE, Delaney K, Hawkes R, Hamilton L, Pressman A, Khalsa PS, Deyo RA. A randomized trial comparing acupuncture, simulated acupuncture, and usual care for chronic low back pain. Arch Intern Med. 2009 May 11;169(9):858-66.
5. Chou R, Deyo R, Friedly J, Skelly A, Hashimoto R, Weimer M, et al. AHRQ Comparative Effectiveness Reviews. Noninvasive Treatments for Low Back Pain. Rockville (MD): Agency for Healthcare Research and Quality (US); 2016.
6. Chou R, Deyo R, Friedly J, Skelly A, Hashimoto R, Weimer M, et al. Nonpharmacologic Therapies for Low Back Pain: A Systematic Review for an American College of Physicians Clinical Practice Guideline. Ann Intern Med. 2017;166:493–505. doi:10.7326/M16-2459.
7. Furlan A, Tulder M, Cherkin D, Tsukayama H, Lao L, Koes B, Berman B. Acupuncture and dry-needling for low back pain. Cochrane Database Syst Rev. 2005 Jan 25; (1): CD001351. doi:10.1002/14651858.CD001351.pub2.
8. Haake M, Müller HH, Schade-Brittinger C, Basler HD, Schäfer H, Maier C, Endres HG, Trampisch HJ, Molsberger A. German Acupuncture Trials (GERAC) for chronic low back pain: randomized, multicenter, blinded, parallel-group trial with 3 groups. Arch Intern Med. 2007 Sep 24;167(17):1892-8. doi:10.1001/archinte.167.17.1892.
9. Hempel S, Taylor SL, Solloway MR, Miake-Lye IM, Beroes JM, Shanman R, et al. VA Evidence-based Synthesis Program Reports. Evidence Map of Acupuncture. Washington (DC): Department of Veterans Affairs; 2014.
10. Horn KK, Jennings S, Richardson G, Vliet DV, Hefford C, Abbott JH. The patient-specific functional scale: psychometrics, clinimetrics, and application as a clinical outcome measure. J Orthop Sports Phys Ther. 2012 Jan;42(1):30-42. doi:10.2519/jospt.2012.3727.
11. Ji M, Wang X, Chen M, Shen Y, Zhang X, Yang J. The Efficacy of Acupuncture for the Treatment of Sciatica: A Systematic Review and Meta-Analysis. Evid Based Complement Alternat Med. 2015;2015:192808. doi:10.1155/2015/192808.
12. Kaptchuk T. The Web That Has No Weaver. Contemporary Books. 2000.
13. Kelly RB. Acupuncture for pain. Am Fam Physician. 2009 Sep 1;80(5):481-4.
14. Kligler B, Nielsen A, Kohrrer C, Schmid T, Waltermaurer E, Perez E, Merrell W. Acupuncture Therapy in a Group Setting for Chronic Pain. Pain Med. 2017 Jun 8. doi:10.1093/pm/pnx134.
15. Lam M, Galvin R, Curry P. Effectiveness of acupuncture for nonspecific chronic low back pain: a systematic review and meta-analysis. Spine (Phila Pa 1976). 2013 Nov 15;38(24):2124-38. doi:10.1097/01.brs.0000435025.65564.b7.
16. Lee JH, Choi TY, Lee MS, Lee H, Shin BC, Lee H. Acupuncture for acute low back pain: a systematic review. Clin J Pain. 2013 Feb;29(2):172-85. doi:10.1097/AJP.0b013e31824909f9
17. Lewis K, Abdi S. Acupuncture for lower back pain: a review. Clin J Pain. 2010 Jan;26(1):60-9. doi:10.1097/AJP.0b013e3181bad71e.
18. Lewis RA, Williams NH, Sutton AJ, Burton K, Din NU, Matar HE, et al. Comparative clinical effectiveness of management strategies for sciatica: systematic review and network meta-analyses. Spine J. 2015 Jun 1;15(6):1461-77. doi:10.1016/j.spinee.2013.08.049.
19. Li X, Wang R, Xing X, et al. Acupuncture for Myofascial Pain Syndrome: A Network Meta-Analysis of 33 Randomized Controlled Trials. Pain Physician. 2017 Sep;20(6):E883-E902.
20. Liu L, Skinner M, McDonough S, Mabire L, Baxter GD. Acupuncture for low back pain: an overview of systematic reviews. Evid Based Complement Alternat Med. 2015;2015:328196. doi:10.1155/2015/328196.
21. Maciocia G. The Foundations of Chinese Medicine: A Comprehensive Text; Churchill Livingstone, 2005.

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22. MacPherson H, Vertosick EA, Foster NE, Lewith G, Linde K, Sherman KJ, et al. The persistence of the effects of acupuncture after a course of treatment: A meta-analysis of patients with chronic pain. Pain. 2016 Oct 17. doi:10.1097/j.pain.0000000000000747.
23. Magee DJ. Orthopedic Physical Assessment, Second Edition, W.B. Saunders Company, 2007.
24. Manheimer E, White A, Berman B, Forys K, Ernst E. Meta-analysis: acupuncture for low back pain. Ann Intern Med. 2005 Apr 19;142(8):651-63. doi:10.7326/0003-4819-142-8-200504190-00014.
25. McDonald J, Janz S. The Acupuncture Evidence Project: A Comparative Literature Review (Revised Edition). Brisbane: Australian Acupuncture and Chinese Medicine Association Ltd; 2017.
26. National Health and Medical Research Council. NHMRC additional levels of evidence and grades for recommendations for developers of guidelines. Table 3. NHMRC Evidence Hierarchy: designations of 'levels of evidence' according to type of research question (including explanatory notes). National Health and Medical Research Council; 2009.
27. O'Connor J, Bensky D. Acupuncture: A Comprehensive Text. Chicago: Eastland Press; 1981.
28. Olson WH, Brumback RA, Gascon G, Iyer V; Handbook of Symptom Oriented Neurology; Year Book Medical Publishers, Inc.; 2002.
29. Porter, R; The Merck Manual, Merck, 2011.
30. Qin Z, Liu X, Wu J, Zhai Y, Liu Z. Effectiveness of Acupuncture for Treating Sciatica: A Systematic Review and Meta-Analysis. Evid Based Complement Alternat Med. 2015;2015:425108. doi: 10.1155/2015/425108.
31. Roy S, Irvin R, Iverson D. Sports Medicine, Prevention, Education, Management, and Rehabilitation, Benjamin Cummings, 1998.
32. Rubinstein SM, van Middelkoop M, Kuijpers T, Ostelo R, Verhagen AP, de Boer MR, Koes BW, van Tulder MW. A systematic review on the effectiveness of complementary and alternative medicine for chronic non-specific low-back pain. Eur Spine J. 2010 Aug;19(8):1213-28. doi:10.1007/s00586-010-1356-3.
33. Tang S, Mo Z, Zhang R. Acupuncture for lumbar disc herniation: a systematic review and meta-analysis. Acupunct Med. 2018 Apr;36(2):62-70. doi:10.1136/acupmed-2016-011332.
34. Thomas KJ, Macpherson H, Thorpe L, Brazier J, Fitter M, Campbell MJ, Roman M, Walters SJ, Nicholl J. Randomised controlled trial of a short course of traditional acupuncture compared with usual care for persistent non-specific low back pain. BMJ. 2006 Sep 15. doi:10.1136/bmj.38878.907361.7C.
35. Trigkilidas D. Acupuncture therapy for chronic lower back pain: a systematic review. Annals of The Royal College of Surgeons of England. 2010;92(7):595-598. doi:10.1308/003588410X12699663904196.
36. Wang R, Li X, Zhou S, Zhang X, Yang K, Li X. Manual acupuncture for myofascial pain syndrome: a systematic review and meta-analysis. Acupunct Med. 2017 Aug;35(4):241-250. doi:10.1136/acupmed-2016-011176.
37. Weinstein S, Buckwalter J. Orthopaedics Principles and Their Applications. Lippincott, Williams, & Wilkins, 2005.
38. Xiang A, Cheng K, Shen X, Xu P, Liu S. The Immediate Analgesic Effect of Acupuncture for Pain: A Systematic Review and Meta-Analysis. Evid Based Complement Alternat Med. 2017;2017:3837194. doi:10.1155/2017/3837194.
39. Yuan J, Purepong N, Hunter RF, Kerr DP, Park J, Bradbury I, McDonough S. Different frequencies of acupuncture treatment for chronic low back pain: an assessor-blinded pilot randomised controlled trial. Complement Ther Med. 2009 Jun;17(3):131-40. doi:10.1016/j.ctim.2008.10.003.
40. Yuan Q-l, Guo T-m, Liu L, Sun F, Zhang Y-g (2015) Traditional Chinese Medicine for Neck Pain and Low Back Pain: A Systematic Review and Meta-Analysis. PLoS ONE 10(2): e0117146. doi:10.1371/ journal.pone.0117146.
41. Zhao HJ, Tan JY, Wang T, Jin L. Auricular therapy for chronic pain management in adults: A synthesis of evidence. Complement Ther Clin Pract. 2015 May;21(2):68-78. doi:10.1016/j.ctcp.2015.03.006.

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ACU-7.0: Lumbosacral Conditions (Non-Specific)

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ACU-7.1: Lumbago, Backache NOS

Synonyms

- Low back pain

Definition

Lumbago is a low back pain, nonspecific in origin and/or nature marked by a restriction of lumbar movements and reports of locking. Lumbago can be acute or chronic in nature; and is generally not used to describe episodes, which involve radicular symptoms.

Oriental Medicine Diagnoses

- Qi and Blood Stagnation
  - Stagnation results in pain; may have numerous causations; can be related to trauma or underlying syndromes.
- Kidney Yang Deficiency
  - Underlying condition with additional symptoms caused by either illness, stress, and/or lifestyle choices, such as irregular or “incorrect” food choice, irregular eating times, lack of sleep, excess of activities, which result in depletion of this energy, or congenital insufficiency.
- Bi Syndrome, Cold Damp with Painful Obstruction
  - Accumulation of Cold Damp can result from lifestyle choices, such as irregular or “incorrect” food choice, irregular eating times, lack of sleep, or external pathogens.

History

- Patient history may include:
  - General demographics
  - Occupation/employment
  - Hand dominance
  - Living environment
  - History of current condition
  - Functional status & activity level
  - Medications
  - Other tests and measurements (laboratory and diagnostic tests)
  - Past history (including history of prior Oriental Medicine treatment, and response to prior treatment)

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Specific Aspects of History

- Rule out red flags (require medical management).
- Identify co-morbidities requiring medical management, and those that affect acupuncture and Oriental Medicine management.
- Determine if trauma-related; determine nature and extent of traumatic event.

Red Flag	Possible Consequence or Cause	Action Required
Severe trauma	Fracture	Immediate referral to emergency department
Onset following minor fall or heavy lifting in elderly or osteoporotic patient	Fracture	Immediate referral to emergency department
Direct Blow to the back in young adult	Fracture	Immediate referral to emergency department
Saddle anesthesia	Cauda equina syndrome	Immediate referral to emergency department
Severe or progressive neurologic complaints	Cauda equina syndrome	Immediate referral to emergency department
Global or progressive motor weakness in the lower extremities	Cauda equina syndrome	Immediate referral to emergency department
Recent onset of bowel dysfunction or acute onset of bladder dysfunction; in association with low back pain	Cauda equina syndrome	Immediate referral to emergency department
Unexplained weight loss	Malignancy	Prompt referral to Primary Care Provider
Prior history of cancer	Malignancy	Prompt referral to Primary Care Provider
Pain that is worse with recumbency or worse at night	Malignancy	Prompt referral to Primary Care Provider
Fever or recent bacterial infection	Infection	Prompt referral to Primary Care Provider
Intravenous drug abuse or immunosuppression	Infection	Prompt referral to Primary Care Provider
Prolonged steroid use	Osteoporosis	Prompt referral to Primary Care Provider
Pain that does not change with change in position	Kidney disease	Immediate referral to emergency department

Presentation

Pain may arise gradually through repetitive stress, or suddenly due to injury or trauma. Location of pain may involve any area from the middle back to the glutes. Client may complain of a dull ache, stabbing pain, stiffness, or numbness.

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Subjective Findings

- Pain may be worse with motion
- Stiffness upon arising from a seated position
- May report history of occasional sciatica, but lower back symptoms predominate
- Essentially constant awareness of some level of back discomfort or limitations in motion
- Pain and stiffness in lower back
- Pain should be documented as a numeric pain scale 0-10

Functional Assessment

- Documentation of a patient's level of function is an important aspect of patient care. This documentation is required in order to establish the medical necessity of ongoing acupuncture treatment. The Patient Specific Functional Scale (PSFS) is a patient reported outcome assessment that is easy and appropriate for acupuncturists to use. The PSFS has been studied in peer-reviewed scientific literature, and it has been proven to be a valid, reliable, and responsive measure for a variety of pain syndromes (neck, back, knee, etc.).

Objective Findings

Scope of Lumbar Examination

- Inspection
- Palpation of bony and soft tissue
- Range of motion
- Motion palpation of spine
- Orthopedic testing
- Neurologic testing

Specific Aspects of Lumbar Examination

Examine the musculoskeletal system for possible causes or contributing factors to the complaint. Gather information that leads to a prognosis and the selection of appropriate interventions.

Note: The most serious cause of low back pain is malignant tumor. Most malignant tumors are metastatic and some may cause bony collapse and paralysis. Cancers that most commonly metastasize to bone consist of adrenal, breast, kidney, lung, prostate, and thyroid.

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Findings of Lumbago

- May relate tenderness to palpation in the lumbar spine and sacroiliac joints
- May demonstrate range of motion restrictions in the lumbar spine
- Neurological exam is generally negative

Differential Diagnoses

- Extra spinal causes (ovarian cyst, kidney stone, pancreatitis, ulcer)
- Osteoporosis and compression fractures (major trauma, or minor trauma in elderly/osteoporotic patient)
- Infection in disc or bone (fever, history of IV drug use, history of severe pain)
- Inflammatory arthritides (family history, patient age/sex, morning stiffness)
- Metastatic disease, myeloma, lymphoma (pathologic fracture, severe night pain)
- Spinal tuberculosis (lower socioeconomic groups, AIDS)
- Depression

Oriental Medicine Management [18, 33, 35]

- Oriental Medicine management goals are to resolve pain, restore the highest level of function possible, and educate the patient to prevent recurrent symptoms.
- To be considered medically necessary, patient's symptoms must be the direct result of a primary neuromusculoskeletal injury or illness.
- Confirmation of appropriate medical co-management is always required when treating children age 14 and under.
- Treatment frequency should be commensurate with severity of the chief complaint.
- When significant improvements in patient's subjective findings and objective findings are demonstrated—continued treatment with decreased frequency is appropriate.
- As treatment progresses, one should see an increase in the active regimen of care, a decrease in the passive regimen of care, and a fading of treatment frequency.
- If the condition has not progressed towards resolution, refer the patient to an appropriate health care provider to explore other treatment alternatives.
- eviCore's consideration of requests for continued acupuncture treatment depends on updated clinical information submitted regarding patient's progress.
- Adequate and legible patient progress information that contains a history and examination, and/or eviCore's Acupuncture Treatment Request Form is required to determine medical necessity.
- In addition to improvements in the table below, significant progress may also be documented by increases in functional capacity and increasingly longer durations of pain relief.

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- Discharge occurs when reasonable functional goals and expected outcomes have been achieved.
- The patient is discharged when the patient/care-giver can continue management of symptoms with an independent home program.
- Treatment is discontinued when the patient is unable to progress towards outcomes because of medical complications, psychosocial factors or other personal circumstances.
- If the member has been non-compliant with treatment as is evidenced by the clinical documentation, and/or the lack of demonstrated progress, treatment will be deemed to be not medically necessary and the member should be discharged from treatment.

Week	Progress
0-1	◆ Some reduction of pain severity and frequency ◆ Some reduction of muscle spasm
2-4	◆ 50% decrease in pain severity and frequency ◆ 50% improvement in function
5-8	◆ 75% decrease in pain severity and frequency ◆ 75% improvement in function
9-12	◆ Gradual improvement leading toward resolution ◆ Reinforce self-management techniques ◆ Discharge patient to elective care, or to their primary care provider for alternative treatment options when a plateau is reached, or by week 12, whichever occurs first

Referral Guidelines

- Improvement does not meet the above guidelines or improvement has reached a plateau
- Fever, chills, unexplained weight loss, significant night time pain
- Presence of pathological fracture
- Obvious deformity
- Saddle anesthesia
- Loss of major motor function
- Bowel or bladder dysfunction
- Abdominal pain
- Visceral dysfunction
- Increasing neurologic signs/symptoms: increasing lower extremity weakness, increasing lower extremity pain, increasing lower extremity numbness/tingling, and decreasing lower extremity reflexes

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Appropriate Procedures/ Modalities

- Acupuncture
- Electro-acupuncture
- Cupping
- Moxibustion
- Gua Sha
- Myofascial release
- Acupressure
- Trigger point massage
- Tui Na (not to include osseous manipulation)
- Herbal formulas

Note: Not all of these modalities are covered by the patient's health-plan; review documentation regarding coverage. Acupuncture and herbs must be appropriate for covered diagnoses under the patient's insurance policy. Acupuncturist is responsible for determining which procedures/modalities are most appropriate for the patient's condition.

Inappropriate Procedures/Modalities

- Scarring moxa
- Applied kinesiology techniques
- Electro-acupuncture using more than 9 volts
- Any technique outside the scope of practice in your state

Self-Management Techniques

- Rest and reduce strenuous activities
- Ergonomics, Postural advice, postural exercises
- Appropriate exercises/stretching
- Tai Qi, Qi Gong, Yoga
- Stress management, meditation
- Joint protection
- Weight loss
- Self-massage, Self-acupressure
- Hot packs/cold packs, if needed, to relieve discomfort

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Alternatives to Oriental Medicine Management

(listed in alphabetical order)

- Chiropractic
- Dietary/Nutritional Medicine Counseling
- Injection therapy/Pain management
- Massage therapy
- Medication
- Occupational therapy
- Osteopathic Manipulation
- Physical Therapy
- Psychological counseling
- Physiatry

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References

1. Balshem H, Helfand M, Schunemann HJ, Oxman AD, Kunz R, Brozek J, et al. GRADE guidelines: 3. Rating the quality of evidence. J Clin Epidemiol. 2011 Apr;64(4):401-6. doi:10.1016/j.jclinepi.2010.07.015.
2. Brinkhaus B, Witt CM, Jena S, Linde K, Streng A, Wagenpfeil S, Irnich D, Walther HU, Melchart D, Willich SN. Acupuncture in patients with chronic low back pain: a randomized controlled trial. Arch Intern Med. 2006 Feb 27;166(4):450-7. doi:10.1001/archinte.166.4.450.
3. Cheng X, Deng L. Chinese Acupuncture and Moxibustion. Beijing: Foreign Language Press; 2010.
4. Cherkin DC, Sherman KJ, Avins AL, Erro JH, Ichikawa L, Barlow WE, Delaney K, Hawkes R, Hamilton L, Pressman A, Khalsa PS, Deyo RA. A randomized trial comparing acupuncture, simulated acupuncture, and usual care for chronic low back pain. Arch Intern Med. 2009 May 11;169(9):858-66. doi:10.1001/archinternmed.2009.65.
5. Chou R, Deyo R, Friedly J, Skelly A, Hashimoto R, Weimer M, et al. AHRQ Comparative Effectiveness Reviews. Noninvasive Treatments for Low Back Pain. Rockville (MD): Agency for Healthcare Research and Quality (US); 2016.
6. Chou R, Deyo R, Friedly J, Skelly A, Hashimoto R, Weimer M, et al. Nonpharmacologic Therapies for Low Back Pain: A Systematic Review for an American College of Physicians Clinical Practice Guideline. Ann Intern Med. 2017;166:493–505. doi:10.7326/M16-2459.
7. Furlan A, Tulder M, Cherkin D, Tsukayama H, Lao L, Koes B, Berman B. Acupuncture and dry-needling for low back pain. Cochrane Database Syst Rev. 2005 Jan 25; (1): CD001351. doi:10.1002/14651858.CD001351.pub2.
8. Haake M, Müller HH, Schade-Brittinger C, Basler HD, Schäfer H, Maier C, Endres HG, Trampisch HJ, Molsberger A. German Acupuncture Trials (GERAC) for chronic low back pain: randomized, multicenter, blinded, parallel-group trial with 3 groups. Arch Intern Med. 2007 Sep 24;167(17):1892-8. doi:10.1001/archinte.167.17.1892.
9. Hempel S, Taylor SL, Solloway MR, Miake-Lye IM, Beroes JM, Shanman R, et al. VA Evidence-based Synthesis Program Reports. Evidence Map of Acupuncture. Washington (DC): Department of Veterans Affairs; 2014.
10. Horn KK, Jennings S, Richardson G, Vliet DV, Hefford C, Abbott JH. The patient-specific functional scale: psychometrics, clinimetrics, and application as a clinical outcome measure. J Orthop Sports Phys Ther. 2012 Jan;42(1):30-42. doi:10.2519/jospt.2012.3727.
11. Kaptchuk T. The Web That Has No Weaver. Contemporary Books. 2000.
12. Kelly RB. Acupuncture for pain. Am Fam Physician. 2009 Sep 1;80(5):481-4.
13. Kligler B, Nielsen A, Kohrrer C, Schmid T, Waltermaurer E, Perez E, Merrell W. Acupuncture Therapy in a Group Setting for Chronic Pain. Pain Med. 2017 Jun 8. doi:10.1093/pm/pnx134.
14. Lam M, Galvin R, Curry P. Effectiveness of acupuncture for nonspecific chronic low back pain: a systematic review and meta-analysis. Spine (Phila Pa 1976). 2013 Nov 15;38(24):2124-38. doi:10.1097/01.brs.0000435025.65564.b7.
15. Lee JH, Choi TY, Lee MS, Lee H, Shin BC, Lee H. Acupuncture for acute low back pain: a systematic review. Clin J Pain. 2013 Feb;29(2):172-85. doi:10.1097/AJP.0b013e31824909f9.
16. Lewis K, Abdi S. Acupuncture for lower back pain: a review. Clin J Pain. 2010 Jan;26(1):60-9. doi:10.1097/AJP.0b013e3181bad71e.
17. Lewis RA, Williams NH, Sutton AJ, Burton K, Din NU, Matar HE, et al. Comparative clinical effectiveness of management strategies for sciatica: systematic review and network meta-analyses. Spine J. 2015 Jun 1;15(6):1461-77. doi:10.1016/j.spinee.2013.08.049.
18. Li X, Wang R, Xing X, et al. Acupuncture for Myofascial Pain Syndrome: A Network Meta-Analysis of 33 Randomized Controlled Trials. Pain Physician. 2017 Sep;20(6):E883-E902.
19. Liu L, Skinner M, McDonough S, Mabire L, Baxter GD. Acupuncture for low back pain: an overview of systematic reviews. Evid Based Complement Alternat Med. 2015;2015:328196. doi:10.1155/2015/328196.
20. Maciocia G. The Foundations of Chinese Medicine: A Comprehensive Text; Churchill Livingstone, 2005.
21. MacPherson H, Vertosick EA, Foster NE, Lewith G, Linde K, Sherman KJ, et al. The persistence of the effects of acupuncture after a course of treatment: A meta-analysis of patients with chronic pain. Pain. 2016 Oct 17. doi:10.1097/j.pain.0000000000000747.
22. Magee D J. Orthopedic Physical Assessment, Second Edition, W.B. Saunders Company, 2007

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23. Manheimer E, White A, Berman B, Forys K, Ernst E. Meta-analysis: acupuncture for low back pain. Ann Intern Med. 2005 Apr 19;142(8):651-63. doi:10.7326/0003-4819-142-8-200504190-00014.
24. McDonald J, Janz S. The Acupuncture Evidence Project: A Comparative Literature Review (Revised Edition). Brisbane: Australian Acupuncture and Chinese Medicine Association Ltd; 2017.
25. National Health and Medical Research Council. NHMRC additional levels of evidence and grades for recommendations for developers of guidelines. Table 3. NHMRC Evidence Hierarchy: designations of 'levels of evidence' according to type of research question (including explanatory notes). National Health and Medical Research Council; 2009.
26. O'Connor J, Bensky D. Acupuncture: A Comprehensive Text. Chicago: Eastland Press; 1981.
27. Olson WH, Brumback RA, Gascon G, Iyer V; Handbook of Symptom Oriented Neurology; Year Book Medical Publishers, Inc.; 2002.
28. Porter R. The Merck Manual, Merck, 2011.
29. Roy S., Irvin R., Iverson D. Sports Medicine, Prevention, Education, Management, and Rehabilitation, Benjamin Cummings, 1998.
30. Rubinstein SM, van Middelkoop M, Kuijpers T, Ostelo R, Verhagen AP, de Boer MR, Koes BW, van Tulder MW. A systematic review on the effectiveness of complementary and alternative medicine for chronic non-specific low-back pain. Eur Spine J. 2010 Aug;19(8):1213-28. doi:10.1007/s00586-010-1356-3.
31. Thomas KJ, Macpherson H, Thorpe L, Brazier J, Fitter M, Campbell MJ, Roman M, Walters SJ, Nicholl J. Randomised controlled trial of a short course of traditional acupuncture compared with usual care for persistent non-specific low back pain. BMJ. 2006 Sep 15. doi:10.1136/bmj.38878.907361.7C.
32. Trigkilidas D. Acupuncture therapy for chronic lower back pain: a systematic review. Annals of The Royal College of Surgeons of England. 2010;92(7):595-598. doi:10.1308/003588410X12699663904196.
33. Wang R, Li X, Zhou S, Zhang X, Yang K, Li X. Manual acupuncture for myofascial pain syndrome: a systematic review and meta-analysis. Acupunct Med. 2017 Aug;35(4):241-250. doi:10.1136/acupmed-2016-011176.
34. Weinstein S, Buckwalter J. Orthopaedics Principles and Their Applications. Lippincott, Williams, & Wilkins, 2005.
35. Xiang A, Cheng K, Shen X, Xu P, Liu S. The Immediate Analgesic Effect of Acupuncture for Pain: A Systematic Review and Meta-Analysis. Evid Based Complement Alternat Med. 2017;2017:3837194. doi:10.1155/2017/3837194.
36. Yuan J, Purepong N, Hunter RF, Kerr DP, Park J, Bradbury I, McDonough S. Different frequencies of acupuncture treatment for chronic low back pain: an assessor-blinded pilot randomised controlled trial. Complement Ther Med. 2009 Jun;17(3):131-40. doi:10.1016/j.ctim.2008.10.003.
37. Yuan Q-l, Guo T-m, Liu L, Sun F, Zhang Y-g (2015) Traditional Chinese Medicine for Neck Pain and Low Back Pain: A Systematic Review and Meta-Analysis. PLoS ONE 10(2): e0117146. doi:10.1371/ journal.pone.0117146.
38. Zhao HJ, Tan JY, Wang T, Jin L. Auricular therapy for chronic pain management in adults: A synthesis of evidence. Complement Ther Clin Pract. 2015 May;21(2):68-78. doi:10.1016/j.ctcp.2015.03.006.

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ACU-7.2: Lumbar Spondylosis

Synonyms

- Lumbar degenerative joint disease
- Lumbar arthritis
- Low back pain

Definition

Chronic low back pain and stiffness, occasionally with radicular pain, due to narrowing or stenosis of the spinal canal or intervertebral foramen. Narrowing may be caused by osteophytes, buckling or protrusion of the interlaminar ligaments, or lumbar disc herniation. Pain may be acute or chronic.

Oriental Medicine Diagnoses

- Qi and Blood Stagnation
  - Stagnation results in the painful condition; may have numerous causation; can be related to trauma or underlying syndromes.
- Bi Syndromes—particularly Wind Damp Bi
  - Resulting from the invasion of Wind and Damp or Internal Wind and Damp.
- Kidney Yin and Yang Deficiency
  - Underlying condition with additional symptoms caused by either illness, stress, or lifestyle choices that result in depletion of this energy, or congenital insufficiency.
- Kidney Qi and Liver Blood Deficiency
  - Can result from lifestyle choices that diminish Qi and Blood, chronic illness.

History

- Patient history may include:
  - General demographics
  - Occupation/employment
  - Hand dominance
  - Living environment
  - History of current condition
  - Functional status & activity level
  - Medications
  - Other tests and measurements (laboratory and diagnostic tests)
  - Past history (including history of prior Oriental Medicine treatment, and response to prior treatment)

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Specific Aspects of History

- Rule out red flags (require medical management).
- Identify co-morbidities requiring medical management, and those that affect acupuncture and Oriental Medicine management.
- Determine if trauma-related; determine nature and extent of traumatic event.

Red Flag	Possible Consequence or Cause	Action Required
Severe trauma	Fracture	Immediate referral to emergency department
Onset following minor fall or heavy lifting or osteopathic patient	Fracture	Immediate referral to emergency department
Direct blow to the back in a young adult	Fracture	Immediate referral to emergency department
Global or progressive motor weakness in the lower extremities	Cauda Equina Syndrome	Immediate referral to emergency department
Saddle anesthesia	Cauda Equina Syndrome	Immediate referral to emergency department
Severe or progressive neurologic complaints	Cauda Equina Syndrome	Immediate referral to emergency department
Recent onset of bowel dysfunction or acute onset of bladder dysfunction in association with low back pain	Cauda Equina Syndrome	Immediate referral to emergency department
Unexplained weight loss	Malignancy	Prompt referral to Primary Care Provider
Prior history of cancer	Malignancy	Prompt referral to Primary Care Provider
Pain that is worse with recumbency or worse at night	Malignancy	Prompt referral to Primary Care Provider
Fever or recent bacterial infection	Infection	Prompt referral to Primary Care Provider
Intravenous drug abuse or immunosuppression	Infection	Prompt referral to Primary Care Provider
Prolonged steroid use	Osteoporosis	Prompt referral to Primary Care Provider

Presentation

Patient complains of insidious onset of pain, and may report a prior history of several episodes of low back and/or leg pain and/or history of low back trauma. Patient often reports morning pain/stiffness that decreases with motion, but is aggravated by excessive motions or strenuous activity.

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Subjective Findings

- Pain and stiffness in the low back
- Pain may be worse with motion
- May report crepitus with certain low back motions
- Non-dermatomal lower extremity pain (unilateral or bilateral) may occur with lateral recess stenosis and nerve root entrapment
- Pain should be documented as a numeric pain scale 0-10
- Lower extremity symptom frequency, duration and numeric pain scale should be documented

Functional Assessment

- Documentation of a patient's level of function is an important aspect of patient care. This documentation is required in order to establish the medical necessity of ongoing acupuncture treatment. The Patient Specific Functional Scale (PSFS) is a patient reported outcome assessment that is easy and appropriate for acupuncturists to use. The PSFS has been studied in peer-reviewed scientific literature, and it has been proven to be a valid, reliable, and responsive measure for a variety of pain syndromes (neck, back, knee, etc.).

Objective Findings

Scope of Lumbar Examination

- Inspection (including postural evaluation)
- Palpation of bony and soft tissue
- Range of motion
- Motion palpation of spine
- Orthopedic testing
- Neurologic testing

Specific Aspects of Lumbar Examination

Examine the neuromusculoskeletal system for possible causes or contributing factors to the low back pain.

Note: Diseases that may refer pain to the cervical spine include: brain lesions, CAD, dental disease, esophageal disease, upper airway disease, lymphadenopathy.

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Findings of Lumbar Spondylosis

- May relate tenderness to palpation in lateral portions of lower back and along spinous processes.
- May demonstrate range of motion restrictions in the lumbar spine—electrical shock-like sensations down the legs with flexion may indicate myelopathy or a disorder of the central nervous system that requires medical evaluation.
- Nerve root tension signs (SLR) may be positive.
- Kemp's test may cause radiating lower extremity pain.
- Dejerine's triad may be positive.
- Signs of upper motor neuron involvement may suggest compression of the spinal cord, which should be evaluated medically.

Differential Diagnoses

- Metastatic tumor (awakened by constant and severe night pain that is not relieved by changing position, especially when there is a known or suspected history of cancer)
- Spinal cord tumor
- Syringomyelia (superficial abdominal reflexes absent, insensitive to pain)
- Extra spinal nerve entrapment (due to abdominal or pelvic mass)
- Cauda equina syndrome (saddle anesthesia, bladder or bowel dysfunction, bilateral involvement)
- Myelopathy due to thoracic disc herniation
- Demyelinating disease
- Lateral femoral cutaneous nerve entrapment (lateral thigh, sensory only, reverse SLR or femoral nerve stretch test)
- Trochanteric bursitis (no nerve root tension signs, pain on lateral thigh/leg, exquisite tenderness to palpation over trochanter)
- Disc protrusion
- Herniated nucleus pulposis
- Osteoporosis
- Spondylitis
- Peripheral vascular disease
- Kidney disease (referred pain)

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Oriental Medicine Management [18, 33, 35]

- Oriental Medicine management goals are to resolve pain, restore the highest level of function possible, and educate the patient to prevent recurrent symptoms.
- To be considered medically necessary, patient's symptoms must be the direct result of a primary neuromusculoskeletal injury or illness.
- Confirmation of appropriate medical co-management is always required when treating children age 14 and under.
- Treatment frequency should be commensurate with severity of the chief complaint.
- When significant improvements in patient's subjective findings and objective findings are demonstrated—continued treatment with decreased frequency is appropriate.
- As treatment progresses, one should see an increase in the active regimen of care, a decrease in the passive regimen of care, and a fading of treatment frequency.
- If the condition has not progressed towards resolution, refer the patient to an appropriate health care provider to explore other treatment alternatives.
- eviCore's consideration of requests for continued acupuncture treatment depends on updated clinical information submitted regarding patient's progress.
- Adequate and legible patient progress information that contains a history and examination, and/or eviCore's Acupuncture Treatment Request Form is required to determine medical necessity.
- In addition to improvements in the table below, significant progress may also be documented by increases in functional capacity and increasingly longer durations of pain relief.
- Discharge occurs when reasonable functional goals and expected outcomes have been achieved.
- The patient is discharged when the patient/care-giver can continue management of symptoms with an independent home program.
- Treatment is discontinued when the patient is unable to progress towards outcomes because of medical complications, psychosocial factors or other personal circumstances.
- If the member has been non-compliant with treatment as is evidenced by the clinical documentation, and/or the lack of demonstrated progress, treatment will be deemed to be not medically necessary and the member should be discharged from treatment.

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Week	Progress
0-1	◆ Some reduction of pain frequency and severity ◆ Some reduction of muscle spasm
2-4	◆ 50% decrease in pain severity and frequency ◆ 50% improvement in function ◆ Pain distribution is centralizing
5-8	◆ Continued reduction of pain frequency and severity ◆ Continued increase in function ◆ Pain distribution continues to centralize
9-12	◆ 75% improvement in pain severity and frequency ◆ 75% improvement in function ◆ Pain distribution is centralized to back ◆ Reinforce self-management techniques
13-16	◆ Gradual improvement leading toward resolution ◆ Reinforce self-management techniques ◆ Discharge patient to elective care, or to their primary care provider for alternative treatment options when a plateau is reached, or by week 16, whichever occurs first

Referral Guidelines

- Improvement has reached a plateau
- Fever, chills, unexplained weight loss, significant night time pain
- Presence of pathological fracture
- Obvious deformity
- Saddle anesthesia
- Loss of major motor function
- Bowel or bladder dysfunction
- Abdominal pain
- Visceral dysfunction
- Increasing neurologic signs/symptoms: increasing LE weakness, increasing LE pain, increasing LE numbness/tingling, and decreasing LE reflexes

Appropriate Procedures/ Modalities

- Acupuncture
- Electro-acupuncture
- Cupping
- Moxibustion
- Gua Sha
- Myofascial release
- Acupressure

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- Trigger point massage
- Tui Na (not to include osseous manipulation)
- Herbal formulas

Note: Not all of these modalities are covered by the patient's health-plan; review documentation regarding coverage. Acupuncture and herbs must be appropriate for covered diagnoses under the patient's insurance policy. Acupuncturist is responsible for determining which procedures/modalities are most appropriate for the patient's condition.

Inappropriate Procedures/Modalities

- Scarring moxa
- Applied kinesiology techniques
- Electro-acupuncture using more than 9 volts
- Any technique outside the scope of practice in your state

Self-Management Techniques

- Rest and reduce strenuous activities
- Ergonomics, Postural advice, postural exercises
- Appropriate exercises/stretching
- Tai Qi, Qi Gong, Yoga
- Stress management, meditation
- Joint protection
- Weight loss
- Self-massage, Self-acupressure
- Hot packs/cold packs, if needed, to relieve discomfort
- Lumbar stabilization exercises
- Aerobic conditioning, such as walking or swimming

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Alternatives to Oriental Medicine Management

(listed in alphabetical order)

- Chiropractic
- Dietary/Nutritional Medicine Counseling
- Injection therapy/Pain management
- Massage therapy
- Medication
- Occupational therapy
- Osteopathic Manipulation
- Physical Therapy
- Psychological counseling

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References

1. Balshem H, Helfand M, Schunemann HJ, Oxman AD, Kunz R, Brozek J, et al. GRADE guidelines: 3. Rating the quality of evidence. J Clin Epidemiol. 2011 Apr;64(4):401-6. doi:10.1016/j.jclinepi.2010.07.015.
2. Brinkhaus B, Witt CM, Jena S, Linde K, Streng A, Wagenpfeil S, Irnich D, Walther HU, Melchart D, Willich SN. Acupuncture in patients with chronic low back pain: a randomized controlled trial. Arch Intern Med. 2006 Feb 27;166(4):450-7. doi:10.1001/archinte.166.4.450.
3. Cheng X, Deng L. Chinese Acupuncture and Moxibustion. Beijing: Foreign Language Press; 2010.
4. Cherkin DC, Sherman KJ, Avins AL, Erro JH, Ichikawa L, Barlow WE, Delaney K, Hawkes R, Hamilton L, Pressman A, Khalsa PS, Deyo RA. A randomized trial comparing acupuncture, simulated acupuncture, and usual care for chronic low back pain. Arch Intern Med. 2009 May 11;169(9):858-66. doi:10.1001/archinternmed.2009.65.
5. Chou R, Deyo R, Friedly J, Skelly A, Hashimoto R, Weimer M, et al. AHRQ Comparative Effectiveness Reviews. Noninvasive Treatments for Low Back Pain. Rockville (MD): Agency for Healthcare Research and Quality (US); 2016.
6. Chou R, Deyo R, Friedly J, Skelly A, Hashimoto R, Weimer M, et al. Nonpharmacologic Therapies for Low Back Pain: A Systematic Review for an American College of Physicians Clinical Practice Guideline. Ann Intern Med. 2017;166:493–505. doi:10.7326/M16-2459.
7. Furlan A, Tulder M, Cherkin D, Tsukayama H, Lao L, Koes B, Berman B. Acupuncture and dry-needling for low back pain. Cochrane Database Syst Rev. 2005 Jan 25; (1): CD001351. doi:10.1002/14651858.CD001351.pub2.
8. Haake M, Müller HH, Schade-Brittinger C, Basler HD, Schäfer H, Maier C, Endres HG, Trampisch HJ, Molsberger A. German Acupuncture Trials (GERAC) for chronic low back pain: randomized, multicenter, blinded, parallel-group trial with 3 groups. Arch Intern Med. 2007 Sep 24;167(17):1892-8. doi:10.1001/archinte.167.17.1892.
9. Hempel S, Taylor SL, Solloway MR, Miake-Lye IM, Beroes JM, Shanman R, et al. VA Evidence-based Synthesis Program Reports. Evidence Map of Acupuncture. Washington (DC): Department of Veterans Affairs; 2014.
10. Horn KK, Jennings S, Richardson G, Vliet DV, Hefford C, Abbott JH. The patient-specific functional scale: psychometrics, clinimetrics, and application as a clinical outcome measure. J Orthop Sports Phys Ther. 2012 Jan;42(1):30-42. doi:10.2519/jospt.2012.3727.
11. Kaptchuk T. The Web That Has No Weaver. Contemporary Books. 2000.
12. Kelly RB. Acupuncture for pain. Am Fam Physician. 2009 Sep 1;80(5):481-4.
13. Kligler B, Nielsen A, Kohrrer C, Schmid T, Waltermaurer E, Perez E, Merrell W. Acupuncture Therapy in a Group Setting for Chronic Pain. Pain Med. 2017 Jun 8. doi:10.1093/pm/pnx134.
14. Lam M, Galvin R, Curry P. Effectiveness of acupuncture for nonspecific chronic low back pain: a systematic review and meta-analysis. Spine (Phila Pa 1976). 2013 Nov 15;38(24):2124-38. doi:10.1097/01.brs.0000435025.65564.b7.
15. Lee JH, Choi TY, Lee MS, Lee H, Shin BC, Lee H. Acupuncture for acute low back pain: a systematic review. Clin J Pain. 2013 Feb;29(2):172-85. doi:10.1097/AJP.0b013e31824909f9.
16. Lewis K, Abdi S. Acupuncture for lower back pain: a review. Clin J Pain. 2010 Jan;26(1):60-9. doi:10.1097/AJP.0b013e3181bad71e.
17. Lewis RA, Williams NH, Sutton AJ, Burton K, Din NU, Matar HE, et al. Comparative clinical effectiveness of management strategies for sciatica: systematic review and network meta-analyses. Spine J. 2015 Jun 1;15(6):1461-77. doi:10.1016/j.spinee.2013.08.049.
18. Li X, Wang R, Xing X, et al. Acupuncture for Myofascial Pain Syndrome: A Network Meta-Analysis of 33 Randomized Controlled Trials. Pain Physician. 2017 Sep;20(6):E883-E902.
19. Liu L, Skinner M, McDonough S, Mabire L, Baxter GD. Acupuncture for low back pain: an overview of systematic reviews. Evid Based Complement Alternat Med. 2015;2015:328196. doi:10.1155/2015/328196.
20. Maciocia G. The Foundations of Chinese Medicine: A Comprehensive Text; Churchill Livingstone, 2005.
21. MacPherson H, Vertosick EA, Foster NE, Lewith G, Linde K, Sherman KJ, et al. The persistence of the effects of acupuncture after a course of treatment: A meta-analysis of patients with chronic pain. Pain. 2016 Oct 17.
22. Magee DJ. Orthopedic Physical Assessment, Second Edition, W.B. Saunders Company, 2007

© 2019 eviCore healthcare. All Rights Reserved.

23. Manheimer E, White A, Berman B, Forys K, Ernst E. Meta-analysis: acupuncture for low back pain. Ann Intern Med. 2005 Apr 19;142(8):651-63. doi:10.7326/0003-4819-142-8-200504190-00014
24. McDonald J, Janz S. The Acupuncture Evidence Project: A Comparative Literature Review (Revised Edition). Brisbane: Australian Acupuncture and Chinese Medicine Association Ltd; 2017.
25. National Health and Medical Research Council. NHMRC additional levels of evidence and grades for recommendations for developers of guidelines. Table 3. NHMRC Evidence Hierarchy: designations of 'levels of evidence' according to type of research question (including explanatory notes). National Health and Medical Research Council; 2009.
26. O'Connor J, Bensky D. Acupuncture: A Comprehensive Text. Chicago: Eastland Press; 1981.
27. Olson WH, Brumback RA, Gascon G, Iyer V. Handbook of Symptom Oriented Neurology; Year Book Medical Publishers, Inc.; 2002.
28. Porter R. The Merck Manual, Merck, 2011.
29. Roy S, Irvin R, Iverson, D. Sports Medicine, Prevention, Education, Management, and Rehabilitation, Benjamin Cummings, 1998.
30. Rubinstein SM, van Middelkoop M, Kuijpers T, Ostelo R, Verhagen AP, de Boer MR, Koes BW, van Tulder MW. A systematic review on the effectiveness of complementary and alternative medicine for chronic non-specific low-back pain. Eur Spine J. 2010 Aug;19(8):1213-28. doi:10.1007/s00586-010-1356-3.
31. Thomas KJ, Macpherson H, Thorpe L, Brazier J, Fitter M, Campbell MJ, Roman M, Walters SJ, Nicholl J. Randomised controlled trial of a short course of traditional acupuncture compared with usual care for persistent non-specific low back pain. BMJ. 2006 Sep 15. doi:10.1136/bmj.38878.907361.7C.
32. Trigkilidas D. Acupuncture therapy for chronic lower back pain: a systematic review. Annals of The Royal College of Surgeons of England. 2010;92(7):595-598. doi:10.1308/003588410X12699663904196.
33. Wang R, Li X, Zhou S, Zhang X, Yang K, Li X. Manual acupuncture for myofascial pain syndrome: a systematic review and meta-analysis. Acupunct Med. 2017 Aug;35(4):241-250. doi:10.1136/acupmed-2016-011176.
34. Weinstein S, Buckwalter J. Orthopaedics Principles and Their Applications. Lippincott, Williams, & Wilkins, 2005.
35. Xiang A, Cheng K, Shen X, Xu P, Liu S. The Immediate Analgesic Effect of Acupuncture for Pain: A Systematic Review and Meta-Analysis. Evid Based Complement Alternat Med. 2017;2017:3837194. doi:10.1155/2017/3837194.
36. Yuan J, Purepong N, Hunter RF, Kerr DP, Park J, Bradbury I, McDonough S. Different frequencies of acupuncture treatment for chronic low back pain: an assessor-blinded pilot randomised controlled trial. Complement Ther Med. 2009 Jun;17(3):131-40. doi:10.1016/j.ctim.2008.10.003.
37. Yuan Q-l, Guo T-m, Liu L, Sun F, Zhang Y-g (2015) Traditional Chinese Medicine for Neck Pain and Low Back Pain: A Systematic Review and Meta-Analysis. *PLoS ONE* 10(2): e0117146. doi:10.1371/ journal.pone.0117146.
38. Zhao HJ, Tan JY, Wang T, Jin L. Auricular therapy for chronic pain management in adults: A synthesis of evidence. Complement Ther Clin Pract. 2015 May;21(2):68-78. doi:10.1016/j.ctcp.2015.03.006.

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ACU-7.3: Lumbar Sprain/Strain

Synonyms

- Low back strain
- Lumbar sprain
- Pulled low back
- Lumbago

Definitions

Strain

An overstretching or tearing of a muscle or tendon.

Sprain

An overstretching or tearing of ligamentous tissue.

Non-radicular lower back pain that may extend into the buttocks and occurs either suddenly or following a trauma, which may be either instantaneous or repetitive. Episode may result in incomplete annular tear, which may allow substances to leak that cause irritation to the lower lumbar roots. In patients age 45 and younger, lumbar sprain/strain is the most common cause for lost work time and disability.

Oriental Medicine Diagnoses

- Qi and Blood Stagnation
  - Stagnation results in painful condition; may have numerous causations; can be related to trauma or underlying syndromes.
- Kidney Yang Deficiency
  - Underlying condition with additional symptoms caused by illness, stress, or lifestyle choices that result in depletion of this energy, or congenital insufficiency.
- Cold Damp Bi, Cold Damp with Painful Obstruction
  - Accumulation of cold damp can result from lifestyle that results in the underlying imbalance leading to this syndrome.

Note: While the above pathways represent classical causations for a lumbar sprain/strain within the paradigm of Oriental Medicine diagnoses, they are not necessarily eligible for authorization or coverage under eviCore's acupuncture benefit plans. To be eligible for coverage and reimbursement, lumbar sprain/strain symptoms and/or a diagnosis of “lumbar sprain/strain" must be the direct result of a primary neuromusculoskeletal injury or illness.

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History

Specific Aspects of History

- Rule out red flags (require medical management).
- Identify co-morbidities requiring medical management, and those that affect acupuncture and Oriental Medicine management.
- Determine if trauma-related; determine nature and extent of traumatic event.

Red Flag	Possible Consequence or Cause	Action Required
Severe trauma	Fracture	Immediate referral to emergency department
Onset following minor fall or heavy lifting or osteopathic patient	Fracture	Immediate referral to emergency department
Direct blow to the back in a young adult	Fracture	Immediate referral to emergency department
Global or progressive motor weakness in the lower extremities	Cauda Equina Syndrome	Immediate referral to emergency department
Saddle anesthesia	Cauda Equina Syndrome	Immediate referral to emergency department
Severe or progressive neurologic complaints	Cauda Equina Syndrome	Immediate referral to emergency department
Recent onset of bowel dysfunction or acute onset of bladder dysfunction in association with low back pain	Cauda Equina Syndrome	Immediate referral to emergency department
Unexplained weight loss	Malignancy	Prompt referral to Primary Care Provider
Prior history of cancer	Malignancy	Prompt referral to Primary Care Provider
Pain that is worse with recumbency or worse at night	Malignancy	Prompt referral to Primary Care Provider
Fever or recent bacterial infection	Infection	Prompt referral to Primary Care Provider
Intravenous drug abuse or immunosuppression	Infection	Prompt referral to Primary Care Provider
Prolonged steroid use	Osteoporosis	Prompt referral to Primary Care Provider

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Signs and Symptoms Indicative of Red Flags

- Improvement does not meet the above guidelines or improvement has reached a plateau
- Fever, chills, unexplained weight loss, significant night time pain
- Presence of pathological fracture
- Obvious deformity
- Saddle anesthesia
- Loss of major motor function
- Bowel or bladder dysfunction

Presentation

Strain
Overexertion of the back in some static or dynamic activity; overstretching; or contusion. Back pain is worse with initial activity, and rest typically relieves the pain. Trauma may precipitate the condition.

Sprain
Chronic manifestations typically involves prolonged periods of postural abuse. Acute onset typically involves a sudden motion or poor body mechanics while performing an activity. Trauma may precipitate the condition.

Subjective Findings

Strain
Pain and stiffness in a muscle/tendon group of the lumbar region.

Sprain
Pain and stiffness in the lumbar area.

General
- Low back pain that may radiate into the buttocks; needs to frequently shift position; may have difficulty standing upright.
  - Pain should be documented as a numeric pain scale 0-10
  - Lower extremity symptom frequency, duration and numeric pain scale should be documented

Functional Assessment
- Documentation of a patient's level of function is an important aspect of patient care. This documentation is required in order to establish the medical necessity of ongoing acupuncture treatment. The Patient Specific Functional Scale (PSFS) is a patient reported outcome assessment that is easy and appropriate for acupuncturists to use. The PSFS has been studied in peer-reviewed scientific literature, and it has been proven to be a valid, reliable, and responsive measure for a variety of pain syndromes (neck, back, knee, etc.).

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Objective Findings

Scope of Lumbar Examination

- Inspection, including Oriental Medicine assessment techniques
- Palpation of bony and soft tissue including Oriental Medicine inspection techniques
- Range of motion (where allowed by law)
- Orthopedic testing (where allowed by law)
- Neurologic testing if complaints radiate to lower extremities or signs/symptoms of cauda equina syndrome are present (where allowed by law)

Specific Aspects of Lumbar Sprain/Strain Examination

- Examine the musculoskeletal system for possible causes or contributing factors to the complaint.
  - Posture may be antalgic (flexion)
  - Tenderness and possible swelling in the muscle or tendon
  - Pain on isometric contraction or active motion of the involved lumbar musculature
  - Mild bilateral discomfort with SLR may be noted if midline disc bulge present

Findings of Lumbar Sprain/Strain

- Posture may be antalgic (flexion)
- Tenderness and possible swelling in the muscle or tendon
- Pain on isometric contraction or active motion of the involved lumbar musculature
- Mild bilateral discomfort with SLR may be noted if midline disc bulge present
- Tenderness +2 or greater in the immediate area of the involved joint(s)
- Localized spasm and/or swelling in the tissues of the lumbar region
- Pain is intensified by passive motion of the lumbar spine

Differential Diagnoses

- Extra spinal causes (ovarian cyst, kidney stone, pancreatitis, ulcer)
- Lumbar vertebral body fracture (major trauma, or minor trauma in elderly/osteoporotic patient)
- Infection (fever)
- Inflammatory arthritides (family history, patient age/sex, morning stiffness)
- Myeloma (night sweats)

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Oriental Medicine Management [18, 33, 35]

- Oriental Medicine management goals are to resolve pain, restore the highest level of function possible, and educate patient to prevent recurrent symptoms.
- To be considered medically necessary, patient's symptoms must be the direct result of a primary neuromusculoskeletal injury or illness.
- Confirmation of appropriate medical co-management is always required when treating children age 14 and under.
- Treatment frequency should be commensurate with severity of the chief complaint.
- When significant improvements in patient's subjective findings and objective findings are demonstrated—continued treatment with decreased frequency is appropriate.
- As treatment progresses, one should see an increase in the active regimen of care, a decrease in the passive regimen of care, and a fading of treatment frequency.
- If the condition has not progressed towards resolution, refer the patient to an appropriate health care provider to explore other treatment alternatives.
- eviCore's consideration of requests for continued acupuncture treatment depends on updated clinical information submitted regarding patient's progress.
- Adequate and legible patient progress information that contains a history and examination, and/or eviCore's Acupuncture Treatment Request Form is required to determine medical necessity.
- In addition to improvements in the table below, significant progress may also be documented by increases in functional capacity and increasingly longer durations of pain relief.
- Discharge occurs when reasonable functional goals and expected outcomes have been achieved.
- The patient is discharged when the patient/care-giver can continue management of symptoms with an independent home program.
- Treatment is discontinued when the patient is unable to progress towards outcomes because of medical complications, psychosocial factors or other personal circumstances.
- If the member has been non-compliant with treatment as is evidenced by the clinical documentation, and/or the lack of demonstrated progress, treatment will be deemed to be not medically necessary and the member should be discharged from treatment.

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Week	Progress
0-1	◆ Some reduction of pain severity and frequency ◆ Some reduction of muscle spasm
2-4	◆ 50% decrease in pain severity and frequency ◆ 50% improvement in function
5-8	◆ 75% decrease in pain severity and frequency ◆ 75% improvement in function
9-12	◆ Gradual improvement leading toward resolution ◆ Reinforce self-management techniques ◆ Discharge patient to elective care, or to their primary care provider for alternative treatment options when a plateau is reached, or by week 12, whichever occurs first

Referral Guidelines

If improvement following the initial two weeks is not at least 25-50%, reassess case for other possible causes or complicating factors and consider different interventions. If patient is not asymptomatic, or at least 75% improved at the end of the second two week trial, or has reached a plateau, refer patient back to the referring physician to explore other treatment alternatives.

Appropriate Procedures/Modalities

- Acupuncture
- Electro-acupuncture
- Cupping
- Moxibustion
- Gua Sha
- Myofascial release
- Acupressure
- Trigger point massage
- Tui Na (not to include osseous manipulation
- Herbal formulas

Note: Not all of these modalities are covered by the patient's health-plan; review documentation regarding coverage. Acupuncture and herbs must be appropriate for covered diagnoses under the patient's insurance policy. Acupuncturist is responsible for determining which procedures/modalities are most appropriate for the patient's condition.

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Inappropriate Procedures/Modalities

- Scarring moxa
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- Electro-acupuncture using more than 9 volts
- Any technique outside the scope of practice in your state

Self-Management Techniques

- Rest and reduce strenuous activities
- Ergonomics, Postural advice, postural exercises
- Appropriate exercises/stretching
- Tai Qi, Qi Gong, Yoga
- Stress management, meditation
- Joint protection
- Weight loss
- Self-massage, Self-acupressure
- Hot packs/cold packs, if needed, to relieve discomfort

Alternatives to Oriental Medicine Management

(listed in alphabetical order)

- Chiropractic
- Dietary/Nutritional Medicine Counseling
- Injection therapy/Pain management
- Massage therapy
- Medication
- Occupational therapy
- Osteopathic Manipulation
- Physical Therapy
- Psychological counseling

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References

1. Balshem H, Helfand M, Schunemann HJ, Oxman AD, Kunz R, Brozek J, et al. GRADE guidelines: 3. Rating the quality of evidence. J Clin Epidemiol. 2011 Apr;64(4):401-6. doi:10.1016/j.jclinepi.2010.07.015.
2. Brinkhaus B, Witt CM, Jena S, Linde K, Streng A, Wagenpfeil S, Irnich D, Walther HU, Melchart D, Willich SN. Acupuncture in patients with chronic low back pain: a randomized controlled trial. Arch Intern Med. 2006 Feb 27;166(4):450-7. doi:10.1001/archinte.166.4.450.
3. Cheng X, Deng L. Chinese Acupuncture and Moxibustion. Beijing: Foreign Language Press; 2010.
4. Cherkin DC, Sherman KJ, Avins AL, Erro JH, Ichikawa L, Barlow WE, Delaney K, Hawkes R, Hamilton L, Pressman A, Khalsa PS, Deyo RA. A randomized trial comparing acupuncture, simulated acupuncture, and usual care for chronic low back pain. Arch Intern Med. 2009 May 11;169(9):858-66. doi:10.1001/archinternmed.2009.65.
5. Chou R, Deyo R, Friedly J, Skelly A, Hashimoto R, Weimer M, et al. AHRQ Comparative Effectiveness Reviews. Noninvasive Treatments for Low Back Pain. Rockville (MD): Agency for Healthcare Research and Quality (US); 2016.
6. Chou R, Deyo R, Friedly J, Skelly A, Hashimoto R, Weimer M, et al. Nonpharmacologic Therapies for Low Back Pain: A Systematic Review for an American College of Physicians Clinical Practice Guideline. Ann Intern Med. 2017;166:493–505. doi:10.7326/M16-2459.
7. Furlan A, Tulder M, Cherkin D, Tsukayama H, Lao L, Koes B, Berman B. Acupuncture and dry-needling for low back pain. Cochrane Database Syst Rev. 2005 Jan 25; (1): CD001351. doi:10.1002/14651858.CD001351.pub2.
8. Haake M, Müller HH, Schade-Brittinger C, Basler HD, Schäfer H, Maier C, Endres HG, Trampisch HJ, Molsberger A. German Acupuncture Trials (GERAC) for chronic low back pain: randomized, multicenter, blinded, parallel-group trial with 3 groups. Arch Intern Med. 2007 Sep 24;167(17):1892-8. doi:10.1001/archinte.167.17.1892.
9. Hempel S, Taylor SL, Solloway MR, Miake-Lye IM, Beroes JM, Shanman R, et al. VA Evidence-based Synthesis Program Reports. Evidence Map of Acupuncture. Washington (DC): Department of Veterans Affairs; 2014.
10. Horn KK, Jennings S, Richardson G, Vliet DV, Hefford C, Abbott JH. The patient-specific functional scale: psychometrics, clinimetrics, and application as a clinical outcome measure. J Orthop Sports Phys Ther. 2012 Jan;42(1):30-42. doi:10.2519/jospt.2012.3727.
11. Kaptchuk T. The Web That Has No Weaver. Contemporary Books. 2000.
12. Kelly RB. Acupuncture for pain. Am Fam Physician. 2009 Sep 1;80(5):481-4.
13. Kligler B, Nielsen A, Kohrrer C, Schmid T, Waltermaurer E, Perez E, Merrell W. Acupuncture Therapy in a Group Setting for Chronic Pain. Pain Med. 2017 Jun 8. doi:10.1093/pm/pnx134.
14. Lam M, Galvin R, Curry P. Effectiveness of acupuncture for nonspecific chronic low back pain: a systematic review and meta-analysis. Spine (Phila Pa 1976). 2013 Nov 15;38(24):2124-38. doi:10.1097/01.brs.0000435025.65564.b7.
15. Lee JH, Choi TY, Lee MS, Lee H, Shin BC, Lee H. Acupuncture for acute low back pain: a systematic review. Clin J Pain. 2013 Feb;29(2):172-85. doi:10.1097/AJP.0b013e31824909f9.
16. Lewis K, Abdi S. Acupuncture for lower back pain: a review. Clin J Pain. 2010 Jan;26(1):60-9. doi:10.1097/AJP.0b013e3181bad71e.
17. Lewis RA, Williams NH, Sutton AJ, Burton K, Din NU, Matar HE, et al. Comparative clinical effectiveness of management strategies for sciatica: systematic review and network meta-analyses. Spine J. 2015 Jun 1;15(6):1461-77. doi:10.1016/j.spinee.2013.08.049.
18. Li X, Wang R, Xing X, et al. Acupuncture for Myofascial Pain Syndrome: A Network Meta-Analysis of 33 Randomized Controlled Trials. Pain Physician. 2017 Sep;20(6):E883-E902.
19. Liu L, Skinner M, McDonough S, Mabire L, Baxter GD. Acupuncture for low back pain: an overview of systematic reviews. Evid Based Complement Alternat Med. 2015;2015:328196. doi:10.1155/2015/328196.
20. Maciocia G. The Foundations of Chinese Medicine: A Comprehensive Text; Churchill Livingstone, 2005.
21. MacPherson H, Vertosick EA, Foster NE, Lewith G, Linde K, Sherman KJ, et al. The persistence of the effects of acupuncture after a course of treatment: A meta-analysis of patients with chronic pain. Pain. 2016 Oct 17.doi:10.1097/j.pain.0000000000000747.
22. Magee DJ., Orthopedic Physical Assessment, Second Edition, W.B. Saunders Company, 2007

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23. Manheimer E, White A, Berman B, Forys K, Ernst E. Meta-analysis: acupuncture for low back pain. Ann Intern Med. 2005 Apr 19;142(8):651-63. doi:10.7326/0003-4819-142-8-200504190-00014.
24. McDonald J, Janz S. The Acupuncture Evidence Project: A Comparative Literature Review (Revised Edition). Brisbane: Australian Acupuncture and Chinese Medicine Association Ltd; 2017.
25. National Health and Medical Research Council. NHMRC additional levels of evidence and grades for recommendations for developers of guidelines. Table 3. NHMRC Evidence Hierarchy: designations of 'levels of evidence' according to type of research question (including explanatory notes). National Health and Medical Research Council; 2009.
26. O'Connor J, Bensky D. Acupuncture: A Comprehensive Text. Chicago: Eastland Press; 1981.
27. Olson WH, Brumback RA, Gascon G, Iyer V. Handbook of Symptom Oriented Neurology; Year Book Medical Publishers, Inc.; 2002.
28. Porter, R; The Merck Manual, Merck, 2011.
29. Roy S., Irvin R, Iverson D; Sports Medicine, Prevention, Education, Management, and Rehabilitation, Benjamin Cummings, 1998.
30. Rubinstein SM, van Middelkoop M, Kuijpers T, Ostelo R, Verhagen AP, de Boer MR, Koes BW, van Tulder MW. A systematic review on the effectiveness of complementary and alternative medicine for chronic non-specific low-back pain. Eur Spine J. 2010 Aug;19(8):1213-28.. doi:10.1007/s00586-010-1356-3.
31. Thomas KJ, Macpherson H, Thorpe L, Brazier J, Fitter M, Campbell MJ, Roman M, Walters SJ, Nicholl J. Randomised controlled trial of a short course of traditional acupuncture compared with usual care for persistent non-specific low back pain. BMJ. 2006 Sep 15. doi:10.1136/bmj.38878.907361.7C.
32. Trigkilidas D. Acupuncture therapy for chronic lower back pain: a systematic review. Annals of The Royal College of Surgeons of England. 2010;92(7):595-598. doi:10.1308/003588410X12699663904196.
33. Wang R, Li X, Zhou S, Zhang X, Yang K, Li X. Manual acupuncture for myofascial pain syndrome: a systematic review and meta-analysis. Acupunct Med. 2017 Aug;35(4):241-250. doi:10.1136/acupmed-2016-011176.
34. Weinstein S, Buckwalter J. Orthopaedics Principles and Their Applications. Lippincott, Williams, & Wilkins, 2005.
35. Xiang A, Cheng K, Shen X, Xu P, Liu S. The Immediate Analgesic Effect of Acupuncture for Pain: A Systematic Review and Meta-Analysis. Evid Based Complement Alternat Med. 2017;2017:3837194. doi:10.1155/2017/3837194.
36. Yuan J, Purepong N, Hunter RF, Kerr DP, Park J, Bradbury I, McDonough S. Different frequencies of acupuncture treatment for chronic low back pain: an assessor-blinded pilot randomised controlled trial. Complement Ther Med. 2009 Jun;17(3):131-40. doi:10.1016/j.ctim.2008.10.003.
37. Yuan Q-l, Guo T-m, Liu L, Sun F, Zhang Y-g (2015) Traditional Chinese Medicine for Neck Pain and Low Back Pain: A Systematic Review and Meta-Analysis. PLoS ONE 10(2): e0117146. doi:10.1371/ journal.pone.0117146.
38. Zhao HJ, Tan JY, Wang T, Jin L. Auricular therapy for chronic pain management in adults: A synthesis of evidence. Complement Ther Clin Pract. 2015 May;21(2):68-78. doi:10.1016/j.ctcp.2015.03.006.

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ACU-7.4: Lumbosacral Sprain/Strain

Synonyms

- Low back pain

Definition

Abnormal or altered functional relationship between contiguous lumbar and lumbo/sacral vertebrae.

Oriental Medicine Diagnoses

- Qi and Blood Stagnation
  - Stagnation results in pain; may have numerous causations; can be related to trauma or underlying syndromes.
- Kidney Yang Deficiency
  - Underlying condition with additional symptoms caused by either illness, stress, lifestyle choices, such as irregular or “incorrect” food choice, irregular eating times, lack of sleep, excess of activities, that result in depletion of this energy or congenital insufficiency.
- Cold Damp Bi, Cold Damp with Painful Obstruction
  - Accumulation of cold damp can result from lifestyle choices, such as irregular or “incorrect” food choice, irregular eating times, lack of sleep, or external pathogens.

History

Acute or chronic localized pain and stiffness with or without history of trauma.

Specific Aspects of History

- Rule out red flags (require medical management).
- Identify co-morbidities requiring medical management, and those that affect acupuncture and Oriental Medicine management.
- Determine if trauma-related; determine nature and extent of traumatic event.

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Red Flag	Possible Consequence or Cause	Action Required
Severe trauma	Fracture	Immediate referral to emergency department
Onset following minor fall or heavy lifting in elderly or osteoporotic patient	Fracture	Immediate referral to emergency department
Direct blow to the back in young adult	Fracture	Immediate referral to emergency department
Saddle anesthesia	Cauda equina syndrome	Immediate referral to emergency department
Severe or progressive neurologic complaints	Cauda equina syndrome	Immediate referral to emergency department
Global or progressive motor weakness in the lower extremities	Cauda equina syndrome	Immediate referral to emergency department
Recent onset of bowel dysfunction or acute onset of bladder dysfunction in association with low back pain	Cauda equina syndrome	Immediate referral to emergency department
Unexplained weight loss	Malignancy	Prompt referral to Primary Care Provider
Prior history of cancer	Malignancy	Prompt referral to Primary Care Provider
Pain that is worse with recumbency or worse at night	Malignancy	Prompt referral to Primary Care Provider
Fever, recent bacterial infection or recent surgery	Infection	Immediate referral to emergency department
Intravenous drug abuse or immunosuppression	Infection	Prompt referral to Primary Care Provider
Prolonged steroid use	Osteoporosis	Prompt referral to Primary Care Provider

Presentation

Localized pain and stiffness in the region of the affected joints/segments. Often arises from a "non-specific onset." Some form of acute or chronic postural abuse is often involved. May be prior history of trauma to the involved region. May be a sequela of, and secondary to, another primary diagnosis, such as sprain, strain, or capsulitis.

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Subjective Findings

- Complaint of pain and/or stiffness in the affected region.
  - Pain should be documented as a numeric pain scale 0-10
  - Associated symptom frequency, duration and numeric pain scale should be documented

Note: Extra spinal diseases that may refer pain to the back include: aortic aneurysm, colon cancer, pancreatic cancer, endometriosis, hip disease, kidney disease (especially Pyelonephritis), kidney stones, ovarian disease, pancreatitis, pelvic infections, tumors or cysts of the reproductive tract, uterine cancer.

Functional Assessment

- Documentation of a patient's level of function is an important aspect of patient care. This documentation is required in order to establish the medical necessity of ongoing acupuncture treatment. The Patient Specific Functional Scale (PSFS) is a patient reported outcome assessment that is easy and appropriate for acupuncturists to use. The PSFS has been studied in peer-reviewed scientific literature, and it has been proven to be a valid, reliable, and responsive measure for a variety of pain syndromes (neck, back, knee, etc.).

Objective Findings

Scope of Musculoskeletal Examination

- Inspection
- Palpation of bony and soft tissue
- Range of motion, active and passive
- Orthopedic and neurologic testing if neurologic signs are present
- Manual muscle testing

Specific Aspects of Lumbar Segmental Dysfunction Examination

Examine the musculoskeletal system for possible causes or contributing factors to the complaint.

Findings of Lumbar Segmental Dysfunction

- Tenderness typically at the affected spinal joints/segments only
- Associated soft tissue may be shortened with degrees of muscle hypertonicity
- Range of motion typically limited asymmetrically
- Joint fixation upon motion palpation

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Differential Diagnoses

- Abdominal aortic aneurysm
- Colon cancer
- Endometriosis
- Hip disease
- Kidney disease
- Kidney stones
- Ovarian disease
- Pancreatitis
- Pelvic infections
- Tumors or cysts of the reproductive tract
- Uterine cancer
- Extra spinal nerve entrapment (due to abdominal or pelvic mass)
- Cauda equina syndrome (saddle anesthesia, bladder or bowel dysfunction, bilateral involvement)
- Myelopathy due to thoracic disc herniation
- Demyelinating disease
- Lateral femoral cutaneous nerve entrapment (lateral thigh, sensory only, reverse SLR or femoral nerve stretch test)
- Trochanteric bursitis (no nerve root tension signs, pain on lateral thigh/leg, exquisite tenderness to palpation over trochanter)

Oriental Medicine Management [18, 33, 35]

- Oriental Medicine management goals are to resolve pain, restore the highest level of function possible, and educate patient to prevent recurrent symptoms.
- To be considered medically necessary, patient's symptoms must be the direct result of a primary neuromusculoskeletal injury or illness.
- Confirmation of appropriate medical co-management is always required when treating children age 14 and under.
- Treatment frequency should be commensurate with severity of the chief complaint.
- When significant improvements in patient's subjective findings and objective findings are demonstrated—continued treatment with decreased frequency is appropriate.
- As treatment progresses, one should see an increase in the active regimen of care, a decrease in the passive regimen of care, and a fading of treatment frequency.
- If the condition has not progressed towards resolution, refer the patient to an appropriate health care provider to explore other treatment alternatives.

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- eviCore's consideration of requests for continued acupuncture treatment depends on updated clinical information submitted regarding patient's progress.
- Adequate and legible patient progress information that contains a history and examination, and/or eviCore's Acupuncture Treatment Request Form is required to determine medical necessity.
- In addition to improvements in the table below, significant progress may also be documented by increases in functional capacity and increasingly longer durations of pain relief.
- Discharge occurs when reasonable functional goals and expected outcomes have been achieved.
- The patient is discharged when the patient/care-giver can continue management of symptoms with an independent home program.
- Treatment is discontinued when the patient is unable to progress towards outcomes because of medical complications, psychosocial factors or other personal circumstances.
- If the member has been non-compliant with treatment as is evidenced by the clinical documentation, and/or the lack of demonstrated progress, treatment will be deemed to be not medically necessary and the member should be discharged from treatment.

Week	Progress
0-1	◆ Some reduction of pain severity and frequency ◆ Some reduction of muscle spasm
2-4	◆ 50% decrease in pain severity and frequency ◆ 50% improvement in function
5-8	◆ 75% decrease in pain severity and frequency ◆ 75% improvement in function
9-12	◆ Gradual improvement leading toward resolution ◆ Reinforce self-management techniques ◆ Discharge patient to elective care, or to their primary care provider for alternative treatment options when a plateau is reached, or by week 12, whichever occurs first

Appropriate Procedures/ Modalities

- Acupuncture
- Electro-acupuncture
- Cupping
- Moxibustion
- Gua Sha
- Myofascial release
- Acupressure
- Trigger point massage

Lumbosacral Conditions (Non Specific)

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- Tui Na (not to include osseous manipulation)
- Herbal formulas

Note: Not all of these modalities are covered by the patient's health-plan; review documentation regarding coverage. Acupuncture and herbs must be appropriate for covered diagnoses under the patient's insurance policy. Acupuncturist is responsible for determining which procedures/modalities are most appropriate for the patient's condition.

Inappropriate Procedures/Modalities

- Scarring moxa
- Applied kinesiology techniques
- Electro-acupuncture using more than 9 volts
- Any technique outside the scope of practice in your state

Self-Management Techniques

- Rest and reduce strenuous activities
- Ergonomics, Postural advice, postural exercises
- Appropriate exercises/stretching
- Tai Qi, Qi Gong, Yoga
- Stress management, meditation
- Joint protection
- Weight loss
- Self-massage, Self-acupressure
- Hot packs/cold packs, if needed, to relieve discomfort

Alternatives to Oriental Medicine Management

(listed in alphabetical order)

- Chiropractic
- Dietary/Nutritional Medicine Counseling
- Injection therapy/Pain management
- Massage therapy
- Medication
- Occupational therapy
- Osteopathic Manipulation
- Physical Therapy
- Psychological counseling

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References

1. Balshem H, Helfand M, Schunemann HJ, Oxman AD, Kunz R, Brozek J, et al. GRADE guidelines: 3. Rating the quality of evidence. J Clin Epidemiol. 2011 Apr;64(4):401-6. doi:10.1016/j.jclinepi.2010.07.015.
2. Brinkhaus B, Witt CM, Jena S, Linde K, Streng A, Wagenpfeil S, Irnich D, Walther HU, Melchart D, Willich SN. Acupuncture in patients with chronic low back pain: a randomized controlled trial. Arch Intern Med. 2006 Feb 27;166(4):450-7. doi:10.1001/archinte.166.4.450.
3. Cheng X, Deng L. Chinese Acupuncture and Moxibustion. Beijing: Foreign Language Press; 2010.
4. Cherkin DC, Sherman KJ, Avins AL, Erro JH, Ichikawa L, Barlow WE, Delaney K, Hawkes R, Hamilton L, Pressman A, Khalsa PS, Deyo RA. A randomized trial comparing acupuncture, simulated acupuncture, and usual care for chronic low back pain. Arch Intern Med. 2009 May 11;169(9):858-66. doi:10.1001/archinternmed.2009.65.
5. Chou R, Deyo R, Friedly J, Skelly A, Hashimoto R, Weimer M, et al. AHRQ Comparative Effectiveness Reviews. Noninvasive Treatments for Low Back Pain. Rockville (MD): Agency for Healthcare Research and Quality (US); 2016.
6. Chou R, Deyo R, Friedly J, Skelly A, Hashimoto R, Weimer M, et al. Nonpharmacologic Therapies for Low Back Pain: A Systematic Review for an American College of Physicians Clinical Practice Guideline. Ann Intern Med. 2017;166:493–505. doi:10.7326/M16-2459.
7. Furlan A, Tulder M, Cherkin D, Tsukayama H, Lao L, Koes B, Berman B. Acupuncture and dry-needling for low back pain. Cochrane Database Syst Rev. 2005 Jan 25; (1): CD001351. doi:10.1002/14651858.CD001351.pub2.
8. Haake M, Müller HH, Schade-Brittinger C, Basler HD, Schäfer H, Maier C, Endres HG, Trampisch HJ, Molsberger A. German Acupuncture Trials (GERAC) for chronic low back pain: randomized, multicenter, blinded, parallel-group trial with 3 groups. Arch Intern Med. 2007 Sep 24;167(17):1892-8.
9. Hempel S, Taylor SL, Solloway MR, Miake-Lye IM, Beroes JM, Shanman R, et al. VA Evidence-based Synthesis Program Reports. Evidence Map of Acupuncture. Washington (DC): Department of Veterans Affairs; 2014.
10. Horn KK, Jennings S, Richardson G, Vliet DV, Hefford C, Abbott JH. The patient-specific functional scale: psychometrics, clinimetrics, and application as a clinical outcome measure. J Orthop Sports Phys Ther. 2012 Jan;42(1):30-42. doi:10.2519/jospt.2012.3727.
11. Kaptchuk T. The Web That Has No Weaver. Contemporary Books. 2000.
12. Kelly RB. Acupuncture for pain. Am Fam Physician. 2009 Sep 1;80(5):481-4.
13. Kligler B, Nielsen A, Kohrrer C, Schmid T, Waltermaurer E, Perez E, Merrell W. Acupuncture Therapy in a Group Setting for Chronic Pain. Pain Med. 2017 Jun 8. doi:10.1093/pm/pnx134.
14. Lam M, Galvin R, Curry P. Effectiveness of acupuncture for nonspecific chronic low back pain: a systematic review and meta-analysis. Spine (Phila Pa 1976). 2013 Nov 15;38(24):2124-38. doi:10.1097/01.brs.0000435025.65564.b7.
15. Lee JH, Choi TY, Lee MS, Lee H, Shin BC, Lee H. Acupuncture for acute low back pain: a systematic review. Clin J Pain. 2013 Feb;29(2):172-85. doi:10.1097/AJP.0b013e31824909f9.
16. Lewis K, Abdi S. Acupuncture for lower back pain: a review. Clin J Pain. 2010 Jan;26(1):60-9. doi:10.1097/AJP.0b013e3181bad71e.
17. Lewis RA, Williams NH, Sutton AJ, Burton K, Din NU, Matar HE, et al. Comparative clinical effectiveness of management strategies for sciatica: systematic review and network meta-analyses. Spine J. 2015 Jun 1;15(6):1461-77. doi:10.1016/j.spinee.2013.08.049.
18. Li X, Wang R, Xing X, et al. Acupuncture for Myofascial Pain Syndrome: A Network Meta-Analysis of 33 Randomized Controlled Trials. Pain Physician. 2017 Sep;20(6):E883-E902.
19. Liu L, Skinner M, McDonough S, Mabire L, Baxter GD. Acupuncture for low back pain: an overview of systematic reviews. Evid Based Complement Alternat Med. 2015;2015:328196. doi:10.1155/2015/328196.
20. Maciocia, G; The Foundations of Chinese Medicine: A Comprehensive Text; Churchill Livingstone, 2005.
21. MacPherson H, Vertosick EA, Foster NE, Lewith G, Linde K, Sherman KJ, et al. The persistence of the effects of acupuncture after a course of treatment: A meta-analysis of patients with chronic pain. Pain. 2016 Oct 17. doi:10.1097/j.pain.0000000000000747.

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22. Magee, David J., Orthopedic Physical Assessment, Second Edition, W.B. Saunders Company, 2007.
23. Manheimer E, White A, Berman B, Forys K, Ernst E. Meta-analysis: acupuncture for low back pain. Ann Intern Med. 2005 Apr 19;142(8):651-63. doi:10.7326/0003-4819-142-8-200504190-00014.
24. McDonald J, Janz S. The Acupuncture Evidence Project: A Comparative Literature Review (Revised Edition). Brisbane: Australian Acupuncture and Chinese Medicine Association Ltd; 2017.
25. National Health and Medical Research Council. NHMRC additional levels of evidence and grades for recommendations for developers of guidelines. Table 3. NHMRC Evidence Hierarchy: designations of 'levels of evidence' according to type of research question (including explanatory notes). National Health and Medical Research Council; 2009.
26. O'Connor J, Bensky D. Acupuncture: A Comprehensive Text. Chicago: Eastland Press; 1981.
27. Olson WH, Brumback RA, Gascon G, Iyer V; Handbook of Symptom Oriented Neurology; Year Book Medical Publishers, Inc.; 2002.
28. Porter, R; The Merck Manual, Merck, 2011.
29. Roy, S., Irvin, R., and Iverson, D; Sports Medicine, Prevention, Education, Management, and Rehabilitation, Benjamin Cummings, 1998.
30. Rubinstein SM, van Middelkoop M, Kuijpers T, Ostelo R, Verhagen AP, de Boer MR, Koes BW, van Tulder MW. A systematic review on the effectiveness of complementary and alternative medicine for chronic non-specific low-back pain. Eur Spine J. 2010 Aug;19(8):1213-28. doi:10.1007/s00586-010-1356-3.
31. Thomas KJ, Macpherson H, Thorpe L, Brazier J, Fitter M, Campbell MJ, Roman M, Walters SJ, Nicholl J. Randomised controlled trial of a short course of traditional acupuncture compared with usual care for persistent non-specific low back pain. BMJ. 2006 Sep 15. doi:10.1136/bmj.38878.907361.7C.
32. Trigkilidas D. Acupuncture therapy for chronic lower back pain: a systematic review. Annals of The Royal College of Surgeons of England. 2010;92(7):595-598. doi:10.1308/003588410X12699663904196.
33. Wang R, Li X, Zhou S, Zhang X, Yang K, Li X. Manual acupuncture for myofascial pain syndrome: a systematic review and meta-analysis. Acupunct Med. 2017 Aug;35(4):241-250. doi:10.1136/acupmed-2016-011176.
34. Weinstein, S, and Buckwalter, J. Orthopaedics Principles and Their Applications. Lippincott, Williams, & Wilkins, 2005.
35. Xiang A, Cheng K, Shen X, Xu P, Liu S. The Immediate Analgesic Effect of Acupuncture for Pain: A Systematic Review and Meta-Analysis. Evid Based Complement Alternat Med. 2017;2017:3837194. doi:10.1155/2017/3837194.
36. Yuan J, Purepong N, Hunter RF, Kerr DP, Park J, Bradbury I, McDonough S. Different frequencies of acupuncture treatment for chronic low back pain: an assessor-blinded pilot randomised controlled trial. Complement Ther Med. 2009 Jun;17(3):131-40. doi:10.1016/j.ctim.2008.10.003.
37. Yuan Q-l, Guo T-m, Liu L, Sun F, Zhang Y-g (2015) Traditional Chinese Medicine for Neck Pain and Low Back Pain: A Systematic Review and Meta-Analysis. PLoS ONE 10(2): e0117146. doi:10.1371/ journal.pone.0117146.
38. Zhao HJ, Tan JY, Wang T, Jin L. Auricular therapy for chronic pain management in adults: A synthesis of evidence. Complement Ther Clin Pract. 2015 May;21(2):68-78. doi:10.1016/j.ctcp.2015.03.006.

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ACU-7.5: Sacroiliac Sprain/Strain

Synonyms

- Low back strain
- Pulled low back
- Low back pain

Definition

Strain

An overstretching or tearing of a muscle or tendon.

Sprain

An overstretching or tearing of ligamentous tissue.

Non-radicular lower posterolateral back pain that may extend into the buttocks or groin and occurs either suddenly or following a trauma, which may be either instantaneous or repetitive.

Oriental Medicine Diagnoses

- Qi and Blood Stagnation
  - Stagnation results in pain; may have numerous causations; can be related to trauma or underlying syndromes.
- Kidney Yang Deficiency
  - Underlying condition with additional symptoms caused by either illness, stress, and/or lifestyle choices, such as irregular or “incorrect” food choice, irregular eating times, lack of sleep, excess of activities, that result in depletion of this energy or congenital insufficiency.
- Cold Damp Bi, Cold Damp with Painful Obstruction
  - Accumulation of cold damp can result from lifestyle choices, such as irregular or “incorrect” food choice, irregular eating times, lack of sleep, or external pathogens.

Note: While the above pathways represent classical causations for a sacroiliac sprain/strain within the paradigm of Oriental Medicine diagnoses, they are not necessarily eligible for authorization or coverage under eviCore's acupuncture benefit plans. To be eligible for coverage and reimbursement, sacroiliac sprain/strain symptoms, and/or a diagnosis of “lumbar sprain/strain" must be the direct result of a primary neuromusculoskeletal injury or illness.

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History

Goals of Sacroiliac Complaint History

- Rule out red flags (require medical management).
- Identify co-morbidities requiring medical management, and those that affect acupuncture and Oriental Medicine management.
- Determine if trauma-related; determine nature and extent of traumatic event.
- Determine OPQRST (Onset, Provocative/Palliative factors, Quality, Radiation/Referral pattern, Site [location], Timing of complaint).

Red Flag	Possible Consequence or Cause	Action Required
Severe trauma	Fracture	Immediate referral to emergency department
Onset following minor fall or heavy lifting in elderly or osteoporotic patient	Fracture	Immediate referral to emergency department
Direct blow to the back or pelvis in young adult	Fracture	Immediate referral to emergency department
Saddle anesthesia	Cauda equina syndrome	Immediate referral to emergency department
Severe or progressive neurologic complaints	Cauda equina syndrome	Immediate referral to emergency department
Global or progressive motor weakness in the lower extremities	Cauda equina syndrome	Immediate referral to emergency department
Recent onset of bowel dysfunction or acute onset of bladder dysfunction in association with low back pain	Cauda equina syndrome	Immediate referral to emergency department
Unexplained weight loss	Malignancy	Prompt referral to Primary Care Provider
Prior history of cancer	Malignancy	Prompt referral to Primary Care Provider
Pain that is worse with recumbency or worse at night	Malignancy	Prompt referral to Primary Care Provider
Fever or recent bacterial infection	Infection	Prompt referral to Primary Care Provider
Intravenous drug abuse or immunosuppression	Infection	Prompt referral to Primary Care Provider
Prolonged steroid use	Infection	Prompt referral to Primary Care Provider

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Presentation

Strain
Pain and stiffness in the muscles/tendons that cross the sacroiliac joint.

Sprain
Pain and stiffness in the lower lumbosacral/sacroiliac area.

Subjective Findings

- Low back pain that may diffusely radiate into the buttocks or groin on the affected side
- Need to frequently shift position
- May have difficulty standing upright
- Pain should be documented as a numeric pain scale 0-10
- Radiating symptom frequency, duration and numeric pain scale should be documented

Functional Assessment

- Documentation of a patient's level of function is an important aspect of patient care. This documentation is required in order to establish the medical necessity of ongoing acupuncture treatment. The Patient Specific Functional Scale (PSFS) is a patient reported outcome assessment that is easy and appropriate for acupuncturists to use. The PSFS has been studied in peer-reviewed scientific literature, and it has been proven to be a valid, reliable, and responsive measure for a variety of pain syndromes (neck, back, knee, etc.).

Objective Findings

Scope of Lumbar and Sacroiliac Examination

- Examine the musculoskeletal system for possible causes or contributing factors to the complaint.
  - Inspection
  - Palpation of bony and soft tissue
  - Range of motion
  - Motion palpation of spine
  - Orthopedic testing
  - Neurologic testing if complaints radiate to lower extremities or signs/symptoms of cauda equina syndrome are present

Note: The most serious cause of low back and pelvic pain is malignant tumor. Most malignant tumors are metastatic and some may cause bony collapse and paralysis. Cancers that most commonly metastasize to bone consist of adrenal, breast, kidney, lung, prostate, and thyroid.

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Findings of Sacroiliac Sprain/Strain

- Posture may be antalgic (flexion)
- Tenderness and possible swelling in the muscle or tendon
- Pain on isometric contraction or active motion of the involved lumbar and hip musculature
- Mild unilateral discomfort with SLR may be noted with hip flexion
- Tenderness +2 or greater in the immediate area of the involved joint(s)
- Localized spasm and/or swelling in the tissues of the lumbar or sacroiliac region
- Pain is intensified by passive motion of the iliac.

Differential Diagnoses

- Extra spinal causes (ovarian cyst, kidney stone, pancreatitis, ulcer)
- Lumbar vertebral body and pelvic fracture (major trauma, or minor trauma in elderly/osteoporotic patient)
- Infection (fever)
- Inflammatory arthritides (family history, patient age/sex, morning stiffness)
- Myeloma (night sweats)

Oriental Medicine Management [18, 33, 35]

- Oriental Medicine management goals are to resolve pain, restore the highest level of function possible, and educate patient to prevent recurrent symptoms.
- To be considered medically necessary, patient's symptoms must be the direct result of a primary neuromusculoskeletal injury or illness.
- Confirmation of appropriate medical co-management is always required when treating children age 14 and under.
- Treatment frequency should be commensurate with severity of the chief complaint.
- When significant improvement in patient's subjective findings and objective findings are demonstrated—continued treatment with decreased frequency is appropriate.
- As treatment progresses, one should see an increase in the active regimen of care, a decrease in the passive regimen of care, and a fading of treatment frequency.
- If the condition has not progressed towards resolution, refer the patient to an appropriate health care provider to explore other treatment alternatives.
- eviCore's consideration of requests for continued acupuncture treatment depends on updated clinical information submitted regarding patient's progress.
- Adequate and legible patient progress information that contains a history and examination, and/or eviCore's Acupuncture Treatment Request Form is required to determine medical necessity.

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- In addition to improvements in the table below, significant progress may be documented by increases in functional capacity and increasingly longer durations of pain relief.
- If improvement following the initial two weeks is not at least 25-50%, reassess case for other possible causes or complicating factors and consider different interventions.
- If patient is not asymptomatic, or at least 75% improved at the end of the second two week trial, or has reached a plateau, refer patient back to the referring physician to explore other treatment alternatives.
- Discharge occurs when reasonable functional goals and expected outcomes have been achieved.
- The patient is discharged when the patient/care-giver can continue management of symptoms with an independent home program.
- Treatment is discontinued when the patient is unable to progress towards outcomes because of medical complications, psychosocial factors or other personal circumstances.
- If the member has been non-compliant with treatment as is evidenced by the clinical documentation, and/or the lack of demonstrated progress, treatment will be deemed to be not medically necessary and the member should be discharged from treatment.

Week	Progress
0-1	◆ Some reduction of pain severity and frequency ◆ Some reduction of muscle spasm
2-4	◆ 50% decrease in pain severity and frequency ◆ 50% improvement in function
5-8	◆ 75% decrease in pain severity and frequency ◆ 75% improvement in function
9-12	◆ Gradual improvement leading toward resolution ◆ Reinforce self-management techniques ◆ Discharge patient to elective care, or to their primary care provider for alternative treatment options when a plateau is reached, or by week 12, whichever occurs first

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Referral Guidelines

- Improvement does not meet the above guidelines or improvement has reached a plateau
- Fever, chills, unexplained weight loss, significant night time pain
- Presence of pathological fracture
- Obvious deformity
- Saddle anesthesia
- Loss of major motor function
- Bowel or bladder dysfunction
- Abdominal pain
- Visceral dysfunction

Appropriate Procedures/ Modalities

- Acupuncture
- Electro-acupuncture
- Cupping
- Moxibustion
- Gua Sha
- Myofascial release
- Acupressure
- Trigger point massage
- Tui Na (not to include osseous manipulation)
- Herbal formulas

Note: Not all of these modalities are covered by the patient's health-plan; review documentation regarding coverage. Acupuncture and herbs must be appropriate for covered diagnoses under the patient's insurance policy. Acupuncturist is responsible for determining which procedures/modalities are most appropriate for the patient's condition.

Inappropriate Procedures/Modalities

- Scarring moxa
- Applied kinesiology techniques
- Electro-acupuncture using more than 9 volts
- Any technique outside the scope of practice in your state

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Self-Management Techniques

- Rest and reduce strenuous activities
- Ergonomics, Postural advice, postural exercises
- Appropriate exercises/stretching
- Tai Qi, Qi Gong, Yoga
- Stress management, meditation
- Joint protection
- Weight loss
- Self-massage, Self-acupressure
- Hot packs/cold packs, if needed, to relieve discomfort
- Lumbar and Sacroiliac stabilization exercises
- Aerobic conditioning, such as walking or swimming

Alternatives to Oriental Medicine Management

(listed in alphabetical order)

- Chiropractic
- Dietary/Nutritional Medicine Counseling
- Injection therapy/Pain management
- Massage therapy
- Medication
- Occupational therapy
- Osteopathic Manipulation
- Physical Therapy
- Psychological counseling

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References

1. Balshem H, Helfand M, Schunemann HJ, Oxman AD, Kunz R, Brozek J, et al. GRADE guidelines: 3. Rating the quality of evidence. J Clin Epidemiol. 2011 Apr;64(4):401-6. doi:10.1016/j.jclinepi.2010.07.015.
2. Brinkhaus B, Witt CM, Jena S, Linde K, Streng A, Wagenpfeil S, Irnich D, Walther HU, Melchart D, Willich SN. Acupuncture in patients with chronic low back pain: a randomized controlled trial. Arch Intern Med. 2006 Feb 27;166(4):450-7. doi:10.1001/archinte.166.4.450.
3. Cheng X, Deng L. Chinese Acupuncture and Moxibustion. Beijing: Foreign Language Press; 2010.
4. Cherkin DC, Sherman KJ, Avins AL, Erro JH, Ichikawa L, Barlow WE, Delaney K, Hawkes R, Hamilton L, Pressman A, Khalsa PS, Deyo RA. A randomized trial comparing acupuncture, simulated acupuncture, and usual care for chronic low back pain. Arch Intern Med. 2009 May 11;169(9):858-66. doi:10.1001/archinternmed.2009.65.
5. Chou R, Deyo R, Friedly J, Skelly A, Hashimoto R, Weimer M, et al. AHRQ Comparative Effectiveness Reviews. Noninvasive Treatments for Low Back Pain. Rockville (MD): Agency for Healthcare Research and Quality (US); 2016.
6. Chou R, Deyo R, Friedly J, Skelly A, Hashimoto R, Weimer M, et al. Nonpharmacologic Therapies for Low Back Pain: A Systematic Review for an American College of Physicians Clinical Practice Guideline. Ann Intern Med. 2017;166:493–505. doi:10.7326/M16-2459.
7. Furlan A, Tulder M, Cherkin D, Tsukayama H, Lao L, Koes B, Berman B. Acupuncture and dry-needling for low back pain. Cochrane Database Syst Rev. 2005 Jan 25; (1): CD001351. doi:10.1002/14651858.CD001351.pub2.
8. Haake M, Müller HH, Schade-Brittinger C, Basler HD, Schäfer H, Maier C, Endres HG, Trampisch HJ, Molsberger A. German Acupuncture Trials (GERAC) for chronic low back pain: randomized, multicenter, blinded, parallel-group trial with 3 groups. Arch Intern Med. 2007 Sep 24;167(17):1892-8. doi:10.1001/archinte.167.17.1892.
9. Hempel S, Taylor SL, Solloway MR, Miake-Lye IM, Beroes JM, Shanman R, et al. VA Evidence-based Synthesis Program Reports. Evidence Map of Acupuncture. Washington (DC): Department of Veterans Affairs; 2014.
10. Horn KK, Jennings S, Richardson G, Vliet DV, Hefford C, Abbott JH. The patient-specific functional scale: psychometrics, clinimetrics, and application as a clinical outcome measure. J Orthop Sports Phys Ther. 2012 Jan;42(1):30-42. doi:10.2519/jospt.2012.3727.
11. Kaptchuk T. The Web That Has No Weaver. Contemporary Books. 2000.
12. Kelly RB. Acupuncture for pain. Am Fam Physician. 2009 Sep 1;80(5):481-4.
13. Kligler B, Nielsen A, Kohrrer C, Schmid T, Waltermaurer E, Perez E, Merrell W. Acupuncture Therapy in a Group Setting for Chronic Pain. Pain Med. 2017 Jun 8. doi:10.1093/pm/pnx134.
14. Lam M, Galvin R, Curry P. Effectiveness of acupuncture for nonspecific chronic low back pain: a systematic review and meta-analysis. Spine (Phila Pa 1976). 2013 Nov 15;38(24):2124-38. doi:10.1097/01.brs.0000435025.65564.b7.
15. Lee JH, Choi TY, Lee MS, Lee H, Shin BC, Lee H. Acupuncture for acute low back pain: a systematic review. Clin J Pain. 2013 Feb;29(2):172-85. doi:10.1097/AJP.0b013e31824909f9.
16. Lewis K, Abdi S. Acupuncture for lower back pain: a review. Clin J Pain. 2010 Jan;26(1):60-9. doi:10.1097/AJP.0b013e3181bad71e..
17. Lewis RA, Williams NH, Sutton AJ, Burton K, Din NU, Matar HE, et al. Comparative clinical effectiveness of management strategies for sciatica: systematic review and network meta-analyses. Spine J. 2015 Jun 1;15(6):1461-77. doi:10.1016/j.spinee.2013.08.049.
18. Li X, Wang R, Xing X, et al. Acupuncture for Myofascial Pain Syndrome: A Network Meta-Analysis of 33 Randomized Controlled Trials. Pain Physician. 2017 Sep;20(6):E883-E902.
19. Liu L, Skinner M, McDonough S, Mabire L, Baxter GD. Acupuncture for low back pain: an overview of systematic reviews. Evid Based Complement Alternat Med. 2015;2015:328196. doi:10.1155/2015/328196.
20. Maciocia, G; The Foundations of Chinese Medicine: A Comprehensive Text; Churchill Livingstone, 2005.
21. MacPherson H, Vertosick EA, Foster NE, Lewith G, Linde K, Sherman KJ, et al. The persistence of the effects of acupuncture after a course of treatment: A meta-analysis of patients with chronic pain. Pain. 2016 Oct 17. doi:10.1097/j.pain.0000000000000747.

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22. Magee, David J., Orthopedic Physical Assessment, Second Edition, W.B. Saunders Company, 2007
23. Manheimer E, White A, Berman B, Forys K, Ernst E. Meta-analysis: acupuncture for low back pain. Ann Intern Med. 2005 Apr 19;142(8):651-63. doi:10.7326/0003-4819-142-8-200504190-00014.
24. McDonald J, Janz S. The Acupuncture Evidence Project: A Comparative Literature Review (Revised Edition). Brisbane: Australian Acupuncture and Chinese Medicine Association Ltd; 2017.
25. National Health and Medical Research Council. NHMRC additional levels of evidence and grades for recommendations for developers of guidelines. Table 3. NHMRC Evidence Hierarchy: designations of 'levels of evidence' according to type of research question (including explanatory notes). National Health and Medical Research Council; 2009.
26. O'Connor J, Bensky D. Acupuncture: A Comprehensive Text. Chicago: Eastland Press; 1981.
27. Olson WH, Brumback RA, Gascon G, Iyer V; Handbook of Symptom Oriented Neurology; Year Book Medical Publishers, Inc.; 2002.
28. Porter, R; The Merck Manual, Merck, 2011.
29. Roy, S., Irvin, R., and Iverson, D; Sports Medicine, Prevention, Education, Management, and Rehabilitation, Benjamin Cummings, 1998.
30. Rubinstein SM, van Middelkoop M, Kuijpers T, Ostelo R, Verhagen AP, de Boer MR, Koes BW, van Tulder MW. A systematic review on the effectiveness of complementary and alternative medicine for chronic non-specific low-back pain. Eur Spine J. 2010 Aug;19(8):1213-28. doi:10.1007/s00586-010-1356-3.
31. Thomas KJ, Macpherson H, Thorpe L, Brazier J, Fitter M, Campbell MJ, Roman M, Walters SJ, Nicholl J. Randomised controlled trial of a short course of traditional acupuncture compared with usual care for persistent non-specific low back pain. BMJ. 2006 Sep 15. doi:10.1136/bmj.38878.907361.7C.
32. Trigkilidas D. Acupuncture therapy for chronic lower back pain: a systematic review. Annals of The Royal College of Surgeons of England. 2010;92(7):595-598. doi:10.1308/003588410X12699663904196.
33. Wang R, Li X, Zhou S, Zhang X, Yang K, Li X. Manual acupuncture for myofascial pain syndrome: a systematic review and meta-analysis. Acupunct Med. 2017 Aug;35(4):241-250. doi:10.1136/acupmed-2016-011176.
34. Weinstein, S, and Buckwalter, J. Orthopaedics Principles and Their Applications. Lippincott, Williams, & Wilkins, 2005.
35. Xiang A, Cheng K, Shen X, Xu P, Liu S. The Immediate Analgesic Effect of Acupuncture for Pain: A Systematic Review and Meta-Analysis. Evid Based Complement Alternat Med. 2017;2017:3837194. doi:10.1155/2017/3837194.
36. Yuan J, Purepong N, Hunter RF, Kerr DP, Park J, Bradbury I, McDonough S. Different frequencies of acupuncture treatment for chronic low back pain: an assessor-blinded pilot randomised controlled trial. Complement Ther Med. 2009 Jun;17(3):131-40.
37. Yuan Q-l, Guo T-m, Liu L, Sun F, Zhang Y-g (2015) Traditional Chinese Medicine for Neck Pain and Low Back Pain: A Systematic Review and Meta-Analysis. PLoS ONE 10(2): e0117146. doi:10.1371/ journal.pone.0117146. .
38. Zhao HJ, Tan JY, Wang T, Jin L. Auricular therapy for chronic pain management in adults: A synthesis of evidence. Complement Ther Clin Pract. 2015 May;21(2):68-78. doi:10.1016/j.ctcp.2015.03.006.

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ACU-8.0: Upper Extremity Conditions

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ACU-8.1: Bursitis of the Shoulder and Rotator Cuff Syndrome

Synonyms

- Shoulder pain

Definition

Shoulder girdle bursitis is generally a secondary condition brought on by calcific tendonitis or pathology of the rotator cuff. It can be primary in patients who have rheumatic illnesses or bacterial infections. Pain may be acute or chronic.

Oriental Medicine Diagnoses

- Qi and Blood Stagnation
  - Stagnation results in the painful condition. May have numerous causes. Can be related to trauma or underlying syndromes.
- Bi Syndrome—Wind, Cold and Dampness
  - Wind, Cold and Dampness from an external pathogen or from underlying causation producing Wind, Cold and Damp "attacking" the area of the shoulder

History

Key features of the patient history include sub-acute onset of unilateral shoulder pain with little to no trauma or overuse, a distinct component of night pain, and marked limitation in shoulder movement.

Specific Aspects of History

- Rule out red flags (require medical management).
- Identify co-morbidities requiring medical management, and those that affect acupuncture and Oriental Medicine management.
- Determine if trauma-related; determine nature and extent of traumatic event.

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Red Flag	Possible Consequence or Cause	Action Required
Severe trauma	Fracture, rotator cuff tear	Immediate referral to emergency department
Exertional, history of cardiac diagnosis	Cardiac pain can radiate to the shoulder	Immediate referral to emergency department
Constant, relieved/worse with meals, positional, associated with fatty meals	Gastrointestinal diseases including cholelithiasis	Immediate referral to emergency department
Pleuritic, shortness of breath, associated with cough	Pulmonary diseases	Prompt referral to Primary Care Provider
Multiple joint involvement	Rheumatology diseases (Gout)	Prompt referral to Primary Care Provider
Fever, severe pain	Possible infection	Immediate referral to emergency department
Cancer history	Cause of symptoms (metastatic or primary)	Prompt referral to Primary Care Provider
Unilateral edema	Upper extremity deep vein thrombosis	Immediate referral to emergency department
Immune-compromised state	Infection	Prompt referral to Primary Care Provider

Presentation

Usually there is no history of trauma, but may follow an injury or overuse. Onset of pain develops over several hours or the course of a day. Pain at rest, particularly at night, is characteristic. Active range of motion is limited, as is passive range of motion. Passive limitations are not in a capsular pattern.

Subjective Findings

Pain should be documented as a numeric pain scale 0-10

Functional Assessment

- Documentation of a patient's level of function is an important aspect of patient care. This documentation is required in order to establish the medical necessity of ongoing acupuncture treatment. The Patient Specific Functional Scale (PSFS) is a patient reported outcome assessment that is easy and appropriate for acupuncturists to use. The PSFS has been studied in peer-reviewed scientific literature, and it has been proven to be a valid, reliable, and responsive measure for a variety of pain syndromes (neck, back, knee, etc.).

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Objective Findings

Scope of Musculoskeletal Examination

- Inspection
- Palpation of bony and soft tissue
- Range of motion, active and passive
- Orthopedic and neurologic testing if neurologic signs are present

Specific Aspects of Bursitis of the Shoulder Examination

Examine the musculoskeletal system for possible causes or contributing factors to the complaint.

Findings of Bursitis of the Shoulder

- Limited active range of motion, especially in abduction, flexion, and external rotation, when compared with PROM
- Palpation is severely painful on the bursa
- Feeling of spongy swelling at the subacromial space, not present on the uninvolved shoulder

Differential Diagnoses

- Referred pain from cardiac, pulmonary, or gastrointestinal pathology
- Inflammatory diseases
- Infection
- Fracture
- Rotator cuff pathology
- Glenohumeral arthritis
- Rheumatoid arthritis
- Osteoarthritis
- Fracture
- Ligamentous injury
- Tendonitis

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Oriental Medicine Management [8, 18, 20]

- Oriental Medicine management goals are to resolve pain, restore the highest level of function possible, and educate the patient to prevent recurrent symptoms.
- To be considered medically necessary, patient's symptoms must be the direct result of a primary neuromusculoskeletal injury or illness.
- Confirmation of appropriate medical co-management is always required when treating children age 14 and under.
- Treatment frequency should be commensurate with severity of the chief complaint.
- When significant improvements in patient's subjective findings and objective findings are demonstrated—continued treatment with decreased frequency is appropriate.
- As treatment progresses, one should see an increase in the active regimen of care, a decrease in the passive regimen of care, and a fading of treatment frequency.
- If the condition has not progressed towards resolution, refer the patient to an appropriate health care provider to explore other treatment alternatives.
- eviCore's consideration of requests for continued acupuncture treatment depends on updated clinical information submitted regarding patient's progress.
- Adequate and legible patient progress information that contains a history and examination, and/or eviCore's Acupuncture Treatment Request Form is required to determine medical necessity.
- In addition to the improvements in the table below, significant progress may be documented by increases in functional capacity and increasingly longer durations of pain relief.
- Discharge occurs when reasonable functional goals and expected outcomes have been achieved.
- The patient is discharged when the patient/care-giver can continue management of symptoms with an independent home program.
- Treatment is discontinued when the patient is unable to progress towards outcomes because of medical complications, psychosocial factors or other personal circumstances.
- If the member has been non-compliant with treatment as is evidenced by the clinical documentation, and/or the lack of demonstrated progress, treatment will be deemed to be not medically necessary and the member should be discharged from treatment.

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Week	Progress
0-1	◆ Some reduction of pain frequency and severity ◆ Some reduction of muscle spasm
2-4	◆ 50% decrease in pain severity and frequency ◆ 50% improvement in function
5-8	◆ 75% decrease in pain severity and frequency ◆ 75% improvement in function
9-12	◆ Gradual improvement leading toward resolution ◆ Reinforce self-management techniques ◆ Discharge patient to elective care, or to their primary care provider for alternative treatment options when a plateau is reached, or by week 12, whichever occurs first

Appropriate Procedures/ Modalities

- Acupuncture
- Electro-acupuncture
- Cupping
- Moxibustion
- Gua Sha
- Myofascial release
- Acupressure
- Trigger point massage
- Tui Na (not to include osseous manipulation)
- Herbal formulas

Note: Not all of these modalities are covered by the patient's health-plan; review documentation regarding coverage. Acupuncture and herbs must be appropriate for covered diagnoses under the patient's insurance policy. Acupuncturist is responsible for determining which procedures/modalities are most appropriate for the patient's condition.

Inappropriate Procedures/Modalities

- Scarring moxa
- Applied kinesiology techniques
- Electro-acupuncture using more than 9 volts
- Any technique outside the scope of practice in your state

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Self-Management Techniques

- Rest and reduce strenuous activities
- Ergonomics, Postural advice, postural exercises
- Appropriate exercises/stretching
- Tai Qi, Qi Gong, Yoga
- Stress management, meditation
- Joint protection
- Weight loss
- Self-massage, Self-acupressure
- Hot packs/cold packs, if needed, to relieve discomfort

Alternatives to Oriental Medicine Management

(listed in alphabetical order)

- Chiropractic
- Dietary/Nutritional Medicine Counseling
- Injection therapy/Pain management
- Massage therapy
- Medication
- Occupational therapy
- Osteopathic Manipulation
- Physical Therapy
- Psychological counseling

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References

1. Balshem H, Helfand M, Schunemann HJ, Oxman AD, Kunz R, Brozek J, et al. GRADE guidelines: 3. Rating the quality of evidence. J Clin Epidemiol. 2011 Apr;64(4):401-6. doi:10.1016/j.jclinepi.2010.07.015.
2. Cheng X, Deng L. Chinese Acupuncture and Moxibustion. Beijing: Foreign Language Press; 2010.
3. Hempel S, Taylor SL, Solloway MR, Miake-Lye IM, Beroes JM, Shanman R, et al. VA Evidence-based Synthesis Program Reports. Evidence Map of Acupuncture. Washington (DC): Department of Veterans Affairs; 2014.
4. Horn KK, Jennings S, Richardson G, Vliet DV, Hefford C, Abbott JH. The patient-specific functional scale: psychometrics, clinimetrics, and application as a clinical outcome measure. J Orthop Sports Phys Ther. 2012 Jan;42(1):30-42. doi:10.2519/jospt.2012.3727.
5. Kaptchuk T. The Web That Has No Weaver. Contemporary Books. 2000.
6. Kelly RB. Acupuncture for pain. Am Fam Physician. 2009 Sep 1;80(5):481-4.
7. Kligler B, Nielsen A, Kohrrer C, Schmid T, Waltermaurer E, Perez E, Merrell W. Acupuncture Therapy in a Group Setting for Chronic Pain. Pain Med. 2017 Jun 8. doi:10.1093/pm/pnx134.
8. Li X, Wang R, Xing X, et al. Acupuncture for Myofascial Pain Syndrome: A Network Meta-Analysis of 33 Randomized Controlled Trials. Pain Physician. 2017 Sep;20(6):E883-E902.
9. Maciocia, G; The Foundations of Chinese Medicine: A Comprehensive Text; Churchill Livingstone, 2005.
10. MacPherson H, Vertosick EA, Foster NE, Lewith G, Linde K, Sherman KJ, et al. The persistence of the effects of acupuncture after a course of treatment: A meta-analysis of patients with chronic pain. Pain. 2016 Oct 17. doi:10.1097/j.pain.0000000000000747.
11. Magee, David J., Orthopedic Physical Assessment, Second Edition, W.B. Saunders Company, 2007.
12. McDonald J, Janz S. The Acupuncture Evidence Project: A Comparative Literature Review (Revised Edition). Brisbane: Australian Acupuncture and Chinese Medicine Association Ltd; 2017.
13. National Health and Medical Research Council. NHMRC additional levels of evidence and grades for recommendations for developers of guidelines. Table 3. NHMRC Evidence Hierarchy: designations of 'levels of evidence' according to type of research question (including explanatory notes). National Health and Medical Research Council; 2009.
14. O'Connor J, Bensky D. Acupuncture: A Comprehensive Text. Chicago: Eastland Press; 1981.
15. Olson WH, Brumback RA, Gascon G, Iyer V; Handbook of Symptom Oriented Neurology; Year Book Medical Publishers, Inc.; 2002.
16. Porter, R; The Merck Manual, Merck, 2011.
17. Roy, S., Irvin, R., and Iverson, D; Sports Medicine, Prevention, Education, Management, and Rehabilitation, Benjamin Cummings, 1998.
18. Wang R, Li X, Zhou S, Zhang X, Yang K, Li X. Manual acupuncture for myofascial pain syndrome: a systematic review and meta-analysis. Acupunct Med. 2017 Aug;35(4):241-250.
19. Weinstein, S, and Buckwalter, J. Orthopaedics Principles and Their Applications. Lippincott, Williams, & Wilkins, 2005.
20. Xiang A, Cheng K, Shen X, Xu P, Liu S. The Immediate Analgesic Effect of Acupuncture for Pain: A Systematic Review and Meta-Analysis. Evid Based Complement Alternat Med. 2017;2017:3837194. doi:10.1155/2017/3837194.
21. Yuan J, Purepong N, Hunter RF, Kerr DP, Park J, Bradbury I, McDonough S. Different frequencies of acupuncture treatment for chronic low back pain: an assessor-blinded pilot randomised controlled trial. Complement Ther Med. 2009 Jun;17(3):131-40. doi:10.1016/j.ctim.2008.10.003.
22. Zhao HJ, Tan JY, Wang T, Jin L. Auricular therapy for chronic pain management in adults: A synthesis of evidence. Complement Ther Clin Pract. 2015 May;21(2):68-78. doi:10.1016/j.ctcp.2015.03.006.

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ACU-8.2: Carpal Tunnel Syndrome (Now Excluded)

- There is insufficient evidence that acupuncture is an effective treatment for Carpal Tunnel Syndrome.
- As such, acupuncture treatment for this condition does not meet medical necessity criteria.

Synonyms

- Wrist pain, hand pain

Definition

Carpal tunnel syndrome (CTS) is a compression neuropathy affecting the median nerve in the carpal tunnel leading to symptoms in the radial 3.5 digits, and possibly thenar muscle atrophy or fasciculation. It usually presents with an insidious onset characterized by paresthesias and numbness in the fingers and deep palm. Women are more likely to develop carpel tunnel than men. Individuals with rheumatoid arthritis are also at high risk.

When non-operative treatment fails to relieve symptoms, or when either thenar atrophy or significant electro-diagnostic studies occur, surgical intervention is the treatment of choice. Carpal tunnel release is the definitive treatment, and is usually a very successful procedure. Cutting the transverse carpal ligament is the standard surgical procedure to relieve pressure on the carpal ligament. Surgical treatment involves either open or endoscopic release of the transverse carpal ligament. Open release involves a mid-palmar incision at the wrist through which the transverse carpal ligament is cut, and the incision is closed. Endoscopic release involves smaller incisions through which an endoscope is inserted to visualize the transverse carpal ligament before it is cut.

Oriental Medicine Diagnosis

- Qi and Blood Stagnation
  - Stagnation results in the painful condition; may have numerous causes; can be related to trauma or underlying syndromes.

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History

Specific Aspects of History

- Rule out red flags (require medical management).
- Identify co-morbidities requiring medical management, and those that affect acupuncture and Oriental Medicine management.
- Determine if trauma-related; determine nature and extent of traumatic event.

Red Flag	Possible Consequence or Cause	Action Required
Severe trauma	Fracture	Immediate referral to emergency department
Fever, severe pain	Possible infection	Immediate referral to emergency department
Cancer history	Cause of symptoms (metastatic, primary or paraneoplastic), potential complications of chemotherapy	Prompt referral to Primary Care Provider
Unilateral edema	Upper extremity deep vein thrombosis	Immediate referral to emergency department
Immune-compromised state	Infection	Prompt referral to Primary Care Provider
Cold Intolerance, fatigue, constipation	Hypothyroidism	Prompt referral to Primary Care Provider
Multiple joint involvement, unusual skin rashes, other vascular involvement	Rheumatologic diseases (e.g., Rheumatoid arthritis, Sjogren's Syndrome, Systemic Lupus Erythematosis, Polyarteritis nodosa)	Prompt referral to Primary Care Provider
Stocking-glove neurological involvement	Diabetes, alcoholism, B12 deficiency	Prompt referral to Primary Care Provider
Auto repair occupation, battery exposure	Lead poisoning	Prompt referral to Primary Care Provider
Hand/skull disproportionately large	Acromegaly	Prompt referral to Primary Care Provider

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Subjective Findings

- Wrist pain, frequently with proximal radiation
- Numbness and tingling in the hand
- Pain of a “pins and needles” feeling at night, frequently awakening patient
- Weakness in grip or pinch
- Feeling of incoordination, clumsiness
- Pain should be documented as a numeric pain scale 0-10
- Neuropathic symptom frequency, duration and numeric pain scale should be documented

Functional Assessment

- Documentation of a patient’s level of function is an important aspect of patient care. This documentation is required in order to establish the medical necessity of ongoing acupuncture treatment. The Patient Specific Functional Scale (PSFS) is a patient reported outcome assessment that is easy and appropriate for acupuncturists to use. The PSFS has been studied in peer-reviewed scientific literature, and it has been proven to be a valid, reliable, and responsive measure for a variety of pain syndromes (neck, back, knee, etc.).

Objective Findings

Scope of Musculoskeletal Examination

- Inspection (including thenar eminence size and structure)
- Palpation of bony and soft tissue
- Range of motion, active and passive
- Orthopedic and neurologic testing if neurologic signs are present

Specific Aspects of Carpal Tunnel Syndrome Examination

Examine the musculoskeletal system for possible causes or contributing factors to the complaint.

Findings of Carpal Tunnel Syndrome

- Decreased sensory testing (light touch) in the radial 3.5 digits (the thumb, index finger, middle finger, and radial half of the ring finger), depending on severity
- Decreased grip and pinch, depending on severity

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Differential Diagnoses

- Cervical radiculopathy
- Proximal nerve impingement
- Pregnancy secondary to fluid retention

Oriental Medicine Management [3, 14]

- There is insufficient evidence that acupuncture is an effective treatment for Carpal Tunnel Syndrome. As such, acupuncture treatment for this condition does not meet medical necessity criteria.

Alternatives to Oriental Medicine Management

(listed in alphabetical order)

- Chiropractic
- Dietary/Nutritional Medicine Counseling
- Injection therapy/Pain management
- Massage therapy
- Medication
- Occupational therapy
- Osteopathic Manipulation
- Physical Therapy
- Psychological counseling
- Surgery
- Physiatry

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References

1. Balshem H, Helfand M, Schunemann HJ, Oxman AD, Kunz R, Brozek J, et al. GRADE guidelines: 3. Rating the quality of evidence. J Clin Epidemiol. 2011 Apr;64(4):401-6. doi:10.1016/j.jclinepi.2010.07.015.
2. Cheng X, Deng L. Chinese Acupuncture and Moxibustion. Beijing: Foreign Language Press; 2010.
3. Choi GH, Wieland LS, Lee H, Sim H, Lee MS, Shin BC. Acupuncture and related interventions for the treatment of symptoms associated with carpal tunnel syndrome. Cochrane Database Syst Rev. 2018 Dec 2;12:CD011215. doi:10.1002/14651858.CD011215.pub2.
4. Hadianfard M, Bazrafshan E, Momeninejad H, Jahani N. Efficacies of Acupuncture and Anti-inflammatory Treatment for Carpal Tunnel Syndrome. J Acupunct Meridian Stud. 2015 Oct;8(5):229-35.
5. Hempel S, Taylor SL, Solloway MR, Miake-Lye IM, Beroes JM, Shanman R, et al. VA Evidence-based Synthesis Program Reports. Evidence Map of Acupuncture. Washington (DC): Department of Veterans Affairs; 2014.
6. Horn KK, Jennings S, Richardson G, Vliet DV, Hefford C, Abbott JH. The patient-specific functional scale: psychometrics, clinimetrics, and application as a clinical outcome measure. J Orthop Sports Phys Ther. 2012 Jan;42(1):30-42. doi:10.2519/jospt.2012.3727.
7. Kaptchuk T. The Web That Has No Weaver. Contemporary Books. 2000.
8. Kelly RB. Acupuncture for pain. Am Fam Physician. 2009 Sep 1;80(5):481-4.
9. Kligler B, Nielsen A, Kohrrer C, Schmid T, Waltermaurer E, Perez E, Merrell W. Acupuncture Therapy in a Group Setting for Chronic Pain. Pain Med. 2017 Jun 8. doi:10.1093/pm/pnx134.
10. Li X, Wang R, Xing X, et al. Acupuncture for Myofascial Pain Syndrome: A Network Meta-Analysis of 33 Randomized Controlled Trials. Pain Physician. 2017 Sep;20(6):E88
11. Maciocia, G; The Foundations of Chinese Medicine: A Comprehensive Text; Churchill Livingstone, 2005.
12. MacPherson H, Vertosick EA, Foster NE, Lewith G, Linde K, Sherman KJ, et al. The persistence of the effects of acupuncture after a course of treatment: A meta-analysis of patients with chronic pain. Pain. 2016 Oct 17. doi:10.1097/j.pain.0000000000000747.
13. Magee, David J., Orthopedic Physical Assessment, Second Edition, W.B. Saunders Company, 2007.
14. McDonald J, Janz S. The Acupuncture Evidence Project: A Comparative Literature Review (Revised Edition). Brisbane: Australian Acupuncture and Chinese Medicine Association Ltd; 2017.
15. National Health and Medical Research Council. NHMRC additional levels of evidence and grades for recommendations for developers of guidelines. Table 3. NHMRC Evidence Hierarchy: designations of 'levels of evidence' according to type of research question (including explanatory notes). National Health and Medical Research Council; 2009.
16. O'Connor J, Bensky D. Acupuncture: A Comprehensive Text. Chicago: Eastland Press; 1981.
17. Olson WH, Brumback RA, Gascon G, Iyer V; Handbook of Symptom Oriented Neurology; Year Book Medical Publishers, Inc.; 2002.
18. Porter, R; The Merck Manual, Merck, 2011.
19. Roy, S., Irvin, R., and Iverson, D; Sports Medicine, Prevention, Education, Management, and Rehabilitation, Benjamin Cummings, 1998.
20. Sim H, Shin BC, Lee MS, Jung A, Lee H, Ernst E. Acupuncture for Carpal Tunnel Syndrome: A Systematic Review of Randomized Controlled Trials. J Pain. 2010 Nov 17. doi:10.1016/j.jpain.2010.08.006.
21. Wang R, Li X, Zhou S, Zhang X, Yang K, Li X. Manual acupuncture for myofascial pain syndrome: a systematic review and meta-analysis. Acupunct Med. 2017 Aug;35(4):241-250. doi:10.1136/acupmed-2016-011176.
22. Weinstein, S, and Buckwalter, J. Orthopaedics Principles and Their Applications. Lippincott, Williams, & Wilkins, 2005.
23. Xiang A, Cheng K, Shen X, Xu P, Liu S. The Immediate Analgesic Effect of Acupuncture for Pain: A Systematic Review and Meta-Analysis. Evid Based Complement Alternat Med. 2017;2017:3837194. doi:10.1155/2017/3837194.
24. Yang CP, Hsieh CL, Wang NH, Li TC, Hwang KL, Yu SC, Chang MH. Acupuncture in patients with carpal tunnel syndrome: A randomized controlled trial. Clin J Pain. 2009 May;25(4):327-33. doi:10.1097/AJP.0b013e318190511c.

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25. Yang CP, Wang NH, Li TC, Hsieh CL, Chang HH, Hwang KL, Ko WS, Chang MH. A randomized clinical trial of acupuncture versus oral steroids for carpal tunnel syndrome: a long-term follow-up. J Pain. 2011 Feb;12(2):272-9. doi:10.1016/j.jpain.2010.09.001.
26. Yuan J, Purepong N, Hunter RF, Kerr DP, Park J, Bradbury I, McDonough S. Different frequencies of acupuncture treatment for chronic low back pain: an assessor-blinded pilot randomised controlled trial. Complement Ther Med. 2009 Jun;17(3):131-40. doi:10.1016/j.ctim.2008.10.003.
27. Zhao HJ, Tan JY, Wang T, Jin L. Auricular therapy for chronic pain management in adults: A synthesis of evidence. Complement Ther Clin Pract. 2015 May;21(2):68-78. doi:10.1016/j.ctcp.2015.03.006.

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ACU-8.3: Forearm, Joint Pain and Osteoarthrosis

Synonyms

- Osteoarthritis
- Degenerative arthritis
- Degenerative joint disease
- Hypertrophic arthritis
- Forearm pain, elbow pain, wrist pain

Definition

Degenerative and sometimes hypertrophic changes in bone and cartilage of one or more joints, and a progressive wearing down of opposing joint surfaces with consequent distortion of joint position. Pain may be acute or chronic.

Oriental Medicine Diagnoses

Various types of arthritis are contained under the singular rubric of blockage, or Painful Obstruction in Chinese Medicine. Condition occurs when the circulation of Qi and Blood through channels is hindered by Wind, Cold and/or Dampness. Dampness, or if at a certain stage of the disease Cold becomes Heat, then Heat blockage can occur.

There are four principal blockages or obstructions in Chinese Medicine, commonly referred to as Bi Syndrome.

Condition can be any combination of those below:

- Wind Bi, Moving Painful Obstruction
  - Pain in the joints is widespread and moves from one area of the body to another.
- Damp Bi, Stationary Painful Obstruction
  - Pain is localized and does not move.
- Cold Bi, Painful Obstruction
  - Severe pain in one part, or over one half of the body, which becomes worse when patient encounters cold and diminishes when patient is warm.
- Heat Bi, Heat Painful Obstruction
  - Flesh is hot, area of pain is red and swollen, pain increases upon contact.

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History

Specific Aspects of History

- Rule out red flags (require medical management),
- Identify co-morbidities requiring medical management, and those that affect acupuncture and Oriental Medicine management.
- Determine if trauma-related; determine nature and extent of traumatic event.

Red Flag	Possible Consequence or Cause	Action Required
Severe trauma	Fracture, ligament/meniscus tear	Immediate referral to emergency department
Fever, severe pain	Infection	Immediate referral to emergency department
Severe arm pain 12-24 hours after trauma	Compartment syndrome	Immediate referral to emergency department
Diabetes	Neuropathy	Prompt referral to Primary Care Provider
Multiple joint involvement	Rheumatologic diseases	Prompt referral to Primary Care Provider
Unilateral edema	Deep vein thrombosis	Immediate referral to emergency department
Cancer	Cause of symptoms (metastatic or primary)	Prompt referral to Primary Care Provider
Discoloration of hand or arm	Arterial occlusion	Immediate referral to emergency department
Immune-compromised state	Infection	Prompt referral to Primary Care Provider

Subjective Findings

- Pain is localized to the joint area
- Warmth may be felt over the affected joint, in the inflammatory stage
- Pain with range of motion may be described
- Onset is usually gradual and insidious
- Patient will complain of stiffness
- Pain should be documented as a numeric pain scale 0-10

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Functional Assessment

- Documentation of a patient's level of function is an important aspect of patient care. This documentation is required in order to establish the medical necessity of ongoing acupuncture treatment. The Patient Specific Functional Scale (PSFS) is a patient reported outcome assessment that is easy and appropriate for acupuncturists to use. The PSFS has been studied in peer-reviewed scientific literature, and it has been proven to be a valid, reliable, and responsive measure for a variety of pain syndromes (neck, back, knee, etc.).

Objective Findings

Scope of Musculoskeletal Examination

- Inspection
- Palpation of bony and soft tissue
- Range of motion, active and passive (if allowed by law)
- Orthopedic and neurologic testing if neurologic signs are present (if allowed by law)

Specific Aspects of Examination for Osteoarthrosis

Examine the musculoskeletal system for possible causes or contributing factors to the complaint.

Findings of Osteoarthrosis

- Swelling may be present in inflammatory phase
- Calor (warmth) may be noted over affected joint in inflammatory phase
- Pain over the joint
- Pain with ROM, loss of ROM

Differential Diagnoses

- Lateral epicondylitis
- Medial epicondylitis
- Olecranon bursitis

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Oriental Medicine Management [10, 22, 24]

- Oriental Medicine management goals are to resolve pain, restore the highest level of function possible, and educate patient to prevent recurrent symptoms.
- To be considered medically necessary, patient's symptoms must be the direct result of a primary neuromusculoskeletal injury or illness.
- Confirmation of appropriate medical co-management is always required when treating children age 14 and under.
- Treatment frequency should be commensurate with severity of the chief complaint.
- If at least 50% improvement in pain frequency and severity is reported by patient—continued treatment with decreased frequency is appropriate.
- As treatment progresses, one should see an increase in the active regimen of care, a decrease in the passive regimen of care, and a fading of treatment frequency.
- If the condition has not progressed towards resolution, refer the patient to an appropriate health care provider to explore other treatment alternatives.
- eviCore's consideration of requests for continued acupuncture treatment depends on updated clinical information submitted regarding patient's progress.
- Adequate and legible patient progress information that contains a history and examination, and/or eviCore's Acupuncture Treatment Request Form is required to determine medical necessity.
- In addition to improvements in the table below, significant progress may also be documented by increases in functional capacity and increasingly longer durations of pain relief.
- Discharge occurs when reasonable functional goals and expected outcomes have been achieved.
- The patient is discharged when the patient/care-giver can continue management of symptoms with an independent home program.
- Treatment is discontinued when the patient is unable to progress towards outcomes because of medical complications, psychosocial factors or other personal circumstances.
- If the member has been non-compliant with treatment as is evidenced by the clinical documentation, and/or the lack of demonstrated progress, treatment will be deemed to be not medically necessary and the member should be discharged from treatment.

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Week	Progress
0-1	◆ Some reduction of pain frequency and severity ◆ Some reduction of muscle spasm
2-4	◆ 50% decrease in pain severity and frequency ◆ 50% improvement in function
5-8	◆ 75% decrease in pain severity and frequency ◆ 75% improvement in function
9-12	◆ Gradual improvement leading toward resolution ◆ Reinforce self-management techniques ◆ Discharge patient to elective care, or to their primary care provider for alternative treatment options when a plateau is reached, or by week 12, whichever occurs first

Appropriate Procedures/ Modalities

- Acupuncture
- Electro-acupuncture
- Cupping
- Moxibustion
- Gua Sha
- Myofascial release
- Acupressure
- Trigger point massage
- Tui Na (not to include osseous manipulation)
- Herbal formulas

Note: Not all of these modalities are covered by patient's health-plan; review documentation regarding coverage. Acupuncture and herbs must be appropriate for covered diagnoses under the patient's insurance policy. Acupuncturist is responsible for determining which procedures/modalities are most appropriate for the patient's condition.

Inappropriate Procedures/Modalities

- Scarring moxa
- Applied kinesiology techniques
- Electro-acupuncture using more than 9 volts
- Any technique outside the scope of practice in your state

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Self-Management Techniques

- Rest and reduce strenuous activities
- Ergonomics, Postural advice, postural exercises
- Appropriate exercises/stretching
- Tai Qi, Qi Gong, Yoga
- Stress management, meditation
- Joint protection
- Weight loss
- Self-massage, Self-acupressure
- Hot packs/cold packs, if needed, to relieve discomfort

Alternatives to Oriental Medicine Management

(listed in alphabetical order)

- Chiropractic
- Dietary/Nutritional Medicine Counseling
- Injection therapy/Pain management
- Massage therapy
- Medication
- Occupational therapy
- Osteopathic Manipulation
- Physical Therapy
- Psychological counseling

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References

1. Amezaga Urruela M, Suarez-Almazor ME. Acupuncture in the treatment of rheumatic diseases. Curr Rheumatol Rep. 2012;14(6):589-597. doi:10.1007/s11926-012-0295-x.
2. Balshem H, Helfand M, Schunemann HJ, Oxman AD, Kunz R, Brozek J, et al. GRADE guidelines: 3. Rating the quality of evidence. J Clin Epidemiol. 2011 Apr;64(4):401-6. doi:10.1016/j.jclinepi.2010.07.015.
3. Cheng X, Deng L. Chinese Acupuncture and Moxibustion. Beijing: Foreign Language Press; 2010.
4. Hempel S, Taylor SL, Solloway MR, Miake-Lye IM, Beroes JM, Shanman R, et al. VA Evidence-based Synthesis Program Reports. Evidence Map of Acupuncture. Washington (DC): Department of Veterans Affairs; 2014.
5. Horn KK, Jennings S, Richardson G, Vliet DV, Hefford C, Abbott JH. The patient-specific functional scale: psychometrics, clinimetrics, and application as a clinical outcome measure. J Orthop Sports Phys Ther. 2012 Jan;42(1):30-42. doi:10.2519/jospt.2012.3727.
6. Kaptchuk T. The Web That Has No Weaver. Contemporary Books. 2000.
7. Kelly RB. Acupuncture for pain. Am Fam Physician. 2009 Sep 1;80(5):481-4.
8. Kligler B, Nielsen A, Kohrrer C, Schmid T, Waltermaurer E, Perez E, Merrell W. Acupuncture Therapy in a Group Setting for Chronic Pain. Pain Med. 2017 Jun 8. doi:10.1093/pm/pnx134.
9. Lansdown H, Howard K, Brealey S, MacPherson H. Acupuncture for pain and osteoarthritis of the knee: a pilot study for an open parallel-arm randomised controlled trial. BMC Musculoskelet Disord. 2009 Oct 24;10:130. doi:10.1186/1471-2474-10-130.
10. Li X, Wang R, Xing X, et al. Acupuncture for Myofascial Pain Syndrome: A Network Meta-Analysis of 33 Randomized Controlled Trials. Pain Physician. 2017 Sep;20(6):E88
11. Maciocia, G; The Foundations of Chinese Medicine: A Comprehensive Text; Churchill Livingstone, 2005.
12. MacPherson H, Vertosick EA, Foster NE, Lewith G, Linde K, Sherman KJ, et al. The persistence of the effects of acupuncture after a course of treatment: A meta-analysis of patients with chronic pain. Pain. 2016 Oct 17 doi:10.1097/j.pain.0000000000000747..
13. Magee, David J., Orthopedic Physical Assessment, Second Edition, W.B. Saunders Company, 2007.
14. Manyanga T, Froese M, Zarychanski R, Abou-Setta A, Friesen C, Tennenhouse M, et al. Pain management with acupuncture in osteoarthritis: a systematic review and meta-analysis. BMC Complement Altern Med. 2014;14:312. doi:10.1186/1472-6882-14-312.
15. McDonald J, Janz S. The Acupuncture Evidence Project: A Comparative Literature Review (Revised Edition). Brisbane: Australian Acupuncture and Chinese Medicine Association Ltd; 2017.
16. Minor ,M.A., Hewett, J.E., Webel, R.R., Anderson, S., & Kay, D.R. Efficacy of physical conditioning exercise in patients with rheumatoid arthritis and osteoarthritis. Arthritis and Rheumatism, 1989; 32(11): 1396-1405.
17. National Health and Medical Research Council. NHMRC additional levels of evidence and grades for recommendations for developers of guidelines. Table 3. NHMRC Evidence Hierarchy: designations of 'levels of evidence' according to type of research question (including explanatory notes). National Health and Medical Research Council; 2009.
18. O'Connor J, Bensky D. Acupuncture: A Comprehensive Text. Chicago: Eastland Press; 1981.
19. Olson WH, Brumback RA, Gascon G, Iyer V; Handbook of Symptom Oriented Neurology; Year Book Medical Publishers, Inc.; 2002.
20. Porter, R; The Merck Manual, Merck, 2011.
21. Roy, S., Irvin, R., and Iverson, D; Sports Medicine, Prevention, Education, Management, and Rehabilitation, Benjamin Cummings, 1998.
22. Wang R, Li X, Zhou S, Zhang X, Yang K, Li X. Manual acupuncture for myofascial pain syndrome: a systematic review and meta-analysis. Acupunct Med. 2017 Aug;35(4):241-250. doi:10.1136/acupmed-2016-011176.
23. Weinstein, S, and Buckwalter, J. Orthopaedics Principles and Their Applications. Lippincott, Williams, & Wilkins, 2005.
24. Xiang A, Cheng K, Shen X, Xu P, Liu S. The Immediate Analgesic Effect of Acupuncture for Pain: A Systematic Review and Meta-Analysis. Evid Based Complement Alternat Med. 2017;2017:3837194. doi:10.1155/2017/3837194.

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25. Yuan J, Purepong N, Hunter RF, Kerr DP, Park J, Bradbury I, McDonough S. Different frequencies of acupuncture treatment for chronic low back pain: an assessor-blinded pilot randomised controlled trial. Complement Ther Med. 2009 Jun;17(3):131-40. doi:10.1016/j.ctim.2008.10.003.
26. Zhao HJ, Tan JY, Wang T, Jin L. Auricular therapy for chronic pain management in adults: A synthesis of evidence. Complement Ther Clin Pract. 2015 May;21(2):68-78. doi:10.1016/j.ctcp.2015.03.006.

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ACU-8.4: Hand, Joint Pain and Osteoarthrosis

Synonyms

- Osteoarthritis
- Degenerative arthritis
- Degenerative joint disease
- Hypertrophic arthritis
- Hand pain, finger pain

Definition

Degenerative, and sometimes hypertrophic changes in bone and cartilage of one or more joints, and a progressive wearing down of opposing joint surfaces with consequent distortion of joint position. Pain may be acute or chronic.

Oriental Medicine Diagnoses

Various types of arthritis are contained under the singular rubric of blockage, or Painful Obstruction, in Chinese Medicine. Condition occurs when circulation of Qi and Blood through channels is hindered by Wind, Cold and/or Dampness. Dampness, or if at a certain stage of the disease cold becomes Heat, then Heat blockage can occur.

There are five principal blockages or obstruction in Chinese Medicine. Commonly referred to as Bi Syndrome, the condition can be any combination of the below:

- Wind Bi, Moving (Wind) Painful Obstruction
  - Pain in the joints is widespread and moves from one area of the body to another.
- Damp Bi, Stationary (Damp) Painful Obstruction
  - Pain is localized and does not move.
- Cold Bi, Painful (Cold) Painful Obstruction
  - Severe pain in one part, or over one half of the body, which becomes worse when patient encounters cold and diminishes when patient is warm.
- Heat Bi, Heat Painful Obstruction
  - Flesh is hot, area of pain is red and swollen, pain increases upon contact.

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History

Specific Aspects of History

- Rule out red flags (require medical management).
- Identify co-morbidities requiring medical management, and those that affect acupuncture and Oriental Medicine management.
- Determine if trauma-related; determine nature and extent of traumatic event.

Red Flag	Possible Consequence or Cause	Action Required
Severe trauma	Fracture, ligament/meniscus tear	Immediate referral to emergency department
Fever, severe pain	Infection	Immediate referral to emergency department
Severe arm pain 12-24 hours after trauma	Compartment syndrome	Immediate referral to emergency department
Diabetes	Neuropathy	Prompt referral to Primary Care Provider
Multiple joint involvement	Rheumatologic diseases	Prompt referral to Primary Care Provider
Unilateral edema	Deep vein thrombosis	Immediate referral to emergency department
Cancer	Cause of symptoms (metastatic or primary)	Prompt referral to Primary Care Provider
Discoloration of hand or arm	Arterial occlusion	Immediate referral to emergency department
Immune-compromised state	Infection	Prompt referral to Primary Care Provider

Subjective Findings

- Pain is localized to joint area
- Warmth may be felt over affected joint, in inflammatory stage
- Pain with range of motion may be described
- Onset is usually gradual and insidious
- Patient will complain of stiffness
- Pain should be documented as a numeric pain scale 0-10

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Functional Assessment

- Documentation of a patient's level of function is an important aspect of patient care. This documentation is required in order to establish the medical necessity of ongoing acupuncture treatment. The Patient Specific Functional Scale (PSFS) is a patient reported outcome assessment that is easy and appropriate for acupuncturists to use. The PSFS has been studied in peer-reviewed scientific literature, and it has been proven to be a valid, reliable, and responsive measure for a variety of pain syndromes (neck, back, knee, etc.).

Objective Findings

Scope of Musculoskeletal Examination

- Inspection
- Palpation of bony and soft tissue
- Range of motion, active and passive (if allowed by law)
- Orthopedic and neurologic testing if neurologic signs are present (if allowed by law)

Specific Aspects of Examination for Osteoarthrosis

Examine the musculoskeletal system for possible causes or contributing factors to the complaint.

Findings of Osteoarthrosis

- Swelling may be present in the inflammatory phase
- Calor (warmth) may be noted over the affected joint in the inflammatory phase
- Pain over the joint
- Pain with ROM, loss of ROM

Differential Diagnoses

- Tendonitis
- Tenosynovitis
- Carpal Tunnel syndrome
- de Quervain's syndrome

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Oriental Medicine Management [10, 22, 24]

- Oriental Medicine management goals are to resolve pain, restore the highest level of function possible, and educate patient to prevent recurrent symptoms.
- To be considered medically necessary, patient's symptoms must be the direct result of a primary neuromusculoskeletal injury or illness.
- Confirmation of appropriate medical co-management is always required when treating children age 14 and under.
- Treatment frequency should be commensurate with severity of the chief complaint.
- If at least 50% improvement in pain frequency and severity is reported by the patient, then continued treatment with decreased frequency is appropriate.
- As treatment progresses, one should see an increase in the active regimen of care, a decrease in the passive regimen of care, and a fading of treatment frequency.
- If the condition has not progressed towards resolution, refer the patient to an appropriate health care provider to explore other treatment alternatives.
- eviCore's consideration of requests for continued acupuncture treatment depends on updated clinical information submitted regarding patient's progress.
- Adequate and legible patient progress information that contains a history and examination, and/or eviCore's Acupuncture Treatment Request Form is required to determine medical necessity.
- In addition to improvements listed in the table below, significant progress may be documented by increases in functional capacity and increasingly longer durations of pain relief.
- Discharge occurs when reasonable functional goals and expected outcomes have been achieved.
- The patient is discharged when the patient/care-giver can continue management of symptoms with an independent home program.
- Treatment is discontinued when the patient is unable to progress towards outcomes because of medical complications, psychosocial factors or other personal circumstances.
- If the member has been non-compliant with treatment as is evidenced by the clinical documentation, and/or the lack of demonstrated progress, treatment will be deemed to be not medically necessary and the member should be discharged from treatment.

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Week	Progress
0-1	◆ Some reduction of pain frequency and severity ◆ Some reduction of muscle spasm
2-4	◆ 50% decrease in pain severity and frequency ◆ 50% improvement in function
5-8	◆ 75% decrease in pain severity and frequency ◆ 75% improvement in function
9-12	◆ Gradual improvement leading toward resolution ◆ Reinforce self-management techniques ◆ Discharge patient to elective care, or to their primary care provider for alternative treatment options when a plateau is reached, or by week 12, whichever occurs first

Appropriate Procedures/ Modalities

- Acupuncture
- Electro-acupuncture
- Cupping
- Moxibustion
- Gua Sha
- Myofascial release
- Acupressure
- Trigger point massage
- Tui Na (not to include osseous manipulation)
- Herbal formulas

Note: Not all of these modalities are covered by the patient's health-plan; review documentation regarding coverage. Acupuncture and herbs must be appropriate for covered diagnoses under the patient's insurance policy. Acupuncturist is responsible for determining which procedures/modalities are most appropriate for the patient's condition.

Inappropriate Procedures/Modalities

- Scarring moxa
- Applied kinesiology techniques
- Electro-acupuncture using more than 9 volts
- Any technique outside the scope of practice in your state

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Self-Management Techniques

- Rest and reduce strenuous activities
- Ergonomics, Postural advice, postural exercises
- Appropriate exercises/stretching
- Tai Qi, Qi Gong, Yoga
- Stress management, meditation
- Joint protection
- Weight loss
- Self-massage, Self-acupressure
- Hot packs/cold packs, if needed, to relieve discomfort

Alternatives to Oriental Medicine Management

(listed in alphabetical order)

- Chiropractic
- Dietary/Nutritional Medicine Counseling
- Injection therapy/Pain management
- Massage therapy
- Medication
- Occupational therapy
- Osteopathic Manipulation
- Physical Therapy
- Psychological counseling

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References

1. Amezaga Urruela M, Suarez-Almazor ME. Acupuncture in the treatment of rheumatic diseases. Curr Rheumatol Rep. 2012;14(6):589-597. doi:10.1007/s11926-012-0295-x.
2. Balshem H, Helfand M, Schunemann HJ, Oxman AD, Kunz R, Brozek J, et al. GRADE guidelines: 3. Rating the quality of evidence. J Clin Epidemiol. 2011 Apr;64(4):401-6. doi:10.1016/j.jclinepi.2010.07.015.
3. Cheng X, Deng L. Chinese Acupuncture and Moxibustion. Beijing: Foreign Language Press; 2010.
4. Hempel S, Taylor SL, Solloway MR, Miake-Lye IM, Beroes JM, Shanman R, et al. VA Evidence-based Synthesis Program Reports. Evidence Map of Acupuncture. Washington (DC): Department of Veterans Affairs; 2014.
5. Horn KK, Jennings S, Richardson G, Vliet DV, Hefford C, Abbott JH. The patient-specific functional scale: psychometrics, clinimetrics, and application as a clinical outcome measure. J Orthop Sports Phys Ther. 2012 Jan;42(1):30-42. doi:10.2519/jospt.2012.3727.
6. Kaptchuk T. The Web That Has No Weaver. Contemporary Books. 2000.
7. Kelly RB. Acupuncture for pain. Am Fam Physician. 2009 Sep 1;80(5):481-4.
8. Kligler B, Nielsen A, Kohrrer C, Schmid T, Waltermaurer E, Perez E, Merrell W. Acupuncture Therapy in a Group Setting for Chronic Pain. Pain Med. 2017 Jun 8. doi: 10.1093/pm/pnx134.
9. Lansdown H, Howard K, Brealey S, MacPherson H. Acupuncture for pain and osteoarthritis of the knee: a pilot study for an open parallel-arm randomised controlled trial. BMC Musculoskelet Disord. 2009 Oct 24;10:130. doi:10.1186/1471-2474-10-130.
10. Li X, Wang R, Xing X, et al. Acupuncture for Myofascial Pain Syndrome: A Network Meta-Analysis of 33 Randomized Controlled Trials. Pain Physician. 2017 Sep;20(6):E883-E902.
11. Maciocia, G; The Foundations of Chinese Medicine: A Comprehensive Text; Churchill Livingstone, 2005.
12. MacPherson H, Vertosick EA, Foster NE, Lewith G, Linde K, Sherman KJ, et al. The persistence of the effects of acupuncture after a course of treatment: A meta-analysis of patients with chronic pain. Pain. 2016 Oct 17. doi:10.1097/j.pain.0000000000000747.
13. Magee, David J., Orthopedic Physical Assessment, Second Edition, W.B. Saunders Company, 2007.
14. Manyanga T, Froese M, Zarychanski R, Abou-Setta A, Friesen C, Tennenhouse M, et al. Pain management with acupuncture in osteoarthritis: a systematic review and meta-analysis. BMC Complement Altern Med. 2014;14:312. doi:10.1186/1472-6882-14-312.
15. McDonald J, Janz S. The Acupuncture Evidence Project: A Comparative Literature Review (Revised Edition). Brisbane: Australian Acupuncture and Chinese Medicine Association Ltd; 2017.
16. Minor ,M.A., Hewett, J.E., Webel, R.R., Anderson, S., & Kay, D.R. Efficacy of physical conditioning exercise in patients with rheumatoid arthritis and osteoarthritis. Arthritis and Rheumatism, 1989; 32(11): 1396-1405.
17. National Health and Medical Research Council. NHMRC additional levels of evidence and grades for recommendations for developers of guidelines. Table 3. NHMRC Evidence Hierarchy: designations of 'levels of evidence' according to type of research question (including explanatory notes). National Health and Medical Research Council; 2009.
18. O'Connor J, Bensky D. Acupuncture: A Comprehensive Text. Chicago: Eastland Press; 1981.
19. Olson WH, Brumback RA, Gascon G, Iyer V; Handbook of Symptom Oriented Neurology; Year Book Medical Publishers, Inc.; 2002.
20. Porter, R; The Merck Manual, Merck, 2011.
21. Roy, S., Irvin, R., and Iverson, D; Sports Medicine, Prevention, Education, Management, and Rehabilitation, Benjamin Cummings, 1998.
22. Wang R, Li X, Zhou S, Zhang X, Yang K, Li X. Manual acupuncture for myofascial pain syndrome: a systematic review and meta-analysis. Acupunct Med. 2017 Aug;35(4):241-250. doi:10.1136/acupmed-2016-011176.
23. Weinstein, S, and Buckwalter, J. Orthopaedics Principles and Their Applications. Lippincott, Williams, & Wilkins, 2005.
24. Xiang A, Cheng K, Shen X, Xu P, Liu S. The Immediate Analgesic Effect of Acupuncture for Pain: A Systematic Review and Meta-Analysis. Evid Based Complement Alternat Med. 2017;2017:3837194. doi:10.1155/2017/3837194.

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25. Yuan J, Purepong N, Hunter RF, Kerr DP, Park J, Bradbury I, McDonough S. Different frequencies of acupuncture treatment for chronic low back pain: an assessor-blinded pilot randomised controlled trial. Complement Ther Med. 2009 Jun;17(3):131-40. doi:10.1016/j.ctim.2008.10.003.
26. Zhao HJ, Tan JY, Wang T, Jin L. Auricular therapy for chronic pain management in adults: A synthesis of evidence. Complement Ther Clin Pract. 2015 May;21(2):68-78. doi:10.1016/j.ctcp.2015.03.006.

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ACU-8.5: Lateral Epicondylitis

Synonyms

- Tennis Elbow
- Epitrochlear bursitis
- Epicondylitis
- Elbow pain

Definition

Degeneration of the tendon of the common extensor muscle group of the forearm at the origin on the humerus; most common in the 4th decade. Injury is typically caused by repetitive extension of the wrist and/or rotation of the forearm. There may be a partial tear of tendon fibers at or near their point of insertion on the humerus. Pain may be acute or chronic. Risk factors are repetitive forceful wrist or forearm movement.

Oriental Medicine Diagnoses

- Qi and Blood Stagnation
  - Stagnation results in the painful condition; may have numerous causes; can be related to trauma or underlying syndromes.
- Weakness of Defensive and Nutritive Qi
  - Causation from long term illness, stress (both physical or emotional), lifestyle choices that deplete Defensive and Nutritive Qi at the root
- Consumption of Qi and Blood
  - Causation from long term illness or lifestyle choices that deplete Qi and Blood.
- Accumulation of Phlegm and Blood
  - Accumulation can be the result of trauma or underlying channels and collaterals stagnation or underlying syndromes. Can transform and form a sharp osteophyte at the epicondyle.

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History

Specific Aspects of History

- Rule out red flags (require medical management).
- Identify co-morbidities requiring medical management, and those that affect acupuncture and Oriental Medicine management
- Determine if trauma-related; determine nature and extent of traumatic event

Red Flag	Possible Consequence or Cause	Action Required
Severe trauma	Fracture	Immediate referral to emergency department
Fever, severe pain	Possible infection	Immediate referral to emergency department
Unilateral edema	Upper extremity deep vein thrombosis	Immediate referral to emergency department
Immune-compromised state	Infection	Prompt referral to Primary Care Provider
Cancer history	Cause of symptoms (metastatic or primary)	Prompt referral to Primary Care Provider
Discoloration of hand/fingers	Vascular occlusion, shunt emboli (dialysis patients)	Immediate referral to emergency department
Exertional symptoms, history of cardiac disease	Anginal equivalent (Acute heart disease)	Immediate referral to emergency department

Subjective Findings

- Tenderness and pain at lateral epicondyle
- Pain is made worse by activities that require extending the wrist or holding an object in the hand with the wrist stiff
- Weak grasp
- Dropping items
- Patients might report either insidious onset or trauma
- Pain should be documented as a numeric pain scale 0-10
- Frequency of weakness and dropping should be documented

Functional Assessment

- Documentation of a patient's level of function is an important aspect of patient care. This documentation is required in order to establish the medical necessity of ongoing acupuncture treatment. The Patient Specific Functional Scale (PSFS) is a patient reported outcome assessment that is easy and appropriate for acupuncturists to use. The PSFS has been studied in peer-reviewed scientific literature, and it has been proven to be a valid, reliable, and responsive measure for a variety of pain syndromes (neck, back, knee, etc.).

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Objective Findings

Scope of Musculoskeletal Examination

- Inspection including Oriental Medicine inspection techniques
- Palpation of bony and soft tissue including Oriental Medicine palpation techniques
- Range of motion, active and passive (if allowed by law)
- Orthopedic and neurologic testing if neurologic signs are present (if allowed by law)

Specific Aspects of Examination for Lateral Epicondylitis

Examine the musculoskeletal system for possible causes or contributing factors to the complaint.

Findings of Lateral Epicondylitis

Tender to palpation over lateral epicondyle. Greatest tension is elicited with the elbow in extension, forearm in pronation, and wrist in flexion.

Differential Diagnoses

- C6 or C7 cervical nerve root compression
- Posterior Interosseous Nerve Syndrome (PINS) entrapment of nerve as it travels through the radial tunnel
- Radial head arthritis
- Posterolateral plica
- Posterolateral rotatory instability
- Olecranon bursitis
- Crystalline deposition such as gout and pseudogout (Chondrocalcinosis)
- Occult fractures of the radial head or lateral humeral epicondyle
- Tendinitis of the long head of the biceps at insertion on the radius

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Oriental Medicine Management [10, 22, 24]

- Oriental Medicine management goals are to resolve pain, restore the highest level of function possible, and educate patient to prevent recurrent symptoms.
- To be considered medically necessary, patient's symptoms must be the direct result of a primary neuromusculoskeletal injury or illness.
- Confirmation of appropriate medical co-management is always required when treating children age 14 and under.
- Treatment frequency should be commensurate with severity of the chief complaint.
- When significant improvements in the patient's subjective findings and objective findings are demonstrated—continued treatment with decreased frequency is appropriate.
- As treatment progresses, one should see an increase in the active regimen of care, a decrease in the passive regimen of care, and a fading of treatment frequency.
- If the condition has not progressed towards resolution, refer the patient to an appropriate health care provider to explore other treatment alternatives.
- eviCore's consideration of requests for continued acupuncture treatment depends on updated clinical information submitted regarding patient's progress.
- Adequate and legible patient progress information that contains a history and examination, and/or eviCore's Acupuncture Treatment Request Form is required to determine medical necessity.
- In addition to improvements in the table below, significant progress may be documented by increases in functional capacity and increasingly longer durations of pain relief.
- Discharge occurs when reasonable functional goals and expected outcomes have been achieved.
- The patient is discharged when the patient/care-giver can continue management of symptoms with an independent home program.
- Treatment is discontinued when the patient is unable to progress towards outcomes because of medical complications, psychosocial factors or other personal circumstances.
- If the member has been non-compliant with treatment as is evidenced by the clinical documentation, and/or the lack of demonstrated progress, treatment will be deemed to be not medically necessary and the member should be discharged from treatment.

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Week	Progress
0-1	◆ Some reduction of pain frequency and severity ◆ Some reduction of muscle spasm
2-4	◆ 50% decrease in pain severity and frequency ◆ 50% improvement in function
5-8	◆ 75% decrease in pain severity and frequency ◆ 75% improvement in function
9-12	◆ Gradual improvement leading toward resolution ◆ Reinforce self-management techniques ◆ Discharge patient to elective care, or to their primary care provider for alternative treatment options when a plateau is reached, or by week 12, whichever occurs first

Appropriate Procedures/ Modalities

- Acupuncture
- Electro-acupuncture
- Cupping
- Moxibustion
- Gua Sha
- Myofascial release
- Acupressure
- Trigger point massage
- Tui Na (not to include osseous manipulation)
- Herbal formulas

Note: Not all of these modalities are covered by the patient's health-plan; review documentation regarding coverage. Acupuncture and herbs must be appropriate for covered diagnoses under the patient's insurance policy. Acupuncturist is responsible for determining which procedures/modalities are most appropriate for the patient's condition.

Inappropriate Procedures/Modalities

- Scarring moxa
- Applied kinesiology techniques
- Electro-acupuncture using more than 9 volts
- Any technique outside the scope of practice in your state

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Self-Management Techniques

- Rest and reduce strenuous activities
- Ergonomics, Postural advice, postural exercises
- Appropriate exercises/stretching
- Tai Qi, Qi Gong, Yoga
- Stress management, meditation
- Joint protection
- Weight loss
- Self-massage, Self-acupressure
- Hot packs/cold packs, if needed, to relieve discomfort

Alternatives to Oriental Medicine Management

(listed in alphabetical order)

- Chiropractic
- Dietary/Nutritional Medicine Counseling
- Injection therapy/Pain management
- Massage therapy
- Medication
- Occupational therapy
- Osteopathic Manipulation
- Physical Therapy
- Psychological counseling
- Surgery (as last resort)

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References

1. Balshem H, Helfand M, Schunemann HJ, Oxman AD, Kunz R, Brozek J, et al. GRADE guidelines: 3. Rating the quality of evidence. J Clin Epidemiol. 2011 Apr;64(4):401-6. doi:10.1016/j.jclinepi.2010.07.015.
2. Buchbinder R, Green S, Struijs P. Tennis elbow. Am Fam Physician. 2007 Mar 1;75(5):701-2.
3. Cheng X, Deng L. Chinese Acupuncture and Moxibustion. Beijing: Foreign Language Press; 2010.
4. Hempel S, Taylor SL, Solloway MR, Miake-Lye IM, Beroes JM, Shanman R, et al. VA Evidence-based Synthesis Program Reports. Evidence Map of Acupuncture. Washington (DC): Department of Veterans Affairs; 2014.
5. Horn KK, Jennings S, Richardson G, Vliet DV, Hefford C, Abbott JH. The patient-specific functional scale: psychometrics, clinimetrics, and application as a clinical outcome measure. J Orthop Sports Phys Ther. 2012 Jan;42(1):30-42. doi:10.2519/jospt.2012.3727.
6. Johnson GW, Cadwallader K, Scheffel SB, Epperly TD. Treatment of lateral epicondylitis. Am Fam Physician. 2007 Sep 15;76(6):843-8.
7. Kaptchuk T. The Web That Has No Weaver. Contemporary Books. 2000.
8. Kelly RB. Acupuncture for pain. Am Fam Physician. 2009 Sep 1;80(5):481-4.
9. Kligler B, Nielsen A, Kohrrer C, Schmid T, Waltermaurer E, Perez E, Merrell W. Acupuncture Therapy in a Group Setting for Chronic Pain. Pain Med. 2017 Jun 8. doi:10.1093/pm/pnx134.
10. Li X, Wang R, Xing X, et al. Acupuncture for Myofascial Pain Syndrome: A Network Meta-Analysis of 33 Randomized Controlled Trials. Pain Physician. 2017 Sep;20(6):E883-E902.
11. Maciocia, G; The Foundations of Chinese Medicine: A Comprehensive Text; Churchill Livingstone, 2005.
12. MacPherson H, Vertosick EA, Foster NE, Lewith G, Linde K, Sherman KJ, et al. The persistence of the effects of acupuncture after a course of treatment: A meta-analysis of patients with chronic pain. Pain. 2016 Oct 17. doi:10.1097/j.pain.0000000000000747.
13. Magee, David J., Orthopedic Physical Assessment, Second Edition, W.B. Saunders Company, 2007.
14. McDonald J, Janz S. The Acupuncture Evidence Project: A Comparative Literature Review (Revised Edition). Brisbane: Australian Acupuncture and Chinese Medicine Association Ltd; 2017.
15. National Health and Medical Research Council. NHMRC additional levels of evidence and grades for recommendations for developers of guidelines. Table 3. NHMRC Evidence Hierarchy: designations of 'levels of evidence' according to type of research question (including explanatory notes). National Health and Medical Research Council; 2009.
16. O'Connor J, Bensky D. Acupuncture: A Comprehensive Text. Chicago: Eastland Press; 1981.
17. Olson WH, Brumback RA, Gascon G, Iyer V; Handbook of Symptom Oriented Neurology; Year Book Medical Publishers, Inc.; 2002.
18. Porter, R; The Merck Manual, Merck, 2011.
19. Roy, S., Irvin, R., and Iverson, D; Sports Medicine, Prevention, Education, Management, and Rehabilitation, Benjamin Cummings, 1998.
20. Tang H, Fan H, Chen J, Yang M, Yi X, Dai G, et al. Acupuncture for Lateral Epicondylitis: A Systematic Review. Evid Based Complement Alternat Med. 2015;2015:861849. doi:10.1155/2015/861849.
21. Trudel D, Duley J, Zastrow I, Kerr EW, Davidson R, MacDermid JC. Rehabilitation for patients with lateral epicondylitis: a systematic review. J Hand Ther. 2004 Apr-Jun;17(2):243-66. doi:10.1197/j.jht.2004.02.011.
22. Wang R, Li X, Zhou S, Zhang X, Yang K, Li X. Manual acupuncture for myofascial pain syndrome: a systematic review and meta-analysis. Acupunct Med. 2017 Aug;35(4):241-250. doi:10.1136/acupmed-2016-011176.
23. Xiang A, Cheng K, Shen X, Xu P, Liu S. The Immediate Analgesic Effect of Acupuncture for Pain: A Systematic Review and Meta-Analysis. Evid Based Complement Alternat Med. 2017;2017:3837194. doi:10.1155/2017/3837194.
24. Weinstein, S, and Buckwalter, J. Orthopaedics Principles and Their Applications. Lippincott, Williams, & Wilkins, 2005.
25. Yuan J, Purepong N, Hunter RF, Kerr DP, Park J, Bradbury I, McDonough S. Different frequencies of acupuncture treatment for chronic low back pain: an assessor-blinded pilot randomised controlled trial. Complement Ther Med. 2009 Jun;17(3):131-40. doi:10.1016/j.ctim.2008.10.003.

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26. Zhao HJ, Tan JY, Wang T, Jin L. Auricular therapy for chronic pain management in adults: A synthesis of evidence. Complement Ther Clin Pract. 2015 May;21(2):68-78. doi:10.1016/j.ctcp.2015.03.006.

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ACU-8.6: Medial Epicondylitis

Synonyms

- Golfer's Elbow
- Peritendinitis
- Epicondylitis
- Elbow pain

Definition

Degeneration of the forearm flexor muscle group tendons near their origin on the humerus, possibly due to overuse. There may be a partial tear of tendon fibers at or near their point of insertion on the humerus. Pain may be acute or chronic. Risk factors are repetitive forceful wrist or forearm movement.

Oriental Medicine Diagnoses

- Qi and Blood Stagnation
  - Stagnation results in the painful condition; may have numerous causes; can be related to trauma or underlying syndromes.
- Weakness of Defensive and Nutritive Qi
  - Causation from long term illness, stress (both physical or emotional), lifestyle choices that deplete Defensive and Nutritive Qi.
- Consumption of Qi and Blood
  - Causation from long term illness or lifestyle choices that deplete Qi and Blood.
- Accumulation of Phlegm and Blood
  - Accumulation can be the result of trauma or underlying channels and collaterals stagnation or underlying syndromes. Can transform and form a sharp osteophyte at the epicondyle.

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History

Specific Aspects of History

- Rule out red flags (require medical management).
- Identify co-morbidities requiring medical management, and those that affect acupuncture and Oriental Medicine management.
- Determine if trauma-related; determine nature and extent of traumatic event.

Red Flag	Possible Consequence or Cause	Action Required
Severe trauma	Fracture	Immediate referral to emergency department
Fever, severe pain	Possible infection	Immediate referral to emergency department
Unilateral edema	Upper extremity deep vein thrombosis	Immediate referral to emergency department
Immune-compromised state	Infection	Prompt referral to Primary Care Provider
Cancer history	Cause of symptoms (metastatic or primary)	Prompt referral to Primary Care Provider
Discoloration of hand/fingers	Vascular occlusion, shunt emboli (dialysis patients)	Immediate referral to emergency department
Exertional symptoms, history of cardiac disease	Anginal equivalent	Immediate referral to emergency department
Multiple joint involvement, tophi	Rheumatological conditions, gout	Prompt referral to Primary Care Provider

Subjective Findings

- Pain at medial epicondyle
- Pain is made worse by gripping, and resisted wrist flexion
- Weak grasp in severe cases
- Possible medial collateral ligament laxity
- Pain should be documented as a numeric pain scale 0-10

Functional Assessment

- Documentation of a patient's level of function is an important aspect of patient care. This documentation is required in order to establish the medical necessity of ongoing acupuncture treatment. The Patient Specific Functional Scale (PSFS) is a patient reported outcome assessment that is easy and appropriate for acupuncturists to use. The PSFS has been studied in peer-reviewed scientific literature, and it has been proven to be a valid, reliable, and responsive measure for a variety of pain syndromes (neck, back, knee, etc.).

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Objective Findings

Scope of Musculoskeletal Examination

- Inspection including Oriental Medicine inspection techniques
- Palpation of bony and soft tissue including Oriental Medicine palpation techniques
- Range of motion, active and passive
- Orthopedic and neurologic testing if neurologic signs are present (where allowed by law)

Specific Aspects of Examination for Medial Epicondylitis

- Examine the musculoskeletal system for possible causes or contributing factors to the complaint.

Findings of Medial Epicondylitis

- Tender to palpation over medial epicondyle
- Manual muscle testing of affected wrist flexors and elbow-wrist mechanism is weak
- Resisted wrist flexion and forearm pronation is painful

Differential Diagnoses

- Cervical nerve root compression
- Ulnar nerve entrapment syndrome
- May accompany lateral epicondylitis
- Crystalline deposition such as gout and pseudogout (Chondrocalcinosis)
- Acute or chronic infection
- Olecranon bursitis

Oriental Medicine Management [10, 22, 24]

- Oriental Medicine management goals are to resolve pain, restore the highest level of function possible, and educate patient to prevent recurrent symptoms.
- To be considered medically necessary, patient's symptoms must be the direct result of a primary neuromusculoskeletal injury or illness.
- Confirmation of appropriate medical co-management is always required when treating children age 14 and under.
- Treatment frequency should be commensurate with severity of the chief complaint.
- When significant improvements in patient's subjective findings and objective findings are demonstrated—continued treatment with decreased frequency is appropriate.
- As treatment progresses, one should see an increase in the active regimen of care, a decrease in the passive regimen of care, and a fading of treatment frequency.

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- If the condition has not progressed towards resolution, refer the patient to an appropriate health care provider to explore other treatment alternatives.
- eviCore's consideration of requests for continued acupuncture treatment depends on updated clinical information submitted regarding patient's progress.
- Adequate and legible patient progress information that contains a history and examination, and/or eviCore's Acupuncture Treatment Request Form is required to determine medical necessity.
- In addition to improvements in the table below, significant progress may also be documented by increases in functional capacity and increasingly longer durations of pain relief.
- Discharge occurs when reasonable functional goals and expected outcomes have been achieved.
- The patient is discharged when the patient/care-giver can continue management of symptoms with an independent home program.
- Treatment is discontinued when the patient is unable to progress towards outcomes because of medical complications, psychosocial factors or other personal circumstances.
- If the member has been non-compliant with treatment as is evidenced by the clinical documentation, and/or the lack of demonstrated progress, treatment will be deemed to be not medically necessary and the member should be discharged from treatment.

Week	Progress
0-1	◆ Some reduction of pain frequency and severity ◆ Some reduction of muscle spasm
2-4	◆ 50% decrease in pain severity and frequency ◆ 50% improvement in function
5-8	◆ 75% decrease in pain severity and frequency ◆ 75% improvement in function
9-12	◆ Gradual improvement leading toward resolution ◆ Reinforce self-management techniques ◆ Discharge patient to elective care, or to their primary care provider for alternative treatment options when a plateau is reached, or by week 12, whichever occurs first

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Appropriate Procedures/ Modalities

- Acupuncture
- Electro-acupuncture
- Cupping
- Moxibustion
- Gua Sha
- Myofascial release
- Acupressure
- Trigger point massage
- Tui Na (not to include osseous manipulation)
- Herbal formulas

Note: Not all of these modalities are covered by the patient's health-plan; review documentation regarding coverage. Acupuncture and herbs must be appropriate for covered diagnoses under the patient's insurance policy. Acupuncturist is responsible for determining which procedures/modalities are most appropriate for the patient's condition.

Inappropriate Procedures/Modalities

- Scarring moxa
- Applied kinesiology techniques
- Electro-acupuncture using more than 9 volts
- Any technique outside the scope of practice in your state

Self-Management Techniques

- Rest and reduce strenuous activities
- Ergonomics, Postural advice, postural exercises
- Appropriate exercises/stretching
- Tai Qi, Qi Gong, Yoga
- Stress management, meditation
- Joint protection
- Weight loss
- Self-massage, Self-acupressure
- Hot packs/cold packs, if needed, to relieve discomfort

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Alternatives to Oriental Medicine Management

(listed in alphabetical order)

- Chiropractic
- Dietary/Nutritional Medicine Counseling
- Injection therapy/Pain management
- Massage therapy
- Medication
- Occupational therapy
- Osteopathic Manipulation
- Physical Therapy
- Psychological counseling
- Surgery (as last resort)

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References

1. Balshem H, Helfand M, Schunemann HJ, Oxman AD, Kunz R, Brozek J, et al. GRADE guidelines: 3. Rating the quality of evidence. J Clin Epidemiol. 2011 Apr;64(4):401-6. doi:10.1016/j.jclinepi.2010.07.015.
2. Buchbinder R, Green S, Struijs P. Tennis elbow. Am Fam Physician. 2007 Mar 1;75(5):701-2.
3. Cheng X, Deng L. Chinese Acupuncture and Moxibustion. Beijing: Foreign Language Press; 2010.
4. Hempel S, Taylor SL, Solloway MR, Miake-Lye IM, Beroes JM, Shanman R, et al. VA Evidence-based Synthesis Program Reports. Evidence Map of Acupuncture. Washington (DC): Department of Veterans Affairs; 2014.
5. Horn KK, Jennings S, Richardson G, Vliet DV, Hefford C, Abbott JH. The patient-specific functional scale: psychometrics, clinimetrics, and application as a clinical outcome measure. J Orthop Sports Phys Ther. 2012 Jan;42(1):30-42. doi:10.2519/jospt.2012.3727.
6. Johnson GW, Cadwallader K, Scheffel SB, Epperly TD. Treatment of lateral epicondylitis. Am Fam Physician. 2007 Sep 15;76(6):843-8.
7. Kaptchuk T. The Web That Has No Weaver. Contemporary Books. 2000.
8. Kelly RB. Acupuncture for pain. Am Fam Physician. 2009 Sep 1;80(5):481-4.
9. Kligler B, Nielsen A, Kohrrer C, Schmid T, Waltermaurer E, Perez E, Merrell W. Acupuncture Therapy in a Group Setting for Chronic Pain. Pain Med. 2017 Jun 8. doi:10.1093/pm/pnx134.
10. Li X, Wang R, Xing X, et al. Acupuncture for Myofascial Pain Syndrome: A Network Meta-Analysis of 33 Randomized Controlled Trials. Pain Physician. 2017 Sep;20(6):E883-E902.
11. Maciocia, G; The Foundations of Chinese Medicine: A Comprehensive Text; Churchill Livingstone, 2005.
12. MacPherson H, Vertosick EA, Foster NE, Lewith G, Linde K, Sherman KJ, et al. The persistence of the effects of acupuncture after a course of treatment: A meta-analysis of patients with chronic pain. Pain. 2016 Oct 17. doi:10.1097/j.pain.0000000000000747.
13. Magee, David J., Orthopedic Physical Assessment, Second Edition, W.B. Saunders Company, 2007.
14. McDonald J, Janz S. The Acupuncture Evidence Project: A Comparative Literature Review (Revised Edition). Brisbane: Australian Acupuncture and Chinese Medicine Association Ltd; 2017.
15. National Health and Medical Research Council. NHMRC additional levels of evidence and grades for recommendations for developers of guidelines. Table 3. NHMRC Evidence Hierarchy: designations of 'levels of evidence' according to type of research question (including explanatory notes). National Health and Medical Research Council; 2009.
16. O'Connor J, Bensky D. Acupuncture: A Comprehensive Text. Chicago: Eastland Press; 1981.
17. Olson WH, Brumback RA, Gascon G, Iyer V; Handbook of Symptom Oriented Neurology; Year Book Medical Publishers, Inc.; 2002.
18. Porter, R; The Merck Manual, Merck, 2011.
19. Roy, S., Irvin, R., and Iverson, D; Sports Medicine, Prevention, Education, Management, and Rehabilitation, Benjamin Cummings, 1998.
20. Tang H, Fan H, Chen J, Yang M, Yi X, Dai G, et al. Acupuncture for Lateral Epicondylitis: A Systematic Review. Evid Based Complement Alternat Med. 2015;2015:861849. doi:10.1155/2015/861849.
21. Trudel D, Duley J, Zastrow I, Kerr EW, Davidson R, MacDermid JC. Rehabilitation for patients with lateral epicondylitis: a systematic review. J Hand Ther. 2004 Apr-Jun;17(2):243-66.
22. Wang R, Li X, Zhou S, Zhang X, Yang K, Li X. Manual acupuncture for myofascial pain syndrome: a systematic review and meta-analysis. Acupunct Med. 2017 Aug;35(4):241-250. doi:10.1136/acupmed-2016-011176.
23. Weinstein, S, and Buckwalter, J. Orthopaedics Principles and Their Applications. Lippincott, Williams, & Wilkins, 2005.
24. Xiang A, Cheng K, Shen X, Xu P, Liu S. The Immediate Analgesic Effect of Acupuncture for Pain: A Systematic Review and Meta-Analysis. Evid Based Complement Alternat Med. 2017;2017:3837194. doi:10.1155/2017/3837194.
25. Yuan J, Purepong N, Hunter RF, Kerr DP, Park J, Bradbury I, McDonough S. Different frequencies of acupuncture treatment for chronic low back pain: an assessor-blinded pilot randomised controlled trial. Complement Ther Med. 2009 Jun;17(3):131-40. doi:10.1016/j.ctim.2008.10.003.

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26. Zhao HJ, Tan JY, Wang T, Jin L. Auricular therapy for chronic pain management in adults: A synthesis of evidence. Complement Ther Clin Pract. 2015 May;21(2):68-78. doi:10.1016/j.ctcp.2015.03.006.

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ACU-8.7: Radial Nerve Entrapment

Synonyms

- Elbow pain, arm pain

Definition

Entrapment between anatomical structures causing compression resulting in paresthesias, pain and weakness. Pain may be acute or chronic.

Oriental Medicine Diagnoses

- Qi and Blood Stagnation
  - Stagnation results in this painful condition; may have numerous causation; can be related to trauma or underlying syndromes.

History

A number of radial nerve entrapments are recognized. They are named according to the location where they occur:

High radial nerve palsy
Radial nerve palsy is frequently related to humeral fractures, and may occur by direct trauma or callus formation, or by compression from scarring or musculature. Weakness of the wrist and finger extensors is present, and with sensory deficits.

Radial tunnel syndrome (RTS)

- Radial tunnel syndrome involves compression of the deep branch of the radial nerve. The same structures implicated in PIN compression syndrome can cause radial tunnel syndrome, although RTS is often thought of as a dynamic compression syndrome.
- Compression of the nerve occurs during elbow extension, forearm pronation, and wrist flexion, which caused the ECRB and the fibrous edge of the superficial part of the supinator to tighten around the nerve.
- Symptoms mimic those of tennis elbow: tenderness over the lateral aspect of the elbow, pain on passive stretching of the extensor muscles, and pain on resisted extension of the wrist and fingers.
- Men and women are equally affected, and onset is common in the fourth to sixth decades of life.
- Pain, poorly localized over the radial aspect of the proximal forearm is the most common primary presenting symptom.
- Maximal tenderness is usually elicited over the radial tunnel and the pain may be reproduced by resisted middle finger extension.

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Superficial radial nerve palsy

- Wartenberg's syndrome or Cheiralgia Paresthetica are terms used to describe a mononeuritis of the superficial radial nerve that can become entrapped where it pierces the fascia between the brachioradialis and extensor carpi radialis longus tendons.
- Symptoms include shooting or burning pain along the posterior-radial forearm, wrist, and thumb associated with wrist flexion and ulnar deviation. Symptoms may lead to the belief that the anatomic snuffbox joint and tendons are involved, or that de Quervain's disease is present.

Posterior interosseous nerve syndrome (PINS)

- Following are five potential sites of compression of PINS as it traverses through the radial tunnel:
  - Fibrous bands that connect the brachialis to brachioradialis.
  - Vascular leash of Henry, a fan of Blood vessels that cross the nerve at the level of the radial neck.
  - Medial proximal portion (leading edge) of the ECRB.
  - Between fibrous bands at the proximal and distal edge of the supinator. Proximal border is referred to as the Arcade of Fröhse.
  - PINS involves the loss of motor function of some or all of the muscles innervated by the posterior interosseous nerve and is characterized by weakness.

Specific Aspects of History

- Rule out red flags (require medical management),
- Identify co-morbidities requiring medical management, and those that affect acupuncture and Oriental Medicine management.
- Determine if trauma-related; determine nature and extent of traumatic event.

Red Flag	Possible Consequence or Cause	Action Required
Severe trauma	Fracture	Immediate referral to emergency department
Fever, severe pain	Possible infection	Immediate referral to emergency department
Unilateral edema	Upper extremity deep vein thrombosis	Immediate referral to emergency department
Immune-compromised state	Infection	Prompt referral to Primary Care Provider
Cancer history	Cause of symptoms (metastatic or primary)	Prompt referral to Primary Care Provider
Discoloration of hand/fingers	Vascular occlusion, shunt emboli (dialysis patients)	Immediate referral to emergency department
Exertional symptoms, history of cardiac disease	Anginal equivalent	Immediate referral to emergency department

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Presentation

- Patient's specific presentation will depend on severity, duration and location of the nerve compression. Weakness of the wrist and finger extensors, abnormal sensation, and pain are common complaints, varying in location and prominence with each area of entrapment.
  - Pain should be documented as a numeric pain scale 0-10
  - Neuropathic symptom frequency, duration and numeric pain scale should be documented

Functional Assessment

- Documentation of a patient's level of function is an important aspect of patient care. This documentation is required in order to establish the medical necessity of ongoing acupuncture treatment. The Patient Specific Functional Scale (PSFS) is a patient reported outcome assessment that is easy and appropriate for acupuncturists to use. The PSFS has been studied in peer-reviewed scientific literature, and it has been proven to be a valid, reliable, and responsive measure for a variety of pain syndromes (neck, back, knee, etc.).

Objective Findings

Scope of Musculoskeletal Examination

- Inspection
- Palpation of bony and soft tissue
- Range of motion, active and passive
- Orthopedic testing
- Neurologic testing
- Manual muscle testing

Specific Aspects of Examination for Radial Nerve Entrapment

- Examine the musculoskeletal system for possible causes or contributing factors to the complaint.

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Findings of Radial Nerve Entrapment

- High Radial Nerve Palsy
  - Weakness noted in the extensors
  - Abnormal sensation on the dorsum of the hand
- Radial Tunnel Syndrome
  - Lateral forearm pain
  - Weakness of wrist extensors
- Radial Sensory Nerve Entrapment
  - Distal forearm pain
  - Abnormal sensation of the dorsum of the hand
- Posterior interosseous nerve syndrome
  - Weakness in the extensors, sometimes with sparing of radial deviation
  - Forearm pain

Differential Diagnoses

- C6 or C7 cervical nerve root compression
- Crystalline deposition such as gout and pseudogout (Chondrocalcinosis)
- Lateral epicondylitis
- de Quervain's disease
- Olecranon bursitus

Oriental Medicine Management [8, 18, 20]

- Most patients with this diagnosis will already have consulted with their Primary Care Provider. If not, however, they should be directed to make an appointment with their MD at their earliest opportunity.
- Confirmation of appropriate medical co-management is always required when treating children age 14 and under.
- Oriental Medicine management goals are to resolve pain, restore the highest level of function possible, and educate patient to prevent recurrent symptoms.
- To be considered medically necessary, patient's symptoms must be the direct result of a primary neuromusculoskeletal injury or illness.
- Treatment frequency should be commensurate with severity of the chief complaint.
- If at least 50% improvement in pain frequency and severity is reported by the patient—continued treatment with decreased frequency is appropriate.
- As treatment progresses, one should see an increase in the active regimen of care, a decrease in the passive regimen of care, and a fading of treatment frequency.
- If the condition has not progressed towards resolution, refer the patient to an appropriate health care provider to explore other treatment alternatives.

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- eviCore's consideration of requests for continued acupuncture treatment depends on updated clinical information submitted regarding patient's progress.
- Adequate and legible patient progress information that contains a history and examination, and/or eviCore's Acupuncture Treatment Request Form is required to determine medical necessity.
- In addition to improvements in the table below, significant progress may be documented by increases in functional capacity and increasingly longer durations of pain relief.
- Discharge occurs when reasonable functional goals and expected outcomes have been achieved.
- The patient is discharged when the patient/care-giver can continue management of symptoms with an independent home program.
- Treatment is discontinued when the patient is unable to progress towards outcomes because of medical complications, psychosocial factors or other personal circumstances.
- If the member has been non-compliant with treatment as is evidenced by the clinical documentation, and/or the lack of demonstrated progress, treatment will be deemed to be not medically necessary and the member should be discharged from treatment.

Week	Progress
0-1	◆ Some reduction of pain severity and frequency ◆ Some reduction of muscle spasm
2-4	◆ 50% improvement in pain severity and frequency ◆ 50% increase in function ◆ Pain distribution is centralizing ◆ Reinforce self-management techniques
5-8	◆ Continued reduction of pain severity and frequency ◆ Continued increase in function ◆ Pain distribution continues to centralize ◆ Reinforce self-management techniques
9-12	◆ 75% improvement in pain severity and frequency ◆ 75% improvement in function ◆ Pain distribution is centralized to back ◆ Reinforce self-management techniques
13-16	◆ Gradual improvement leading toward resolution ◆ Reinforce self-management techniques ◆ Discharge patient to elective care, or to their primary care provider for alternative treatment options when a plateau is reached, or by week 16, whichever occurs first

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Appropriate Procedures/ Modalities

- Acupuncture
- Electro-acupuncture
- Cupping
- Moxibustion
- Gua Sha
- Myofascial release
- Acupressure
- Trigger point massage
- Tui Na (not to include osseous manipulation)
- Herbal formulas

Note: Not all of these modalities are covered by the patient's health-plan; review documentation regarding coverage. Acupuncture and herbs must be appropriate for covered diagnoses under the patient's insurance policy. Acupuncturist is responsible for determining which procedures/modalities are most appropriate for the patient's condition.

Inappropriate Procedures/Modalities

- Scarring moxa
- Applied kinesiology techniques
- Electro-acupuncture using more than 9 volt
- Any technique outside the scope of practice in your state

Self-Management Techniques

- Tai Qi
- Qi gong
- Self-acupressure
- Rest and reduce strenuous activities
- Hot packs/Cold packs, if needed, to relieve discomfort
- Home range of motion exercises
- Progression to therapeutic exercise: strengthening exercises

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Alternatives to Oriental Medicine Management

(listed in alphabetical order)

- Chiropractic
- Dietary/Nutritional Medicine Counseling
- Injection therapy/Pain management
- Massage therapy
- Medication
- Occupational therapy
- Osteopathic Manipulation
- Physical Therapy
- Psychological counseling

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References

1. Balshem H, Helfand M, Schunemann HJ, Oxman AD, Kunz R, Brozek J, et al. GRADE guidelines: 3. Rating the quality of evidence. J Clin Epidemiol. 2011 Apr;64(4):401-6. doi:10.1016/j.jclinepi.2010.07.015.
2. Cheng X, Deng L. Chinese Acupuncture and Moxibustion. Beijing: Foreign Language Press; 2010.
3. Hempel S, Taylor SL, Solloway MR, Miake-Lye IM, Beroes JM, Shanman R, et al. VA Evidence-based Synthesis Program Reports. Evidence Map of Acupuncture. Washington (DC): Department of Veterans Affairs; 2014.
4. Horn KK, Jennings S, Richardson G, Vliet DV, Hefford C, Abbott JH. The patient-specific functional scale: psychometrics, clinimetrics, and application as a clinical outcome measure. J Orthop Sports Phys Ther. 2012 Jan;42(1):30-42. doi:10.2519/jospt.2012.3727.
5. Kaptchuk T. The Web That Has No Weaver. Contemporary Books. 2000.
6. Kelly RB. Acupuncture for pain. Am Fam Physician. 2009 Sep 1;80(5):481-4.
7. Kligler B, Nielsen A, Kohrrer C, Schmid T, Waltermaurer E, Perez E, Merrell W. Acupuncture Therapy in a Group Setting for Chronic Pain. Pain Med. 2017 Jun 8. doi:10.1093/pm/pnx134.
8. Li X, Wang R, Xing X, et al. Acupuncture for Myofascial Pain Syndrome: A Network Meta-Analysis of 33 Randomized Controlled Trials. Pain Physician. 2017 Sep;20(6):E883-E902.
9. Maciocia, G; The Foundations of Chinese Medicine: A Comprehensive Text; Churchill Livingstone, 2005.
10. MacPherson H, Vertosick EA, Foster NE, Lewith G, Linde K, Sherman KJ, et al. The persistence of the effects of acupuncture after a course of treatment: A meta-analysis of patients with chronic pain. Pain. 2016 Oct 17. doi:10.1097/j.pain.0000000000000747.
11. Magee, David J., Orthopedic Physical Assessment, Second Edition, W.B. Saunders Company, 2007.
12. McDonald J, Janz S. The Acupuncture Evidence Project: A Comparative Literature Review (Revised Edition). Brisbane: Australian Acupuncture and Chinese Medicine Association Ltd; 2017.
13. National Health and Medical Research Council. NHMRC additional levels of evidence and grades for recommendations for developers of guidelines. Table 3. NHMRC Evidence Hierarchy: designations of 'levels of evidence' according to type of research question (including explanatory notes). National Health and Medical Research Council; 2009.
14. O'Connor J, Bensky D. Acupuncture: A Comprehensive Text. Chicago: Eastland Press; 1981.
15. Olson WH, Brumback RA, Gascon G, Iyer V; Handbook of Symptom Oriented Neurology; Year Book Medical Publishers, Inc.; 2002.
16. Porter, R; The Merck Manual, Merck, 2011.
17. Roy, S., Irvin, R., and Iverson, D; Sports Medicine, Prevention, Education, Management, and Rehabilitation, Benjamin Cummings, 1998.
18. Wang R, Li X, Zhou S, Zhang X, Yang K, Li X. Manual acupuncture for myofascial pain syndrome: a systematic review and meta-analysis. Acupunct Med. 2017 Aug;35(4):241-250. doi:10.1136/acupmed-2016-011176.
19. Weinstein, S, and Buckwalter, J. Orthopaedics Principles and Their Applications. Lippincott, Williams, & Wilkins, 2005.
20. Xiang A, Cheng K, Shen X, Xu P, Liu S. The Immediate Analgesic Effect of Acupuncture for Pain: A Systematic Review and Meta-Analysis. Evid Based Complement Alternat Med. 2017;2017:3837194. doi:10.1155/2017/3837194.
21. Yuan J, Purepong N, Hunter RF, Kerr DP, Park J, Bradbury I, McDonough S. Different frequencies of acupuncture treatment for chronic low back pain: an assessor-blinded pilot randomised controlled trial. Complement Ther Med. 2009 Jun;17(3):131-40. doi:10.1016/j.ctim.2008.10.003.
22. Zhao HJ, Tan JY, Wang T, Jin L. Auricular therapy for chronic pain management in adults: A synthesis of evidence. Complement Ther Clin Pract. 2015 May;21(2):68-78. doi:10.1016/j.ctcp.2015.03.006.

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ACU-8.8: Shoulder, Adhesive Capsulitis

Synonym

- Frozen shoulder
- Shoulder pain

Definition

- Adhesive capsulitis develops when the capsule surrounding the humeral head becomes contracted thereby limiting or preventing motion.
- Adhesive capsulitis has typically been classified into two forms:
  - Primary or idiopathic form—no known precipitating event can be identified.
  - Secondary form—associated with, or attributable to other illnesses or events.
- Cause of adhesive capsulitis remains unknown. End result appears to be fibrotic thickening of the anterior capsule at the rotator interval. Onset of adhesive capsulitis is usually gradual.
- Following are the three clinical stages of the disease:

Freezing stage	Frozen stage	Thawing stage
Lasts from onset to between 10 and 36 weeks. Characterized by the most severe pain and a gradual diminution of articular volume.	Lasts between 4 and 12 months. Pain decreases gradually but without appreciable improvement in motion.	Marked by gradual return of motion, and may be as short as 12 months, or last for years. Motions most frequently limited are abduction and external rotation.

Oriental Medicine Diagnoses

- Qi and Blood Stagnation
  - Stagnation results in this painful condition; may have numerous causes; can be related to trauma or underlying syndromes.
- Bi Syndrome—Wind, Cold and Dampness
  - Wind, Cold and Dampness from an external pathogen, or from underlying causation producing Wind, Cold and Damp "attacking" the area of the shoulder

History

Key features of patient's history include sub-acute onset of unilateral shoulder pain with little to no trauma or overuse, a distinct component of night pain, and marked limitation in shoulder movement. Following are some risk factors for developing frozen shoulder:

- Age & Gender
  - Frozen shoulder most commonly affects patients between the ages of 40 to 60 years old, and is twice as common in women than in men.
- Endocrine Disorders

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- Patients with diabetes are at particular risk for developing a frozen shoulder. Other endocrine abnormalities, such as thyroid problems, can also lead to this condition.

- Shoulder Trauma or Surgery
  - Patients who sustain a shoulder injury, or undergo shoulder surgery can develop a frozen shoulder joint. When injury or surgery is followed by prolonged joint immobilization, the risk of developing a frozen shoulder is highest.
- Other Systemic Conditions
  - Several systemic conditions, such as heart disease and Parkinson's disease have also been associated with an increased risk for developing a frozen shoulder.

Specific Aspects of History

- Rule out red flags (require medical management).
- Identify co-morbidities requiring medical management, and those that affect acupuncture and Oriental Medicine management.
- Determine if trauma-related; determine nature and extent of traumatic event.

Red Flag	Possible Consequence or Cause	Action Required
Severe trauma	Fracture, rotator cuff tear	Immediate referral to emergency department
Exertional, history of cardiac diagnosis	Cardiac pain can radiate to the shoulder	Immediate referral to emergency department
Constant, relieved/worse with meals, positional, associated with fatty meals	Gastrointestinal diseases including cholelithiasis	Immediate referral to emergency department
Pleuritic, shortness of breath, associated with cough	Pulmonary diseases	Prompt referral to Primary Care Provider
Multiple joint involvement	Rheumatology diseases	Prompt referral to Primary Care Provider
Fever, severe pain	Possible infection	Immediate referral to emergency department
Cancer history	Cause of symptoms (metastatic or primary)	Prompt referral to Primary Care Provider
Unilateral edema	Upper extremity deep vein thrombosis	Immediate referral to emergency department
Immune-compromised state	Infection	Prompt referral to Primary Care Provider

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Presentation

A marked limitation in active and passive range of shoulder motion. All planes of motion seem to be affected, with external rotation and abduction being the most limited. In testing passive motion, the end point is firm but not quite as firm as that of a bony block. Manual muscle testing of the rotator cuff muscles should reveal well-preserved muscle strength with little to no pain.

Subjective Findings

- Shoulder pain, which may radiate distally or proximally
- Pain with range of motion
- Loss of range of motion
- Pain should be documented as a numeric pain scale 0-10
- Radiating symptom frequency, duration and numeric pain scale should be documented

Functional Assessment

- Documentation of a patient's level of function is an important aspect of patient care. This documentation is required in order to establish the medical necessity of ongoing acupuncture treatment. The Patient Specific Functional Scale (PSFS) is a patient reported outcome assessment that is easy and appropriate for acupuncturists to use. The PSFS has been studied in peer-reviewed scientific literature, and it has been proven to be a valid, reliable, and responsive measure for a variety of pain syndromes (neck, back, knee, etc.).

Objective Findings

Scope of Musculoskeletal Examination

- Inspection
- Palpation of bony and soft tissue
- Range of motion, active and passive
- Orthopedic and neurologic testing

Specific Aspects of Examination for Adhesive Capsulitis

Examine the musculoskeletal system for possible causes or contributing factors to the complaint.

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Findings of Adhesive Capsulitis

- Limited active range of motion and passive range of motion of the affected shoulder
- Manual muscle testing of the affected shoulder is strong and pain-free
- Patient presents with “capsular pattern”: most limited in external rotation, followed by abduction, followed by flexion, followed by internal rotation
- “Firm” end point

Differential Diagnoses

- Referred pain from cardiac, pulmonary, or gastrointestinal pathology
- Inflammatory diseases
- Infection
- Fracture
- Rotator cuff pathology
- Glenohumeral arthritis

Oriental Medicine Management [8, 18, 20]

- Oriental Medicine management goals are to resolve pain, restore the highest level of function possible, and educate patient to prevent recurrent symptoms.
- To be considered medically necessary, patient’s symptoms must be the direct result of a primary neuromusculoskeletal injury or illness.
- Confirmation of appropriate medical co-management is always required when treating children age 14 and under.
- Treatment frequency should be commensurate with severity of the chief complaint.
- When significant improvements in patient’s subjective findings and objective findings are demonstrated—continued treatment with decreased frequency is appropriate.
- As treatment progresses, one should see an increase in the active regimen of care, a decrease in the passive regimen of care, and a fading of treatment frequency.
- If the condition has not progressed towards resolution, refer the patient to an appropriate health care provider to explore other treatment alternatives.
- eviCore’s consideration of requests for continued acupuncture treatment depends on updated clinical information submitted regarding patient’s progress.
- Adequate and legible patient progress information that contains a history and examination, and/or eviCore’s Acupuncture Treatment Request Form is required to determine medical necessity.
- In addition to improvements in the table below, significant progress may be documented by increases in functional capacity and increasingly longer durations of pain relief.

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- Discharge occurs when reasonable functional goals and expected outcomes have been achieved.
- The patient is discharged when the patient/care-giver can continue management of symptoms with an independent home program.
- Treatment is discontinued when the patient is unable to progress towards outcomes because of medical complications, psychosocial factors or other personal circumstances.
- If the member has been non-compliant with treatment as is evidenced by the clinical documentation, and/or the lack of demonstrated progress, treatment will be deemed to be not medically necessary and the member should be discharged from treatment.

Week	Progress
0-1	◆ Some reduction of pain severity and frequency ◆ Some reduction of muscle spasm
2-4	◆ 50% decrease in pain severity and frequency ◆ 50% improvement in function
5-8	◆ 75% decrease in pain severity and frequency ◆ 75% improvement in function
9-12	◆ Gradual improvement leading toward resolution ◆ Reinforce self-management techniques ◆ Discharge patient to elective care, or to their primary care provider for alternative treatment options when a plateau is reached, or by week 12, whichever occurs first

Appropriate Procedures/ Modalities

- Acupuncture
- Electro-acupuncture
- Cupping
- Moxibustion
- Gua Sha
- Myofascial release
- Acupressure
- Trigger point massage
- Tui Na (not to include osseous manipulation)
- Herbal formulas

Note: Not all of these modalities are covered by the patient's health-plan; review documentation regarding coverage. Acupuncture and herbs must be appropriate for covered diagnoses under the patient's insurance policy. Acupuncturist is responsible for determining which procedures/modalities are most appropriate for the patient's condition.

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Inappropriate Procedures/Modalities

- Scarring moxa
- Applied kinesiology techniques
- Electro-acupuncture using more than 9 volts
- Any technique outside the scope of practice in your state

Self-Management Techniques

- Tai Qi
- Qi gong
- Self-acupressure
- Rest and reduce strenuous activities
- Educate patients about the causes
- Appropriate exercises
- Postural advice
- Hot packs/cold packs, if needed, to relieve discomfort

Alternatives to Oriental Medicine Management

(listed in alphabetical order)

- Chiropractic
- Dietary/Nutritional Medicine Counseling
- Injection therapy/Pain management
- Massage therapy
- Medication
- Occupational therapy
- Osteopathic Manipulation
- Physical Therapy
- Psychological counseling

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References

1. Balshem H, Helfand M, Schunemann HJ, Oxman AD, Kunz R, Brozek J, et al. GRADE guidelines: 3. Rating the quality of evidence. J Clin Epidemiol. 2011 Apr;64(4):401-6. doi:10.1016/j.jclinepi.2010.07.015.
2. Cheng X, Deng L. Chinese Acupuncture and Moxibustion. Beijing: Foreign Language Press; 2010.
3. Hempel S, Taylor SL, Solloway MR, Miake-Lye IM, Beroes JM, Shanman R, et al. VA Evidence-based Synthesis Program Reports. Evidence Map of Acupuncture. Washington (DC): Department of Veterans Affairs; 2014.
4. Horn KK, Jennings S, Richardson G, Vliet DV, Hefford C, Abbott JH. The patient-specific functional scale: psychometrics, clinimetrics, and application as a clinical outcome measure. J Orthop Sports Phys Ther. 2012 Jan;42(1):30-42. doi:10.2519/jospt.2012.3727.
5. Kaptchuk T. The Web That Has No Weaver. Contemporary Books. 2000.
6. Kelly RB. Acupuncture for pain. Am Fam Physician. 2009 Sep 1;80(5):481-4.
7. Kligler B, Nielsen A, Kohrrer C, Schmid T, Waltermaurer E, Perez E, Merrell W. Acupuncture Therapy in a Group Setting for Chronic Pain. Pain Med. 2017 Jun 8. doi:10.1093/pm/pnx134.
8. Li X, Wang R, Xing X, et al. Acupuncture for Myofascial Pain Syndrome: A Network Meta-Analysis of 33 Randomized Controlled Trials. Pain Physician. 2017 Sep;20(6):E883-E902.
9. Maciocia, G; The Foundations of Chinese Medicine: A Comprehensive Text; Churchill Livingstone, 2005.
10. MacPherson H, Vertosick EA, Foster NE, Lewith G, Linde K, Sherman KJ, et al. The persistence of the effects of acupuncture after a course of treatment: A meta-analysis of patients with chronic pain. Pain. 2016 Oct 17. doi:10.1097/j.pain.0000000000000747.
11. Magee, David J., Orthopedic Physical Assessment, Second Edition, W.B. Saunders Company, 2007.
12. McDonald J, Janz S. The Acupuncture Evidence Project: A Comparative Literature Review (Revised Edition). Brisbane: Australian Acupuncture and Chinese Medicine Association Ltd; 2017.
13. National Health and Medical Research Council. NHMRC additional levels of evidence and grades for recommendations for developers of guidelines. Table 3. NHMRC Evidence Hierarchy: designations of 'levels of evidence' according to type of research question (including explanatory notes). National Health and Medical Research Council; 2009.
14. O'Connor J, Bensky D. Acupuncture: A Comprehensive Text. Chicago: Eastland Press; 1981.
15. Olson WH, Brumback RA, Gascon G, Iyer V; Handbook of Symptom Oriented Neurology; Year Book Medical Publishers, Inc.; 2002.
16. Porter, R; The Merck Manual, Merck, 2011.
17. Roy, S., Irvin, R., and Iverson, D; Sports Medicine, Prevention, Education, Management, and Rehabilitation, Benjamin Cummings, 1998.
18. Wang R, Li X, Zhou S, Zhang X, Yang K, Li X. Manual acupuncture for myofascial pain syndrome: a systematic review and meta-analysis. Acupunct Med. 2017 Aug;35(4):241-250. doi:10.1136/acupmed-2016-011176.
19. Weinstein, S, and Buckwalter, J. Orthopaedics Principles and Their Applications. Lippincott, Williams, & Wilkins, 2005.
20. Xiang A, Cheng K, Shen X, Xu P, Liu S. The Immediate Analgesic Effect of Acupuncture for Pain: A Systematic Review and Meta-Analysis. Evid Based Complement Alternat Med. 2017;2017:3837194. doi:10.1155/2017/3837194.
21. Yuan J, Purepong N, Hunter RF, Kerr DP, Park J, Bradbury I, McDonough S. Different frequencies of acupuncture treatment for chronic low back pain: an assessor-blinded pilot randomised controlled trial. Complement Ther Med. 2009 Jun;17(3):131-40. doi:10.1016/j.ctim.2008.10.003.
22. Zhao HJ, Tan JY, Wang T, Jin L. Auricular therapy for chronic pain management in adults: A synthesis of evidence. Complement Ther Clin Pract. 2015 May;21(2):68-78. doi:10.1016/j.ctcp.2015.03.006.

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ACU-8.9: Shoulder, Joint Pain and Osteoarthrosis

Synonyms

- Osteoarthritis
- Degenerative arthritis
- Degenerative joint disease
- Hypertrophic arthritis
- Shoulder pain

Definition

Degenerative, and sometimes hypertrophic changes in the bone and cartilage of one or more joints, and a progressive wearing down of opposing joint surfaces with consequent distortion of joint position. Pain may be acute or chronic.

Oriental Medicine Diagnoses

Various types of arthritis are contained under the singular rubric of blockage, or Painful Obstruction, in Chinese Medicine. Condition occurs when the circulation of Qi and Blood through channels is hindered by Wind, Cold and/or Dampness. Dampness, or if at a certain stage of the disease cold becomes Heat, then Heat Blockage can occur.

Following are the five principal Blockages or Obstructions in Chinese Medicine. Commonly referred to as Bi Syndrome, the condition can be any combination of the below:

- Wind Bi, Moving (Wind) Painful Obstruction
  - Pain in the joints is widespread and moves from one area of the body to another.
- Damp Bi, Stationary (Damp) Painful Obstruction
  - Pain is localized and does not move.
- Cold Bi, Painful (Cold) Painful Obstruction
  - Severe pain in one part, or over one half of the body, which becomes worse when patient encounters cold and diminishes when patient is warm.
- Heat Bi, Heat Painful Obstruction
  - Flesh is hot, area of pain is red and swollen, pain increases upon contact.

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History

Specific Aspects of History

- Rule out red flags (require medical management).
- Identify co-morbidities requiring medical management, and those that affect acupuncture and Oriental Medicine management.
- Determine if trauma-related; determine nature and extent of traumatic event.

Red Flag	Possible Consequence or Cause	Action Required
Severe trauma	Fracture, ligament/meniscus tear	Immediate referral to emergency department
Fever, severe pain	Infection	Immediate referral to emergency department
Severe arm pain 12-24 hours after trauma	Compartment syndrome	Immediate referral to emergency department
Diabetes	Neuropathy	Prompt referral to Primary Care Provider
Multiple joint involvement	Rheumatologic diseases	Prompt referral to Primary Care Provider
Unilateral edema	Deep vein thrombosis	Immediate referral to emergency department
Cancer	Cause of symptoms (metastatic or primary)	Prompt referral to Primary Care Provider
Discoloration of hand or arm	Arterial occlusion	Immediate referral to emergency department
Immune-compromised state	Infection	Prompt referral to Primary Care Provider

Subjective Findings

- Pain is localized to the joint area
- Warmth may be felt over the affected joint, in the inflammatory stage
- Pain with range of motion may be described
- Onset is usually gradual and insidious
- Patient will complain of stiffness
- Pain should be documented as a numeric pain scale 0-10Functional Assessment

Functional Assessment

- Documentation of a patient's level of function is an important aspect of patient care. This documentation is required in order to establish the medical necessity of ongoing acupuncture treatment. The Patient Specific Functional Scale (PSFS) is a patient reported outcome assessment that is easy and appropriate for acupuncturists to use. The PSFS has been studied in peer-reviewed scientific literature, and it has been proven to be a valid, reliable, and responsive measure for a variety of pain syndromes (neck, back, knee, etc.).

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Objective Findings

Scope of Musculoskeletal Examination

- Inspection
- Palpation of bony and soft tissue
- Range of motion, active and passive (if allowed by law)
- Orthopedic and neurologic testing if neurologic signs are present (if allowed by law)

Specific Aspects of Examination for Osteoarthrosis

- Examine the musculoskeletal system for possible causes or contributing factors to the complaint.

Findings of Osteoarthrosis

- Swelling may be present in the inflammatory phase
- Calor (warmth) may be noted over the affected joint in the inflammatory phase
- Pain over the joint
- Pain with ROM, loss of ROM

Differential Diagnoses

- Rotator cuff tendonitis
- Rotator cuff tears
- Calcific tendonitis
- Bicipital tendonitis
- Acromioclavicular arthritis
- Adhesive capsulitis

Oriental Medicine Management [10, 22, 24]

- Oriental Medicine management goals are to resolve pain, restore the highest level of function possible, and educate patient to prevent recurrent symptoms.
- To be considered medically necessary, patient's symptoms must be the direct result of a primary neuromusculoskeletal injury or illness.
- Confirmation of appropriate medical co-management is always required when treating children age 14 and under.
- Treatment frequency should be commensurate with severity of the chief complaint.
- If at least 50% improvement in pain frequency and severity is reported by patient—continued treatment with decreased frequency is appropriate.
- As treatment progresses, one should see an increase in the active regimen of care, a decrease in the passive regimen of care, and a fading of treatment frequency.

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- If the condition has not progressed towards resolution, refer the patient to an appropriate health care provider to explore other treatment alternatives.
- eviCore's consideration of requests for continued acupuncture treatment depends on updated clinical information submitted regarding patient's progress.
- Adequate and legible patient progress information that contains a history and examination, and/or eviCore's Acupuncture Treatment Request Form is required to determine medical necessity.
- In addition to improvements in the table below, significant progress may be documented by increases in functional capacity and increasingly longer durations of pain relief.
- Discharge occurs when reasonable functional goals and expected outcomes have been achieved.
- The patient is discharged when the patient/care-giver can continue management of symptoms with an independent home program.
- Treatment is discontinued when the patient is unable to progress towards outcomes because of medical complications, psychosocial factors or other personal circumstances.
- If the member has been non-compliant with treatment as is evidenced by the clinical documentation, and/or the lack of demonstrated progress, treatment will be deemed to be not medically necessary and the member should be discharged from treatment.

Week	Progress
0-1	◆ Some reduction of pain severity and frequency ◆ Some reduction of muscle spasm
2-4	◆ 50% decrease in pain severity and frequency ◆ 50% improvement in function
5-8	◆ 75% decrease in pain severity and frequency ◆ 75% improvement in function
9-12	◆ Gradual improvement leading toward resolution ◆ Reinforce self-management techniques ◆ Discharge patient to elective care, or to their primary care provider for alternative treatment options when a plateau is reached, or by week 12, whichever occurs first

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Appropriate Procedures/ Modalities

- Acupuncture
- Electro-acupuncture
- Cupping
- Moxibustion
- Gua Sha
- Myofascial release
- Acupressure
- Trigger point massage
- Tui Na (not to include osseous manipulation)
- Herbal formulas

Note: Not all of these modalities are covered by the patient's health-plan; review documentation regarding coverage. Acupuncture and herbs must be appropriate for covered diagnoses under the patient's insurance policy. Acupuncturist is responsible for determining which procedures/modalities are most appropriate for the patient's condition.

Inappropriate Procedures/Modalities

- Scarring moxa
- Applied kinesiology techniques
- Electro-acupuncture using more than 9 volts
- Any technique outside the scope of practice in your state

Self-Management Techniques

- Tai Qi
- Qi gong
- Self-acupressure
- Rest and reduce strenuous activities
- Educate patients about the causes
- Appropriate exercises
- Hot packs/cold packs, if needed, to relieve discomfort

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Alternatives to Oriental Medicine Management

(listed in alphabetical order)

- Chiropractic
- Dietary/Nutritional Medicine Counseling
- Injection therapy/Pain management
- Massage therapy
- Medication
- Occupational therapy
- Osteopathic Manipulation
- Physical Therapy
- Psychological counseling

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References

1. Amezaga Urruela M, Suarez-Almazor ME. Acupuncture in the treatment of rheumatic diseases. Curr Rheumatol Rep. 2012;14(6):589-597. doi:10.1007/s11926-012-0295-x.
2. Balshem H, Helfand M, Schunemann HJ, Oxman AD, Kunz R, Brozek J, et al. GRADE guidelines: 3. Rating the quality of evidence. J Clin Epidemiol. 2011 Apr;64(4):401-6. doi:10.1016/j.jclinepi.2010.07.015.
3. Cheng X, Deng L. Chinese Acupuncture and Moxibustion. Beijing: Foreign Language Press; 2010.
4. Hempel S, Taylor SL, Solloway MR, Miake-Lye IM, Beroes JM, Shanman R, et al. VA Evidence-based Synthesis Program Reports. Evidence Map of Acupuncture. Washington (DC): Department of Veterans Affairs; 2014.
5. Horn KK, Jennings S, Richardson G, Vliet DV, Hefford C, Abbott JH. The patient-specific functional scale: psychometrics, clinimetrics, and application as a clinical outcome measure. J Orthop Sports Phys Ther. 2012 Jan;42(1):30-42. doi:10.2519/jospt.2012.3727.
6. Kaptchuk T. The Web That Has No Weaver. Contemporary Books. 2000.
7. Kelly RB. Acupuncture for pain. Am Fam Physician. 2009 Sep 1;80(5):481-4.
8. Kligler B, Nielsen A, Kohrrer C, Schmid T, Waltermaurer E, Perez E, Merrell W. Acupuncture Therapy in a Group Setting for Chronic Pain. Pain Med. 2017 Jun 8. doi:10.1093/pm/pnx134.
9. Lansdown H, Howard K, Brealey S, MacPherson H. Acupuncture for pain and osteoarthritis of the knee: a pilot study for an open parallel-arm randomised controlled trial. BMC Musculoskelet Disord. 2009 Oct 24;10:130. doi:10.1186/1471-2474-10-130.
10. Li X, Wang R, Xing X, et al. Acupuncture for Myofascial Pain Syndrome: A Network Meta-Analysis of 33 Randomized Controlled Trials. Pain Physician. 2017 Sep;20(6):E883-E902.
11. Maciocia, G; The Foundations of Chinese Medicine: A Comprehensive Text; Churchill Livingstone, 2005.
12. MacPherson H, Vertosick EA, Foster NE, Lewith G, Linde K, Sherman KJ, et al. The persistence of the effects of acupuncture after a course of treatment: A meta-analysis of patients with chronic pain. Pain. 2016 Oct 17. doi:10.1097/j.pain.0000000000000747.
13. Magee, David J., Orthopedic Physical Assessment, Second Edition, W.B. Saunders Company, 2007.
14. Manyanga T, Froese M, Zarychanski R, Abou-Setta A, Friesen C, Tennenhouse M, et al. Pain management with acupuncture in osteoarthritis: a systematic review and meta-analysis. BMC Complement Altern Med. 2014;14:312. doi:10.1186/1472-6882-14-312.
15. McDonald J, Janz S. The Acupuncture Evidence Project: A Comparative Literature Review (Revised Edition). Brisbane: Australian Acupuncture and Chinese Medicine Association Ltd; 2017. Date last accessed 01/15/18.
16. Minor ,M.A., Hewett, J.E., Webel, R.R., Anderson, S., & Kay, D.R. Efficacy of physical conditioning exercise in patients with rheumatoid arthritis and osteoarthritis. Arthritis and Rheumatism, 1989; 32(11): 1396-1405.
17. National Health and Medical Research Council. NHMRC additional levels of evidence and grades for recommendations for developers of guidelines. Table 3. NHMRC Evidence Hierarchy: designations of 'levels of evidence' according to type of research question (including explanatory notes). National Health and Medical Research Council; 2009.
18. O'Connor J, Bensky D. Acupuncture: A Comprehensive Text. Chicago: Eastland Press; 1981.
19. Olson WH, Brumback RA, Gascon G, Iyer V; Handbook of Symptom Oriented Neurology; Year Book Medical Publishers, Inc.; 2002.
20. Porter, R; The Merck Manual, Merck, 2011.
21. Roy, S., Irvin, R., and Iverson, D; Sports Medicine, Prevention, Education, Management, and Rehabilitation, Benjamin Cummings, 1998.
22. Wang R, Li X, Zhou S, Zhang X, Yang K, Li X. Manual acupuncture for myofascial pain syndrome: a systematic review and meta-analysis. Acupunct Med. 2017 Aug;35(4):241-250. doi:10.1136/acupmed-2016-011176
23. Weinstein, S, and Buckwalter, J. Orthopaedics Principles and Their Applications. Lippincott, Williams, & Wilkins, 2005.
24. Xiang A, Cheng K, Shen X, Xu P, Liu S. The Immediate Analgesic Effect of Acupuncture for Pain: A Systematic Review and Meta-Analysis. Evid Based Complement Alternat Med. 2017;2017:3837194. doi:10.1155/2017/3837194.

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25. Yuan J, Purepong N, Hunter RF, Kerr DP, Park J, Bradbury I, McDonough S. Different frequencies of acupuncture treatment for chronic low back pain: an assessor-blinded pilot randomised controlled trial. Complement Ther Med. 2009 Jun;17(3):131-40. doi:10.1016/j.ctim.2008.10.003.
26. Zhao HJ, Tan JY, Wang T, Jin L. Auricular therapy for chronic pain management in adults: A synthesis of evidence. Complement Ther Clin Pract. 2015 May;21(2):68-78. doi:10.1016/j.ctcp.2015.03.006.

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ACU-8.10: Upper Extremity Post-Surgical

Common Surgeries

- Rotator cuff repair
- Shoulder total joint replacement (arthroplasty)
- Elbow Collateral Ligament Reconstruction
- Wrist Ulnar Nerve Entrapment Release

Discussion and Definitions

The rotator cuff is made up of four interrelated muscles (supraspinatus, infraspinatus, teres minor, subscapularis) arising from the scapula and attaching to the tuberosities. Impingement may cause tendon degeneration and progression to a complete tear, referred to as an attritional or degenerative tear. Acute injury such as a fall on an outstretched arm or an abduction movement of high force and velocity can also tear the rotator cuff. Surgical repair is most common with the supraspinatus tendon being sewn back to its attachment. The distal clavicle is sometimes excised during the rotator cuff repair when the distal clavicle is felt to be impinging upon the rotator cuff.

Total shoulder joint replacement involves replacing the shoulder joint surfaces with artificial materials. Replacement of the humeral component only is similar to a hemiarthroplasty of the hip. The prosthesis may be cemented or, in the presence of good cortical bone, an in-growth prosthesis placed. The glenoid component is the more problematic aspect of the replacement, and not performed if the glenoid is acceptable. The bone of the scapula is relatively thin, which precludes the use of a thick anchoring system. As in total knee replacement, the shoulder prosthesis may be unconstrained, semi constrained, or constrained, having long-term range of motion implications.

Reconstruction of the collateral ligament is one of the most common surgeries performed on a throwing athlete. The detached ulnar collateral ligament is reattached to its point of origin or insertion. Posterior olecranon osteophytes, if present, are removed. The ulnar nerve is typically mobilized and transposed during the procedure. Post-operatively, the elbow is immobilized in a posterior splint for 7 to 10 days at 90 degrees of flexion, in neutral rotation, or in a bulky dressing.

Release of the ulnar nerve is most commonly performed at the elbow or the wrist, though entrapment can occur at other areas along the path of the ulnar nerve. The surgical procedure varies depending on the site but the common goal is to enlarge those spaces where compression is occurring. At the elbow the nerve is sometimes moved, or transposed, anterior to its original position.

Please refer to eviCore's Physical and Occupational Therapy Clinical Guidelines for additional discussion and definitions.

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Oriental Medicine Diagnoses

- Qi and Blood Stagnation:
  - This stagnation results in a painful condition, may have numerous causation, but for this diagnosis trauma is the primary causation, perhaps with underlying Qi deficiency syndrome.
- Damp Bi, Stationary (Damp) Painful Obstruction:
  - Pain is localized and does not move.
- Cold Bi, Painful (Cold) Painful Obstruction:
  - Severe pain in one part, or over one half of the body, which becomes worse when patient encounters cold and diminishes when patient is warm.
- Heat Painful Obstruction:
  - Flesh is hot, area of pain is red and swollen, pain increases upon contact.
- Bi Syndrome:
  - Condition can be any combination of the above.

History

- Documentation of pain level using a validated pain scale (VAS/NRS) and its frequency
- General demographics
- Occupation/employment
- Living environment
- History of current condition
- Functional status & activity level
- Medications
- Other tests and measurements (laboratory and diagnostic tests)
- Past history (including history of prior acupuncture and response to prior treatment)
- In addition to the standard information gathered, a complete understanding of the surgical procedure performed should be obtained from surgeon.

Specific Aspects of History

- Rule out red flags (require medical management).
- Determine if trauma-related; determine nature and extent of traumatic event.
- Identify co-morbidities requiring medical management, and those that affect acupuncture and Oriental Medicine management.
- Determine OPQRST (Onset, Provocative/Palliative factors, Quality, Radiation/Referral pattern, Site [location], Timing of complaint).

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Red Flag	Possible Consequence or Cause	Action Required
Trauma, post-operative	Fracture, dislocation	Immediate referral to emergency department
Fever, severe pain, drainage, swelling	Possible infection	Prompt referral to Primary Care Provider
Pain at rest, or radiating pain	Neurological or metastatic disease	Prompt referral to Primary Care Provider
Unilateral edema	Deep vein thrombosis	Immediate referral to emergency department
Exertional arm pain	CAD, vascular insufficiency	Immediate referral to emergency department
Recent invasive procedures post op (dental work, urologic procedures	Infection	Prompt referral to Primary Care Provider
Diabetes	Neuropathy	Prompt referral to Primary Care Provider
Multiple joint involvement	Rheumatologic diseases, gout	Prompt referral to Primary Care Provider
Cancer	Cause of symptoms (metastatic or primary)	Prompt referral to Primary Care Provider
Immune-compromised state	Infection	Prompt referral to Primary Care Provider
Pleuritic pain, shortness of breath, associated with cough	Pulmonary diseases	Prompt referral to Primary Care Provider
Popliteal fossa pain, sudden onset	Popliteal aneurysm	Immediate referral to emergency department
Discoloration of foot/leg, or exertional foot/leg pain	Arterial occlusion; vascular insufficiency; compartment syndrome	Immediate referral to emergency department
Severe pain, swelling, discoloration, cold to touch within 12-24 hours following trauma	Compartment syndrome	Immediate referral to emergency department
Lower extremity shortening or internal rotation	Dislocation	Prompt referral to Primary Care Provider
“Pistoning” during gait	Dislocation	Prompt referral to Primary Care Provider
Shoulder pain that is constant, relieved or worse with meals, positional, or associated with fatty meals	Gastrointestinal diseases including cholelithiasis and perforated ulcer	Prompt referral to Primary Care Provider

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Presentation

Patient presents with signs and symptoms post operatively. There may be surgery specific precautions dictated by the surgeon. Post-surgical rehabilitation should be managed by a multidisciplinary team including at least an MD and a physical therapist. Active rehabilitation, including physical therapy and/or occupational therapy, is critical for optimal recovery. The goal is to transition the patient as quickly as possible to active care, self-management and functional independence.

Subjective Findings

- Pain at surgical site
- Pain with motion
- Pain should be documented as a numeric pain scale 0-10
- Loss of range of motion
- Swelling
- Weakness and/or apprehension
- Stiffness
- Antalgic gait
- Functional losses

Functional Assessment

- Documentation of a patient's level of function is an important aspect of patient care. This documentation is required in order to establish the medical necessity of ongoing acupuncture treatment. The Patient Specific Functional Scale (PSFS) is a patient reported outcome assessment that is easy and appropriate for acupuncturists to use. The PSFS has been studied in peer-reviewed scientific literature, and it has been proven to be a valid, reliable, and responsive measure for a variety of pain syndromes (neck, back, knee, etc.).

Objective Findings

- Pain at surgical site, particularly with movement
- Swelling
- Weakness
- Limited range of motion
- Impaired motor function
- Restrictions/precautions set by surgeon (bracing, weight bearing)

Scope of Examination

- Examine the musculoskeletal system for possible causes, or contributing factors to the complaint.

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Examination Considerations

- Evaluate for potential of post-surgical complications or other red flags. Refer appropriately if signs or symptoms of post-surgical complications develop.
- All of the following objective tests may not be appropriate, but should be assessed according to the member's condition and surgery type:
  - Pain: Determine OPQRST (Onset, Provocative/Palliative factors, Quality, Radiation/Referral pattern, Site [location], Timing of complaint). Observe surgical precautions.
  - Skin/Wound Integrity: Skin characteristics (blistering, color, sensation, temperature, texture), Surgical wound (signs of infection, scar tissue characteristics, stage of healing). Observe surgical precautions.
  - Palpation of bony and soft tissue: Palpate involved muscles for tender nodule, taut band, tight ropiness, Observe pattern of referred pain, Provocation tests. Observe surgical precautions.
  - Edema (measure both sides for comparison): Girth measurements, Palpation, Volume measurements. Observe surgical precautions.
  - Postural assessment: Postural alignment and position. Observe surgical precautions.
  - Range of motion: Active and passive movement of affected area and joint above and below and contralateral joints, Functional range of motion (e.g. squat tests, toe touch tests). Observe surgical precautions.
  - Manual Muscle Testing: Test related joints. Observe surgical precautions.
  - Assistive, protective and supportive devices
  - Neurologic tests: Proprioception, Sensation. Observe surgical precautions.
  - Gait and Locomotion: Gait indexes, Mobility skills profiles, Functional assessment profiles. Observe surgical precautions.
  - Motor Function Tests: Use standardized tests appropriate to the affected area. Observe surgical precautions.

Oriental Medicine Management [15, 25, 28]

- Post-surgical rehabilitation should be managed by a multidisciplinary team including at least an MD and a physical therapist. Active rehabilitation, including physical therapy and occupational therapy, is critical for optimal recovery. The goal is to transition the patient as quickly as possible to active care, self-management and functional independence.
- Confirmation of appropriate medical co-management is always required when treating children age 14 and under.
- Treatment frequency should be commensurate with the severity of the chief complaint, natural history of the condition, and expectation for functional improvement.
- When significant improvements in patient's subjective findings and objective findings are demonstrated—continued treatment with decreased frequency is appropriate.

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- As treatment progresses, one should see an increase in the active regimen of care, a decrease in the passive regimen of care, and a fading of treatment frequency.
- If the condition has not progressed towards resolution, refer the patient to an appropriate health care provider to explore other treatment alternatives.
- eviCore's consideration of requests for continued acupuncture treatment depends on updated clinical information submitted regarding patient's progress.
- Adequate and legible patient progress information that contains a history and examination, and/or eviCore's Treatment Request Form for each treatment is required to determine medical necessity.
- In addition to the improvements in the table below, significant progress may be documented by increases in functional capacity and increasingly longer durations of pain relief.
- Discharge occurs when reasonable functional goals and expected outcomes have been achieved.
- The patient is discharged when the patient/care-giver can continue management of symptoms with an independent home program.
- Treatment is discontinued when the patient is unable to progress towards outcomes because of medical complications, psychosocial factors or other personal circumstances.
- If the member has been non-compliant with treatment as is evidenced by the clinical documentation, and/or the lack of demonstrated progress, treatment will be deemed to be not medically necessary and the member should be discharged from treatment.

Week	Progress
0-1	◆ Some reduction of pain severity and frequency ◆ Observation of post-surgical activity restrictions, if any
2-4	◆ 25% decrease in pain severity and frequency ◆ Observation of post-surgical activity restrictions, if any ◆ Meet functional goals set by MD, PT or OT ◆ Reinforce self-management techniques
5-8	◆ 50% decrease in pain severity and frequency ◆ Observation of post-surgical activity restrictions, if any ◆ Meet functional goals set by MD, PT or OT ◆ Reinforce self-management techniques
9-12	◆ Gradual improvement leading toward resolution of pain ◆ Meet functional goals set by MD, PT or OT ◆ Reinforce self-management techniques ◆ Discharge patient to elective care, active rehabilitation, or to their primary care provider for alternative treatment options when a plateau is reached, or by week 12, whichever occurs first

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Referral Guidelines

- Refer patient to their primary care provider for evaluation of alternative treatment options if:
  - Improvement does not meet above guidelines, or improvement has reached a plateau
  - Atrophy of lower extremity occurs
  - Range of motion plateaus or decreases
  - Re-injury occurs
  - Signs of infection
  - Signs or symptoms of any post-surgical complication or red flag

Appropriate Procedures/Modalities

- Acupuncture
- Electro-acupuncture
- Cupping
- Moxibustion
- Gua Sha
- Myofascial release
- Acupressure
- Trigger point massage
- Tui Na (not to include osseous manipulation)
- Herbal formulas

Note: Not all of these modalities are covered by the patient's health-plan; review documentation regarding coverage. Acupuncture and herbs must be appropriate for covered diagnoses under the patient's insurance policy. Acupuncturist is responsible for determining which procedures/modalities are most appropriate for the patient's condition.

Inappropriate Procedures/Modalities

- Scarring moxa
- Applied kinesiology techniques
- Electro-acupuncture using more than 9 volts
- Any techniques outside of the scope of practice in your state

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Self-Management Techniques

- Observation of surgical restrictions/precautions
- Rest and reduce strenuous activities
- Use of home medical equipment as advised by MD or PT
- Gradual increase in activity
- Compliance with home exercise/stretching program as assigned by PT
- Cold packs after incision heals, or as directed by MD
- Ergonomics, Postural advice, postural exercises
- Appropriate exercises/stretching
- Tai Qi, Qi Gong, Yoga
- Stress management, meditation
- Joint protection
- Weight loss
- Self-massage, Self-acupressure

Alternatives to Oriental Medicine Management

(listed in alphabetical order)

- Chiropractic
- Dietary/Nutritional Medicine Counseling
- Injection therapy/Pain management
- Massage therapy
- Medication
- Occupational therapy
- Osteopathic Manipulation
- Physical Therapy
- Psychological counseling

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References

1. Balshem H, Helfand M, Schunemann HJ, Oxman AD, Kunz R, Brozek J, et al. GRADE guidelines: 3. Rating the quality of evidence. J Clin Epidemiol. 2011 Apr;64(4):401-6. doi:10.1016/j.jclinepi.2010.07.015.
2. Chen W-T, Fu G-Q, Shen W-D. [Progresses of studies on acupuncture analgesia for postoperative reaction]. Zhen Ci Yan Jiu. 2013;38(1):83-87.
3. Cheng X, Deng L. Chinese Acupuncture and Moxibustion. Beijing: Foreign Language Press; 2010.
4. Deadman P, Khafaji MA-, Baker K. A Manual of Acupuncture. Hove: Journal of Chinese Medicine Publications; 2011.
5. Dines JS. Outcomes Analysis of Revision Total Shoulder Replacement. The Journal of Bone and Joint Surgery (American) J Bone Joint Surg Am. 2006;88(7):1494. doi:10.2106/jbjs.d.02946.
6. Fuentealba Cargill F, Biagini Alarcón L. Acupuncture for postoperative pain, a literature review. Rev Med Chil. 2016;144(3):325-332. doi:10.4067/S0034-98872016000300007.
7. Hempel S, Taylor SL, Solloway MR, Miake-Lye IM, Beroes JM, Shanman R, et al. VA Evidence-based Synthesis Program Reports. Evidence Map of Acupuncture. Washington (DC): Department of Veterans Affairs; 2014.
8. Hertling D, Kessler RM. Management of Common Musculoskeletal Disorders: Physical Therapy Principles and Methods. Philadelphia: Lippincott Williams & Wilkins; 2006.
9. Horn KK, Jennings S, Richardson G, Vliet DV, Hefford C, Abbott JH. The patient-specific functional scale: psychometrics, clinimetrics, and application as a clinical outcome measure. J Orthop Sports Phys Ther. 2012 Jan;42(1):30-42. doi:10.2519/jospt.2012.3727.
10. Jones B. 8.7 Complications of total knee replacement. Oxford Textbook of Trauma and Orthopaedics. January 2011.
11. Kaptchuk T. The Web That Has No Weaver. Contemporary Books. 2000.
12. Kelly RB. Acupuncture for pain. Am Fam Physician. 2009 Sep 1;80(5):481-4.
13. Kligler B, Nielsen A, Kohrrer C, Schmid T, Waltermaurer E, Perez E, Merrell W. Acupuncture Therapy in a Group Setting for Chronic Pain. Pain Med. 2017 Jun 8. doi:10.1093/pm/pnx134.
14. Lee MS, Ernst E. Acupuncture for surgical conditions: an overview of systematic reviews. Int J Clin Pract. 2014 Jun;68(6):783-9. doi:10.1111/ijcp.12372
15. Li X, Wang R, Xing X, et al. Acupuncture for Myofascial Pain Syndrome: A Network Meta-Analysis of 33 Randomized Controlled Trials. Pain Physician. 2017 Sep;20(6):E883-E902.
16. Maciocia, G; The Foundations of Chinese Medicine: A Comprehensive Text; Churchill Livingstone, 2005.
17. MacPherson H, Vertosick EA, Foster NE, Lewith G, Linde K, Sherman KJ, et al. The persistence of the effects of acupuncture after a course of treatment: A meta-analysis of patients with chronic pain. Pain. 2016 Oct 17. doi:10.1097/j.pain.0000000000000747.
18. Magee, David J., Orthopedic Physical Assessment, Second Edition, W.B. Saunders Company, 2007.
19. McDonald J, Janz S. The Acupuncture Evidence Project: A Comparative Literature Review (Revised Edition). Brisbane: Australian Acupuncture and Chinese Medicine Association Ltd; 2017.
20. National Health and Medical Research Council. NHMRC additional levels of evidence and grades for recommendations for developers of guidelines. Table 3. NHMRC Evidence Hierarchy: designations of 'levels of evidence' according to type of research question (including explanatory notes). National Health and Medical Research Council; 2009.
21. O'Connor J, Bensky D. Acupuncture: A Comprehensive Text. Chicago: Eastland Press; 1981.
22. Olson WH, Brumback RA, Gascon G, Iyer V; Handbook of Symptom Oriented Neurology; Year Book Medical Publishers, Inc.; 2002.
23. Porter, R; The Merck Manual, Merck, 2011.
24. Roy, S., Irvin, R., and Iverson, D; Sports Medicine, Prevention, Education, Management, and Rehabilitation, Benjamin Cummings, 1998.
25. Wang R, Li X, Zhou S, Zhang X, Yang K, Li X. Manual acupuncture for myofascial pain syndrome: a systematic review and meta-analysis. Acupunct Med. 2017 Aug;35(4):241-250. doi:10.1136/acupmed-2016-011176.
26. Weinstein, S, and Buckwalter, J. Orthopaedics Principles and Their Applications. Lippincott, Williams, & Wilkins, 2005.

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27. Wu MS, Chen KH, Chen IF, Huang SK, Tzeng PC, Yeh ML, et al. The Efficacy of Acupuncture in Post-Operative Pain Management: A Systematic Review and Meta-Analysis. PLOS ONE. 2016;11(3):e0150367. doi:10.1371/journal.pone.0150367.
28. Xiang A, Cheng K, Shen X, Xu P, Liu S. The Immediate Analgesic Effect of Acupuncture for Pain: A Systematic Review and Meta-Analysis. Evid Based Complement Alternat Med. 2017;2017:3837194. doi:10.1155/2017/3837194.
29. Yuan J, Purepong N, Hunter RF, Kerr DP, Park J, Bradbury I, McDonough S. Different frequencies of acupuncture treatment for chronic low back pain: an assessor-blinded pilot randomised controlled trial. Complement Ther Med. 2009 Jun;17(3):131-40. doi:10.1016/j.ctim.2008.10.003.
30. Zhao HJ, Tan JY, Wang T, Jin L. Auricular therapy for chronic pain management in adults: A synthesis of evidence. Complement Ther Clin Pract. 2015 May;21(2):68-78. doi:10.1016/j.ctcp.2015.03.006.

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ACU-8.11: Wrist Sprain/Strain

Synonyms

- Wrist pain

Definition

Strains of wrist are generally an issue of overuse creating micro trauma to muscles and tendons. Sprains usually involve a trauma, in which some fibers of the involved ligaments are disrupted. In its worst case a ligament can tear completely with loss of joint integrity. Pain may be acute or chronic. The wrist has multiple ligamentous attachments between the carpals, and the radius and ulna. Dorsal strains/sprains are more common due to hyper-flexion injuries.

Oriental Medicine Diagnoses

- Qi and Blood Stagnation
  - Stagnation results in the painful condition; may have numerous causations; can be related to trauma or underlying syndromes.

History

Specific Aspects of History

- Rule out red flags (require medical management).
- Identify co-morbidities requiring medical management, and those that affect acupuncture and Oriental Medicine management.
- Determine if trauma-related; determine nature and extent of traumatic event.

Red Flag	Possible Consequence or Cause	Action Required
Severe trauma	Colles' fracture, displaced distal radial epiphysis in children, tendon avulsion, muscle rupture, carpal fracture, particularly the scaphoid and lunate, traumatic instability, or ligament tear.	Immediate referral to emergency department
Pain at the "anatomical snuffbox"	Navicular fracture (scaphoid)	Immediate referral to emergency department
Pain on supination/pronation, prominence of ulna	Injury to the distal Radio-Ulna joint	Immediate referral to emergency department
Fever, severe pain	Infection	Immediate referral to emergency department
Diabetes; stocking glove numbness	Neuropathy; B12 deficiency, hypothyroidism, lead poisoning	Immediate referral to emergency department
Multiple joint involvement	Rheumatologic diseases, gout	Prompt referral to Primary Care Provider

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Red Flag	Possible Consequence or Cause	Action Required
Unilateral upper extremity edema	Deep vein thrombosis	Immediate referral to emergency department
Cancer	Cause of symptoms (metastatic or primary)	Prompt referral to Primary Care Provider
Discoloration of arm or hand	Arterial occlusion	Immediate referral to emergency department
Immune-compromised state	Infection	Prompt referral to Primary Care Provider

Presentation

Patient usually presents following overexertion, over stretching, or trauma to wrist. In the case of trauma, pain is immediate, then subsides and returns. Swelling frequently follows within one-two hours, and if enough soft tissue injury occurs, ecchymosis develops in 6-12 hours.

Subjective Findings

- Complaint of pain on movement
- Localized tenderness
  - Pain should be documented as a numeric pain scale 0-10

Functional Assessment

- Documentation of a patient's level of function is an important aspect of patient care. This documentation is required in order to establish the medical necessity of ongoing acupuncture treatment. The Patient Specific Functional Scale (PSFS) is a patient reported outcome assessment that is easy and appropriate for acupuncturists to use. The PSFS has been studied in peer-reviewed scientific literature, and it has been proven to be a valid, reliable, and responsive measure for a variety of pain syndromes (neck, back, knee, etc.).

Objective Findings

Scope of Musculoskeletal Examination

- Inspection
- Palpation of bony and soft tissue
- Range of motion, active and passive
- Manual muscle testing
- Orthopedic and neurologic testing

Specific Aspects of Examination for Strain/Sprain of Wrist

- Examine the musculoskeletal system for possible causes or contributing factors to the complaint.

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Findings of Strain/Sprain of the Wrist

- Swelling and bruising may be visually apparent
- Restricted motion is common
- Localized tenderness
- Weakened grip and pinch strength
- Pain present with active or passive stretch of the involved soft tissues

Differential Diagnoses

- Osteoarthritis
- Tendonitis
- Spastic contracture in hemiplegia
- Ulnar nerve paralysis
- Other problems to be considered—
  - Articular cartilage pathology including neoplastic pathology
  - Osteonecrosis
  - Crystalline deposition diseases including gout and pseudogout (chondrocalcinosis)

Oriental Medicine Management [8, 18, 20]

- Oriental Medicine management goals are to resolve pain, restore the highest level of function possible, and educate patient to prevent recurrent symptoms.
- To be considered medically necessary, patient's symptoms must be the direct result of a primary neuromusculoskeletal injury or illness.
- Confirmation of appropriate medical co-management is always required when treating children age 14 and under.
- Treatment frequency should be commensurate with severity of the chief complaint.
- When significant improvement in patient's subjective findings and objective findings are demonstrated—continued treatment with decreased frequency is appropriate.
- As treatment progresses, one should see an increase in the active regimen of care, a decrease in the passive regimen of care, and a fading of treatment frequency.
- If the condition has not progressed towards resolution, refer the patient to an appropriate health care provider to explore other treatment alternatives.
- eviCore's consideration of requests for continued acupuncture treatment depends on updated clinical information submitted regarding patient's progress.
- Adequate and legible patient progress information that contains a history and examination, and/or EviCore's Acupuncture Treatment Request Form is required to determine medical necessity.

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- In addition to improvements in the table below, significant progress may be documented by increases in functional capacity and increasingly longer durations of pain relief.
- Discharge occurs when reasonable functional goals and expected outcomes have been achieved.
- The patient is discharged when the patient/care-giver can continue management of symptoms with an independent home program.
- Treatment is discontinued when the patient is unable to progress towards outcomes because of medical complications, psychosocial factors or other personal circumstances.
- If the member has been non-compliant with treatment as is evidenced by the clinical documentation, and/or the lack of demonstrated progress, treatment will be deemed to be not medically necessary and the member should be discharged from treatment.

Week	Progress
0-1	◆ Some reduction of pain severity and frequency ◆ Some reduction of muscle spasm
2-4	◆ 50% decrease in pain severity and frequency ◆ 50% improvement in function
5-8	◆ 75% decrease in pain severity and frequency ◆ 75% improvement in function
9-12	◆ Gradual improvement leading toward resolution ◆ Reinforce self-management techniques ◆ Discharge patient to elective care, or to their primary care provider for alternative treatment options when a plateau is reached, or by week 12, whichever occurs first

Appropriate Procedures/Modalities

- Acupuncture
- Electro-acupuncture
- Cupping
- Moxibustion
- Gua Sha
- Myofascial release
- Acupressure
- Trigger point massage
- Tui Na (not to include osseous manipulation)
- Herbal formulas

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Note: Not all of these modalities are covered by the patient's health-plan; review documentation regarding coverage. Acupuncture and herbs must be appropriate for covered diagnoses under the patient's insurance policy. Acupuncturist is responsible for determining which procedures/modalities are most appropriate for the patient's condition.

Inappropriate Procedures/Modalities

- Scarring moxa
- Applied kinesiology techniques
- Electro-acupuncture using more than 9 volts
- Any technique outside the scope of practice in your state

Self-Management Techniques

- Tai Qi
- Qi Gong
- Self-acupressure
- Rest and reduce strenuous activities
- Educate patients about the causes
- Appropriate exercises
- Hot packs/cold packs, if needed, to relieve discomfort

Alternatives to Oriental Medicine Management

(listed in alphabetical order)

- Chiropractic
- Dietary/Nutritional Medicine Counseling
- Injection therapy/Pain management
- Massage therapy
- Medication
- Occupational therapy
- Osteopathic Manipulation
- Physical Therapy
- Psychological counseling

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References

1. Balshem H, Helfand M, Schunemann HJ, Oxman AD, Kunz R, Brozek J, et al. GRADE guidelines: 3. Rating the quality of evidence. J Clin Epidemiol. 2011 Apr;64(4):401-6. doi:10.1016/j.jclinepi.2010.07.015.
2. Cheng X, Deng L. Chinese Acupuncture and Moxibustion. Beijing: Foreign Language Press; 2010.
3. Hempel S, Taylor SL, Solloway MR, Miake-Lye IM, Beroes JM, Shanman R, et al. VA Evidence-based Synthesis Program Reports. Evidence Map of Acupuncture. Washington (DC): Department of Veterans Affairs; 2014.
4. Horn KK, Jennings S, Richardson G, Vliet DV, Hefford C, Abbott JH. The patient-specific functional scale: psychometrics, clinimetrics, and application as a clinical outcome measure. J Orthop Sports Phys Ther. 2012 Jan;42(1):30-42. doi:10.2519/jospt.2012.3727.
5. Kaptchuk T. The Web That Has No Weaver. Contemporary Books. 2000.
6. Kelly RB. Acupuncture for pain. Am Fam Physician. 2009 Sep 1;80(5):481-4.
7. Kligler B, Nielsen A, Kohrrer C, Schmid T, Waltermaurer E, Perez E, Merrell W. Acupuncture Therapy in a Group Setting for Chronic Pain. Pain Med. 2017 Jun 8. doi:10.1093/pm/pnx134.
8. Li X, Wang R, Xing X, et al. Acupuncture for Myofascial Pain Syndrome: A Network Meta-Analysis of 33 Randomized Controlled Trials. Pain Physician. 2017 Sep;20(6):E883-E902.
9. Maciocia, G; The Foundations of Chinese Medicine: A Comprehensive Text; Churchill Livingstone, 2005.
10. MacPherson H, Vertosick EA, Foster NE, Lewith G, Linde K, Sherman KJ, et al. The persistence of the effects of acupuncture after a course of treatment: A meta-analysis of patients with chronic pain. Pain. 2016 Oct 17. doi:10.1097/j.pain.0000000000000747.
11. Magee, David J., Orthopedic Physical Assessment, Second Edition, W.B. Saunders Company, 2007.
12. McDonald J, Janz S. The Acupuncture Evidence Project: A Comparative Literature Review (Revised Edition). Brisbane: Australian Acupuncture and Chinese Medicine Association Ltd; 2017.
13. National Health and Medical Research Council. NHMRC additional levels of evidence and grades for recommendations for developers of guidelines. Table 3. NHMRC Evidence Hierarchy: designations of 'levels of evidence' according to type of research question (including explanatory notes). National Health and Medical Research Council; 2009.
14. O'Connor J, Bensky D. Acupuncture: A Comprehensive Text. Chicago: Eastland Press; 1981.
15. Olson WH, Brumback RA, Gascon G, Iyer V; Handbook of Symptom Oriented Neurology; Year Book Medical Publishers, Inc.; 2002.
16. Porter, R; The Merck Manual, Merck, 2011.
17. Roy, S., Irvin, R., and Iverson, D; Sports Medicine, Prevention, Education, Management, and Rehabilitation, Benjamin Cummings, 1998.
18. Wang R, Li X, Zhou S, Zhang X, Yang K, Li X. Manual acupuncture for myofascial pain syndrome: a systematic review and meta-analysis. Acupunct Med. 2017 Aug;35(4):241-250. doi:10.1136/acupmed-2016-011176.
19. Weinstein, S, and Buckwalter, J. Orthopaedics Principles and Their Applications. Lippincott, Williams, & Wilkins, 2005.
20. Xiang A, Cheng K, Shen X, Xu P, Liu S. The Immediate Analgesic Effect of Acupuncture for Pain: A Systematic Review and Meta-Analysis. Evid Based Complement Alternat Med. 2017;2017:3837194. doi:10.1155/2017/3837194.
21. Yuan J, Purepong N, Hunter RF, Kerr DP, Park J, Bradbury I, McDonough S. Different frequencies of acupuncture treatment for chronic low back pain: an assessor-blinded pilot randomised controlled trial. Complement Ther Med. 2009 Jun;17(3):131-40. doi:10.1016/j.ctim.2008.10.003.
22. Zhao HJ, Tan JY, Wang T, Jin L. Auricular therapy for chronic pain management in adults: A synthesis of evidence. Complement Ther Clin Pract. 2015 May;21(2):68-78. doi:10.1016/j.ctcp.2015.03.006.

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ACU-9.0: Lower Extremity Conditions

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ACU-9.1: Ankle and Foot, Joint Pain and Osteoarthrosis

Synonyms

- Osteoarthritis
- Degenerative arthritis
- Degenerative joint disease
- Hypertrophic arthritis
- Ankle pain, foot pain

Definition

Degenerative and sometimes hypertrophic changes in the bone and cartilage of one or more joints and a progressive wearing down of opposing joint surfaces with consequent distortion of joint position. Pain may be acute or chronic

Oriental Medicine Diagnoses

Various types of arthritis are contained under the singular rubric of blockage, or Painful Obstruction, in Chinese Medicine. Condition occurs when the circulation of Qi and Blood through channels is hindered by Wind, Cold and/or Dampness. Dampness, or if at a certain stage of the disease Cold becomes Heat, then Heat blockage can occur.

Following are the five principal blockages or obstructions in Chinese Medicine. Commonly referred to as Bi Syndrome, the condition can be any combination of the below:

- Wind Bi, Moving (Wind) Painful Obstruction
  - Pain in the joints is widespread and moves from one area of the body to another.
- Damp Bi, Stationary (Damp) Painful Obstruction
  - Pain is localized and does not move.
- Cold Bi, Painful (Cold) Painful Obstruction
  - Severe pain in one part, or over one half of the body, which becomes worse when patient encounters cold and diminishes when patient is warm.
- Heat Bi, Heat Painful Obstruction
  - Flesh is hot, area of pain is red and swollen, pain increases upon contact.

History

Specific Aspects of History

- Rule out red flags (require medical management).
- Determine if trauma-related; determine nature and extent of traumatic event.
- Identify co-morbidities requiring medical management, and those that affect acupuncture and Oriental Medicine management.

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Red Flag	Possible Consequence or Cause	Action Required
Severe trauma	Fracture, ligament/meniscus tear	Immediate referral to emergency department
Fever, severe pain	Infection	Immediate referral to emergency department
Popliteal fossa pain, sudden onset	Popliteal aneurysm	Immediate referral to emergency department
Severe leg pain 12-24 hours after trauma	Compartment syndrome	Immediate referral to emergency department
Diabetes	Neuropathy	Prompt referral to Primary Care Provider
Multiple joint involvement	Rheumatologic diseases	Prompt referral to Primary Care Provider
Unilateral edema	Deep vein thrombosis	Immediate referral to emergency department
Cancer	Cause of symptoms (metastatic or primary)	Prompt referral to Primary Care Provider
Discoloration of foot or leg	Arterial occlusion	Immediate referral to emergency department
Immune-compromised state	Infection	Prompt referral to Primary Care Provider

Subjective Findings

- Pain is localized to the joint area
- Warmth may be felt over the affected joint, in the inflammatory stage
- Pain with range of motion may be described
- Onset is usually gradual and insidious
- Patient will complain of stiffness
- Pain should be documented as a numeric pain scale 0-10

Functional Assessment

- Documentation of a patient's level of function is an important aspect of patient care. This documentation is required in order to establish the medical necessity of ongoing acupuncture treatment. The Patient Specific Functional Scale (PSFS) is a patient reported outcome assessment that is easy and appropriate for acupuncturists to use. The PSFS has been studied in peer-reviewed scientific literature, and it has been proven to be a valid, reliable, and responsive measure for a variety of pain syndromes (neck, back, knee, etc.).

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Objective Findings

Scope of Musculoskeletal Examination

- Inspection
- Palpation of bony and soft tissue
- Range of motion, active and passive (if allowed by law)
- Orthopedic and neurologic testing if neurologic signs are present (if allowed by law)

Specific Aspects of Examination for Osteoarthrosis

- Examine the musculoskeletal system for possible causes or contributing factors to the complaint.

Findings of Osteoarthrosis

- Swelling may be present in the inflammatory phase
- Calor (warmth) may be noted over the affected joint in the inflammatory phase
- Pain over the joint
- Pain with ROM, loss of ROM

Differential Diagnoses

- Neuropathy/neuropathic disease
- Stress fracture
- Psoriatic Arthritis
- Gout and other crystalline arthropathies
- Hemochromatosis
- Metabolic bone disorders
- Hypermobility syndromes

Oriental Medicine Management [16, 30, 35]

- Oriental Medicine management goals are to resolve pain, restore the highest level of function possible and educate the patient to prevent recurrent symptoms.
- In order to be considered medically necessary the patient's symptoms must be the direct result of a primary neuromusculoskeletal injury or illness.
- Confirmation of appropriate medical co-management is always required when treating children age 14 and under.
- Treatment frequency should be commensurate with the severity of the chief complaint.
- If at least 50% improvement in pain frequency and severity is reported by the patient—continued treatment with decreased frequency is appropriate.

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- As treatment progresses, one should see an increase in the active regimen of care, a decrease in the passive regimen of care, and a fading of treatment frequency.
- If the condition has not progressed towards resolution, refer the patient to an appropriate health care provider to explore other treatment alternatives.
- eviCore's consideration of requests for continued acupuncture treatment depends on updated clinical information submitted regarding patient's progress.
- Adequate and legible patient progress information that contains a history and examination, and/or eviCore's Acupuncture Treatment Request Form is required to determine medical necessity.
- In addition to the improvements in the table below, significant progress may also be documented by increases in functional capacity and increasingly longer durations of pain relief.
- Discharge occurs when reasonable functional goals and expected outcomes have been achieved.
- The patient is discharged when the patient/care-giver can continue management of symptoms with an independent home program.
- Treatment is discontinued when the patient is unable to progress towards outcomes because of medical complications, psychosocial factors or other personal circumstances.
- If the member has been non-compliant with treatment as is evidenced by the clinical documentation, and/or the lack of demonstrated progress, treatment will be deemed to be not medically necessary and the member should be discharged from treatment.

Week	Progress
0-1	◆ Some reduction of pain severity and frequency ◆ Some reduction of muscle spasm
2-4	◆ 50% decrease in pain severity and frequency ◆ 50% improvement in function
5-8	◆ 75% decrease in pain severity and frequency ◆ 75% improvement in function
9-12	◆ Gradual improvement leading toward resolution ◆ Reinforce self-management techniques ◆ Discharge patient to elective care, or to their primary care provider for alternative treatment options when a plateau is reached, or by week 12, whichever occurs first

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Appropriate Procedures/ Modalities

- Acupuncture
- Electro-acupuncture
- Cupping
- Moxibustion
- Gua Sha
- Myofascial release
- Acupressure
- Trigger point massage
- Tui Na (not to include osseous manipulation)
- Herbal formulas

Note: Not all of these modalities are covered by the patient's health-plan; review documentation regarding coverage. Acupuncture and herbs must be appropriate for covered diagnoses under the patient's insurance policy. Acupuncturist is responsible for determining which procedures/modalities are most appropriate for the patient's condition.

Inappropriate Procedures/Modalities

- Scarring moxa
- Applied kinesiology techniques
- Electro-acupuncture using more than 9 volts
- Any techniques outside of the scope of practice in your state

Self-Management Techniques

- Rest and reduce strenuous activities
- Ergonomics, Postural advice, postural exercises
- Appropriate exercises/stretching
- Tai Qi, Qi Gong, Yoga
- Stress management, meditation
- Joint protection
- Weight loss
- Self-massage, Self-acupressure
- Hot packs/cold packs, if needed, to relieve discomfort

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Alternatives to Oriental Medicine Management

(listed in alphabetical order)

- Chiropractic
- Dietary/Nutritional Medicine Counseling
- Injection therapy/Pain management
- Massage therapy
- Medication
- Occupational therapy
- Osteopathic Manipulation
- Physical Therapy
- Psychological counseling

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References

1. Abdulla A, Adams N, Bone M, et al. Guidance on the management of pain in older people. Age Ageing. 2013 Mar;42 Suppl 1:i1-57. doi:10.1093/ageing/afs200.
2. Amezaga Urruela M, Suarez-Almazor ME. Acupuncture in the treatment of rheumatic diseases. Curr Rheumatol Rep. 2012;14(6):589-597. doi:10.1007/s11926-012-0295-x.
3. Balshem H, Helfand M, Schunemann HJ, Oxman AD, Kunz R, Brozek J, et al. GRADE guidelines: 3. Rating the quality of evidence. J Clin Epidemiol. 2011 Apr;64(4):401-6. doi:10.1016/j.jclinepi.2010.07.015.
4. Berman BM, Lao L, Langenberg P, Lee WL, Gilpin AM, Hochberg MC. Effectiveness of acupuncture as adjunctive therapy in osteoarthritis of the knee: a randomized, controlled trial. Ann Intern Med. 2004 Dec 21;141(12):901-10. doi:10.7326/0003-4819-141-12-200412210-00006.
5. Cheng X, Deng L. Chinese Acupuncture and Moxibustion. Beijing: Foreign Language Press; 2010.
6. Corbett MS, Rice SJ, Madurasinghe V, Slack R, Fayter DA, Harden M, et al. Acupuncture and other physical treatments for the relief of pain due to osteoarthritis of the knee: network meta-analysis. Osteoarthritis Cartilage. 2013 Sep;21(9):1290-8. doi:10.1016/j.joca.2013.05.007.
7. Hempel S, Taylor SL, Solloway MR, Miake-Lye IM, Beroes JM, Shanman R, et al. VA Evidence-based Synthesis Program Reports. Evidence Map of Acupuncture. Washington (DC): Department of Veterans Affairs; 2014.
8. Horn KK, Jennings S, Richardson G, Vliet DV, Hefford C, Abbott JH. The patient-specific functional scale: psychometrics, clinimetrics, and application as a clinical outcome measure. J Orthop Sports Phys Ther. 2012 Jan;42(1):30-42. doi:10.2519/jospt.2012.3727.
9. Hou P-W, Fu P-K, Hsu H-C, Hsieh C-L. Traditional Chinese medicine in patients with osteoarthritis of the knee. Journal of Traditional and Complementary Medicine. 2015;5(4):182-196. doi:10.1016/j.jtcme.2015.06.002.
10. Jubb RW, Tukmachi ES, Jones PW, Dempsey E, Waterhouse L, Brailsford S. A blinded randomised trial of acupuncture (manual and electroacupuncture) compared with a non-penetrating sham for the symptoms of osteoarthritis of the knee. Acupunct Med. 2008 Jun;26(2):69-78. doi:10.1136/aim.26.2.69.
11. Kaptchuk T. The Web That Has No Weaver. Contemporary Books. 2000.
12. Kelly RB. Acupuncture for pain. Am Fam Physician. 2009 Sep 1;80(5):481-4.
13. Kligler B, Nielsen A, Kohrrer C, Schmid T, Waltermaurer E, Perez E, Merrell W. Acupuncture Therapy in a Group Setting for Chronic Pain. Pain Med. 2017 Jun 8. doi:10.1093/pm/pnx134.
14. Langworthy MJ, Saad A, Langworthy NM. Conservative treatment modalities and outcomes for osteoarthritis: the concomitant pyramid of treatment. Phys Sportsmed. 2010 Jun;38(2):133-45. doi:10.3810/psm.2010.06.1792.
15. Lansdown H, Howard K, Brealey S, MacPherson H. Acupuncture for pain and osteoarthritis of the knee: a pilot study for an open parallel-arm randomised controlled trial. BMC Musculoskelet Disord. 2009 Oct 24;10:130. doi:10.1186/1471-2474-10-130.
16. Li X, Wang R, Xing X, et al. Acupuncture for Myofascial Pain Syndrome: A Network Meta-Analysis of 33 Randomized Controlled Trials. Pain Physician. 2017 Sep;20(6):E883-E902.
17. Maciocia, G; The Foundations of Chinese Medicine: A Comprehensive Text; Churchill Livingstone, 2005.
18. MacPherson H, Vertosick EA, Foster NE, Lewith G, Linde K, Sherman KJ, et al. The persistence of the effects of acupuncture after a course of treatment: A meta-analysis of patients with chronic pain. Pain. 2016 Oct 17. doi:10.1097/j.pain.0000000000000747.
19. Magee, David J., Orthopedic Physical Assessment, Second Edition, W.B. Saunders Company, 2007.
20. Manyanga T, Froese M, Zarychanski R, Abou-Setta A, Friesen C, Tennenhouse M, et al. Pain management with acupuncture in osteoarthritis: a systematic review and meta-analysis. BMC Complement Altern Med. 2014;14:312. doi:10.1186/1472-6882-14-312.
21. McDonald J, Janz S. The Acupuncture Evidence Project: A Comparative Literature Review (Revised Edition). Brisbane: Australian Acupuncture and Chinese Medicine Association Ltd; 2017.

© 2019 eviCore healthcare. All Rights Reserved.

22. Minor ,M.A., Hewett, J.E., Webel, R.R., Anderson, S., & Kay, D.R. Efficacy of physical conditioning exercise in patients with rheumatoid arthritis and osteoarthritis. Arthritis and Rheumatism, 1989; 32(11): 1396-1405.
23. National Health and Medical Research Council. NHMRC additional levels of evidence and grades for recommendations for developers of guidelines. Table 3. NHMRC Evidence Hierarchy: designations of 'levels of evidence' according to type of research question (including explanatory notes). National Health and Medical Research Council; 2009.
24. O'Connor J, Bensky D. Acupuncture: A Comprehensive Text. Chicago: Eastland Press; 1981.
25. Olson WH, Brumback RA, Gascon G, Iyer V; Handbook of Symptom Oriented Neurology; Year Book Medical Publishers, Inc.; 2002.
26. Porter, R; The Merck Manual, Merck, 2011.
27. Roy, S., Irvin, R., and Iverson, D; Sports Medicine, Prevention, Education, Management, and Rehabilitation, Benjamin Cummings, 1998.
28. Scharf HP, Mansmann U, Streitberger K, Witte S, Kramer J, Maier C, Trampisch HJ, Victor N. Acupuncture and knee osteoarthritis: a three-armed randomized trial. Ann Intern Med. 2006 Jul 4;145(1):12-20. doi:10.7326/0003-4819-145-1-200607040-00005.
29. Selfe TK, Taylor AG. Acupuncture and osteoarthritis of the knee: a review of randomized, controlled trials. Fam Community Health. 2008 Jul-Sep;31(3):247-54. doi:10.1097/01.FCH.0000324482.78577.0f.
30. Weinstein, S, and Buckwalter, J. Orthopaedics Principles and Their Applications. Lippincott, Williams, & Wilkins, 2005.
31. White A, Foster NE, Cummings M, Barlas P. Acupuncture treatment for chronic knee pain: a systematic review. Rheumatology (Oxford). 2007 Mar;46(3):384-90.
32. Witt C, Brinkhaus B, Jena S, Linde K, Streng A, Wagenpfeil S, Hummelsberger J, Walther HU, Melchart D, Willich SN. Acupuncture in patients with osteoarthritis of the knee: a randomised trial. Lancet. 2005 Jul 9-15;366(9480):136-43. doi:10.1093/rheumatology/kel413.
33. Witt CM, Jena S, Brinkhaus B, Liecker B, Wegscheider K, Willich SN. Acupuncture in patients with osteoarthritis of the knee or hip: A randomized, controlled trial with an additional nonrandomized arm. Arthritis Rheum. 2006 Oct 30;54(11):3485-3493. doi:10.1016/S0140-6736(05)66871-7.
34. Xiang A, Cheng K, Shen X, Xu P, Liu S. The Immediate Analgesic Effect of Acupuncture for Pain: A Systematic Review and Meta-Analysis. Evid Based Complement Alternat Med. 2017;2017:3837194. doi:10.1155/2017/3837194.
35. Yuan J, Purepong N, Hunter RF, Kerr DP, Park J, Bradbury I, McDonough S. Different frequencies of acupuncture treatment for chronic low back pain: an assessor-blinded pilot randomised controlled trial. Complement Ther Med. 2009 Jun;17(3):131-40. doi:10.1016/j.ctim.2008.10.003.
36. Zhang W, Nuki G, Moskowitz RW, et al. OARSI recommendations for the management of hip and knee osteoarthritis: part III: Changes in evidence following systematic cumulative update of research published through January 2009. Osteoarthritis Cartilage. 2010 Apr;18(4):476-99. doi:10.1016/j.joca.2010.01.013
37. Zhao HJ, Tan JY, Wang T, Jin L. Auricular therapy for chronic pain management in adults: A synthesis of evidence. Complement Ther Clin Pract. 2015 May;21(2):68-78. doi:10.1016/j.ctcp.2015.03.006.

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ACU-9.2: Ankle Sprain (Now Excluded)

- There is insufficient evidence that acupuncture is an effective treatment for Ankle Sprain.
- As such, acupuncture treatment for this condition does not meet medical necessity criteria.

Synonyms

- Ankle pain

Definition

Most common ankle sprain is injury to the lateral ankle ligaments. These ligaments are responsible for resistance against inversion and internal rotation stress. Specifically the anterior talofibular ligament (ATFL) is most commonly injured, followed by the calcaneofibular ligament (CFL). Posterior talofibular ligament (PTFL) is rarely injured. Medial supporting ligaments are superficial, and deep deltoid ligaments, which are responsible for resistance to eversion and external rotation stress, are less commonly injured.

Oriental Medicine Diagnoses

- Qi and Blood Stagnation
  - This stagnation results in a painful condition, may have numerous causation, but for this diagnosis trauma is the primary causation, perhaps with underlying Qi Deficiency syndrome.

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History

Specific Aspects of History

- Rule out red flags (require medical management).
- Determine if trauma-related; determine nature and extent of traumatic event.
- Identify co-morbidities requiring medical management, and those that affect acupuncture and Oriental Medicine management.

Red Flag	Possible Consequence or Cause	Action Required
Severe trauma	Fracture	Immediate referral to emergency department
Fever, severe pain	Possible infection	Immediate referral to emergency department
Cancer history	Cause of symptoms (metastatic or primary)	Prompt referral to Primary Care Provider
Unilateral edema	Lower extremity deep vein thrombosis	Immediate referral to emergency department
Immune-compromised state	Infection	Prompt referral to Primary Care Provider
Diabetes	Neuropathy	Prompt referral to Primary Care Provider
Discoloration, cool foot	Vascular occlusion	Immediate referral to emergency department

Subjective Findings

- If lateral ligament injury: pain at lateral aspect of ankle
- History of injury is usually described as landing on a plantar flexed and inverted foot
- Pain should be documented as a numeric pain scale 0-10

Functional Assessment

- Documentation of a patient's level of function is an important aspect of patient care. This documentation is required in order to establish the medical necessity of ongoing acupuncture treatment. The Patient Specific Functional Scale (PSFS) is a patient reported outcome assessment that is easy and appropriate for acupuncturists to use. The PSFS has been studied in peer-reviewed scientific literature, and it has been proven to be a valid, reliable, and responsive measure for a variety of pain syndromes (neck, back, knee, etc.).

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Objective Findings

Scope of Musculoskeletal Examination

- Inspection including Oriental Medicine inspection techniques
- Palpation of bony and soft tissue including Oriental Medicine inspection techniques
- Range of motion, active and passive (where allowed by law)
- Orthopedic and neurologic testing if neurologic signs are present (where allowed by law)

Specific Aspects of Examination for Ankle Sprain

Examine the musculoskeletal system for possible causes or contributing factors to the complaint.

Findings of Ankle Sprain

- Direct palpation of the lateral ankle ligaments produces or increases pain (with lateral ligament injury)
- Pain is produced or increased with passive and end range inversion
- Swelling is usually seen but may be diffuse
- Ecchymosis is also frequently found laterally, but it may settle into the lateral or medial heel
- Provocative tests for lateral ankle instability include the anterior drawer test, inversion stress test and the suction sign; two provocative tests for syndesmotic ligament injury are the squeeze test and the external rotation stress test

West Point Ankle Sprain Grading System

Criterion	Grade 1	Grade 2	Grade 3
Location of tenderness	ATFL	ATFL, CFL	ATFL, CFL, PTFL
Edema, ecchymosis	Slight local	Moderate local	Significant diffuse
Weight-bearing ability	Full or partial	Difficult without crutches	Impossible without significant pain
Ligament damage	Stretched	Partial tear	Complete tear
Instability	None	None or slight	Definite

Differential Diagnoses

- Fractures
- Tendon injuries
- Radicular pathology
- Crystalline deposition diseases: gout and pseudogout (Chondrocalcinosis)

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Oriental Medicine Management [13]

There is insufficient evidence that acupuncture is an effective treatment for Ankle Sprain. As such, acupuncture treatment for this condition does not meet medical necessity criteria.

Alternatives to Oriental Medicine Management

(listed in alphabetical order)

- Bracing
- Chiropractic
- Dietary/Nutritional Medicine Counseling
- Injection therapy/Pain management
- Massage therapy
- Medication
- Occupational therapy
- Osteopathic Manipulation
- Physical Therapy
- Psychological counseling
- Surgery (as a last resort in severe cases)

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References

1. Balshem H, Helfand M, Schunemann HJ, Oxman AD, Kunz R, Brozek J, et al. GRADE guidelines: 3. Rating the quality of evidence. J Clin Epidemiol. 2011 Apr;64(4):401-6. doi:10.1016/j.jclinepi.2010.07.015.
2. Cheng X, Deng L. Chinese Acupuncture and Moxibustion. Beijing: Foreign Language Press; 2010.
3. Hempel S, Taylor SL, Solloway MR, Miake-Lye IM, Beroes JM, Shanman R, et al. VA Evidence-based Synthesis Program Reports. Evidence Map of Acupuncture. Washington (DC): Department of Veterans Affairs; 2014.
4. Horn KK, Jennings S, Richardson G, Vliet DV, Hefford C, Abbott JH. The patient-specific functional scale: psychometrics, clinimetrics, and application as a clinical outcome measure. J Orthop Sports Phys Ther. 2012 Jan;42(1):30-42. doi:10.2519/jospt.2012.3727.
5. Kaptchuk T. The Web That Has No Weaver. Contemporary Books. 2000.
6. Kelly RB. Acupuncture for pain. Am Fam Physician. 2009 Sep 1;80(5):481-4.
7. Kim TH, Lee MS, Kim KH, Kang JW, Choi TY, Ernst E. Acupuncture for treating acute ankle sprains in adults. Cochrane Database Syst Rev. 2014(6):Cd009065. doi:10.1002/14651858.CD009065.pub2.
8. Kligler B, Nielsen A, Kohrrer C, Schmid T, Waltermaurer E, Perez E, Merrell W. Acupuncture Therapy in a Group Setting for Chronic Pain. Pain Med. 2017 Jun 8. doi: 10.1093/pm/pnx134.
9. Li X, Wang R, Xing X, et al. Acupuncture for Myofascial Pain Syndrome: A Network Meta-Analysis of 33 Randomized Controlled Trials. Pain Physician. 2017 Sep;20(6):E883-E902.
10. Maciocia, G; The Foundations of Chinese Medicine: A Comprehensive Text; Churchill Livingstone, 2005.
11. MacPherson H, Vertosick EA, Foster NE, Lewith G, Linde K, Sherman KJ, et al. The persistence of the effects of acupuncture after a course of treatment: A meta-analysis of patients with chronic pain. Pain. 2016 Oct 17. doi:10.1097/j.pain.0000000000000747.
12. Magee, David J., Orthopedic Physical Assessment, Second Edition, W.B. Saunders Company, 2007.
13. McDonald J, Janz S. The Acupuncture Evidence Project: A Comparative Literature Review (Revised Edition). Brisbane: Australian Acupuncture and Chinese Medicine Association Ltd; 2017.
14. National Health and Medical Research Council. NHMRC additional levels of evidence and grades for recommendations for developers of guidelines. Table 3. NHMRC Evidence Hierarchy: designations of 'levels of evidence' according to type of research question (including explanatory notes). National Health and Medical Research Council; 2009.
15. O'Connor J, Bensky D. Acupuncture: A Comprehensive Text. Chicago: Eastland Press; 1981.
16. Olson WH, Brumback RA, Gascon G, Iyer V; Handbook of Symptom Oriented Neurology; Year Book Medical Publishers, Inc.; 2002.
17. Park J, Hahn S, Park JY, Park HJ, Lee H. Acupuncture for ankle sprain: systematic review and meta-analysis. BMC Complement Altern Med. 2013;13:55. doi:10.1186/1472-6882-13-55.
18. Porter, R; The Merck Manual, Merck, 2011.
19. Roy, S., Irvin, R., and Iverson, D; Sports Medicine, Prevention, Education, Management, and Rehabilitation, Benjamin Cummings, 1998.
20. Wang R, Li X, Zhou S, Zhang X, Yang K, Li X. Manual acupuncture for myofascial pain syndrome: a systematic review and meta-analysis. Acupunct Med. 2017 Aug;35(4):241-250. doi:10.1136/acupmed-2016-011176.
21. Weinstein, S, and Buckwalter, J. Orthopaedics Principles and Their Applications. Lippincott, Williams, & Wilkins, 2005.
22. Xiang A, Cheng K, Shen X, Xu P, Liu S. The Immediate Analgesic Effect of Acupuncture for Pain: A Systematic Review and Meta-Analysis. Evid Based Complement Alternat Med. 2017;2017:3837194. doi:10.1155/2017/3837194.

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23. Yuan J, Purepong N, Hunter RF, Kerr DP, Park J, Bradbury I, McDonough S. Different frequencies of acupuncture treatment for chronic low back pain: an assessor-blinded pilot randomised controlled trial. Complement Ther Med. 2009 Jun;17(3):131-40. doi:10.1016/j.ctim.2008.10.003.
24. Zhao HJ, Tan JY, Wang T, Jin L. Auricular therapy for chronic pain management in adults: A synthesis of evidence. Complement Ther Clin Pract. 2015 May;21(2):68-78. doi:10.1016/j.ctcp.2015.03.006.

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ACU-9.3: Chrondromalacia Patella

Synonyms

- Patellae-femoral grinding
- Patellofemoral syndrome
- Anterior knee pain from patellar malalignment
- Knee pain

Definition

Degeneration of the articular cartilage (softening or wearing away and cracking) on the posterior aspect of the patella, and is estimated to occur in fewer than 20 percent of persons who present with anterior knee pain. The syndrome is most common in the 12-35 year old age group with a predominance in females. Pain may be acute or chronic. Many theories have been proposed to explain the etiology of patellofemoral pain. These include biomechanical, muscular and overuse theories. In general, the literature and clinical experience suggest that the etiology of patellofemoral pain syndrome is multifactorial.

Oriental Medicine Diagnoses

- Bi Syndrome
  - Movement of Qi and Blood through the channels is effected by the pathogens of Wind, Heat, Cold or Damp. Two types of Bi Syndromes most likely to be diagnosed as oseoarthritis is Cold Bi syndrome and Damp Bi Syndrome or Cold Damp Bi Syndrome.
- Qi and Blood Stagnation
  - Stagnation results in pain; may have numerous causations; can be related to trauma or underlying syndromes.
- Kidney Yang Deficiency
  - Underlying condition with additional symptoms caused by either illness, stress, or lifestyle choices, such as irregular or “incorrect” food choice, irregular eating times, lack of sleep, excess of activities that result in depletion of this energy, or congenital insufficiency.

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History

Specific Aspects of History

- Rule out red flags (require medical management).
- Determine if trauma-related; determine nature and extent of traumatic event.
- Identify co-morbidities requiring medical management, and those that affect acupuncture and Oriental Medicine management.

Red Flag	Possible Consequence or Cause	Action Required
Severe trauma	Fracture, ligament/meniscal tear	Immediate referral to emergency department
Fever, severe pain	Infection	Immediate referral to emergency department
Popliteal fossa pain, sudden onset	Popliteal aneurysm	Immediate referral to emergency department
Diabetes	Neuropathy	Prompt referral to Primary Care Provider
Multiple joint involvement	Rheumatologic diseases	Prompt referral to Primary Care Provider
Unilateral edema	Deep vein thrombosis	Immediate referral to emergency department
Cancer	Cause of symptoms (metastatic or primary)	Prompt referral to Primary Care Provider
Discoloration of foot or leg	Arterial occlusion	Immediate referral to emergency department
Immune-compromised state	Infection	Prompt referral to Primary Care Provider

Subjective Findings

- Knee tenderness
- Knee pain in the front of the knee that worsens after sitting for prolonged time, or with walking, running, or jumping
- Knee pain that worsens with using stairs, getting out of a chair, or squatting
- Crepitation (feeling of grating) as knee actively flexes or extends
- Recurrent effusion, depending on activity
- Pain should be documented as a numeric pain scale 0-10

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Functional Assessment

- Documentation of a patient's level of function is an important aspect of patient care. This documentation is required in order to establish the medical necessity of ongoing acupuncture treatment. The Patient Specific Functional Scale (PSFS) is a patient reported outcome assessment that is easy and appropriate for acupuncturists to use. The PSFS has been studied in peer-reviewed scientific literature, and it has been proven to be a valid, reliable, and responsive measure for a variety of pain syndromes (neck, back, knee, etc.).

Objective Findings

Scope of Musculoskeletal Examination

- Inspection
- Palpation of bony and soft tissue
- Range of motion, active and passive
- Manual muscle testing
- Orthopedic and neurologic testing

Specific Aspects of Examination for Chondromalacia Patella

Examine the musculoskeletal system for possible causes or contributing factors to the complaint.

Findings of Chondromalacia Patella

- Crepitation as the patella is passively moved within the femoral groove while pressure is exerted simultaneously
- Pain and recurrence of symptoms with passive movement of, and simultaneous pressure to patella within the femoral groove
- Pain with contraction of quadriceps while patella is held in groove
- Q-angle greater than 15 degrees
- Tenderness on palpation of borders and underside when patella is lifted out of the groove
- Genu valgum deformity
- External tibial torsion with external rotation of the tibial tubercle
- Femoral anteversion combined with external tibial torsion (miserable malalignment syndrome)

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Differential Diagnoses

- Meniscal disease/tear
- Knee sprain
- Torn ligament
- Osteoarthritis
- Inflamed bursas
- Joint effusion from crystal disease (e.g., gout), trauma, infection, rheumatologic diseases
- Baker's cyst
- Diabetic neuropathy
- Developmental abnormalities (e.g., Osgood-Schlatter's)

Oriental Medicine Management [8, 18, 20]

- Oriental Medicine management goals are to resolve pain, restore the highest level of function possible, and educate patient to prevent recurrent symptoms.
- In order to be considered medically necessary, patient's symptoms must be the direct result of a primary neuromusculoskeletal injury or illness.
- Confirmation of appropriate medical co-management is always required when treating children age 14 and under.
- Treatment frequency should be commensurate with severity of the chief complaint.
- If at least 50% improvement in pain frequency and severity is reported by patient—continued treatment with decreased frequency is appropriate.
- As treatment progresses, one should see an increase in the active regimen of care, a decrease in the passive regimen of care, and a fading of treatment frequency.
- If the condition has not progressed towards resolution, refer the patient to an appropriate health care provider to explore other treatment alternatives.
- eviCore's consideration of requests for continued acupuncture treatment depends on updated clinical information submitted regarding patient's progress.
- Adequate and legible patient progress information that contains a history and examination, and/or eviCore's Acupuncture Treatment Request Form is required to determine medical necessity.
- In addition to improvements in the table below, significant progress may also be documented by increases in functional capacity and increasingly longer durations of pain relief.
- Discharge occurs when reasonable functional goals and expected outcomes have been achieved.

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- The patient is discharged when the patient/care-giver can continue management of symptoms with an independent home program.
- Treatment is discontinued when the patient is unable to progress towards outcomes because of medical complications, psychosocial factors or other personal circumstances.
- If the member has been non-compliant with treatment as is evidenced by the clinical documentation, and/or the lack of demonstrated progress, treatment will be deemed to be not medically necessary and the member should be discharged from treatment.

Week	Progress
0-1	◆ Some reduction of pain severity and frequency ◆ Some reduction of muscle spasm
2-4	◆ 50% decrease in pain severity and frequency ◆ 50% improvement in function
5-8	◆ 75% decrease in pain severity and frequency ◆ 75% improvement in function
9-12	◆ Gradual improvement leading toward resolution ◆ Reinforce self-management techniques ◆ Discharge patient to elective care, or to their primary care provider for alternative treatment options when a plateau is reached, or by week 12, whichever occurs first

Appropriate Procedures/ Modalities

- Acupuncture
- Electro-acupuncture
- Cupping
- Moxibustion
- Gua Sha
- Myofascial release
- Acupressure
- Trigger point massage
- Tui Na (not to include osseous manipulation)
- Herbal formulas

Note: Not all of these modalities are covered by the patient's health-plan, please review documentation regarding coverage. Acupuncture and herbs must be appropriate for covered diagnoses under the patient's insurance policy. The acupuncturist is responsible for determining which procedures/modalities are most appropriate for the patient's condition.

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Inappropriate Procedures/Modalities

- Scarring moxa
- Applied kinesiology techniques
- Electro-acupuncture using more than 9 volts
- Any techniques outside of the scope of practice in your state

Self-Management Techniques

- Rest and reduce strenuous activities
- Ergonomics, Postural advice, postural exercises
- Appropriate exercises/stretching
- Tai Qi, Qi Gong, Yoga
- Stress management, meditation
- Joint protection
- Weight loss
- Self-massage, Self-acupressure
- Hot packs/cold packs, if needed, to relieve discomfort

Alternatives to Oriental Medicine Management

(listed in alphabetical order)

- Chiropractic
- Dietary/Nutritional Medicine Counseling
- Injection therapy/Pain management
- Massage therapy
- Medication
- Occupational therapy
- Osteopathic Manipulation
- Physical Therapy
- Psychological counseling
- Surgery (as a last resort)

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References

1. Balshem H, Helfand M, Schunemann HJ, Oxman AD, Kunz R, Brozek J, et al. GRADE guidelines: 3. Rating the quality of evidence. J Clin Epidemiol. 2011 Apr;64(4):401-6. doi:10.1016/j.jclinepi.2010.07.015.
2. Cheng X, Deng L. Chinese Acupuncture and Moxibustion. Beijing: Foreign Language Press; 2010.
3. Hempel S, Taylor SL, Solloway MR, Miake-Lye IM, Beroes JM, Shanman R, et al. VA Evidence-based Synthesis Program Reports. Evidence Map of Acupuncture. Washington (DC): Department of Veterans Affairs; 2014.
4. Horn KK, Jennings S, Richardson G, Vliet DV, Hefford C, Abbott JH. The patient-specific functional scale: psychometrics, clinimetrics, and application as a clinical outcome measure. J Orthop Sports Phys Ther. 2012 Jan;42(1):30-42. doi:10.2519/jospt.2012.3727.
5. Kaptchuk T. The Web That Has No Weaver. Contemporary Books. 2000.
6. Kelly RB. Acupuncture for pain. Am Fam Physician. 2009 Sep 1;80(5):481-4.
7. Kligler B, Nielsen A, Kohrrer C, Schmid T, Waltermaurer E, Perez E, Merrell W. Acupuncture Therapy in a Group Setting for Chronic Pain. Pain Med. 2017 Jun 8. doi:10.1093/pm/pnx134.
8. Li X, Wang R, Xing X, et al. Acupuncture for Myofascial Pain Syndrome: A Network Meta-Analysis of 33 Randomized Controlled Trials. Pain Physician. 2017 Sep;20(6):E883-E902.
9. Maciocia, G; The Foundations of Chinese Medicine: A Comprehensive Text; Churchill Livingstone, 2005.
10. MacPherson H, Vertosick EA, Foster NE, Lewith G, Linde K, Sherman KJ, et al. The persistence of the effects of acupuncture after a course of treatment: A meta-analysis of patients with chronic pain. Pain. 2016 Oct 17. doi:10.1097/j.pain.0000000000000747.
11. Magee, David J., Orthopedic Physical Assessment, Second Edition, W.B. Saunders Company, 2007.
12. McDonald J, Janz S. The Acupuncture Evidence Project: A Comparative Literature Review (Revised Edition). Brisbane: Australian Acupuncture and Chinese Medicine Association Ltd; 2017.
13. National Health and Medical Research Council. NHMRC additional levels of evidence and grades for recommendations for developers of guidelines. Table 3. NHMRC Evidence Hierarchy: designations of 'levels of evidence' according to type of research question (including explanatory notes). National Health and Medical Research Council; 2009.
14. O'Connor J, Bensky D. Acupuncture: A Comprehensive Text. Chicago: Eastland Press; 1981.
15. Olson WH, Brumback RA, Gascon G, Iyer V; Handbook of Symptom Oriented Neurology; Year Book Medical Publishers, Inc.; 2002.
16. Porter, R; The Merck Manual, Merck, 2011.
17. Roy, S., Irvin, R., and Iverson, D; Sports Medicine, Prevention, Education, Management, and Rehabilitation, Benjamin Cummings, 1998.
18. Wang R, Li X, Zhou S, Zhang X, Yang K, Li X. Manual acupuncture for myofascial pain syndrome: a systematic review and meta-analysis. Acupunct Med. 2017 Aug;35(4):241-250. doi:10.1136/acupmed-2016-011176.
19. Weinstein, S, and Buckwalter, J. Orthopaedics Principles and Their Applications. Lippincott, Williams, & Wilkins, 2005.
20. Xiang A, Cheng K, Shen X, Xu P, Liu S. The Immediate Analgesic Effect of Acupuncture for Pain: A Systematic Review and Meta-Analysis. Evid Based Complement Alternat Med. 2017;2017:3837194. doi:10.1155/2017/3837194.
21. Yuan J, Purepong N, Hunter RF, Kerr DP, Park J, Bradbury I, McDonough S. Different frequencies of acupuncture treatment for chronic low back pain: an assessor-blinded pilot randomised controlled trial. Complement Ther Med. 2009 Jun;17(3):131-40. doi:10.1016/j.ctim.2008.10.003.
22. Zhao HJ, Tan JY, Wang T, Jin L. Auricular therapy for chronic pain management in adults: A synthesis of evidence. Complement Ther Clin Pract. 2015 May;21(2):68-78. doi:10.1016/j.ctcp.2015.03.006.

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ACU-9.4: Hip, Joint Pain and Osteoarthrosis

Synonyms

- Osteoarthritis
- Degenerative arthritis
- Degenerative joint disease
- Hypertrophic arthritis
- Hip pain

Definition

Degenerative and sometimes hypertrophic changes in the bone and cartilage of one or more joints, and a progressive wearing down of opposing joint surfaces with consequent distortion of joint position. Pain may be acute or chronic.

Oriental Medicine Diagnoses

Various types of arthritis are contained under the singular rubric of Blockage, or Painful Obstruction, in Chinese Medicine. Condition occurs when circulation of Qi and Blood through channels is hindered by Wind, Cold and/or Dampness. Dampness, or if at a certain stage of the disease, Cold becomes Heat, then Heat blockage can occur.

There are five principal blockages or obstructions in Chinese medicine. Commonly referred to as Bi Syndrome, can be a combination of any of the below:

- Wind Bi, Moving (Wind) Painful Obstruction
  - Pain in the joints is widespread and moves from one area of the body to another.
- Damp Bi, Stationary (Damp) Painful Obstruction
  - Pain is localized and does not move.
- Cold Bi, Painful (Cold) Painful Obstruction
  - Severe pain in one part, or over one half of the body, which becomes worse when patient encounters cold and diminishes when patient is warm.
- Heat Bi, Heat Painful Obstruction
  - Flesh is hot, area of pain is red and swollen, pain increases upon contact.

History

- Rule out red flags (require medical management).
- Determine if trauma-related; determine nature and extent of traumatic event.
- Identify co-morbidities requiring medical management, and those that affect acupuncture and Oriental Medicine management, such as:
  - Coronary Artery Disease

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- Respiratory Disease
- Hypertension
- Obesity
- Diabetes
- Chronic Venous Insufficiency
- Previous surgery
- Macro/Micro Trauma

Red Flag	Possible Consequence or Cause	Action Required
Severe trauma	Ligament tear, pelvic fracture; avascular necrosis	Immediate referral to emergency department
Fever, severe pain	Infection	Immediate referral to emergency department
Loss of distal pulse, beginning 12/24 hours after trauma	Compartment syndrome	Immediate referral to emergency department
Diabetes	Neuropathy	Prompt referral to Primary Care Provider
Multiple joint involvement	Rheumatologic diseases	Prompt referral to Primary Care Provider
Unilateral edema	Deep vein thrombosis	Immediate referral to emergency department
Skin rash in dermatomal pattern	Shingles	Prompt referral to Primary Care Provider
Constipation, bloody stools, unexplained weight loss	Colon, or pelvic organ cancer	Prompt referral to Primary Care Provider
Groin pain	Inguinal hernia, pelvic pathology	Prompt referral to Primary Care Provider
Pain with urination, hematuria	UTI; renal stone	Prompt referral to Primary Care Provider
Cancer	Cause of symptoms (metastatic or primary)	Prompt referral to Primary Care Provider
Discoloration of leg or foot, pain with ambulation	Arterial occlusion	Immediate referral to emergency department
History of steroid use	Avascular necrosis	Prompt referral to Primary Care Provider
Immune-compromised state	Infection	Prompt referral to Primary Care Provider

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Subjective Findings

- Anterior or Lateral hip pain
- Pain may radiate into the thigh
- Pain with activity
- Morning stiffness
- Pain should be documented as a numeric pain scale 0-10
- Radiating symptom frequency, duration and numeric pain scale should be documented

Functional Assessment

- Documentation of a patient's level of function is an important aspect of patient care. This documentation is required in order to establish the medical necessity of ongoing acupuncture treatment. The Patient Specific Functional Scale (PSFS) is a patient reported outcome assessment that is easy and appropriate for acupuncturists to use. The PSFS has been studied in peer-reviewed scientific literature, and it has been proven to be a valid, reliable, and responsive measure for a variety of pain syndromes (neck, back, knee, etc.).

Objective Findings of Osteoarthrosis

- Swelling may be present in the inflammatory phase
- Calor (warmth) may be noted over the affected joint in the inflammatory phase
- Pain over the joint
- Pain with range of motion, loss of range of motion

Examination

Examine the musculoskeletal system for possible causes, or contributing factors to the complaint.

Scope of Musculoskeletal Examination

- Inspection
- Palpation of bony and soft tissue
- Range of motion, active and passive (if allowed by law)
- Orthopedic and neurologic testing if neurologic signs are present (if allowed by law)

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Differential Diagnoses

- Fracture of the femur must be considered if there was significant trauma, particularly in elderly or osteoporotic individuals.
- Lumbosacral radiculopathy can cause pain that radiates down the lower limb.
- Labral tears
- Capsular laxity
- Sacro-iliac joint pain
- Osteitis Pubis

Oriental Medicine Management [16, 30, 35]

- Oriental Medicine management goals are to resolve pain, restore the highest level of function possible, and educate patient to prevent recurrent symptoms.
- In order to be considered medically necessary, patient's symptoms must be the direct result of a primary neuromusculoskeletal injury or illness.
- Confirmation of appropriate medical co-management is always required when treating children age 14 and under.
- Treatment frequency should be commensurate with the severity of the chief complaint, natural history of the condition, and expectation for functional improvement.
- When significant improvements in patient's subjective findings and objective findings are demonstrated—continued treatment with decreased frequency is appropriate.
- As treatment progresses, one should see an increase in the active regimen of care, a decrease in the passive regimen of care, and a fading of treatment frequency.
- If the condition has not progressed towards resolution, refer the patient to an appropriate health care provider to explore other treatment alternatives.
- eviCore's consideration of requests for continued acupuncture treatment depends on updated clinical information submitted regarding patient's progress.
- Adequate and legible patient progress information that contains a history and examination, and/or eviCore's Treatment Request Form for each treatment is required to determine medical necessity.
- In addition to the improvements in the table below, significant progress may be documented by increases in functional capacity and increasingly longer durations of pain relief.
- Discharge occurs when reasonable functional goals and expected outcomes have been achieved.
- The patient is discharged when the patient/care-giver can continue management of symptoms with an independent home program.

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- Treatment is discontinued when the patient is unable to progress towards outcomes because of medical complications, psychosocial factors or other personal circumstances.
- If the member has been non-compliant with treatment as is evidenced by the clinical documentation, and/or the lack of demonstrated progress, treatment will be deemed to be not medically necessary and the member should be discharged from treatment.

Week	Progress
0-1	◆ Some reduction of pain severity and frequency ◆ Some reduction of muscle spasm
2-4	◆ 50% decrease in pain severity and frequency ◆ 50% improvement in function
5-8	◆ 75% decrease in pain severity and frequency ◆ 75% improvement in function
9-12	◆ Gradual improvement leading toward resolution ◆ Reinforce self-management techniques ◆ Discharge patient to elective care, or to their primary care provider for alternative treatment options when a plateau is reached, or by week 12, whichever occurs first

Referral Guidelines

- Refer patient to their primary care provider for evaluation of alternative treatment options if:
  - Improvement does not meet above guidelines, or improvement has reached a plateau
  - Atrophy of the extremity occurs
  - Neurological deficits appear/progress
- Appropriate Procedures/Modalities
  - Acupuncture
  - Electro-acupuncture
  - Cupping
  - Moxibustion
  - Gua Sha
  - Myofascial release
  - Acupressure
  - Trigger point massage
  - Tui Na (not to include osseous manipulation)
  - Herbal formulas

Note: Not all of these modalities are covered by the patient's health-plan; review documentation regarding coverage. Acupuncture and herbs must be appropriate for covered diagnoses under the patient's insurance policy. Acupuncturist is responsible for determining which procedures/modalities are most appropriate for the patient's condition.

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Inappropriate Procedures/Modalities

- Scarring moxa
- Applied kinesiology techniques
- Electro-acupuncture using more than 9 volts
- Any techniques outside of the scope of practice in your state

Self-Management Techniques

- Rest and reduce strenuous activities
- Ergonomics, Postural advice, postural exercises
- Appropriate exercises/stretching
- Tai Qi, Qi Gong, Yoga
- Stress management, meditation
- Joint protection
- Weight loss
- Self-massage, Self-acupressure
- Hot packs/cold packs, if needed, to relieve discomfort

Alternatives to Oriental Medicine Management

(listed in alphabetical order)

- Chiropractic
- Dietary/Nutritional Medicine Counseling
- Injection therapy/Pain management
- Massage therapy
- Medication
- Occupational therapy
- Osteopathic Manipulation
- Physical Therapy
- Psychological counseling

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References

1. Abdulla A, Adams N, Bone M, et al. Guidance on the management of pain in older people. Age Ageing. 2013 Mar;42 Suppl 1:i1-57. doi:10.1093/ageing/afs200.
2. Amezaga Urruela M, Suarez-Almazor ME. Acupuncture in the treatment of rheumatic diseases. Curr Rheumatol Rep. 2012;14(6):589-597. doi:10.1007/s11926-012-0295-x.
3. Balshem H, Helfand M, Schunemann HJ, Oxman AD, Kunz R, Brozek J, et al. GRADE guidelines: 3. Rating the quality of evidence. J Clin Epidemiol. 2011 Apr;64(4):401-6. doi:10.1016/j.jclinepi.2010.07.015.
4. Berman BM, Lao L, Langenberg P, Lee WL, Gilpin AM, Hochberg MC. Effectiveness of acupuncture as adjunctive therapy in osteoarthritis of the knee: a randomized, controlled trial. Ann Intern Med. 2004 Dec 21;141(12):901-10. doi:10.7326/0003-4819-141-12-200412210-00006.
5. Cheng X, Deng L. Chinese Acupuncture and Moxibustion. Beijing: Foreign Language Press; 2010.
6. Corbett MS, Rice SJ, Madurasinghe V, Slack R, Fayter DA, Harden M, et al. Acupuncture and other physical treatments for the relief of pain due to osteoarthritis of the knee: network meta-analysis. Osteoarthritis Cartilage. 2013 Sep;21(9):1290-8. doi:10.1016/j.joca.2013.05.007.
7. Hempel S, Taylor SL, Solloway MR, Miake-Lye IM, Beroes JM, Shanman R, et al. VA Evidence-based Synthesis Program Reports. Evidence Map of Acupuncture. Washington (DC): Department of Veterans Affairs; 2014.
8. Horn KK, Jennings S, Richardson G, Vliet DV, Hefford C, Abbott JH. The patient-specific functional scale: psychometrics, clinimetrics, and application as a clinical outcome measure. J Orthop Sports Phys Ther. 2012 Jan;42(1):30-42. doi:10.2519/jospt.2012.3727.
9. Hou P-W, Fu P-K, Hsu H-C, Hsieh C-L. Traditional Chinese medicine in patients with osteoarthritis of the knee. Journal of Traditional and Complementary Medicine. 2015;5(4):182-196. doi:10.1016/j.jtcme.2015.06.002.
10. Jubb RW, Tukmachi ES, Jones PW, Dempsey E, Waterhouse L, Brailsford S. A blinded randomised trial of acupuncture (manual and electroacupuncture) compared with a non-penetrating sham for the symptoms of osteoarthritis of the knee. Acupunct Med. 2008 Jun;26(2):69-78. doi:10.1136/aim.26.2.69
11. Kaptchuk T. The Web That Has No Weaver. Contemporary Books. 2000.
12. Kelly RB. Acupuncture for pain. Am Fam Physician. 2009 Sep 1;80(5):481-4.
13. Kligler B, Nielsen A, Kohrrer C, Schmid T, Waltermaurer E, Perez E, Merrell W. Acupuncture Therapy in a Group Setting for Chronic Pain. Pain Med. 2017 Jun 8. doi:10.1093/pm/pnx134.
14. Langworthy MJ, Saad A, Langworthy NM. Conservative treatment modalities and outcomes for osteoarthritis: the concomitant pyramid of treatment. Phys Sportsmed. 2010 Jun;38(2):133-45. doi:10.3810/psm.2010.06.1792.
15. Lansdown H, Howard K, Brealey S, MacPherson H. Acupuncture for pain and osteoarthritis of the knee: a pilot study for an open parallel-arm randomised controlled trial. BMC Musculoskelet Disord. 2009 Oct 24;10:130. doi:10.1186/1471-2474-10-130.
16. Li X, Wang R, Xing X, et al. Acupuncture for Myofascial Pain Syndrome: A Network Meta-Analysis of 33 Randomized Controlled Trials. Pain Physician. 2017 Sep;20(6):E883-E902.
17. Maciocia, G; The Foundations of Chinese Medicine: A Comprehensive Text; Churchill Livingstone, 2005.
18. MacPherson H, Vertosick EA, Foster NE, Lewith G, Linde K, Sherman KJ, et al. The persistence of the effects of acupuncture after a course of treatment: A meta-analysis of patients with chronic pain. Pain. 2016 Oct 17. doi:10.1097/j.pain.0000000000000747.
19. Magee, David J., Orthopedic Physical Assessment, Second Edition, W.B. Saunders Company, 2007.
20. Manyanga T, Froese M, Zarychanski R, Abou-Setta A, Friesen C, Tennenhouse M, et al. Pain management with acupuncture in osteoarthritis: a systematic review and meta-analysis. BMC Complement Altern Med. 2014;14:312. doi:10.1186/1472-6882-14-312.
21. McDonald J, Janz S. The Acupuncture Evidence Project: A Comparative Literature Review (Revised Edition). Brisbane: Australian Acupuncture and Chinese Medicine Association Ltd; 2017.

© 2019 eviCore healthcare. All Rights Reserved.

22. Minor ,M.A., Hewett, J.E., Webel, R.R., Anderson, S., & Kay, D.R. Efficacy of physical conditioning exercise in patients with rheumatoid arthritis and osteoarthritis. Arthritis and Rheumatism, 1989; 32(11): 1396-1405.
23. National Health and Medical Research Council. NHMRC additional levels of evidence and grades for recommendations for developers of guidelines. Table 3. NHMRC Evidence Hierarchy: designations of 'levels of evidence' according to type of research question (including explanatory notes). National Health and Medical Research Council; 2009.
24. O'Connor J, Bensky D. Acupuncture: A Comprehensive Text. Chicago: Eastland Press; 1981.
25. Olson WH, Brumback RA, Gascon G, Iyer V; Handbook of Symptom Oriented Neurology; Year Book Medical Publishers, Inc.; 2002.
26. Porter, R; The Merck Manual, Merck, 2011.
27. Roy, S., Irvin, R., and Iverson, D; Sports Medicine, Prevention, Education, Management, and Rehabilitation, Benjamin Cummings, 1998.
28. Scharf HP, Mansmann U, Streitberger K, Witte S, Kramer J, Maier C, Trampisch HJ, Victor N. Acupuncture and knee osteoarthritis: a three-armed randomized trial. Ann Intern Med. 2006 Jul 4;145(1):12-20. doi:10.7326/0003-4819-145-1-200607040-00005.
29. Selfe TK, Taylor AG. Acupuncture and osteoarthritis of the knee: a review of randomized, controlled trials. Fam Community Health. 2008 Jul-Sep;31(3):247-54. doi:10.1097/01.FCH.0000324482.78577.0f.
30. Wang R, Li X, Zhou S, Zhang X, Yang K, Li X. Manual acupuncture for myofascial pain syndrome: a systematic review and meta-analysis. Acupunct Med. 2017 Aug;35(4):241-250. doi:10.1136/acupmed-2016-011176.
31. Weinstein, S, and Buckwalter, J. Orthopaedics Principles and Their Applications. Lippincott, Williams, & Wilkins, 2005.
32. White A, Foster NE, Cummings M, Barlas P. Acupuncture treatment for chronic knee pain: a systematic review. Rheumatology (Oxford). 2007 Mar;46(3):384-90. doi:10.1093/rheumatology/kel413.
33. Witt C, Brinkhaus B, Jena S, Linde K, Streng A, Wagenpfeil S, Hummelsberger J, Walther HU, Melchart D, Willich SN. Acupuncture in patients with osteoarthritis of the knee: a randomised trial. Lancet. 2005 Jul 9-15;366(9480):136-43. doi:10.1016/S0140-6736(05)66871-7
34. Witt CM, Jena S, Brinkhaus B, Liecker B, Wegscheider K, Willich SN. Acupuncture in patients with osteoarthritis of the knee or hip: A randomized, controlled trial with an additional nonrandomized arm. Arthritis Rheum. 2006 Oct 30;54(11):3485-3493. doi:10.1002/art.22154.
35. Xiang A, Cheng K, Shen X, Xu P, Liu S. The Immediate Analgesic Effect of Acupuncture for Pain: A Systematic Review and Meta-Analysis. Evid Based Complement Alternat Med. 2017;2017:3837194. doi:10.1155/2017/3837194.
36. Yuan J, Purepong N, Hunter RF, Kerr DP, Park J, Bradbury I, McDonough S. Different frequencies of acupuncture treatment for chronic low back pain: an assessor-blinded pilot randomised controlled trial. Complement Ther Med. 2009 Jun;17(3):131-40. doi:10.1016/j.ctim.2008.10.003.
37. Zhang W, Nuki G, Moskowitz RW, et al. OARSI recommendations for the management of hip and knee osteoarthritis: part III: Changes in evidence following systematic cumulative update of research published through January 2009. Osteoarthritis Cartilage. 2010 Apr;18(4):476-99. doi:10.1016/j.joca.2010.01.013.
38. Zhao HJ, Tan JY, Wang T, Jin L. Auricular therapy for chronic pain management in adults: A synthesis of evidence. Complement Ther Clin Pract. 2015 May;21(2):68-78. doi:10.1016/j.ctcp.2015.03.006.

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ACU-9.5: Knee, Joint Pain and Osteoarthrosis

Synonyms

- Osteoarthritis
- Degenerative arthritis
- Degenerative joint disease
- Hypertrophic arthritis
- Knee pain

Definition

Degenerative and sometimes hypertrophic changes in the bone and cartilage of one or more joints, and a progressive wearing down of opposing joint surfaces with consequent distortion of joint position. Pain may be acute or chronic.

Oriental Medicine Diagnoses

Various types of arthritis are contained under the singular rubric of Blockage, or Painful Obstruction, in Chinese Medicine. Condition occurs when circulation of Qi and Blood through channels is hindered by Wind, Cold and/or Dampness. Dampness, or if at a certain stage of the disease, Cold becomes Heat, then Heat blockage can occur.

There are five principal blockages or obstructions in Chinese medicine. Commonly referred to as Bi Syndrome, can be a combination of any of the below:

- Wind Bi, Moving (Wind) Painful Obstruction
  - Pain in the joints is widespread and moves from one area of the body to another.
- Damp Bi, Stationary (Damp) Painful Obstruction
  - Pain is localized and does not move.
- Cold Bi, Painful (Cold) Painful Obstruction
  - Severe pain in one part, or over one half of the body, which becomes worse when patient encounters cold and diminishes when patient is warm.
- Heat Bi, Heat Painful Obstruction
  - Flesh is hot, area of pain is red and swollen, pain increases upon contact.

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History

Specific Aspects of History

- Rule out red flags (require medical management).
- Determine if trauma-related; determine nature and extent of traumatic event.
- Identify co-morbidities requiring medical management, and those that affect acupuncture and Oriental Medicine management.

Red Flag	Possible Consequence or Cause	Action Required
Severe trauma	Fracture, ligament/ meniscal tear	Immediate referral to emergency department
Fever, severe pain	Infection	Immediate referral to emergency department
Popliteal fossa pain, sudden onset	Popliteal aneurysm	Immediate referral to emergency department
Severe leg pain 12-24 hours after trauma	Compartment syndrome	Immediate referral to emergency department
Diabetes	Neuropathy	Prompt referral to Primary Care Provider
Multiple joint involvement	Rheumatologic diseases	Prompt referral to Primary Care Provider
Unilateral edema	Deep vein thrombosis	Immediate referral to emergency department
Cancer	Cause of symptoms (metastatic or primary)	Prompt referral to Primary Care Provider
Discoloration of foot or leg	Arterial occlusion	Immediate referral to emergency department
Immune-compromised state	Infection	Prompt referral to Primary Care Provider

Subjective Findings

- Pain is localized to the joint area
- Warmth may be felt over the affected joint, in the inflammatory stage
- Pain with range of motion may be described
- Onset is usually gradual and insidious
- Patient will complain of stiffness
- Pain should be documented as a numeric pain scale 0-10

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Functional Assessment

Documentation of a patient's level of function is an important aspect of patient care. This documentation is required in order to establish the medical necessity of ongoing acupuncture treatment. The Patient Specific Functional Scale (PSFS) is a patient reported outcome assessment that is easy and appropriate for acupuncturists to use. The PSFS has been studied in peer-reviewed scientific literature, and it has been proven to be a valid, reliable, and responsive measure for a variety of pain syndromes (neck, back, knee, etc.).

Objective Findings

Scope of Musculoskeletal Examination

- Inspection
- Palpation of bony and soft tissue
- Range of motion, active and passive (if allowed by law)
- Orthopedic and neurologic testing if neurologic signs are present (if allowed by law)

Specific Aspects of Examination for Osteoarthrosis

Examine the musculoskeletal system for possible causes or contributing factors to the complaint.

Findings of Osteoarthrosis

- Swelling may be present in the inflammatory phase
- Calor (warmth) may be noted over the affected joint in the inflammatory phase
- Pain over the joint
- Pain with range of motion, loss of range of motion

Oriental Medicine Management [5, 17, 31, 36]

- Oriental Medicine management goals are to resolve pain, restore the highest level of function possible, and educate patient to prevent recurrent symptoms.
- In order to be considered medically necessary, patient's symptoms must be the direct result of a primary neuromusculoskeletal injury or illness.
- Confirmation of appropriate medical co-management is always required when treating children age 14 and under.
- Treatment frequency should be commensurate with severity of the chief complaint.
- If at least 50% improvement in pain frequency and severity is reported by patient—continued treatment with decreased frequency is appropriate.

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- As treatment progresses, one should see an increase in the active regimen of care, a decrease in the passive regimen of care, and a fading of treatment frequency.
- If the condition has not progressed towards resolution, refer the patient to an appropriate health care provider to explore other treatment alternatives.
- eviCore's consideration of requests for continued acupuncture treatment depends on updated clinical information submitted regarding patient's progress.
- Adequate and legible patient progress information that contains a history and examination, and/or eviCore's Acupuncture Treatment Request Form is required to determine medical necessity.
- In addition to improvements in the table below, significant progress may be documented by increases in functional capacity and increasingly longer durations of pain relief.
- Discharge occurs when reasonable functional goals and expected outcomes have been achieved.
- The patient is discharged when the patient/care-giver can continue management of symptoms with an independent home program.
- Treatment is discontinued when the patient is unable to progress towards outcomes because of medical complications, psychosocial factors or other personal circumstances.
- If the member has been non-compliant with treatment as is evidenced by the clinical documentation, and/or the lack of demonstrated progress, treatment will be deemed to be not medically necessary and the member should be discharged from treatment.

Week	Progress
0-1	◆ Some reduction of pain severity and frequency ◆ Some reduction of muscle spasm
2-4	◆ 50% decrease in pain severity and frequency ◆ 50% improvement in function
5-8	◆ 75% decrease in pain severity and frequency ◆ 75% improvement in function
9-12	◆ Gradual improvement leading toward resolution ◆ Reinforce self-management techniques ◆ Discharge patient to elective care, or to their primary care provider for alternative treatment options when a plateau is reached, or by week 12, whichever occurs first

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Appropriate Procedures/ Modalities

- Acupuncture
- Electro-acupuncture
- Cupping
- Moxibustion
- Gua Sha
- Myofascial release
- Acupressure
- Trigger point massage
- Tui Na (not to include osseous manipulation)
- Herbal formulas

Note: Not all of these modalities are covered by the patient's health-plan; review documentation regarding coverage. Acupuncture and herbs must be appropriate for covered diagnoses under the patient's insurance policy. Acupuncturist is responsible for determining which procedures/modalities are most appropriate for the patient's condition.

Inappropriate Procedures/Modalities

- Scarring moxa
- Applied kinesiology techniques
- Electro-acupuncture using more than 9 volts
- Any techniques outside of the scope of practice in your state

Self-Management Techniques

- Rest and reduce strenuous activities
- Ergonomics, Postural advice, postural exercises
- Appropriate exercises/stretching
- Tai Qi, Qi Gong, Yoga
- Stress management, meditation
- Joint protection
- Weight loss
- Self-massage, Self-acupressure
- Hot packs/cold packs, if needed, to relieve discomfort

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Alternatives to Oriental Medicine Management

(listed in alphabetical order)

- Chiropractic
- Dietary/Nutritional Medicine Counseling
- Injection therapy/Pain management
- Knee bracing
- Massage therapy
- Medication
- Occupational therapy
- Osteopathic Manipulation
- Physical Therapy
- Psychological counseling

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References

1. Abdulla A, Adams N, Bone M, et al. Guidance on the management of pain in older people. Age Ageing. 2013 Mar;42 Suppl 1:i1-57. doi:10.1093/ageing/afs200.
2. Amezaga Urruela M, Suarez-Almazor ME. Acupuncture in the treatment of rheumatic diseases. Curr Rheumatol Rep. 2012;14(6):589-597. doi:10.1007/s11926-012-0295-x.
3. Balshem H, Helfand M, Schunemann HJ, Oxman AD, Kunz R, Brozek J, et al. GRADE guidelines: 3. Rating the quality of evidence. J Clin Epidemiol. 2011 Apr;64(4):401-6. doi:10.1016/j.jclinepi.2010.07.015.
4. Berman BM, Lao L, Langenberg P, Lee WL, Gilpin AM, Hochberg MC. Effectiveness of acupuncture as adjunctive therapy in osteoarthritis of the knee: a randomized, controlled trial. Ann Intern Med. 2004 Dec 21;141(12):901-10. doi:10.7326/0003-4819-141-12-200412210-00006.
5. Chen N, Wang J, Mucelli A, Zhang X, Wang C. Electro-Acupuncture is Beneficial for Knee Osteoarthritis: The Evidence from Meta-Analysis of Randomized Controlled Trials. Am J Chin Med. 2017;45(5):965-985. doi:10.1142/S0192415X17500513.
6. Cheng X, Deng L. Chinese Acupuncture and Moxibustion. Beijing: Foreign Language Press; 2010.
7. Corbett MS, Rice SJ, Madurasinghe V, Slack R, Fayter DA, Harden M, et al. Acupuncture and other physical treatments for the relief of pain due to osteoarthritis of the knee: network meta-analysis. Osteoarthritis Cartilage. 2013 Sep;21(9):1290-8. doi:10.1016/j.joca.2013.05.007.
8. Hempel S, Taylor SL, Solloway MR, Miake-Lye IM, Beroes JM, Shanman R, et al. VA Evidence-based Synthesis Program Reports. Evidence Map of Acupuncture. Washington (DC): Department of Veterans Affairs; 2014.
9. Horn KK, Jennings S, Richardson G, Vliet DV, Hefford C, Abbott JH. The patient-specific functional scale: psychometrics, clinimetrics, and application as a clinical outcome measure. J Orthop Sports Phys Ther. 2012 Jan;42(1):30-42. doi:10.2519/jospt.2012.3727.
10. Hou P-W, Fu P-K, Hsu H-C, Hsieh C-L. Traditional Chinese medicine in patients with osteoarthritis of the knee. Journal of Traditional and Complementary Medicine. 2015;5(4):182-196. doi:10.1016/j.jtcme.2015.06.002.
11. Jubb RW, Tukmachi ES, Jones PW, Dempsey E, Waterhouse L, Brailsford S. A blinded randomised trial of acupuncture (manual and electroacupuncture) compared with a non-penetrating sham for the symptoms of osteoarthritis of the knee. Acupunct Med. 2008 Jun;26(2):69-78. doi:10.1136/aim.26.2.69.
12. Kaptchuk T. The Web That Has No Weaver. Contemporary Books. 2000.
13. Kelly RB. Acupuncture for pain. Am Fam Physician. 2009 Sep 1;80(5):481-4.
14. Kligler B, Nielsen A, Kohrrer C, Schmid T, Waltermaurer E, Perez E, Merrell W. Acupuncture Therapy in a Group Setting for Chronic Pain. Pain Med. 2017 Jun 8. doi:10.1093/pm/pnx134.
15. Langworthy MJ, Saad A, Langworthy NM. Conservative treatment modalities and outcomes for osteoarthritis: the concomitant pyramid of treatment. Phys Sportsmed. 2010 Jun;38(2):133-45. doi: 10.3810/psm.2010.06.1792.
16. Lansdown H, Howard K, Brealey S, MacPherson H. Acupuncture for pain and osteoarthritis of the knee: a pilot study for an open parallel-arm randomised controlled trial. BMC Musculoskelet Disord. 2009 Oct 24;10:130. doi:10.1186/1471-2474-10-130.
17. Li X, Wang R, Xing X, et al. Acupuncture for Myofascial Pain Syndrome: A Network Meta-Analysis of 33 Randomized Controlled Trials. Pain Physician. 2017 Sep;20(6):E883-E902.
18. Maciocia, G; The Foundations of Chinese Medicine: A Comprehensive Text; Churchill Livingstone, 2005.
19. MacPherson H, Vertosick EA, Foster NE, Lewith G, Linde K, Sherman KJ, et al. The persistence of the effects of acupuncture after a course of treatment: A meta-analysis of patients with chronic pain. Pain. 2016 Oct 17.
20. Magee, David J., Orthopedic Physical Assessment, Second Edition, W.B. Saunders Company, 2007.
21. Manyanga T, Froese M, Zarychanski R, Abou-Setta A, Friesen C, Tennenhouse M, et al. Pain management with acupuncture in osteoarthritis: a systematic review and meta-analysis. BMC Complement Altern Med. 2014;14:312. doi:10.1186/1472-6882-14-312.

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22. McDonald J, Janz S. The Acupuncture Evidence Project: A Comparative Literature Review (Revised Edition). Brisbane: Australian Acupuncture and Chinese Medicine Association Ltd; 2017.
23. Minor MA, Hewett JE, Webel RR, Anderson S, Kay DR. Efficacy of physical conditioning exercise in patients with rheumatoid arthritis and osteoarthritis. Arthritis and Rheumatism, 1989; 32(11): 1396-1405.
24. National Health and Medical Research Council. NHMRC additional levels of evidence and grades for recommendations for developers of guidelines. Table 3. NHMRC Evidence Hierarchy: designations of 'levels of evidence' according to type of research question (including explanatory notes). National Health and Medical Research Council; 2009.
25. O'Connor J, Bensky D. Acupuncture: A Comprehensive Text. Chicago: Eastland Press; 1981.
26. Olson WH, Brumback RA, Gascon G, Iyer V; Handbook of Symptom Oriented Neurology; Year Book Medical Publishers, Inc.; 2002.
27. Porter, R; The Merck Manual, Merck, 2011.
28. Roy, S., Irvin, R., and Iverson, D; Sports Medicine, Prevention, Education, Management, and Rehabilitation, Benjamin Cummings, 1998.
29. Scharf HP, Mansmann U, Streitberger K, Witte S, Kramer J, Maier C, Trampisch HJ, Victor N. Acupuncture and knee osteoarthritis: a three-armed randomized trial. Ann Intern Med. 2006 Jul 4;145(1):12-20. doi:10.7326/0003-4819-145-1-200607040-00005.
30. Selfe TK, Taylor AG. Acupuncture and osteoarthritis of the knee: a review of randomized, controlled trials. Fam Community Health. 2008 Jul-Sep;31(3):247-54. doi:10.1097/01.FCH.0000324482.78577.0f.
31. Wang R, Li X, Zhou S, Zhang X, Yang K, Li X. Manual acupuncture for myofascial pain syndrome: a systematic review and meta-analysis. Acupunct Med. 2017 Aug;35(4):241-250. doi:10.1136/acupmed-2016-011176.
32. Weinstein, S, and Buckwalter, J. Orthopaedics Principles and Their Applications. Lippincott, Williams, & Wilkins, 2005.
33. White A, Foster NE, Cummings M, Barlas P. Acupuncture treatment for chronic knee pain: a systematic review. Rheumatology (Oxford). 2007 Mar;46(3):384-90. doi:10.1093/rheumatology/kel413.
34. Witt C, Brinkhaus B, Jena S, Linde K, Streng A, Wagenpfeil S, Hummelsberger J, Walther HU, Melchart D, Willich SN. Acupuncture in patients with osteoarthritis of the knee: a randomised trial. Lancet. 2005 Jul 9-15;366(9480):136-43.
35. Witt CM, Jena S, Brinkhaus B, Liecker B, Wegscheider K, Willich SN. Acupuncture in patients with osteoarthritis of the knee or hip: A randomized, controlled trial with an additional nonrandomized arm. Arthritis Rheum. 2006 Oct 30;54(11):3485-3493.
36. Xiang A, Cheng K, Shen X, Xu P, Liu S. The Immediate Analgesic Effect of Acupuncture for Pain: A Systematic Review and Meta-Analysis. Evid Based Complement Alternat Med. 2017;2017:3837194. doi:10.1155/2017/3837194.
37. Yuan J, Purepong N, Hunter RF, Kerr DP, Park J, Bradbury I, McDonough S. Different frequencies of acupuncture treatment for chronic low back pain: an assessor-blinded pilot randomised controlled trial. Complement Ther Med. 2009 Jun;17(3):131-40. doi:10.1016/j.ctim.2008.10.003.
38. Zhang W, Nuki G, Moskowitz RW, et al. OARSI recommendations for the management of hip and knee osteoarthritis: part III: Changes in evidence following systematic cumulative update of research published through January 2009. Osteoarthritis Cartilage. 2010 Apr;18(4):476-99. doi:10.1016/j.joca.2010.01.013.
39. Zhao HJ, Tan JY, Wang T, Jin L. Auricular therapy for chronic pain management in adults: A synthesis of evidence. Complement Ther Clin Pract. 2015 May;21(2):68-78. doi:10.1016/j.ctcp.2015.03.006.

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ACU-9.6: Knee, Tear, Medial Meniscus

Synonyms

- Knee pain

Definition

Menisci are two (2) semilunar wedges in the knee joint positioned between the tibia and femur. They are essentially extensions of the tibia that act to deepen the articular surfaces of the otherwise relatively flat tibial plateau to accommodate the relatively round femoral condyles. Superior surfaces are concave and in contact with the femoral condyles; inferior surfaces are flat and conform to the tibial plateaus. Peripheral, convex borders of the menisci are thick and attach to the joint capsule; opposite border tapers inward to a thin free edge centrally. Therefore, menisci have a triangular shape in cross section. Each covers approximately two thirds of the corresponding articular surface of the tibia. Medial and lateral menisci each have distinct, individual anatomic characteristics.

Medial meniscus is semicircular or C-shaped. About 3.5 cm in length from anterior to posterior, it is asymmetric with a considerably wider posterior horn than anterior horn. Peripherally, the medial meniscus is continuously attached to the joint capsule with the middle portion being more firmly attached via connection with fibers of the deep medial collateral ligament. It is anchored to the tibia by the coronary (meniscotibial) ligaments. Posterior horn inserts in the posterior intercondylar fossa directly anterior to the posterior cruciate ligament (PCL). Anterior horn attachment is more variable distributed in a 6- to 8-mm area anterior to the anterior cruciate ligament (ACL) tibial attachment in the anterior intercondylar fossa. Some anterior fibers attach over the anterior periphery of the tibial articular surface, and some posterior fibers of the anterior horn merge with the transverse meniscal ligament that connects to the lateral meniscus.

Medial meniscus has two (2) types of tears: bucket handle meniscus tear and posterior horn tear of the medial meniscus. Tears are also graded from I to III based on the completeness of tears (Grade III is a complete tear of the meniscus). Surgical options include partial meniscectomy and meniscal repair depending on the grade and location. In general, meniscectomy healing is more rapid than meniscal repair but long term outcomes vary depending on the type, grade and surgical technique employed.

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Oriental Medicine Diagnoses

- Qi and Blood Stagnation
  - Stagnation results in pain; may have numerous causations; can be related to trauma or underlying syndromes.
- Kidney Yang Deficiency
  - Underlying condition with additional symptoms caused by illness, stress, lifestyle choices, such as irregular or "incorrect" food choice, irregular eating times, lack of sleep, excess of activities, that result in depletion of this energy, or congenital insufficiency.
- Bi Syndrome, Cold Damp with Painful Obstruction
  - Accumulation of Cold Damp can result from lifestyle or external pathogens.

History

Specific Aspects of History

- Rule out red flags (require medical management).
- Determine if trauma-related; determine nature and extent of traumatic event.
- Identify co-morbidities requiring medical management, and those that affect acupuncture and Oriental Medicine management.

Red Flag	Possible Consequence or Cause	Action Required
Severe trauma	Fracture, ligament/meniscal tear	Immediate referral to emergency department
Fever, severe pain	Infection	Immediate referral to emergency department
Popliteal fossa pain, sudden onset	Popliteal aneurysm	Immediate referral to emergency department
Diabetes	Neuropathy	Prompt referral to Primary Care Provider
Multiple joint involvement	Rheumatologic diseases	Prompt referral to Primary Care Provider
Unilateral edema	Deep vein thrombosis	Immediate referral to emergency department
Cancer	Cause of symptoms (metastatic or primary)	Prompt referral to Primary Care Provider
Discoloration of foot or leg	Arterial occlusion	Immediate referral to emergency department
Immune-compromised state	Infection	Prompt referral to Primary Care Provider

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Presentation

Meniscus tears are sometimes related to trauma, but significant trauma is not necessary. Sudden twist or repeated squatting can tear the meniscus. Timing of injury is important to note, although patients are not often able to describe a specific event. Meniscus tears occur as a result of twisting or change of position of the weight bearing knee in varying degrees of flexion or extension. Pain may be acute or chronic.

Subjective Findings

- Pain is localized to the joint line
- Pain from meniscus injuries is commonly intermittent, and usually the result of synovitis or abnormal motion of the unstable meniscus fragment
- Complaints may include clicking, catching, locking, pinching, or a sensation of giving way
- Pain should be documented as a numeric pain scale 0-10

Functional Assessment

- Documentation of a patient's level of function is an important aspect of patient care. This documentation is required in order to establish the medical necessity of ongoing acupuncture treatment. The Patient Specific Functional Scale (PSFS) is a patient reported outcome assessment that is easy and appropriate for acupuncturists to use. The PSFS has been studied in peer-reviewed scientific literature, and it has been proven to be a valid, reliable, and responsive measure for a variety of pain syndromes (neck, back, knee, etc.).

Objective Findings

Scope of Musculoskeletal Examination

- Inspection
- Palpation of bony and soft tissue
- Range of motion, active and passive
- Manual muscle testing
- Orthopedic and neurologic testing if neurologic signs are present

Specific Aspects of Examination for Medial Meniscus Tear

Examine the musculoskeletal system for possible causes or contributing factors to the complaint.

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Findings of Medial Meniscus Tear

- Swelling usually occurs as a delayed symptom or may not occur at all. Immediate swelling indicates a tear in the peripheral vascular aspect. Degenerative tears often present with recurrent effusions due to synovitis
- Joint line tenderness
- Mechanical block to motion or frank locking can occur with displaced tears
- Restricted motion caused by pain or swelling is common
- McMurray test usually elicits pain or a reproducible click
- Steinmann test may be positive
- Apley test is suggestive of meniscal pathology if pain at the medial joint line is elicited

Differential Diagnoses

- Anterior cruciate ligament injury
- Contusions
- Iliotibial band syndrome
- Knee osteochondritis dissecans
- Lateral collateral knee ligament injury
- Lumbosacral radiculopathy
- Medial collateral knee ligament injury
- Medial synovial plica irritation
- Patellofemoral joint syndromes
- Pes anserine bursitis
- Posterior cruciate ligament injury
- Other problems to be considered:
  - Articular cartilage pathology including arthritis, neoplastic pathology
  - Osteonecrosis of the femur or tibia
  - Crystalline deposition diseases including gout and pseudogout (chondrocalcinosis)
  - Ipsilateral hip disease

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Oriental Medical Management [8, 18, 20]

- Most patients with this diagnosis will already have consulted with their Primary Care Provider. If not, however, they should be directed to make an appointment with their MD at their earliest opportunity.
- Confirmation of appropriate medical co-management is always required when treating children age 14 and under.
- Oriental Medicine management goals are to resolve pain, restore the highest level of function possible, and educate the patient to prevent recurrent symptoms.
- In order to be considered medically necessary, patient's symptoms must be the direct result of a primary neuromusculoskeletal injury or illness.
- Treatment frequency should be commensurate with severity of the chief complaint.
- When significant improvements in patient's subjective complaints and objective findings are demonstrated—continued treatment with decreased frequency is appropriate.
- As treatment progresses, one should see an increase in the active regimen of care, a decrease in the passive regimen of care, and a fading of treatment frequency.
- If the condition has not progressed towards resolution, refer the patient to an appropriate health care provider to explore other treatment alternatives.
- eviCore's consideration of requests for continued acupuncture treatment depends on updated clinical information submitted regarding patient's progress .
- Adequate and legible patient progress information that contains a history and examination, and/or eviCore's Acupuncture Treatment Request Form is required to determine medical necessity.
- In addition to improvements in the table below, significant progress may be documented by increases in functional capacity and increasingly longer durations of pain relief.
- Discharge occurs when reasonable functional goals and expected outcomes have been achieved.
- The patient is discharged when the patient/care-giver can continue management of symptoms with an independent home program.
- Treatment is discontinued when the patient is unable to progress towards outcomes because of medical complications, psychosocial factors or other personal circumstances.

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- If the member has been non-compliant with treatment as is evidenced by the clinical documentation, and/or the lack of demonstrated progress, treatment will be deemed to be not medically necessary and the member should be discharged from treatment.

Week	Progress
0-1	◆ Some reduction of pain severity and frequency ◆ Some reduction of muscle spasm
2-4	◆ 50% decrease in pain severity and frequency ◆ 50% improvement in function
5-8	◆ 75% decrease in pain severity and frequency ◆ 75% improvement in function
9-12	◆ Gradual improvement leading toward resolution ◆ Reinforce self-management techniques ◆ Discharge patient to elective care, or to their primary care provider for alternative treatment options when a plateau is reached, or by week 12, whichever occurs first

Appropriate Procedures/ Modalities

- Acupuncture
- Electro-acupuncture
- Cupping
- Moxibustion
- Gua Sha
- Myofascial release
- Acupressure
- Trigger point massage
- Tui Na (not to include osseous manipulation)
- Herbal formulas

Note: Not all of these modalities are covered by the patient's health-plan; review documentation regarding coverage. Acupuncture and herbs must be appropriate for covered diagnoses under the patient's insurance policy. Acupuncturist is responsible for determining which procedures/modalities are most appropriate for the patient's condition.

Inappropriate Procedures/Modalities

- Scarring moxa
- Applied kinesiology techniques
- Electro-acupuncture using more than 9 volts
- Any technique outside the scope of practice in your state

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Self-Management Techniques

- Rest and reduce strenuous activities
- Ergonomics, Postural advice, postural exercises
- Appropriate exercises/stretching
- Tai Qi, Qi Gong, Yoga
- Stress management, meditation
- Joint protection
- Weight loss
- Self-massage, Self-acupressure
- Hot packs/cold packs, if needed, to relieve discomfort

Alternatives to Oriental Medicine Management

(listed in alphabetical order)

- Chiropractic
- Dietary/Nutritional Medicine Counseling
- Injection therapy/Pain management
- Massage therapy
- Medication
- Occupational therapy
- Osteopathic Manipulation
- Physical Therapy
- Psychological counseling

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References

1. Balshem H, Helfand M, Schunemann HJ, Oxman AD, Kunz R, Brozek J, et al. GRADE guidelines: 3. Rating the quality of evidence. J Clin Epidemiol. 2011 Apr;64(4):401-6. doi:10.1016/j.jclinepi.2010.07.015.
2. Cheng X, Deng L. Chinese Acupuncture and Moxibustion. Beijing: Foreign Language Press; 2010.
3. Hempel S, Taylor SL, Solloway MR, Miake-Lye IM, Beroes JM, Shanman R, et al. VA Evidence-based Synthesis Program Reports. Evidence Map of Acupuncture. Washington (DC): Department of Veterans Affairs; 2014.
4. Horn KK, Jennings S, Richardson G, Vliet DV, Hefford C, Abbott JH. The patient-specific functional scale: psychometrics, clinimetrics, and application as a clinical outcome measure. J Orthop Sports Phys Ther. 2012 Jan;42(1):30-42. doi:10.2519/jospt.2012.3727.
5. Kaptchuk T. The Web That Has No Weaver. Contemporary Books. 2000.
6. Kelly RB. Acupuncture for pain. Am Fam Physician. 2009 Sep 1;80(5):481-4.
7. Kligler B, Nielsen A, Kohrrer C, Schmid T, Waltermaurer E, Perez E, Merrell W. Acupuncture Therapy in a Group Setting for Chronic Pain. Pain Med. 2017 Jun 8. doi:10.1093/pm/pnx134.
8. Li X, Wang R, Xing X, et al. Acupuncture for Myofascial Pain Syndrome: A Network Meta-Analysis of 33 Randomized Controlled Trials. Pain Physician. 2017 Sep;20(6):E883-E902.
9. Maciocia, G; The Foundations of Chinese Medicine: A Comprehensive Text; Churchill Livingstone, 2005.
10. MacPherson H, Vertosick EA, Foster NE, Lewith G, Linde K, Sherman KJ, et al. The persistence of the effects of acupuncture after a course of treatment: A meta-analysis of patients with chronic pain. Pain. 2016 Oct 17. doi:10.1097/j.pain.0000000000000747.
11. Magee, David J., Orthopedic Physical Assessment, Second Edition, W.B. Saunders Company, 2007.
12. McDonald J, Janz S. The Acupuncture Evidence Project: A Comparative Literature Review (Revised Edition). Brisbane: Australian Acupuncture and Chinese Medicine Association Ltd; 2017.
13. National Health and Medical Research Council. NHMRC additional levels of evidence and grades for recommendations for developers of guidelines. Table 3. NHMRC Evidence Hierarchy: designations of 'levels of evidence' according to type of research question (including explanatory notes). National Health and Medical Research Council; 2009.
14. O'Connor J, Bensky D. Acupuncture: A Comprehensive Text. Chicago: Eastland Press; 1981.
15. Olson WH, Brumback RA, Gascon G, Iyer V; Handbook of Symptom Oriented Neurology; Year Book Medical Publishers, Inc.; 2002.
16. Porter, R; The Merck Manual, Merck, 2011.
17. Roy, S., Irvin, R., and Iverson, D; Sports Medicine, Prevention, Education, Management, and Rehabilitation, Benjamin Cummings, 1998.
18. Wang R, Li X, Zhou S, Zhang X, Yang K, Li X. Manual acupuncture for myofascial pain syndrome: a systematic review and meta-analysis. Acupunct Med. 2017 Aug;35(4):241-250. doi:10.1136/acupmed-2016-011176.
19. Weinstein, S, and Buckwalter, J. Orthopaedics Principles and Their Applications. Lippincott, Williams, & Wilkins, 2005.
20. Xiang A, Cheng K, Shen X, Xu P, Liu S. The Immediate Analgesic Effect of Acupuncture for Pain: A Systematic Review and Meta-Analysis. Evid Based Complement Alternat Med. 2017;2017:3837194. doi:10.1155/2017/3837194.
21. Yuan J, Purepong N, Hunter RF, Kerr DP, Park J, Bradbury I, McDonough S. Different frequencies of acupuncture treatment for chronic low back pain: an assessor-blinded pilot randomised controlled trial. Complement Ther Med. 2009 Jun;17(3):131-40. 10.1016/j.ctim.2008.10.003.
22. Zhao HJ, Tan JY, Wang T, Jin L. Auricular therapy for chronic pain management in adults: A synthesis of evidence. Complement Ther Clin Pract. 2015 May;21(2):68-78. doi:10.1016/j.ctcp.2015.03.006.

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ACU-9.7: Lower Extremity Post-Surgical

Common Surgeries

- ACL reconstruction
- Total knee replacement (arthroplasty)
- Ankle ligament reconstruction
- Ankle tendon repair
- Total hip replacement (arthroplasty)

Discussion and Definitions

Reconstructive surgery after ACL injury is performed to provide stability and long- term normal function. The procedure usually involves an intra-articular autograft of the middle third of patellar tendon, or tendons of semitendinosus/gracilis. In total knee arthroplasty, articular surfaces of the knee joint are replaced with artificial materials.

Total knee arthroplasty articular surfaces of the knee joint are replaced with artificial materials. Most commonly in response to disabling pain due to arthritic degeneration. While there are many types of prosthetics produced, most can be categorized by degree of constraint and type of fixation. Unconstrained prostheses are not common and rely on inherent joint stability. Most prostheses are semiconstrained; this type is frequently used in conjunction with the correction of contractures and varus/valgus deformity. Fully constrained prostheses limit motion and are reserved for severely unstable joints and severe deformity. Another distinguishing characteristic is method of fixation. More sedentary patients will receive a cemented prosthesis. More active patients will receive a porous ingrowth prosthesis. Due to difficulties encountered with loosening of tibial components, some surgeons prefer a hybrid fixation, with the femoral and patellar components press fit and the tibial component cemented.

Reconstruction is distinguished from repair, as a technique that re-directs tendons, fascia or grafts to increase stability of the ankle. Repair is designed to re-establish the damaged ligament.

Ankle tendon repair involves suturing the ends of torn tendon into approximation, and usually, immobilization for a period of weeks. It also may involve modification of associated fascial structures. Some tendon tears are treated with immobilization alone, depending on factors such as age, activity level and co-morbidities. Reconstruction is distinguished from repair, as a technique that re-directs tendons, fascia or grafts to increase stability of the ankle. Repair is designed to re-establish the damaged ligament.

Total hip replacement is implantation of an artificial femoral head and acetabulum to replace a degenerative joint. The most common conditions requiring surgery are trauma, arthritis, avascular necrosis, previously failed hip surgery, fracture, osteomyelitis (not active), and hereditary disorders. The procedure may involve replacing only the femoral component (Hemiarthroplasty). Components may be cemented, non-cemented, or hybrid (femoral component cemented, with non-cemented acetabular component).

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Please refer to eviCore's Physical and Occupational Therapy Clinical Guidelines for additional discussion and definitions.

Oriental Medicine Diagnoses

- Qi and Blood Stagnation:
  - This stagnation results in a painful condition, may have numerous causation, but for this diagnosis trauma is the primary causation, perhaps with underlying Qi Deficiency Syndrome.
- Damp Bi, Stationary (Damp) Painful Obstruction:
  - Pain is localized and does not move.
- Cold Bi, Painful (Cold) Painful Obstruction:
  - Severe pain in one part, or over one half of the body, which becomes worse when patient encounters cold and diminishes when patient is warm.
- Heat Bi, Heat Painful Obstruction:
  - Flesh is hot, area of pain is red and swollen, pain increases upon contact.
- Bi Syndrome:
  - Condition can be any combination of the above.

History

- Documentation of pain level using a validated pain scale (VAS/NRS) and its frequency
- General demographics
- Occupation/employment
- Living environment
- History of current condition
- Functional status & activity level
- Medications
- Other tests and measurements (laboratory and diagnostic tests)
- Past history (including history of prior acupuncture and response to prior treatment)
- In addition to the standard information gathered, a complete understanding of the surgical procedure performed should be obtained from surgeon.

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Specific Aspects of History

- Rule out red flags (require medical management).
- Determine if trauma-related; determine nature and extent of traumatic event.
- Identify co-morbidities requiring medical management, and those that affect acupuncture and Oriental Medicine management.
- Determine OPQRST (Onset, Provocative/Palliative factors, Quality, Radiation/Referral pattern, Site [location], Timing of complaint).

Red Flag	Possible Consequence or Cause	Action Required
Trauma, post-operative	Fracture, dislocation	Immediate referral to emergency department
Fever, severe pain, drainage, swelling	Possible infection	Prompt referral to Primary Care Provider
Pain at rest, or radiating pain	Neurological or metastatic disease	Prompt referral to Primary Care Provider
Unilateral edema	Deep vein thrombosis	Immediate referral to emergency department
Exertional arm pain	CAD, vascular insufficiency	Immediate referral to emergency department
Recent invasive procedures post op (dental work, urologic procedures	Infection	Prompt referral to Primary Care Provider
Diabetes	Neuropathy	Prompt referral to Primary Care Provider
Multiple joint involvement	Rheumatologic diseases, gout	Prompt referral to Primary Care Provider
Cancer	Cause of symptoms (metastatic or primary)	Prompt referral to Primary Care Provider
Immune-compromised state	Infection	Prompt referral to Primary Care Provider
Pleuritic pain, shortness of breath, associated with cough	Pulmonary diseases	Prompt referral to Primary Care Provider
Popliteal fossa pain, sudden onset	Popliteal aneurysm	Immediate referral to emergency department
Discoloration of foot/leg, or exertional foot/leg pain	Arterial occlusion; vascular insufficiency; compartment syndrome	Immediate referral to emergency department
Severe pain, swelling, discoloration, cold to touch within 12-24 hours following trauma	Compartment syndrome	Immediate referral to emergency department
Lower extremity shortening or internal rotation	Dislocation	Prompt referral to Primary Care Provider

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Red Flag	Possible Consequence or Cause	Action Required
"Pistoning" during gait	Dislocation	Prompt referral to Primary Care Provider
Shoulder pain that is constant, relieved or worse with meals, positional, or associated with fatty meals	Gastrointestinal diseases including cholelithiasis and perforated ulcer	Prompt referral to Primary Care Provider

Presentation

Patient presents with signs and symptoms post operatively. There may be surgery specific precautions dictated by the surgeon. Post-surgical rehabilitation should be managed by a multidisciplinary team including at least an MD and a physical therapist. Active rehabilitation, including physical therapy and/or occupational therapy, is critical for optimal recovery. The goal is to transition the patient as quickly as possible to active care, self-management and functional independence.

Subjective Findings

- Pain at surgical site
- Pain with motion
- Pain should be documented as a numeric pain scale 0-10
- Loss of range of motion
- Swelling
- Weakness and/or apprehension
- Stiffness
- Antalgic gait
- Functional losses

Functional Assessment

- Documentation of a patient's level of function is an important aspect of patient care. This documentation is required in order to establish the medical necessity of ongoing acupuncture treatment. The Patient Specific Functional Scale (PSFS) is a patient reported outcome assessment that is easy and appropriate for acupuncturists to use. The PSFS has been studied in peer-reviewed scientific literature, and it has been proven to be a valid, reliable, and responsive measure for a variety of pain syndromes (neck, back, knee, etc.).

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Objective Findings

- Pain at surgical site, particularly with movement
- Swelling
- Weakness
- Limited range of motion
- Impaired motor function
- Restrictions/precautions set by surgeon (bracing, weight bearing)

Scope of Examination

Examine the musculoskeletal system for possible causes, or contributing factors to the complaint.

Examination Considerations

- Evaluate for potential of post-surgical complications or other red flags. Refer appropriately if signs or symptoms of post-surgical complications develop.
- All of the following objective tests may not be appropriate, but should be assessed according to the member's condition and surgery type:
  - Pain: Determine OPQRST (Onset, Provocative/Palliative factors, Quality, Radiation/Referral pattern, Site [location], Timing of complaint). Observe surgical precautions.
  - Skin/Wound Integrity: Skin characteristics (blistering, color, sensation, temperature, texture), Surgical wound (signs of infection, scar tissue characteristics, stage of healing). Observe surgical precautions.
  - Palpation of bony and soft tissue: Palpate involved muscles for tender nodule, taut band, tight ropiness, Observe pattern of referred pain, Provocation tests. Observe surgical precautions.
  - Edema (measure both sides for comparison): Girth measurements, Palpation, Volume measurements. Observe surgical precautions.
  - Postural assessment: Postural alignment and position. Observe surgical precautions.
  - Range of motion: Active and passive movement of affected area and joint above and below and contralateral joints, Functional range of motion (e.g. squat tests, toe touch tests). Observe surgical precautions.
  - Manual Muscle Testing: Test related joints. Observe surgical precautions.
  - Assistive, protective and supportive devices
  - Neurologic tests: Proprioception, Sensation. Observe surgical precautions.
  - Gait and Locomotion: Gait indexes, Mobility skills profiles, Functional assessment profiles. Observe surgical precautions.
  - Motor Function Tests: Use standardized tests appropriate to the affected area. Observe surgical precautions.

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Oriental Medicine Management [16, 28, 31]

- Post-surgical rehabilitation should be managed by a multidisciplinary team including at least an MD and a physical therapist. Active rehabilitation, including physical therapy and occupational therapy, is critical for optimal recovery. The goal is to transition the patient as quickly as possible to active care, self-management and functional independence.
- Confirmation of appropriate medical co-management is always required when treating children age 14 and under.
- Treatment frequency should be commensurate with the severity of the chief complaint, natural history of the condition, and expectation for functional improvement.
- When significant improvements in patient's subjective findings and objective findings are demonstrated—continued treatment with decreased frequency is appropriate.
- As treatment progresses, one should see an increase in the active regimen of care, a decrease in the passive regimen of care, and a fading of treatment frequency.
- If the condition has not progressed towards resolution, refer the patient to an appropriate health care provider to explore other treatment alternatives.
- eviCore's consideration of requests for continued acupuncture treatment depends on updated clinical information submitted regarding patient's progress.
- Adequate and legible patient progress information that contains a history and examination, and/or eviCore's Treatment Request Form for each treatment is required to determine medical necessity.
- In addition to the improvements in the table below, significant progress may be documented by increases in functional capacity and increasingly longer durations of pain relief.
- Discharge occurs when reasonable functional goals and expected outcomes have been achieved.
- The patient is discharged when the patient/care-giver can continue management of symptoms with an independent home program.
- Treatment is discontinued when the patient is unable to progress towards outcomes because of medical complications, psychosocial factors or other personal circumstances.
- If the member has been non-compliant with treatment as is evidenced by the clinical documentation, and/or the lack of demonstrated progress, treatment will be deemed to be not medically necessary and the member should be discharged from treatment.

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Week	Progress
0-1	◆ Some reduction of pain severity and frequency ◆ Observation of post-surgical activity restrictions, if any
2-4	◆ 25% decrease in pain severity and frequency ◆ Observation of post-surgical activity restrictions, if any ◆ Meet functional goals set by MD, PT or OT ◆ Reinforce self-management techniques
5-8	◆ 50% decrease in pain severity and frequency ◆ Observation of post-surgical activity restrictions, if any ◆ Meet functional goals set by MD, PT or OT ◆ Reinforce self-management techniques
9-12	◆ Gradual improvement leading toward resolution of pain ◆ Meet functional goals set by MD, PT or OT ◆ Reinforce self-management techniques ◆ Discharge patient to elective care, active rehabilitation, or to their primary care provider for alternative treatment options when a plateau is reached, or by week 12, whichever occurs first

Referral Guidelines

- Refer patient to their primary care provider for evaluation of alternative treatment options if:
  - Improvement does not meet above guidelines, or improvement has reached a plateau
  - Atrophy of lower extremity occurs
  - Range of motion plateaus or decreases
  - Re-injury occurs
  - Signs of infection
  - Signs or symptoms of any post-surgical complication or red flag

Appropriate Procedures/Modalities

- Acupuncture
- Electro-acupuncture
- Cupping
- Moxibustion
- Gua Sha
- Myofascial release
- Acupressure
- Trigger point massage
- Tui Na (not to include osseous manipulation)
- Herbal formulas

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Note: Not all of these modalities are covered by the patient's health-plan; review documentation regarding coverage. Acupuncture and herbs must be appropriate for covered diagnoses under the patient's insurance policy. Acupuncturist is responsible for determining which procedures/modalities are most appropriate for the patient's condition.

Inappropriate Procedures/Modalities

- Scarring moxa
- Applied kinesiology techniques
- Electro-acupuncture using more than 9 volts
- Any techniques outside of the scope of practice in your state

Self-Management Techniques

- Observation of surgical restrictions/precautions
- Rest and reduce strenuous activities
- Use of home medical equipment as advised by MD or PT
- Gradual increase in activity
- Compliance with home exercise/stretching program as assigned by PT
- Cold packs after incision heals, or as directed by MD
- Ergonomics, Postural advice, postural exercises
- Appropriate exercises/stretching
- Tai Qi, Qi Gong, Yoga
- Stress management, meditation
- Joint protection
- Weight loss
- Self-massage, Self-acupressure

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Alternatives to Oriental Medicine Management

(listed in alphabetical order)

- Anesthesia/Pain Management
- Chiropractic
- Dietary/Nutritional Medicine Counseling
- Injection therapy/Pain management
- Massage therapy
- Medication
- Occupational therapy
- Osteopathic Manipulation
- Physical Therapy
- Psychological counseling

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References

1. Balshem H, Helfand M, Schunemann HJ, Oxman AD, Kunz R, Brozek J, et al. GRADE guidelines: 3. Rating the quality of evidence. J Clin Epidemiol. 2011 Apr;64(4):401-6. doi:10.1016/j.jclinepi.2010.07.015.
2. Barlow T, Downham C, Barlow D. The effect of complementary therapies on post-operative pain control in ambulatory knee surgery: a systematic review. Complement Ther Med. 2013;21(5):529-534. doi:10.1016/j.ctim.2013.06.008.
3. Chen W-T, Fu G-Q, Shen W-D. [Progresses of studies on acupuncture analgesia for postoperative reaction]. Zhen Ci Yan Jiu. 2013;38(1):83-87.
4. Cheng X, Deng L. Chinese Acupuncture and Moxibustion. Beijing: Foreign Language Press; 2010.
5. Deadman P, Khafaji MA-, Baker K. A Manual of Acupuncture. Hove: Journal of Chinese Medicine Publications; 2011.
6. Fuentealba Cargill F, Biagini Alarcón L. Acupuncture for postoperative pain, a literature review. Rev Med Chil. 2016;144(3):325-332. doi:10.4067/S0034-98872016000300007.
7. Hempel S, Taylor SL, Solloway MR, Miake-Lye IM, Beroes JM, Shanman R, et al. VA Evidence-based Synthesis Program Reports. Evidence Map of Acupuncture. Washington (DC): Department of Veterans Affairs; 2014.
8. Hertling D, Kessler RM. Management of Common Musculoskeletal Disorders: Physical Therapy Principles and Methods. Philadelphia: Lippincott Williams & Wilkins; 2006.
9. Horn KK, Jennings S, Richardson G, Vliet DV, Hefford C, Abbott JH. The patient-specific functional scale: psychometrics, clinimetrics, and application as a clinical outcome measure. J Orthop Sports Phys Ther. 2012 Jan;42(1):30-42. doi:10.2519/jospt.2012.3727.
10. Jones B. 8.7 Complications of total knee replacement. Oxford Textbook of Trauma and Orthopaedics. January 2011.
11. Kaptchuk T. The Web That Has No Weaver. Contemporary Books. 2000.
12. Kelly RB. Acupuncture for pain. Am Fam Physician. 2009 Sep 1;80(5):481-4.
13. Kligler B, Nielsen A, Kohrrer C, Schmid T, Waltermaurer E, Perez E, Merrell W. Acupuncture Therapy in a Group Setting for Chronic Pain. Pain Med. 2017 Jun 8. doi:10.1093/pm/pnx134.
14. Lan F, Ma YH, Xue JX, Wang TL, Ma DQ. Transcutaneous electrical nerve stimulation on acupoints reduces fentanyl requirement for postoperative pain relief after total hip arthroplasty in elderly patients. Minerva Anestesiol. 2012;78(8):887-895.
15. Lee MS, Ernst E. Acupuncture for surgical conditions: an overview of systematic reviews. Int J Clin Pract. 2014 Jun;68(6):783-9. doi:10.1111/ijcp.12372.
16. Li X, Wang R, Xing X, et al. Acupuncture for Myofascial Pain Syndrome: A Network Meta-Analysis of 33 Randomized Controlled Trials. Pain Physician. 2017 Sep;20(6):E883-E902.
17. Liu G-P, Xue F-S, Sun C, Li R-P. Electroacupuncture for pain treatment after total knee arthroplasty. Acupunct Med. 2015;33(5):433. doi:10.1136/acupmed-2015-010859.
18. Maciocia G; The Foundations of Chinese Medicine: A Comprehensive Text; Churchill Livingstone, 2005.
19. MacPherson H, Vertosick EA, Foster NE, Lewith G, Linde K, Sherman KJ, et al. The persistence of the effects of acupuncture after a course of treatment: A meta-analysis of patients with chronic pain. Pain. 2016 Oct 17. doi:10.1097/j.pain.0000000000000747.
20. Magee, David J., Orthopedic Physical Assessment, Second Edition, W.B. Saunders Company, 2007.
21. McDonald J, Janz S. The Acupuncture Evidence Project: A Comparative Literature Review (Revised Edition). Brisbane: Australian Acupuncture and Chinese Medicine Association Ltd; 2017.
22. Mikashima Y, Takagi T, Tomatsu T, Horikoshi M, Ikari K, Momohara S. Efficacy of acupuncture during post-acute phase of rehabilitation after total knee arthroplasty. J Tradit Chin Med. 2012;32(4):545-548.
23. National Health and Medical Research Council. NHMRC additional levels of evidence and grades for recommendations for developers of guidelines. Table 3. NHMRC Evidence Hierarchy: designations of 'levels of evidence' according to type of research question (including explanatory notes). National Health and Medical Research Council; 2009.
24. O'Connor J, Bensky D. Acupuncture: A Comprehensive Text. Chicago: Eastland Press; 1981.
25. Olson WH, Brumback RA, Gascon G, Iyer V; Handbook of Symptom Oriented Neurology; Year Book Medical Publishers, Inc.; 2002.

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26. Porter, R; The Merck Manual, Merck, 2011.
27. Roy, S., Irvin, R., and Iverson, D; Sports Medicine, Prevention, Education, Management, and Rehabilitation, Benjamin Cummings, 1998.
28. Wang R, Li X, Zhou S, Zhang X, Yang K, Li X. Manual acupuncture for myofascial pain syndrome: a systematic review and meta-analysis. Acupunct Med. 2017 Aug;35(4):241-250. doi:10.1136/acupmed-2016-011176.
29. Weinstein, S, and Buckwalter, J. Orthopaedics Principles and Their Applications. Lippincott, Williams, & Wilkins, 2005.
30. Wu MS, Chen KH, Chen IF, Huang SK, Tzeng PC, Yeh ML, et al. The Efficacy of Acupuncture in Post-Operative Pain Management: A Systematic Review and Meta-Analysis. PLOS ONE. 2016;11(3):e0150367. doi:10.1371/journal.pone.0150367.
31. Xiang A, Cheng K, Shen X, Xu P, Liu S. The Immediate Analgesic Effect of Acupuncture for Pain: A Systematic Review and Meta-Analysis. Evid Based Complement Alternat Med. 2017;2017:3837194. doi:10.1155/2017/3837194.
32. Yuan J, Purepong N, Hunter RF, Kerr DP, Park J, Bradbury I, McDonough S. Different frequencies of acupuncture treatment for chronic low back pain: an assessor-blinded pilot randomised controlled trial. Complement Ther Med. 2009 Jun;17(3):131-40. doi:10.1016/j.ctim.2008.10.003.
33. Zhao HJ, Tan JY, Wang T, Jin L. Auricular therapy for chronic pain management in adults: A synthesis of evidence. Complement Ther Clin Pract. 2015 May;21(2):68-78. doi:10.1016/j.ctcp.2015.03.006.

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ACU-9.8: Piriformis Syndrome

Synonyms

- Low back pain, hip pain, leg pain

Definition

Piriformis syndrome has remained a controversial diagnosis since its initial description in 1928. Piriformis syndrome usually is caused by neuritis of the proximal sciatic nerve. The piriformis muscle can either irritate or compress the proximal sciatic nerve due to spasm and/or contracture, and this problem can mimic a discogenic sciatica (pseudosciatica).

Blunt injury may cause hematoma formation and subsequent scarring between the sciatic nerve and short external rotators. Nerve injury can occur with prolonged pressure on the nerve or vasa nervorum.

Oriental Medicine Diagnoses

- Qi and Blood Stagnation
  - Stagnation results in pain; may have numerous causations; can be related to trauma or underlying syndromes.
- Kidney Qi and Liver Blood Deficiency
  - Can result from lifestyle choices that diminish Qi and Blood, chronic illness.
- Cold Damp Bi, Cold Damp with Painful Obstruction
  - Accumulation of Cold Damp can result from lifestyle or external pathogens.

Note: While the above pathways represent classical causations for sciatica within the paradigm of Oriental Medicine diagnoses, they are not necessarily eligible for authorization or coverage under eviCore's acupuncture benefit plans. In order to be eligible for coverage and reimbursement, sciatica symptoms and/or a diagnosis of “sciatica" must be the direct result of a primary neuromusculoskeletal injury or illness.

History

Piriformis syndrome is often not recognized as a cause of LBP and associated sciatica. Clinical syndrome is due to a compression of the sciatic nerve by the piriformis muscle. Condition is identical in clinical presentation to LBP with associated L5, S1 radiculopathy due to discogenic and/or lower lumbar facet arthropathy with foraminal narrowing. Not uncommon, patients demonstrate both of these clinical entities simultaneously. Pain may be acute or chronic. Diagnostic dilemma highlights the need for patients with LBP and associated radicular pain to undergo a complete history and physical examination.

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Many cases of refractory trochanteric bursitis are observed to have an underlying occult piriformis syndrome due to the insertion of the piriformis muscle on the greater trochanter of the hip. If *both* the trochanteric bursitis *and* the piriformis syndrome are treated inadequately, both conditions remain resistant to medical management.

Specific Aspects of History

- Rule out red flags (require medical management).
- Determine if trauma-related; determine nature and extent of traumatic event.
- Identify co-morbidities requiring medical management, and those that affect acupuncture and Oriental Medicine management.

Red Flag	Possible Consequence or Cause	Action Required
Severe trauma	Fracture	Immediate referral to emergency department
Fever, severe pain, history of TB	Possible infection	Immediate referral to emergency department
Unilateral edema	Lower extremity deep vein thrombosis	Immediate referral to emergency department
Immune-compromised state	Infection	Prompt referral to Primary Care Provider
Cancer history	Cause of symptoms (metastatic or primary)	Prompt referral to Primary Care Provider
Discoloration of foot/toes	Vascular occlusion; arterial insufficiency	Immediate referral to emergency department
Abnormal uterine bleeding, pelvic pain, testicular symptoms	Reproductive tract lesions	Immediate referral to emergency department
Rectal pain, melena	Colon cancer	Prompt referral to Primary Care Provider
Hematuria, fever or pyuria	Pyelonephritis, renal stone	Immediate referral to emergency department
Postprandial abdominal pain, history of vascular disease, smoker	Mesenteric ischemia, abdominal aortic aneurysm, pancreatic Cancer	Immediate referral to emergency department

Refer to the PCP (HMO) or an orthopedic or neurosurgeon (PPO) if there are increasing neurologic signs/symptoms: increasing LE numbness/tingling, increasing LE weakness, increasing LE pain, and/or decreasing LE reflexes, atrophy of extremity. Refer to primary care provider if patient is not progressing during treatment, and is only experiencing palliative relief from treatment or no benefit from treatment to rule out underlying conditions.

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Subjective Findings

- Pain in the hip/buttock area
- Weakness of the hip
- Loss of sensation in the leg
- Tenderness of the buttock
- Pain should be documented as a numeric pain scale 0-10

Functional Assessment

- Documentation of a patient's level of function is an important aspect of patient care. This documentation is required in order to establish the medical necessity of ongoing acupuncture treatment. The Patient Specific Functional Scale (PSFS) is a patient reported outcome assessment that is easy and appropriate for acupuncturists to use. The PSFS has been studied in peer-reviewed scientific literature, and it has been proven to be a valid, reliable, and responsive measure for a variety of pain syndromes (neck, back, knee, etc.).

Objective findings

Scope of Musculoskeletal Examination

- Inspection
- Palpation of bony and soft tissue
- Range of motion, active and passive
- Orthopedic testing
- Neurologic testing if neurologic signs are present
- Manual muscle testing

Specific Aspects of Examination for Piriformis Syndrome

- Tight piriformis muscle
- Tight hip external rotators and adductors
- Hip abductor weakness
- Lower lumbar spine dysfunction
- Sacroiliac joint hypomobility

Findings of Piriformis syndrome

- Tender to palpation
- Manual muscle testing of affected muscle groups is weak and painful

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Differential Diagnoses

- Lumbosacral radiculopathy
- Buttock pain
- Ischial tuberosity, trochanteric bursitis
- Sciatica

Oriental Medicine Management [9, 19, 21]

- Oriental Medicine management goals are to resolve pain, restore the highest level of function possible, and educate the patient to prevent recurrent symptoms.
- In order to be considered medically necessary, patient's symptoms must be the direct result of a primary neuromusculoskeletal injury or illness.
- Confirmation of appropriate medical co-management is always required when treating children age 14 and under.
- In addition to improvements in the table below, significant progress may be documented by increases in functional capacity and increasingly longer durations of pain relief.
- Treatment frequency should be commensurate with severity of the chief complaint.
- If at least 50% improvement in pain frequency and severity is reported by patient—continued treatment with decreased frequency is appropriate.
- As treatment progresses, one should see an increase in the active regimen of care, a decrease in the passive regimen of care, and a fading of treatment frequency.
- If the condition has not progressed towards resolution, refer the patient to an appropriate health care provider to explore other treatment alternatives.
- eviCore's consideration of requests for continued acupuncture treatment depends on updated clinical information submitted regarding patient's progress.
- Adequate and legible patient progress information that contains a history and examination, and/or eviCore's Acupuncture Treatment Request Form is required to determine medical necessity.
- Discharge occurs when reasonable functional goals and expected outcomes have been achieved.
- The patient is discharged when the patient/care-giver can continue management of symptoms with an independent home program.
- Treatment is discontinued when the patient is unable to progress towards outcomes because of medical complications, psychosocial factors or other personal circumstances.
- If the member has been non-compliant with treatment as is evidenced by the clinical documentation, and/or the lack of demonstrated progress, treatment will be deemed to be not medically necessary and the member should be discharged from treatment.

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Week	Progress
0-1	◆ Some reduction of pain severity and frequency ◆ Some reduction of muscle spasm
2-4	◆ 50% decrease in pain severity and frequency ◆ 50% improvement in function
5-8	◆ 75% decrease in pain severity and frequency ◆ 75% improvement in function
9-12	◆ Gradual improvement leading toward resolution ◆ Reinforce self-management techniques ◆ Discharge patient to elective care, or to their primary care provider for alternative treatment options when a plateau is reached, or by week 12, whichever occurs first

Appropriate Procedures/ Modalities

- Acupuncture
- Electro-acupuncture
- Cupping
- Moxibustion
- Gua Sha
- Myofascial release
- Acupressure
- Trigger point massage
- Tui Na (not to include osseous manipulation)
- Herbal formulas

Note: Not all of these modalities are covered by the patient's health-plan; review documentation regarding coverage. Acupuncture and herbs must be appropriate for covered diagnoses under the patient's insurance policy. Acupuncturist is responsible for determining which procedures/modalities are most appropriate for the patient's condition.

Inappropriate Procedures/Modalities

- Scarring moxa
- Applied kinesiology techniques
- Electro-acupuncture using more than 9 volts
- Any technique outside the scope of practice in your state

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Self-Management Techniques

- Rest and reduce strenuous activities
- Ergonomics, Postural advice, postural exercises
- Appropriate exercises/stretching
- Tai Qi, Qi Gong, Yoga
- Stress management, meditation
- Joint protection
- Weight loss
- Self-massage, Self-acupressure
- Hot packs/cold packs, if needed, to relieve discomfort
- Aerobic conditioning, swimming

Alternatives to Oriental Medicine Management

(listed in alphabetical order)

- Chiropractic
- Dietary/Nutritional Medicine Counseling
- Injection therapy/Pain management
- Massage therapy
- Medication
- Occupational therapy
- Osteopathic Manipulation
- Physical Therapy
- Psychological counseling

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References

1. Balshem H, Helfand M, Schunemann HJ, Oxman AD, Kunz R, Brozek J, et al. GRADE guidelines: 3. Rating the quality of evidence. J Clin Epidemiol. 2011 Apr;64(4):401-6. doi:10.1016/j.jclinepi.2010.07.015.
2. Cheng X, Deng L. Chinese Acupuncture and Moxibustion. Beijing: Foreign Language Press; 2010.
3. Hempel S, Taylor SL, Solloway MR, Miake-Lye IM, Beroes JM, Shanman R, et al. VA Evidence-based Synthesis Program Reports. Evidence Map of Acupuncture. Washington (DC): Department of Veterans Affairs; 2014.
4. Horn KK, Jennings S, Richardson G, Vliet DV, Hefford C, Abbott JH. The patient-specific functional scale: psychometrics, clinimetrics, and application as a clinical outcome measure. J Orthop Sports Phys Ther. 2012 Jan;42(1):30-42. doi:10.2519/jospt.2012.3727.
5. Kaptchuk T. The Web That Has No Weaver. Contemporary Books. 2000.
6. Kelly RB. Acupuncture for pain. Am Fam Physician. 2009 Sep 1;80(5):481-4.
7. Kligler B, Nielsen A, Kohrrer C, Schmid T, Waltermaurer E, Perez E, Merrell W. Acupuncture Therapy in a Group Setting for Chronic Pain. Pain Med. 2017 Jun 8. doi:10.1093/pm/pnx134.
8. Lewis K, Abdi S. Acupuncture for lower back pain: a review. Clin J Pain. 2010 Jan;26(1):60-9. doi:10.1097/AJP.0b013e3181bad71e.
9. Li X, Wang R, Xing X, et al. Acupuncture for Myofascial Pain Syndrome: A Network Meta-Analysis of 33 Randomized Controlled Trials. Pain Physician. 2017 Sep;20(6):E883-E902.
10. Maciocia G. The Foundations of Chinese Medicine: A Comprehensive Text; Churchill Livingstone, 2005.
11. MacPherson H, Vertosick EA, Foster NE, Lewith G, Linde K, Sherman KJ, et al. The persistence of the effects of acupuncture after a course of treatment: A meta-analysis of patients with chronic pain. Pain. 2016 Oct 17. doi:10.1097/j.pain.0000000000000747.
12. Magee, David J., Orthopedic Physical Assessment, Second Edition, W.B. Saunders Company, 2007.
13. McDonald J, Janz S. The Acupuncture Evidence Project: A Comparative Literature Review (Revised Edition). Brisbane: Australian Acupuncture and Chinese Medicine Association Ltd; 2017.
14. National Health and Medical Research Council. NHMRC additional levels of evidence and grades for recommendations for developers of guidelines. Table 3. NHMRC Evidence Hierarchy: designations of 'levels of evidence' according to type of research question (including explanatory notes). National Health and Medical Research Council; 2009.
15. O'Connor J, Bensky D. Acupuncture: A Comprehensive Text. Chicago: Eastland Press; 1981.
16. Olson WH, Brumback RA, Gascon G, Iyer V; Handbook of Symptom Oriented Neurology; Year Book Medical Publishers, Inc.; 2002.
17. Porter, R; The Merck Manual, Merck, 2011.
18. Roy, S., Irvin, R., and Iverson, D; Sports Medicine, Prevention, Education, Management, and Rehabilitation, Benjamin Cummings, 1998.
19. Wang R, Li X, Zhou S, Zhang X, Yang K, Li X. Manual acupuncture for myofascial pain syndrome: a systematic review and meta-analysis. Acupunct Med. 2017 Aug;35(4):241-250. doi:10.1136/acupmed-2016-011176.
20. Weinstein, S, and Buckwalter, J. Orthopaedics Principles and Their Applications. Lippincott, Williams, & Wilkins, 2005.
21. Xiang A, Cheng K, Shen X, Xu P, Liu S. The Immediate Analgesic Effect of Acupuncture for Pain: A Systematic Review and Meta-Analysis. Evid Based Complement Alternat Med. 2017;2017:3837194. doi:10.1155/2017/3837194.
22. Yuan J, Purepong N, Hunter RF, Kerr DP, Park J, Bradbury I, McDonough S. Different frequencies of acupuncture treatment for chronic low back pain: an assessor-blinded pilot randomised controlled trial. Complement Ther Med. 2009 Jun;17(3):131-40. doi:10.1016/j.ctim.2008.10.003.
23. Zhao HJ, Tan JY, Wang T, Jin L. Auricular therapy for chronic pain management in adults: A synthesis of evidence. Complement Ther Clin Pract. 2015 May;21(2):68-78. doi:10.1016/j.ctcp.2015.03.006.

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ACU-9.9: Plantar Fasciitis

Synonyms

- Foot pain

Definition

Plantar fasciae are fibrous aponeuroses that provide important support for the longitudinal arches of the feet. Microtears of the fascia from repetitive trauma lead to degeneration of collagen. Although often thought of as an inflammatory process, fascial degeneration and necrosis found in plantar fasciitis is more similar to tendonosis than tendinitis.

Extrinsic factors of plantar fasciitis include training errors, improper footwear, and unyielding surfaces. Intrinsic factors include pes cavus or pes planus, decreased plantar flexion strength, reduced flexibility of the plantar flexor muscles, excess pronation, and torsional malalignments.

Oriental Medicine Diagnoses

- Qi and Blood Stagnation
  - Stagnation results in this painful condition; may have numerous causations; can be related to trauma or underlying syndromes.

History

Specific Aspects of History

- Rule out red flags (require medical management).
- Determine if trauma-related; determine nature and extent of traumatic event.
- Identify co-morbidities requiring medical management, and those that affect acupuncture and Oriental Medicine management.

Red Flag	Possible Consequence or Cause	Action Required
Severe trauma	Fracture	Immediate referral to emergency department
Fever, severe pain	Possible infection	Immediate referral to emergency department
Cancer history	Cause of symptoms (metastatic or primary)	Prompt referral to Primary Care Provider
Unilateral edema	Lower extremity deep vein thrombosis	Immediate referral to emergency department
Immune-compromised state	Infection	Prompt referral to Primary Care Provider
Diabetes	Neuropathy	Prompt referral to Primary Care Provider

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Subjective Findings

- Heel pain is worse in the morning with the first few steps, then gradually it subsides with activity.
- Pain is usually described as a deep ache or bruise at the anteromedial region of the calcaneus on the plantar surface of the foot. Pain may be acute or chronic.
- Pain should be documented as a numeric pain scale 0-10

Functional Assessment

- Documentation of a patient's level of function is an important aspect of patient care. This documentation is required in order to establish the medical necessity of ongoing acupuncture treatment. The Patient Specific Functional Scale (PSFS) is a patient reported outcome assessment that is easy and appropriate for acupuncturists to use. The PSFS has been studied in peer-reviewed scientific literature, and it has been proven to be a valid, reliable, and responsive measure for a variety of pain syndromes (neck, back, knee, etc.).

Objective Findings

Scope of Musculoskeletal Examination

- Inspection
- Palpation of bony and soft tissue
- Range of motion, active and passive
- Orthopedic and neurologic testing if neurologic signs are present

Specific Aspects of Examination for Plantar Fasciitis

Examine the musculoskeletal system for possible causes or contributing factors to the complaint.

Findings of Plantar Fasciitis

- Direct palpation of the medial calcaneal tubercle often causes severe pain.
- Pain is generally localized at the origin of the anatomic central band of the plantar fascia.
- No significant pain on compression of the calcaneus from a medial to a lateral direction.
- Heel pain can often be reproduced by having patients stand on their toes or by passively dorsiflexing the metatarsal phalangeal joints.

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Differential Diagnoses

- Sciatica
- Tarsal tunnel syndrome
- Entrapment of the lateral plantar nerve
- Rupture of the plantar fascia
- Calcaneal stress fracture
- Calcaneal apophysitis (Sever's disease)
- Systemic Disorders: Rheumatoid arthritis, ankylosing spondylitis, psoriatic arthritis, Reiter's syndrome, gout, Behcet's syndrome and systemic lupus erythematosus. Gonorrhea and tuberculosis have also been implicated as causes of heel pain, but such an association is rare.

Oriental Medicine Management [8, 18, 20]

- Oriental Medicine management goals are to resolve pain, restore the highest level of function possible and educate the patient to prevent recurrent symptoms.
- In order to be considered medically necessary, patient's symptoms must be the direct result of a primary neuromusculoskeletal injury or illness.
- Confirmation of appropriate medical co-management is always required when treating children age 14 and under.
- Treatment frequency should be commensurate with severity of the chief complaint.
- When significant improvements in patient's subjective findings and objective findings are demonstrated—continued treatment with decreased frequency is appropriate.
- As treatment progresses, one should see an increase in the active regimen of care, a decrease in the passive regimen of care, and a fading of treatment frequency.
- If the condition has not progressed towards resolution, refer the patient to an appropriate health care provider to explore other treatment alternatives.
- eviCore's consideration of requests for continued acupuncture treatment depends on updated clinical information submitted regarding patient's progress.
- Adequate and legible patient progress information that contains a history and examination, and/or eviCore's Acupuncture Treatment Request Form is required to determine medical necessity.
- In addition to improvements in the table below, significant progress may also be documented by increases in functional capacity and increasingly longer durations of pain relief.
- Discharge occurs when reasonable functional goals and expected outcomes have been achieved.
- The patient is discharged when the patient/care-giver can continue management of symptoms with an independent home program.

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- Treatment is discontinued when the patient is unable to progress towards outcomes because of medical complications, psychosocial factors or other personal circumstances.
- If the member has been non-compliant with treatment as is evidenced by the clinical documentation, and/or the lack of demonstrated progress, treatment will be deemed to be not medically necessary and the member should be discharged from treatment.

Week	Progress
0-1	◆ Some reduction of pain severity and frequency ◆ Some reduction of muscle spasm
2-4	◆ 50% decrease in pain severity and frequency ◆ 50% improvement in function
5-8	◆ 75% decrease in pain severity and frequency ◆ 75% improvement in function
9-12	◆ Gradual improvement leading toward resolution ◆ Reinforce self-management techniques ◆ Discharge patient to elective care, or to their primary care provider for alternative treatment options when a plateau is reached, or by week 12, whichever occurs first

Appropriate Procedures/ Modalities

- Acupuncture
- Electro-acupuncture
- Cupping
- Moxibustion
- Gua Sha
- Myofascial release
- Acupressure
- Trigger point massage
- Tui Na (not to include osseous manipulation)
- Herbal formulas

Note: Not all of these modalities are covered by the patient's health-plan; review documentation regarding coverage. Acupuncture and herbs must be appropriate for covered diagnoses under the patient's insurance policy. Acupuncturist is responsible for determining which procedures/modalities are most appropriate for the patient's condition.

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Inappropriate Procedures/Modalities

- Scarring moxa
- Applied kinesiology techniques
- Electro-acupuncture using more than 9 volts
- Any technique outside the scope of practice in your state

Self-Management Techniques

- Rest and reduce strenuous activities
- Ergonomics, Postural advice, postural exercises
- Appropriate exercises/stretching
- Tai Qi, Qi Gong, Yoga
- Stress management, meditation
- Joint protection
- Weight loss
- Self-massage, Self-acupressure
- Hot packs/cold packs, if needed, to relieve discomfort

Alternatives to Oriental Medicine Management

(listed in alphabetical order)

- Chiropractic
- Dietary/Nutritional Medicine Counseling
- Injection therapy/Pain management
- Massage therapy
- Medication
- Occupational therapy
- Osteopathic Manipulation
- Physical Therapy
- Psychological counseling
- Surgery (as last resort)

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References

1. Balshem H, Helfand M, Schunemann HJ, Oxman AD, Kunz R, Brozek J, et al. GRADE guidelines: 3. Rating the quality of evidence. J Clin Epidemiol. 2011 Apr;64(4):401-6. doi:10.1016/j.jclinepi.2010.07.015.
2. Cheng X, Deng L. Chinese Acupuncture and Moxibustion. Beijing: Foreign Language Press; 2010.
3. Hempel S, Taylor SL, Solloway MR, Miake-Lye IM, Beroes JM, Shanman R, et al. VA Evidence-based Synthesis Program Reports. Evidence Map of Acupuncture. Washington (DC): Department of Veterans Affairs; 2014.
4. Horn KK, Jennings S, Richardson G, Vliet DV, Hefford C, Abbott JH. The patient-specific functional scale: psychometrics, clinimetrics, and application as a clinical outcome measure. J Orthop Sports Phys Ther. 2012 Jan;42(1):30-42. doi:10.2519/jospt.2012.3727.
5. Kaptchuk T. The Web That Has No Weaver. Contemporary Books. 2000.
6. Kelly RB. Acupuncture for pain. Am Fam Physician. 2009 Sep 1;80(5):481-4.
7. Kligler B, Nielsen A, Kohrrer C, Schmid T, Waltermaurer E, Perez E, Merrell W. Acupuncture Therapy in a Group Setting for Chronic Pain. Pain Med. 2017 Jun 8. doi:10.1093/pm/pnx134.
8. Li X, Wang R, Xing X, et al. Acupuncture for Myofascial Pain Syndrome: A Network Meta-Analysis of 33 Randomized Controlled Trials. Pain Physician. 2017 Sep;20(6):E883-E902.
9. Maciocia, G; The Foundations of Chinese Medicine: A Comprehensive Text; Churchill Livingstone, 2005.
10. MacPherson H, Vertosick EA, Foster NE, Lewith G, Linde K, Sherman KJ, et al. The persistence of the effects of acupuncture after a course of treatment: A meta-analysis of patients with chronic pain. Pain. 2016 Oct 17. doi:10.1097/j.pain.0000000000000747.
11. Magee, David J., Orthopedic Physical Assessment, Second Edition, W.B. Saunders Company, 2007.
12. McDonald J, Janz S. The Acupuncture Evidence Project: A Comparative Literature Review (Revised Edition). Brisbane: Australian Acupuncture and Chinese Medicine Association Ltd; 2017.
13. National Health and Medical Research Council. NHMRC additional levels of evidence and grades for recommendations for developers of guidelines. Table 3. NHMRC Evidence Hierarchy: designations of 'levels of evidence' according to type of research question (including explanatory notes). National Health and Medical Research Council; 2009.
14. O'Connor J, Bensky D. Acupuncture: A Comprehensive Text. Chicago: Eastland Press; 1981.
15. Olson WH, Brumback RA, Gascon G, Iyer V; Handbook of Symptom Oriented Neurology; Year Book Medical Publishers, Inc.; 2002.
16. Porter, R; The Merck Manual, Merck, 2011.
17. Roy, S., Irvin, R., and Iverson, D; Sports Medicine, Prevention, Education, Management, and Rehabilitation, Benjamin Cummings, 1998.
18. Wang R, Li X, Zhou S, Zhang X, Yang K, Li X. Manual acupuncture for myofascial pain syndrome: a systematic review and meta-analysis. Acupunct Med. 2017 Aug;35(4):241-250. doi:10.1136/acupmed-2016-011176. Wang R, Li X, Zhou S, Zhang X, Yang K, Li X. Manual acupuncture for myofascial pain syndrome: a systematic review and meta-analysis. Acupunct Med. 2017 Aug;35(4):241-250. doi:10.1136/acupmed-2016-011176.
19. Weinstein, S, and Buckwalter, J. Orthopaedics Principles and Their Applications. Lippincott, Williams, & Wilkins, 2005.
20. Xiang A, Cheng K, Shen X, Xu P, Liu S. The Immediate Analgesic Effect of Acupuncture for Pain: A Systematic Review and Meta-Analysis. Evid Based Complement Alternat Med. 2017;2017:3837194. doi:10.1155/2017/3837194.
21. Yuan J, Purepong N, Hunter RF, Kerr DP, Park J, Bradbury I, McDonough S. Different frequencies of acupuncture treatment for chronic low back pain: an assessor-blinded pilot randomised controlled trial. Complement Ther Med. 2009 Jun;17(3):131-40. doi:10.1016/j.ctim.2008.10.003.
22. Zhao HJ, Tan JY, Wang T, Jin L. Auricular therapy for chronic pain management in adults: A synthesis of evidence. Complement Ther Clin Pract. 2015 May;21(2):68-78. doi:10.1016/j.ctcp.2015.03.006.

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ACU-9.10: Thigh Sprain Strain; Unspecified Site of Hip and Thigh

Synonym

- Groin Strain
- Thigh pain, hip pain

Definition

Strains of the hip adductor muscles, including the gracilis, pectineus, adductor longus, adductor brevis, and adductor magnus are the most frequent cause of groin region pain, with the adductor longus being the most commonly injured. Adductor strains are associated with jumping, running and twisting activities, particularly when external rotation of the affected leg is an added component of the activity.

There are a number of causative factors due to adductor strain, including muscular imbalance of the combined action of the muscles stabilizing the hip joint, resulting from fatigue or abduction overload. Improper management of acute adductor strains or returning to play before pain-free sport-specific activities can be performed may lead to chronic injury.

Chronic adductor strain

- Generally, symptoms are more diffuse with typical complaints of pain and stiffness in the groin region in the morning and at the beginning of athletic activity. Pain and stiffness often resolve after a period of warming up, often recurring after athletic activity.
- Typical findings include tenderness at the origin of the adductor longus and/or the gracilis located at the inferior pubic ramus and pain with resisted adduction.

Improper management of acute adductor strains

- According to a study by Renstrom and Peterson, 42% of athletes with groin muscle-tendon injuries could not return to physical activity for more than 20 weeks following the initial injury. This prolonged length of time seems to indicate the importance of proper management of these injuries in the acute stage.

Oriental Medicine Diagnoses

- Qi and Blood Stagnation
  - Stagnation results in pain; may have numerous causations; can be related to trauma or underlying syndromes.
- Kidney Yang Deficiency
  - Underlying condition with additional symptoms caused by either illness, stress, lifestyle choices, such as irregular or “incorrect” food choice, irregular eating times, lack of sleep, excess of activities, which result in depletion of this energy, or congenital insufficiency.

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- Cold Damp Bi, Cold Damp with Painful Obstruction
  - Accumulation of cold damp can result from lifestyle choices, such as irregular or "incorrect" food choice, irregular eating times, lack of sleep, or external pathogens.

History

Groin pain can represent a number of different diagnoses; kept in mind all differential diagnoses when assessing a patient. Obtain information about the mechanism of injury and loss of function, the location, quality, duration, and severity of pain. Also note all aggravating and alleviating factors.

- Location
  - Pain is usually described at the site of the adductor longus tendon proximally, especially with rapid adduction of the thigh. As injury becomes more chronic, pain may radiate distally along the medial aspect of the thigh and/or proximally toward the rectus abdominis.
  - Exercise-induced medial thigh pain over the area of the adductors, especially after kicking and twisting, may indicate obturator neuropathy.
  - Pain at the symphysis pubis or scrotum may be more consistent with osteitis pubis.
  - Conjoined tendon lesions present as pain that radiates upward into the rectus abdominis or laterally along the inguinal ligament. Exquisite tenderness is present at the site of the injury.
- Quality
  - Acute injuries are described as a sudden ripping or stabbing pain in the groin. Chronic injuries are described as a diffuse dull ache.
- Duration
  - Initial intense pain lasts less than a second; and, is soon replaced with an intense dull ache.
- Severity of pain
  - Pain severity can vary with different patients.
- Loss of function
  - True loss of function is not observed unless a Grade 3 tear is present. In the case of a severe tear, loss of hip adduction occurs. Loss of function also should alert the physician/therapist to possible nerve involvement (obturator nerve entrapment).
- Mechanism of injury
  - Rapid adduction of the hip against an abduction force (i.e., changing direction suddenly in tennis), acute forced abduction that puts an unusual stretch on the tendon (i.e., a rugby tackle), and a sudden acceleration in sprinting are the most common mechanisms of injury.

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Specific Aspects of History

- Rule out red flags (require medical management).
- Identify co-morbidities requiring medical management, and those that affect acupuncture and Oriental Medicine management.

Red Flag	Possible Consequence or Cause	Action Required
Severe trauma	Ligament tear, pelvic fracture; avascular necrosis	Immediate referral to emergency department
Fever, severe pain	Infection	Immediate referral to emergency department
Loss of distal pulse, severe pain beginning 12-24 hours after trauma	Compartment syndrome	Immediate referral to emergency department
Diabetes	Neuropathy	Prompt referral to Primary Care Provider
Multiple joint involvement	Rheumatologic diseases	Prompt referral to Primary Care Provider
Unilateral edema	Deep vein thrombosis	Immediate referral to emergency department
Skin rash in dermatoimal pattern	Shingles	Prompt referral to Primary Care Provider
Constipation, bloody stools, unexplained weight loss	Colon or pelvic organ cancer	Prompt referral to Primary Care Provider
Groin pain	Inguinal hernia, pelvic pathology	Immediate referral to emergency department
Pain with urination, hematuria	UTI; renal stone	Immediate referral to emergency department
Cancer	Cause of symptoms (metastatic or primary)	Prompt referral to Primary Care Provider
Discoloration of leg or foot, pain with ambulation	Arterial occlusion	Immediate referral to emergency department
History of steroid use	Avascular necrosis	Immediate referral to emergency department
Immune-compromised state	Infection	Prompt referral to Primary Care Provider

Presentation

- Adductor tendons have a small insertion area that attaches to the periosteum-free bone. This transitional zone is characterized by poor Blood supply and rich nerve supply, explaining the high level of perceived pain and poor healing characteristics of adductor strains.
- Failure to stretch adductor muscles properly puts them at increased risk for injury. Weakness of adductor muscles also puts these muscles at increased risk for injury, as the load to failure is much less in weaker muscles.
  - Pain should be documented as a numeric pain scale 0-10

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Functional Assessment

- Documentation of a patient's level of function is an important aspect of patient care. This documentation is required in order to establish the medical necessity of ongoing acupuncture treatment. The Patient Specific Functional Scale (PSFS) is a patient reported outcome assessment that is easy and appropriate for acupuncturists to use. The PSFS has been studied in peer-reviewed scientific literature, and it has been proven to be a valid, reliable, and responsive measure for a variety of pain syndromes (neck, back, knee, etc.).

Objective Findings

Scope of Musculoskeletal Examination

- Inspection
- Palpation of bony and soft tissue
- Range of motion, active and passive
- Orthopedic and neurologic testing if neurologic signs are present
- Manual muscle testing

Specific Aspects of Examination

- Examine the musculoskeletal system for possible causes or contributing factors to the complaint.
  - Iliopsoas bursitis
  - Iliopsoas tendinitis
  - Rectus femoris tendinitis
  - Urological disorders
  - Sacroiliac dysfunction
  - Nerve entrapment
  - Malignant/nonmalignant tumors
  - Sportsman's hernia
  - Avulsion fracture
  - Hip disorders (e.g., osteoarthritis [OA], degenerative joint disease [DJD], slipped capital femoral epiphysis [SCFE])
  - Gastrointestinal disorders
  - Sexually transmitted diseases
  - Gynecological complaints

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Findings of Adductor Strain

- Twinging or stabbing pain in the groin area with quick starts and stops
- Edema or echemosis
- Acute adductor strain commonly occurs at the musculotendinous junction
- Tenderness, swelling, and ecchymosis can be observed at the superior medial thigh several days post injury
- Defect in muscle can be palpated in severe ruptures
- Pain is noted with resisted adduction and full passive abduction of the hip
- Muscle guarding
- Pure hip adductor strain can be distinguished from combination injuries involving the hip flexors (e.g., iliopsoas, rectus femoris) by having patient lie in the supine position. If more discomfort is reproduced with resistive adduction when the knee and hip are extended than if the hip and knee are flexed, a pure hip adductor strain can be assumed.

Physical findings can help distinguish adductor strains from other causes of groin pain such as the following:

- Iliopsoas strain
  - Hip flexion against resistance is painful; tenderness is difficult to localize because the insertion of the iliopsoas is deep.
- Osteitis pubis
  - Tenderness of the symphysis pubis and possible loss of full rotation of one or both hip joints are noted.
- Conjoined tendon lesions (i.e., sportsman's hernia)
  - Exquisite tenderness upon palpation at the inguinal canal; having patient cough reproduces pain.
- Obturator neuropathy
  - Adductor muscle weakness, muscle spasm, and paresthesia over the medial aspect of the distal thigh may be present. Loss of adductor tendon reflex with preservation of other muscle stretch reflexes often is observed. A positive Howship-Romberg sign (medial knee pain induced by forced hip abduction, extension, and internal rotation) sometimes is observed.

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Differential Diagnoses

- Mechanical low back pain
- Osteitis Pubis
- Stress Fracture of femoral neck or pubic ramus
- Legg-Calve-Perthes disease
- Acetabular labral tears
- Iliopectineal bursitis
- Avulsion fracture
- Strain of the thigh muscles or rectus abdominis
- Inguinal hernia
- Ilioinguinal neuralgia

Oriental Medicine Management [8, 18, 20]

Oriental Medicine management goals are to resolve pain, restore the highest level of function possible, and educate the patient to prevent recurrent symptoms.

In order to be considered medically necessary, patient's symptoms must be the direct result of a primary neuromusculoskeletal injury or illness.

Confirmation of appropriate medical co-management is always required when treating children age 14 and under.

- Treatment frequency should be commensurate with the severity of the chief complaint.
- When significant improvements in patient's subjective findings and objective findings are demonstrated—continued treatment with decreased frequency is appropriate.
- As treatment progresses, one should see an increase in the active regimen of care, a decrease in the passive regimen of care, and a fading of treatment frequency.
- If the condition has not progressed towards resolution, refer the patient to an appropriate health care provider to explore other treatment alternatives.
- eviCore's consideration of requests for continued acupuncture treatment depends on updated clinical information submitted regarding patient's progress.
- Adequate and legible patient progress information that contains a history and examination, and/or eviCore's Acupuncture Treatment Request Form is required to determine medical necessity.
- In addition to improvements in the table below, significant progress may also be documented by increases in functional capacity and increasingly longer durations of pain relief.
- Discharge occurs when reasonable functional goals and expected outcomes have been achieved.

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- The patient is discharged when the patient/care-giver can continue management of symptoms with an independent home program.
- Treatment is discontinued when the patient is unable to progress towards outcomes because of medical complications, psychosocial factors or other personal circumstances.
- If the member has been non-compliant with treatment as is evidenced by the clinical documentation, and/or the lack of demonstrated progress, treatment will be deemed to be not medically necessary and the member should be discharged from treatment.

Week	Progress
0-1	◆ Some reduction of pain severity and frequency ◆ Some reduction of muscle spasm
2-4	◆ 50% decrease in pain severity and frequency ◆ 50% improvement in function
5-8	◆ 75% decrease in pain severity and frequency ◆ 75% improvement in function
9-12	◆ Gradual improvement leading toward resolution ◆ Reinforce self-management techniques. ◆ Discharge patient to elective care, or to their primary care provider for alternative treatment options when a plateau is reached, or by week 12, whichever occurs first

Appropriate Procedures/ Modalities

- Acupuncture
- Electro-acupuncture
- Cupping
- Moxibustion
- Gua Sha
- Myofascial release
- Acupressure
- Trigger point massage
- Tui Na (not to include osseous manipulation)
- Herbal formulas

Note: Not all of these modalities are covered by the patient's health-plan; review documentation regarding coverage. Acupuncture and herbs must be appropriate for covered diagnoses under the patient's insurance policy. Acupuncturist is responsible for determining which procedures/modalities are most appropriate for the patient's condition.

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Inappropriate Procedures/Modalities

- Scarring moxa
- Applied kinesiology techniques
- Electro-acupuncture using more than 9 volts
- Any technique outside the scope of practice in your state

Self-Management Techniques

- Rest and reduce strenuous activities
- Ergonomics, Postural advice, postural exercises
- Appropriate exercises/stretching
- Tai Qi, Qi Gong, Yoga
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Alternatives to Oriental Medicine Management

(listed in alphabetical order)

- Chiropractic
- Dietary/Nutritional Medicine Counseling
- Injection therapy/Pain management
- Massage therapy
- Medication
- Occupational therapy
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- Psychological counseling

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References

1. Balshem H, Helfand M, Schunemann HJ, Oxman AD, Kunz R, Brozek J, et al. GRADE guidelines: 3. Rating the quality of evidence. J Clin Epidemiol. 2011 Apr;64(4):401-6. doi:10.1016/j.jclinepi.2010.07.015.
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3. Hempel S, Taylor SL, Solloway MR, Miake-Lye IM, Beroes JM, Shanman R, et al. VA Evidence-based Synthesis Program Reports. Evidence Map of Acupuncture. Washington (DC): Department of Veterans Affairs; 2014.
4. Horn KK, Jennings S, Richardson G, Vliet DV, Hefford C, Abbott JH. The patient-specific functional scale: psychometrics, clinimetrics, and application as a clinical outcome measure. J Orthop Sports Phys Ther. 2012 Jan;42(1):30-42. doi:10.2519/jospt.2012.3727.
5. Kaptchuk T. The Web That Has No Weaver. Contemporary Books. 2000.
6. Kelly RB. Acupuncture for pain. Am Fam Physician. 2009 Sep 1;80(5):481-4.
7. Kligler B, Nielsen A, Kohrrer C, Schmid T, Waltermaurer E, Perez E, Merrell W. Acupuncture Therapy in a Group Setting for Chronic Pain. Pain Med. 2017 Jun 8. doi:10.1093/pm/pnx134.
8. Li X, Wang R, Xing X, et al. Acupuncture for Myofascial Pain Syndrome: A Network Meta-Analysis of 33 Randomized Controlled Trials. Pain Physician. 2017 Sep;20(6):E883-E902.
9. Maciocia, G; The Foundations of Chinese Medicine: A Comprehensive Text; Churchill Livingstone, 2005.
10. MacPherson H, Vertosick EA, Foster NE, Lewith G, Linde K, Sherman KJ, et al. The persistence of the effects of acupuncture after a course of treatment: A meta-analysis of patients with chronic pain. Pain. 2016 Oct 17. doi:10.1097/j.pain.0000000000000747.
11. Magee, David J., Orthopedic Physical Assessment, Second Edition, W.B. Saunders Company, 2007.
12. McDonald J, Janz S. The Acupuncture Evidence Project: A Comparative Literature Review (Revised Edition). Brisbane: Australian Acupuncture and Chinese Medicine Association Ltd; 2017.
13. National Health and Medical Research Council. NHMRC additional levels of evidence and grades for recommendations for developers of guidelines. Table 3. NHMRC Evidence Hierarchy: designations of 'levels of evidence' according to type of research question (including explanatory notes). National Health and Medical Research Council; 2009.
14. O'Connor J, Bensky D. Acupuncture: A Comprehensive Text. Chicago: Eastland Press; 1981.
15. Olson WH, Brumback RA, Gascon G, Iyer V; Handbook of Symptom Oriented Neurology; Year Book Medical Publishers, Inc.; 2002.
16. Porter, R; The Merck Manual, Merck, 2011.
17. Roy, S., Irvin, R., and Iverson, D; Sports Medicine, Prevention, Education, Management, and Rehabilitation, Benjamin Cummings, 1998.
18. Wang R, Li X, Zhou S, Zhang X, Yang K, Li X. Manual acupuncture for myofascial pain syndrome: a systematic review and meta-analysis. Acupunct Med. 2017 Aug;35(4):241-250. doi:10.1136/acupmed-2016-011176
19. Weinstein, S, and Buckwalter, J. Orthopaedics Principles and Their Applications. Lippincott, Williams, & Wilkins, 2005.
20. Xiang A, Cheng K, Shen X, Xu P, Liu S. The Immediate Analgesic Effect of Acupuncture for Pain: A Systematic Review and Meta-Analysis. Evid Based Complement Alternat Med. 2017;2017:3837194. doi:10.1155/2017/3837194.
21. Yuan J, Purepong N, Hunter RF, Kerr DP, Park J, Bradbury I, McDonough S. Different frequencies of acupuncture treatment for chronic low back pain: an assessor-blinded pilot randomised controlled trial. Complement Ther Med. 2009 Jun;17(3):131-40. doi:10.1016/j.ctim.2008.10.003.
22. Zhao HJ, Tan JY, Wang T, Jin L. Auricular therapy for chronic pain management in adults: A synthesis of evidence. Complement Ther Clin Pract. 2015 May;21(2):68-78. doi:10.1016/j.ctcp.2015.03.006.

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ACU-10.0: Unlisted Musculoskeletal Disorders

Definition

Musculoskeletal disorders affect the bones, muscles, ligaments, tendons, and nerves. Onset may be acute (having a rapid onset of symptoms) or insidious. Duration of a musculoskeletal condition may be short term (days or weeks) or chronic (long-lasting). Musculoskeletal pain can be localized in one area, or widespread. Musculoskeletal conditions may be caused by an injury to the bones, joints, muscles, tendons, ligaments, and/or nerves. Direct trauma, e.g. motor vehicle accidents, falls, fractures, collisions, or indirect trauma, e.g. poor posture, repetitive strain, prolonged immobilization or loss of mobility, or overuse, generally underlies development of musculoskeletal complaints.

Symptoms and Causes

Bone pain: This is usually deep, penetrating, or dull. It most commonly results from injury such as contusions. It is important to be sure that the pain is not related to a fracture or tumor.

Muscle pain: Muscle pain can be caused by an injury, an autoimmune reaction, loss of Blood flow to the muscle, infection, or a tumor. The pain can also be caused by muscle spasms and trigger points.

Tendon and ligament pain: Tendon and ligament injuries are strain injuries that result in damage to the connective tissue fibers of the tendon or ligament. Tendon injuries range from tendinitis (micro trauma) to rupture (macro trauma). Ligamentous injuries occur when ligament tears either partially or completely. This type of musculoskeletal pain often becomes worse when the affected area is stretched or moved.

Joint pain: Joint injuries and diseases usually produce a stiff, aching, "arthritic" pain. The pain may range from mild to severe and worsens when moving the joint. The joints may also swell. Joint inflammation (arthritis) is a common cause of pain.

Fibromyalgia: This is a condition that may cause pain in the muscles, tendons, joints, and other soft tissue. The pain is usually in multiple locations and can be difficult to describe. Fibromyalgia is usually accompanied by other symptoms.

"Tunnel" syndromes: This refers to musculoskeletal disorders that cause pain due to nerve and/or tendon compression/inflammation. The disorders include carpal tunnel syndrome, cubital tunnel syndrome, and tarsal tunnel syndrome. The pain tends to spread along the path supplied by the nerve and may feel like burning. These disorders are often caused by overuse.

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Oriental Medicine Diagnoses

- Qi and Blood Stagnation:
  - This stagnation results in a painful condition, may have numerous causation, but for this diagnosis trauma is the primary causation, perhaps with underlying Qi Deficiency syndrome.
- Liver Qi Stagnation:
  - Causation can be due to external pathogens, lifestyle choices, such as, irregular or "incorrect" food choice, irregular eating times, lack of sleep, or stress.
- Kidney Qi Deficiency:
  - Can lead to an accumulation of Phlegm, Dampness and Deficiency where one of the symptoms can be headache. Causation is from either congenital deficiency of Kidney Qi and/or lifestyle choices that lead to a depletion of Kidney Qi.
- Wind Bi, Moving (Wind) Painful Obstruction:
  - Pain in the joints is widespread and moves from one area of the body to another.
- Damp Bi, Stationary (Damp) Painful Obstruction:
  - Pain is localized and does not move.
- Cold Bi, Painful (Cold) Painful Obstruction:
  - Severe pain in one part, or over one half of the body, which becomes worse when patient encounters cold and diminishes when patient is warm.
- Heat Bi, Heat Painful Obstruction:
  - Flesh is hot, area of pain is red and swollen, pain increases upon contact.
- Bi Syndrome:
  - Condition can be any combination of the above.

History

- Rule out red flags (require medical management).
- Determine if trauma-related; determine nature and extent of traumatic event.
- Identify co-morbidities requiring medical management, and those that affect acupuncture and Oriental Medicine management, such as:
  - Coronary Artery Disease
  - Respiratory Disease
  - Hypertension
  - Obesity
  - Diabetes
  - Chronic Venous Insufficiency
  - Previous surgery
  - Macro/Micro Trauma

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Red Flag	Possible Consequence or Cause	Action Required
Severe trauma	Fracture	Immediate referral to emergency department
Fever, severe pain	Possible infection	Immediate referral to emergency department
Edema, redness, pain	Lower extremity deep vein thrombosis	Immediate referral to emergency department
Immune-compromised state	Infection	Prompt referral to Primary Care Provider
Cancer history	Cause of symptoms (metastatic or primary)	Prompt referral to Primary Care Provider
Discoloration of the affected area (s)	Vascular occlusion; vascular insufficiency	Prompt referral to Primary Care Provider
Homans Sign	Deep vein thrombosis	Immediate referral to emergency department
Axial compression	Compression fracture	Immediate referral to emergency department
Positive vertebral artery test	Vertebrobasilar ischaemia, TIA	Immediate referral to emergency department
Widespread neurological symptoms	Neurological disease	Prompt referral to Primary Care Provider
Positive Lhermitte Sign	Spinal cord pathology	Prompt referral to Primary Care Provider
Dyspnea	Lung disease/diaphragmatic paralysis	Immediate referral to emergency department

Presentation

Patient may report trauma or insidious onset. Pain may be acute or chronic.

Subjective Findings: Symptoms and Causes

- Pain, numbness, tingling, paresthesia
- Aching or stiffness of the entire body
  - Pain should be documented as a numeric pain scale 0-10
- Feeling that muscles have been pulled or overworked
- Fatigue
- Sleep disturbances
- Swelling or effusion
- Decreased range of motion
- Joint instability
- Muscle guarding or weakness
- Loss of strength, power, endurance
- Inability to perform purposeful, functional, intentional movements

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- Inability to ambulate
- Decreased functional work capacity
- Inability to climb stairs
- Inability to perform repetitive tasks
- Inability to perform self-care tasks
- Inability to reach
- Inability to access the community
- Inability to access transportation
- Limited independence in activities of daily living

Functional Assessment

- Documentation of a patient's level of function is an important aspect of patient care. This documentation is required in order to establish the medical necessity of ongoing acupuncture treatment. The Patient Specific Functional Scale (PSFS) is a patient reported outcome assessment that is easy and appropriate for acupuncturists to use. The PSFS has been studied in peer-reviewed scientific literature, and it has been proven to be a valid, reliable, and responsive measure for a variety of pain syndromes (neck, back, knee, etc.).

Objective Findings

Scope of Examination

- Inspection
- Palpation of bony and soft tissue
- Range of motion
- Orthopedic testing
- Neurologic testing

Examination Considerations

All of the following objective tests may not be appropriate on admission to treatment, but should be assessed as the member's condition allows during the course of care.

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Assistive, protective and supportive devices

- Balance tests (static, dynamic and during functional tasks): Balance scale, Dizziness inventories, Fall scales, Motor impairment scales
- Gait and Locomotion: Gait indexes, Mobility skills profiles, Functional assessment profiles
- Motor Function Tests: Dexterity, Coordination, Agility
- Skin Integrity: Skin characteristics (blistering, color, sensation, temperature, texture), Wound (signs of infection, scar tissue characteristics, stage of healing)
- Palpation of bony and soft tissue: Palpate involved muscles for tender nodule, taut band, tight ropiness, Observe pattern of referred pain, Provocation tests
- Edema (measure both sides for comparison): Girth measurements, Palpation, Volume measurements
- Postural assessment: Postural alignment and position
- Range of motion: Active and passive movement of affected area and joint above and below and contralateral joints, Functional range of motion (e.g. squat tests, toe touch tests)
- Manual Muscle Testing: Test related joints
- Joint Integrity and mobility: Compression and distraction, Apprehension, Joint play and end feel

Outcome Measures by Condition/Diagnosis

There are many validated instruments that may be used. The therapist should choose an appropriate instrument. The following standardized tests may be used to assess functional limitations on admission, and functional change at discharge and periodically during the course of care.

Condition/ Diagnosis	Test	Definition	Author
Elderly > 65 y.o.	Berg Balance Test	Measures both statis and dynamic balance using a 14-item scale	Donoghue and Stokes, 2009
	Gait speed	Measures overall walking performance	Mangione, et al., 2010
	Six Minute Walk test	Tests endurance by measuring the maximum distance that a person can walk in six minutes	Mangione, et al., 2010
	Short Physical Performance Battery (SPPD)	Composite of three timed tests: -Chair rise for 5 repetitions-Standing balance – Walking speed	Mangione, et al., 2010
	Timed Up and GO (TUG)	Functional mobility test generally used for the geriatric population	Mangione, et al., 2010

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Condition/ Diagnosis	Test	Definition	Author
	Performance Oriented Mobility Assessment, Tinetti	Evaluates balance and gait	Faber, et al., 2006 Tinetti, 1986
Hip Fracture with Surgical Repair	Gait Speed	Measures overall walking performance	Latham, et al., 2008
	Six Minute Walk test	Tests endurance by measuring the maximum distance that a person can walk in six minutes	Latham, et al., 2008
	Short Physical Performance Battery (SPPD)	Composite of three timed tests: - Chair rise for 5 repetitions – Standing balance – Walking Speed	Latham, et al., 2008
Hip/Knee Osteoarthritis	Western Ontario and McMaster Universities Osteoarthritis Index (WOMAC)	Disease-specific, self-administered questionnaire used with patients who have hip/knee osteoarthritis	Pua, et al., 2009
	Get UP and Go Test	Measures fall risk	Priva, et al., 2004
	Lower Extremity Functional Scale (LEFS)	20-item condition specific questionnaire designed for use for musculoskeletal conditions of the lower extremity	Binkley, et al., 1999
LE Musculoskeletal Disorder	Lower Extremity Functional Scale (LEFS)	20-item condition specific questionnaire designed for use for musculoskeletal conditions of the lower extremity	Binkley, et al., 1999
	Patient Specific Functional Scale (PSFS)	Patient self-report measure used to quantify activity limitation and measure functional outcome	Chatman, et al., 1997
Low Back Pain, Chronic or Acute	Fear Avoidance Beliefs Questionnaire (FABQ)	Used to quantify fear- avoidance beliefs specific to low back pain and can help predict those who have a high pain avoidance behavior	George, et al., 2010 Waddell, et al., 1993
	Oswestry Disability Index	Self-report questionnaire that measures the degree to which back or leg pain impacts functional activities	Davidson and Keating, 2002 Maughan and Lewis, 2010
	Quebec Back Pain Disability Scale	20-item self-report questionnaire that measures the level of physical functioning in patients with low back pain	Van der Roer, et al., 2006 Davidson and Keating, 2002
	Roland Morris Questionnaire	Self-administered disability questionnaire that consists of 24 statements regarding activity limitations due to back pain	Maughan and Lewis, 2010 Stratford, et al., 1996
	Patient Specific Functional Scale (PSFS)	Patient self-report measure used to quantify activity limitation and measure functional outcome	Cleland, et al., 2006

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Condition/ Diagnosis	Test	Definition	Author
Neck Pain/ Cervical Radiculopathy Pain	Neck Disability Index (NDI)	10 item questionnaire, 7 items related to ADLs, 2 items related to pain, and 1 item related to concentration	Cleland, et al., 2006
	Patient Specific Functional Scale (PSFS)	Patient self-report measure used to quantify activity limitation and measure functional outcome	Cleland, et al., 2006
	Numeric Pain Rating Scale (NPRS)	11-point numerical rating scale for determining pain intensity	Spandoni, et al., 2004
UE Dysfunction/ Musculoskeletal Disorder	American Shoulder and Elbow Surgeons Score (ASES)	Measures functional limitation and pain of the shoulder	Michener, et al., 2002
	Disabilities of Arm, Shoulder, Hand (DASH)	30 item questionnaire, region specific and allow comparisons across diagnosis of the upper extremity	Schmitt and Di Fabio, 2004
	Penn Shoulder Score	Condition specific self-report measure, uses a 100 point scale consisting of 3 subscales – pain, satisfaction, and function	Leggin, et al., 2006
	Shoulder Pain and Disability Index (SPADI)	13-item self-administered questionnaire relating to pain and functional status of the shoulder region	Schmitt and Di Fabio, 2004
	Patient Specific Functional Scale (PSFS)	Patient self-report measure used to quantify activity limitation and measure functional outcome	Hefford, et al., 2012
Total Hip/Knee Arthroplasty	WOMAC	Disease-specific, self-administered questionnaire used with patients who have hip/knee osteoarthritis	Knee-Escobar, et al., 2007 Hip-Quintana, et al., 2005

Oriental Medicine Management [14, 26, 28]

- Oriental Medicine management goals are to resolve pain, restore the highest level of function possible, and educate patient to prevent recurrent symptoms.
- In order to be considered medically necessary, patient's symptoms must be the direct result of a primary neuromusculoskeletal injury or illness.
- Confirmation of appropriate medical co-management is always required when treating children age 14 and under.
- Treatment frequency should be commensurate with the severity of the chief complaint, natural history of the condition, and expectation for functional improvement.
- When significant improvements in patient's subjective findings and objective findings are demonstrated—continued treatment with decreased frequency is appropriate.

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- As treatment progresses, one should see an increase in the active regimen of care, a decrease in the passive regimen of care, and a fading of treatment frequency.
- If the condition has not progressed towards resolution, refer the patient to an appropriate health care provider to explore other treatment alternatives.
- eviCore's consideration of requests for continued acupuncture treatment depends on updated clinical information submitted regarding patient's progress.
- Adequate and legible patient progress information that contains a history and examination, and/or eviCore's Treatment Request Form for each treatment is required to determine medical necessity.
- In addition to the improvements in the table below, significant progress may be documented by increases in functional capacity and increasingly longer durations of pain relief.
- Discharge occurs when reasonable functional goals and expected outcomes have been achieved.
- The patient is discharged when the patient/care-giver can continue management of symptoms with an independent home program.
- Treatment is discontinued when the patient is unable to progress towards outcomes because of medical complications, psychosocial factors or other personal circumstances.
- If the member has been non-compliant with treatment as is evidenced by the clinical documentation, and/or the lack of demonstrated progress, treatment will be deemed to be not medically necessary and the member should be discharged from treatment.

Week	Progress
0-1	◆ Some reduction of pain severity and frequency ◆ Some reduction of muscle spasm
2-4	◆ 50% decrease in pain severity and frequency ◆ 50% improvement in function
5-8	◆ 75% decrease in pain severity and frequency ◆ 75% improvement in function
9-12	◆ Gradual improvement leading toward resolution ◆ Reinforce self-management techniques ◆ Discharge patient to elective care, or to their primary care provider for alternative treatment options when a plateau is reached, or by week 12, whichever occurs first

Referral Guidelines

- Refer patient to their primary care provider for evaluation of alternative treatment options if:
  - Improvement does not meet above guidelines, or improvement has reached a plateau
  - Atrophy of the extremity occurs
  - Neurological deficits appear/progress

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Appropriate Procedures/Modalities

- Acupuncture
- Electro-acupuncture
- Cupping
- Moxibustion
- Gua Sha
- Myofascial release
- Acupressure
- Trigger point massage
- Tui Na (not to include osseous manipulation)
- Herbal formulas

Note: Not all of these modalities are covered by the patient's health-plan; review documentation regarding coverage. Acupuncture and herbs must be appropriate for covered diagnoses under the patient's insurance policy. Acupuncturist is responsible for determining which procedures/modalities are most appropriate for the patient's condition.

Inappropriate Procedures/Modalities

- Scarring moxa
- Applied kinesiology techniques
- Electro-acupuncture using more than 9 volts
- Any techniques outside of the scope of practice in your state

Self-Management Techniques

- Rest and reduce strenuous activities
- Ergonomics, Postural advice, postural exercises
- Appropriate exercises/stretching
- Tai Qi, Qi Gong, Yoga
- Stress management, meditation
- Joint protection
- Weight loss
- Self-massage, Self-acupressure
- Hot packs/cold packs, if needed, to relieve discomfort

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Alternatives to Oriental Medicine Management

(listed in alphabetical order)

- Chiropractic
- Dietary/Nutritional Medicine Counseling
- Injection therapy/Pain management
- Massage therapy
- Medication
- Occupational therapy
- Osteopathic Manipulation
- Physical Therapy
- Psychological counseling

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References

1. Amezaga Urruela M, Suarez-Almazor ME. Acupuncture in the treatment of rheumatic diseases. Curr Rheumatol Rep. 2012;14(6):589-597. doi:10.1007/s11926-012-0295-x.
2. Baeumler PI, Fleckenstein J, Takayama S, Simang M, Seki T, Irnich D. Effects of acupuncture on sensory perception: a systematic review and meta-analysis. PLOS ONE. 2014;9(12):e113731. doi:10.1371/journal.pone.0113731.
3. Balshem H, Helfand M, Schunemann HJ, Oxman AD, Kunz R, Brozek J, et al. GRADE guidelines: 3. Rating the quality of evidence. J Clin Epidemiol. 2011 Apr;64(4):401-6. doi:10.1016/j.jclinepi.2010.07.015.
4. Cheng X, Deng L. Chinese Acupuncture and Moxibustion. Beijing: Foreign Language Press; 2010.
5. Deadman P, Khafaji MA-, Baker K. A Manual of Acupuncture. Hove: Journal of Chinese Medicine Publications; 2011.
6. Ernst E. Musculoskeletal conditions and complementary/alternative medicine. Best Practice & Research Clinical Rheumatology. 2004;18(4):539-556. doi:10.1016/j.berh.2004.03.005.
7. Hempel S, Taylor SL, Solloway MR, Miake-Lye IM, Beroes JM, Shanman R, et al. VA Evidence-based Synthesis Program Reports. Evidence Map of Acupuncture. Washington (DC): Department of Veterans Affairs; 2014.
8. Hopton A, MacPherson H. Acupuncture for chronic pain: is acupuncture more than an effective placebo? A systematic review of pooled data from meta-analyses. Pain Pract. 2010;10(2):94-102. doi:10.1111/j.1533-2500.2009.00337.x.
9. Horn KK, Jennings S, Richardson G, Vliet DV, Hefford C, Abbott JH. The patient-specific functional scale: psychometrics, clinimetrics, and application as a clinical outcome measure. J Orthop Sports Phys Ther. 2012 Jan;42(1):30-42. doi:10.2519/jospt.2012.3727.
10. Kaptchuk T. The Web That Has No Weaver. Contemporary Books. 2000.
11. Kelly RB. Acupuncture for pain. Am Fam Physician. 2009 Sep 1;80(5):481-4.
12. Kligler B, Nielsen A, Kohrrer C, Schmid T, Waltermaurer E, Perez E, Merrell W. Acupuncture Therapy in a Group Setting for Chronic Pain. Pain Med. 2017 Jun 8. doi:10.1093/pm/pnx134.
13. Lansdown H, Howard K, Brealey S, MacPherson H. Acupuncture for pain and osteoarthritis of the knee: a pilot study for an open parallel-arm randomised controlled trial. BMC Musculoskelet Disord. 2009 Oct 24;10:130. doi:10.1186/1471-2474-10-130.
14. Li X, Wang R, Xing X, et al. Acupuncture for Myofascial Pain Syndrome: A Network Meta-Analysis of 33 Randomized Controlled Trials. Pain Physician. 2017 Sep;20(6):E883-E902.
15. Maciocia, G; The Foundations of Chinese Medicine: A Comprehensive Text; Churchill Livingstone, 2005.
16. MacPherson H, Vertosick EA, Foster NE, Lewith G, Linde K, Sherman KJ, et al. The persistence of the effects of acupuncture after a course of treatment: A meta-analysis of patients with chronic pain. Pain. 2016 Oct 17. doi:10.1097/j.pain.0000000000000747.
17. Manyanga T, Froese M, Zarychanski R, Abou-Setta A, Friesen C, Tennenhouse M, et al. Pain management with acupuncture in osteoarthritis: a systematic review and meta-analysis. BMC Complement Altern Med. 2014;14:312. doi:10.1186/1472-6882-14-312.
18. McDonald J, Janz S. The Acupuncture Evidence Project: A Comparative Literature Review (Revised Edition). Brisbane: Australian Acupuncture and Chinese Medicine Association Ltd; 2017.
19. Minor ,M.A., Hewett, J.E., Webel, R.R., Anderson, S., & Kay, D.R. Efficacy of physical conditioning exercise in patients with rheumatoid arthritis and osteoarthritis. Arthritis and Rheumatism, 1989; 32(11): 1396-1405.
20. National Health and Medical Research Council. NHMRC additional levels of evidence and grades for recommendations for developers of guidelines. Table 3. NHMRC Evidence Hierarchy: designations of 'levels of evidence' according to type of research question (including explanatory notes). National Health and Medical Research Council; 2009.
21. O'Connor J, Bensky D. Acupuncture: A Comprehensive Text. Chicago: Eastland Press; 1981.
22. Olson WH, Brumback RA, Gascon G, Iyer V; Handbook of Symptom Oriented Neurology; Year Book Medical Publishers, Inc.; 2002.
23. Porter, R; The Merck Manual, Merck, 2011.
24. Roy, S., Irvin, R., and Iverson, D; Sports Medicine, Prevention, Education, Management, and Rehabilitation, Benjamin Cummings, 1998.

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25. Vickers AJ, Cronin AM, Maschino AC, et al. Acupuncture for chronic pain: individual patient data meta-analysis. Arch Intern Med. 2012;172(19):1444-1453.
26. Wang R, Li X, Zhou S, Zhang X, Yang K, Li X. Manual acupuncture for myofascial pain syndrome: a systematic review and meta-analysis. Acupunct Med. 2017 Aug;35(4):241-250. doi:10.1136/acupmed-2016-011176.
27. Weinstein, S, and Buckwalter, J. Orthopaedics Principles and Their Applications. Lippincott, Williams, & Wilkins, 2005.
28. Xiang A, Cheng K, Shen X, Xu P, Liu S. The Immediate Analgesic Effect of Acupuncture for Pain: A Systematic Review and Meta-Analysis. Evid Based Complement Alternat Med. 2017;2017:3837194. doi:10.1155/2017/3837194.
29. Yuan J, Purepong N, Hunter RF, Kerr DP, Park J, Bradbury I, McDonough S. Different frequencies of acupuncture treatment for chronic low back pain: an assessor-blinded pilot randomised controlled trial. Complement Ther Med. 2009 Jun;17(3):131-40. doi:10.1016/j.ctim.2008.10.003.
30. Zhao HJ, Tan JY, Wang T, Jin L. Auricular therapy for chronic pain management in adults: A synthesis of evidence. Complement Ther Clin Pract. 2015 May;21(2):68-78. doi:10.1016/j.ctcp.2015.03.006.

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ACU-11.0: Neuromusculoskeletal Conditions (Unspecified Region)

ACU-11.1: Adjunct Care for Post-Stroke Rehabilitation	**417**
ACU-11.2: Fibromyalgia (Now Excluded)	**430**
ACU-11.3: Myalgia	**436**

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ACU-11.1: Adjunct Care for Post-Stroke Rehabilitation

Synonyms

- Post-stroke spasticity [41]
- Post-stroke shoulder pain [29, 41]
- Post-stroke insomnia
- Post-stroke dysphagia (swallowing impairment) [18, 40]

Definitions

Stroke is the leading cause of long-term disability in the US. Successful rehabilitation depends on the amount of damage to the brain as well as timing and quality of the rehabilitation program. Only 10% of stroke survivors recover almost completely, and 25% recover with only minor impairments. Moderate or severe impairments are part of life for 40% of stroke survivors, and 10% require long-term care in a nursing home or other facility. The remaining 15% die shortly after the stroke.

The types and degrees of disability that follow a stroke depend upon which area of the brain is damaged. Generally, stroke can cause five types of disabilities: paralysis or problems controlling movement; sensory disturbances including pain; problems using or understanding language; problems with thinking and memory; and emotional disturbances. One specific type of paralysis/problem with movement is dysphagia, which is defined as difficulty in swallowing from the time food/liquid enters the mouth to the time it enters the stomach. Dysphagia affects the ability to maintain adequate nutrition and hydration and may lead to dehydration and aspiration. Rehabilitation helps stroke survivors relearn skills that are lost when part of the brain is damaged.

Stroke rehabilitation requires a sustained and coordinated effort from a large team, including the patient, family and friends, physicians, nurses, physical and occupational therapists, speech-language pathologists, recreation therapists, psychologists, nutritionists, social workers, and others.[3, 5] Rehabilitative therapy begins in the acute-care hospital after the person's overall condition has been stabilized, often within 24 to 48 hours after the stroke. The rate of recovery is generally greatest in the weeks and months after a stroke. The ultimate level of recovery depends on variable factors including the level of neurological damaged sustained and rapid initiation of a rehabilitation program. For some stroke survivors, rehabilitation will be an ongoing process to maintain and refine skills and could involve working with specialists for months or years after the stroke.

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Oriental Medicine Diagnoses

According to Oriental Medicine theory stroke can be caused by any of several combinations of internal, external, excess and deficiency patterns. There are often multiple and interrelated pathologies at play. Pathologies may affect the Channels, Blood Vessels, Organs and Brain. The most common pathologies involved include:

Wind: Underlying Liver or Kidney Yin or Blood Deficiencies can lead to the Liver Yang Rising and generation of Liver Wind. Contributing lifestyle factors may include long term excessive physical exertion, chronic menorrhagia, chronic states of anger, poor diet, excessive alcohol use, or substance use.

Fire: Fire is an extreme form of Heat which can be generated from other pathogenic factors. Fire can damage the Blood Vessels and affect the Mind, in addition to any individual organ pathology. The nature of Fire is to rise to the head, dry fluids, injure Blood and Yin, and deplete Qi. Fire may be the cause or the result of emotional disturbance.

Phlegm: Spleen, Kidney and Lung Deficiency may lead to accumulation of Phlegm. When combined with Heat and Fire this can lead to Phlegm Obstructing the Heart Orifice or Phlegm Misting the Mind. Phlegm obstructing the Channels can cause pain or numbness. Lifestyle factors that contribute to Phlegm formation include poor diet, over worry, over work, lack of physical activity.

Blood Stasis: Qi Deficiency, Qi Stagnation, Blood Deficiency, Heat in the Blood or Interior Cold can cause the Blood to slow down and congeal. The result of Blood Stasis is fixed, boring or stabbing pain. Aging, chronic illness, chronic stress and overwork, and lack of physical activity can contribute to the development of Blood Stasis.

History

Only 15% of major strokes are preceded by transient ischemic attacks (TIA). Stroke can occur at any age and in any demographic. The most common warning signs are sudden onset of numbness or weakness which is typically unilateral, sudden confusion or difficulty communicating, sudden trouble seeing in one or both eyes, sudden difficulty with walking, balance or coordination, or sudden severe headache without known cause. The acronym for recognizing stroke is “F.A.S.T.” which stands for **F**acial drooping, **A**rm weakness, **S**peech difficulty, **T**ime to call 911. Immediate medical attention is needed even if the symptoms were only temporary.

Strokes may be hemorrhagic, ischemic or transient ischemic attacks (TIA). Hemorrhagic strokes are caused by rupture or leakage of a blood vessel in the brain and may result from uncontrolled hypertension, overtreatment with anticoagulants, aneurysm or trauma. Ischemic stroke occurs when a blood vessel in the brain is blocked or narrowed by an embolism or localized thrombosis. TIAs are experienced as temporary symptoms of stroke and may indicate a clot source in the heart or partially blocked artery leading to the brain. All forms of stroke are a medical emergency.

Risk factors for stroke include lack of physical activity, being overweight, cigarette smoking, alcohol, or drug abuse. Medical conditions that may contribute to stroke include hypertension, high cholesterol, diabetes, cardiovascular disease and obstructive

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sleep apnea. Men, African-Americans, people over 55, women who use birth control pills or other estrogen therapy, and those sickle cell anemia or with family history of stroke also have an increased risk level.

Additional Information Required

- Authorization requests for stroke rehabilitation must include additional information. Patients seeking acupuncture as an adjunct therapy should already be engaged in a comprehensive stroke rehabilitation program as directed by the physician and therapist care team. While adjunctive acupuncture may enhance the results of a stroke rehabilitation program, it is not an equivalent or replacement for any aspect of the standard stroke rehabilitation program. Confirmation of participation in the rehabilitation program recommended by the physician and therapist care team is required. Acupuncture that may delay or replace needed medical care does not meet medical necessity criteria.
- Additional information must include:
- Confirmation of participation in the rehabilitation program recommended by the physician and therapist care team
- Detailed current symptomatic evaluation of the symptom(s) treated with acupuncture
- Clear description of progress since the last authorization request

Specific Aspects of History

- Rule out red flags (requires medical management).
- Identify co-morbidities requiring medical management, and those that affect acupuncture and Oriental Medicine management.
- Regardless of any red flags, confirmation of medical evaluation and appropriate medical co-management should be confirmed before initiating a course of acupuncture. Optimal levels of stroke recovery occur in the context of the comprehensive and multimodal rehabilitation program designed by physicians and therapists specializing in stroke rehabilitation. Acupuncture that may delay or replace needed medical care does not meet medical necessity criteria.

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Red Flag	Possible Consequence or Cause	Action Required
Additional or suddenly worsening stroke symptoms, history of previous stroke	Stroke or TIA. Approximately 14% of stroke survivors will experience a second stroke within the year following a stroke.	Immediate referral to emergency department
Hemiparesis, sensory changes, incontinence, older age, nutritional deficiency, use of compression stockings	Pressure ulcer or skin complications	Prompt referral to Primary Care Provider
Hemiparesis, spasticity, failure to follow doctor/therapist recommendations for stretching and/or splint use	Contracture	Prompt referral to Primary Care Provider
Chest congestion after oral intake, Temperature spike within one hour of oral intake, Drop in oxygen saturation levels, Pneumonia	Aspiration/penetration	Immediate referral to emergency department
Swelling, pain, redness, cramping or soreness in the leg, especially the calf. Sudden shortness of breath, chest pain that worsens with cough or inhalation, rapid pulse, hemoptysis.	Deep Vein Thrombosis, Pulmonary Embolism	Immediate referral to emergency department
Impaired mobility, impaired gait, low muscle strength, poor balance, post stroke osteoporosis, older age, nutritional deficiency; severe pain, bruising, swelling	Fracture or other injury caused by fall	Immediate referral to emergency department if fracture is suspected and/or anticoagulant medication is used
Temporary confusion or staring spells, repetitive movements such as blinking or hand rubbing with or without loss of consciousness, sudden body twitching or jerking, collapse, loss of consciousness.	Seizure	Immediate referral to emergency department
Severe disability, history of multiple strokes, cognitive impairment, family history of psychiatric disorder, female, anxiety, lack of physical exercise, lack of motivation to participate in rehabilitation program	Depression	Prompt referral to Primary Care Provider National Suicide Prevention Lifeline is available 24 hours every day 1-800-273-8255.

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Red Flag	Possible Consequence or Cause	Action Required
Poor oral hygiene and dysphagia increase the risk of aspiration pneumonia	Persistent chest pain, cough, shortness of breath, fever and chills	Prompt referral to Primary Care Provider
Depression and emotional distress of caregivers	Potential increased risk of depression and potential decreased risk of rehabilitation program compliance	Referral to community resources and/or encouragement to discuss community resources with doctors or therapists
Unexplained weight loss, Pain that is worse with recumbency or worse at night, Prior history of cancer	Malignancy	Prompt referral to Primary Care Provider
Fever, immune compromised state, intravenous drug use	Infection	Prompt referral to Primary Care Provider
Headache associated with diastolic blood pressure greater than 110 mm/Hg, Exertional pain, history of CAD	Cardiac condition	Immediate referral to emergency department
Suspicion of drug or alcohol dependence	Side effect or withdrawal phenomenon	Immediate referral to emergency department

Subjective Findings

Post-stroke symptoms vary according to the area and extent of cellular damage. Symptoms may include:

- Pain, numbness, spasticity, sensory deficits
- Weakness, hemiparesis, foot drop, paralysis
- Balance problems
- Dysphagia
- Aphasia
- Seizures, epilepsy
- Incontinence
- Sleeping problems, fatigue
- Vision problems
- Depression
- Pseudobulbar affect
- Memory loss, vascular dementia

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Functional Assessment

- Documentation of a patient's level of function is an important aspect of patient care. This documentation is required in order to establish the medical necessity of ongoing acupuncture treatment. The Patient Specific Functional Scale (PSFS) is a patient reported outcome assessment that is easy and appropriate for acupuncturists to use. The PSFS has been studied in peer-reviewed scientific literature, and it has been proven to be a valid, reliable, and responsive measure for a variety of pain syndromes (neck, back, knee, etc.). The PSFS could be adapted to describe the level which insomnia, spasticity or pain affect specific activities.
- Additional assessments commonly used for post-stroke spasticity, pain and insomnia include: Fugl-Meyer Assessment, Modified Ashworth Scale, Pittsburg Sleep Quality Index, Insomnia Severity Index.
- Additional assessments used for post-stroke dysphagia must be performed by a speech therapist or other trained specialist, and may include:
  - Non-Imaging
    - Bedside/Clinical Swallowing Evaluation
    - Electromyography (EMG) (rarely used)
    - Electroglottography (EGG) (rarely used)
    - Pharyngeal Manometry (rarely used)
  - Imaging
    - Modified Barium Swallow Study (MBS) aka Videofluoroscopic Swallow Evaluation (VFSE)
    - Fiberoptic Endoscopic Evaluation of Swallowing (FEES)
    - Ultrasound (rarely used)
    - Scintigraphy (rarely used)

Objective Findings

Scope of Exam

- Inspection including Oriental Medicine inspection techniques
- Measure blood pressure, pulse rate, temperature
- Functional assessments corresponding to the subjective complaints treated with acupuncture

Specific Aspects of Examination for Stroke Recovery

- Confirm current medical evaluation, diagnosis and treatment.
- Rule out other possible causes of symptoms (via medical co-management with MD).
- Referral back to MD if any red flags are present, if any symptoms worsen or new symptoms develop.

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Differential Diagnoses for Stroke

- Seizure
- Systemic infection
- Brain tumor
- Toxic-metabolic disorders, such as hyponatremia and hypoglycemia
- Positional vertigo
- Conversion disorder

*Patients seeking acupuncture for stroke rehabilitation should already have a confirmed stroke diagnosis, and already be participating in a rehabilitation program with stroke rehabilitation specialists. [3, 5]

Oriental Medicine Management [7, 18, 29, 31, 34, 38, 41]

- Patients seeking acupuncture as an adjunct therapy should already be engaged in a comprehensive stroke rehabilitation program as directed by the physician and therapist care team. While adjunctive acupuncture may enhance the results of a stroke rehabilitation program, it is not an equivalent or replacement for any aspect of the standard stroke rehabilitation program. Confirmation of participation in the rehabilitation program recommended by the physician and therapist care team is required.
- Acupuncture that may delay or replace needed medical care does not meet medical necessity criteria.
- Oriental Medicine management goals are to help reduce or resolve symptoms, help restore the highest level of function possible and help educate patient to reduce or prevent recurrent symptoms.
- Treatment frequency should be commensurate with the severity of the chief complaint, natural history of the condition, and expectation for functional improvement.
- When significant improvements in patient's subjective findings and objective findings are demonstrated—continued treatment with decreased frequency is appropriate.
- As treatment progresses, one should see an increase in the effective use of coping mechanisms, a decrease in the dependence on acupuncture services, and a fading of treatment frequency.
- If the condition has not progressed towards resolution, refer the patient to an appropriate health care provider to explore other treatment alternatives.
- eviCore's consideration of requests for continued acupuncture treatment depends on updated clinical information submitted regarding patient's progress.
- Adequate and legible patient progress information that contains a history and examination, and/or eviCore's Treatment Request Form for each treatment is required to determine medical necessity.

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- In addition to the improvements in the table below, significant progress may be documented by increases in functional capacity and increasingly longer durations of symptomatic relief.
- Discharge occurs when reasonable functional goals and expected outcomes have been achieved.
- The patient is discharged when the patient/care-giver can continue management of symptoms with an independent home program.
- Treatment is discontinued when the patient is unable to progress towards outcomes because of medical complications, psychosocial factors or other personal circumstances.
- If the member has been non-compliant with treatment as is evidenced by the clinical documentation, and/or the lack of demonstrated progress, treatment will be deemed to be not medically necessary and the member should be discharged from treatment.

Week	Progress
0-2	◆ Some reduction of symptom severity and frequency ◆ Ensure recent medical evaluation and appropriate co-management with stroke rehabilitation specialists
3-6	◆ At least 20-25% improvement in symptom severity and frequency ◆ Reinforce self-management techniques ◆ Reinforce continued medical co-management with rehabilitation specialists
6-12	◆ At least 45-60% improvement in symptom severity and severity ◆ Reinforce self-management techniques ◆ Reinforce continued medical co-management with rehabilitation specialists
13-24	◆ Recovery is expected to reach a plateau in this time frame ◆ Continued acupuncture is merited with 15-20% progressive monthly improvement ◆ Reinforce self-management techniques ◆ Reinforce continued medical co-management with rehabilitation specialists ◆ Discharge patient to elective care or back to their MD for alternative treatment options, when a plateau is reached or by week 24, whichever occurs first

Referral & Medical Co-Management Guidelines

- Refer patient to their Medical Doctor and/or Licensed Psychological Practitioner for evaluation of alternative treatment options if:
  - Confirmation of current evaluation and diagnosis from Medical Doctor is not provided.
  - There is refusal or inability to participate in other aspects of the stroke rehabilitation program designed by the physician and therapist care team.
  - Consult a registered dietitian to determine nutrition and hydration needs.
  - Social worker for patient or family concerns
  - Psychologist for behavioral and mental health support
  - There are signs of depression or ANY indication of thoughts or plans for self-harm. The National Suicide Prevention Lifeline is available 24 hours every day, call 1-800-273-8255.
  - There is significant worsening of the patient's complaint.

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- The patient shows additional complaints.
- The patient has not responded positively to treatment after a couple of weeks.

Appropriate Procedures/Modalities

- Acupuncture
- Electro-acupuncture [31, 41]
- Herbal formulas

Note: Not all of these modalities are covered by patient's health-plan; review documentation regarding coverage. Acupuncture and herbs must be appropriate for covered diagnoses under the patient's insurance policy. Acupuncturist is responsible for determining which procedures/modalities are most appropriate for the patient's condition.

Inappropriate Procedures/Modalities

- Scarring moxa
- Electro-acupuncture using more than 9 volts
- Any techniques outside of the scope of practice in your state

Self-Management Techniques

- Motor skill exercises as recommended by doctor/therapist
- Range of motion exercises as recommended by doctor/therapist
- Forced use therapy as directed by doctor/therapist
- Mobility aids, assistive devices, safety modifications as recommended by doctor/therapist
- Splints/positioning/supportive devices as recommended by doctor/therapist
- Dietary changes including altered texture/thickness as recommended by doctor/therapist
- Instruct patient to notify primary care physician and/or Speech-Language Pathologist should any changes occur in the swallow function that negatively affects the patient's swallow safety.
- Rest and moderate activities as needed
- Mental imagery of using affected body parts
- Pelvic floor muscle training; timed voiding; fluid, diet or clothing modifications
- Avoid dehydration
- Stay as active as possible, and/or frequent repositioning
- Good sleep hygiene

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- Play word-based games, read aloud or sing
- Practice writing a shopping list or greeting cards
- Create a communication book; draw or write things on paper
- Relaxation, meditation, or hypnosis may help with pain management and stress
- Attend a stroke support group

Alternatives to Oriental Medicine

(listed in alphabetical order)

- Bladder and Bowel Training, or use of a catheter
- Cortical stimulation
- Medication
- Mental Health Therapy
- Neuromuscular Electrical Stimulation
- Occupational Therapy
- Optical Therapy, Eye Movement Therapy, Visual Restoration Therapy
- Pain Management/Injection Therapy
- Physical Therapy
- Speech Therapy
- Surgery, as a last resort

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References

1. Balshem H, Helfand M, Schunemann HJ, Oxman AD, Kunz R, Brozek J, et al. GRADE guidelines: 3. Rating the quality of evidence. J Clin Epidemiol. 2011 Apr;64(4):401-6. doi:10.1016/j.jclinepi.2010.07.015.
2. Cai Y, Zhang CS, Liu S, Wen Z, Zhang AL, Guo X, Lu C, Xue CC. Electroacupuncture for Poststroke Spasticity: A Systematic Review and Meta-Analysis. Arch Phys Med Rehabil. 2017 Dec;98(12):2578-2589.e4. doi:10.1016/j.apmr.2017.03.023.
3. Canadian Partnership for Stroke Recovery. Evidence-Based Review of Stroke Rehabilitation. http://www.ebrsr.com. Accessed June 7, 2019.
4. Edward C Jauch, MD, MS, FAHA, FACEP; Chief Editor: Helmi L Lutsep, MD. Ischemic Stroke Differential Diagnoses.
5. Eltringham, S. A., Kilner, K., et al. Impact of Dysphagia Assessment and Management on Risk of Stroke-Associated Pneumonia: A Systematic Review. Cerebrovascular Diseases. 2018;46(3-4), 97-105. doi: 10.1159/00049273
6. Fink M, Rollnik JD, Bijak M, Borstädt C, Däuper J, Guergueltcheva V, Dengler R, Karst M. Needle acupuncture in chronic poststroke leg spasticity. Arch Phys Med Rehabil. 2004 Apr;85(4):667-72.
7. Geeganage C, Beavan J, Ellender S, Bath PM. Interventions for dysphagia and nutritional support in acute and subacute stroke. Cochrane Database Syst Rev. 2012 Oct 17;10:CD000323. doi:10.1002/14651858.CD000323.pub2.
8. Hempel S, Taylor SL, Solloway MR, Miake-Lye IM, Beroes JM, Shanman R, et al. VA Evidence-based Synthesis Program Reports. Evidence Map of Acupuncture. Washington (DC): Department of Veterans Affairs; 2014.
9. Horn KK, Jennings S, Richardson G, Vliet DV, Hefford C, Abbott JH. The patient-specific functional scale: psychometrics, clinimetrics, and application as a clinical outcome measure. J Orthop Sports Phys Ther. 2012 Jan;42(1):30-42. doi:10.2519/jospt.2012.3727.
10. Hseuh CC, and O'Connor. Acupuncture - A Comprehensive Text. Eastland Press, 1981.
11. Kaptchuk T. The Web That Has No Weaver. Contemporary Books. 2000.
12. Kelly RB. Acupuncture for pain. Am Fam Physician. 2009 Sep 1;80(5):481-4.
13. Kim YS, Lee SH, Jung WS, Park SU, Moon SK, Ko CN, Cho KH, Bae HS. Intradermal acupuncture on shen-men and nei-kuan acupoints in patients with insomnia after stroke. Am J Chin Med. 2004;32(5):771-8. doi:10.1142/S0192415X04002399.
14. Lee SH, Lim SM. Acupuncture for insomnia after stroke: a systematic review and meta-analysis. BMC Complement Altern Med. 2016 Jul 19;16:228. doi:10.1186/s12906-016-1220-z.
15. Lee SH, Lim SM. Acupuncture for Poststroke Shoulder Pain: A Systematic Review and Meta-Analysis. Evid Based Complement Alternat Med. 2016;2016:3549878. doi:10.1155/2016/3549878.
16. Lee SJ, Shin BC, Lee MS, Han CH, Kim JI: Scalp acupuncture for stroke recovery: a systematic review and meta-analysis of randomized controlled trials. Eur J Int Med 2013; 5:87–99. doi:10.1186/s13063-016-1611-y.
17. Lee SY, Baek YH, Park SU, Moon SK, Park JM, Kim YS, Jung WS. Intradermal acupuncture on shen-men and nei-kuan acupoints improves insomnia in stroke patients by reducing the sympathetic nervous activity: a randomized clinical trial. Am J Chin Med. 2009;37(6):1013-21. doi:10.1142/S0192415X09007624.
18. Li LX, Deng K, Qu Y. Acupuncture Treatment for Post-Stroke Dysphagia: An Update Meta-Analysis of Randomized Controlled Trials. Chin J Integr Med. 2018 Sep;24(9):686-695. doi:10.1007/s11655-018-3005-3
19. Li X, Wang R, Xing X, et al. Acupuncture for Myofascial Pain Syndrome: A Network Meta-Analysis of 33 Randomized Controlled Trials. Pain Physician. 2017 Sep;20(6):E883-E902.
20. Lim SM, Yoo J, Lee E, Kim HJ, Shin S, Han G, Ahn HS. Acupuncture for spasticity after stroke: a systematic review and meta-analysis of randomized controlled trials. Evid Based Complement Alternat Med. 2015;2015:870398. doi:10.1155/2015/870398.
21. Liu AJ, Li JH, Li HQ, Fu DL, Lu L, Bian ZX, et al. Electroacupuncture for Acute Ischemic Stroke: A Meta-Analysis of Randomized Controlled Trials. Am J Chin Med. 2015;43(8):1541-66. doi:10.1142/S0192415X15500883.
22. MacPherson H, Vertosick EA, Foster NE, Lewith G, Linde K, Sherman KJ, et al. The persistence of the effects of acupuncture after a course of treatment: A meta-analysis of patients with chronic pain. Pain. 2016 Oct 17. doi:10.1097/j.pain.0000000000000747.

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23. McDonald J, Janz S. The Acupuncture Evidence Project: A Comparative Literature Review (Revised Edition). Brisbane: Australian Acupuncture and Chinese Medicine Association Ltd; 2017.
24. Moon SK, Whang YK, Park SU, Ko CN, Kim YS, Bae HS, Cho KH. Antispastic effect of electroacupuncture and moxibustion in stroke patients. Am J Chin Med. 2003;31(3):467-74. doi:10.1142/S0192415X03001077.
25. National Health and Medical Research Council. NHMRC additional levels of evidence and grades for recommendations for developers of guidelines. Table 3. NHMRC Evidence Hierarchy: designations of 'levels of evidence' according to type of research question (including explanatory notes). National Health and Medical Research Council; 2009.
26. National Institute of Neurological Disorders and Stroke. Stroke Rehabiliation Information. https://www.ninds.nih.gov/Disorders/All-Disorders/NINDS-Stroke-Information-Page/Stroke-Rehabilitation-Information.
27. National Stroke Association. Post-Stroke Conditions. 2018. http://www.stroke.org/we-can-help/survivors/stroke-recovery/post-stroke-conditions.
28. NIH Publication No. 14 1846. Post Stroke Rehabilitation. September 2014. https://stroke.nih.gov/materials/rehabilitation.htm.
29. Peng L, Zhang C, Zhou L, Zuo HX, He XK, Niu YM. Traditional manual acupuncture combined with rehabilitation therapy for shoulder hand syndrome after stroke within the Chinese healthcare system: a systematic review and meta-analysis. Clin Rehabil. 2018 Apr;32(4):429-439. doi:10.1177/0269215517729528
30. Rodriguez-Mansilla J, Espejo-Antunez L, Bustamante-Lopez AI. [Effectiveness of acupuncture in spasticity of the post-stroke patient. Systematic review]. Aten Primaria. 2016 Apr;48(4):226-34. doi:10.1016/j.aprim.2015.05.004.
31. Sharififar S, Shuster JJ, Bishop MD. Adding electrical stimulation during standard rehabilitation after stroke to improve motor function. A systematic review and meta-analysis. Ann Phys Rehabil Med. 2018 Sep;61(5):339-344. doi:10.1016/j.rehab.2018.06.005.
32. Stroke, TIA and Warning Signs. American Stroke Association Let's Talk About Stroke and Warning Signs. American Heart Association, 2018. https://www.stroke.org/-/media/stroke-files/about-stroke/treatment/stroke-tia-and-warning-signs-ucm_309532.pdf
33. Vados L, Ferreira A, Zhao S, Vercelino R, Wang S. Effectiveness of acupuncture combined with rehabilitation for treatment of acute or subacute stroke: a systematic review. Acupunct Med. 2015 Jun;33(3):180-7. doi:10.1136/acupmed-2014-010705.
34. Wang R, Li X, Zhou S, Zhang X, Yang K, Li X. Manual acupuncture for myofascial pain syndrome: a systematic review and meta-analysis. Acupunct Med. 2017 Aug;35(4):241-250. doi:10.1136/acupmed-2016-011176.
35. Wang Y, Shen J, Wang XM, Fu DL, Chen CY, Lu LY, Lu L, Xie CL, Fang JQ, Zheng GQ. Scalp acupuncture for acute ischemic stroke: a meta-analysis of randomized controlled trials. Evid Based Complement Alternat Med. 2012;2012:480950. doi:10.1155/2012/480950.
36. Winstein CJ, Stein J, Arena R, et al. Guidelines for adult stroke rehabilitation and recovery: a guideline for healthcare professionals from the American Heart Association/ American Stroke Association. Stroke 2016;47. Stroke. 2016 Jun;47(6):e98-e169. doi:10.1161/STR.0000000000000098.
37. Wu P, Mills E, Moher D, Seely D. Acupuncture in poststroke rehabilitation: a systematic review and meta-analysis of randomized trials. Stroke. 2010 Apr;41(4):e171-9. doi:10.1161/STROKEAHA.109.573576.
38. Xiang A, Cheng K, Shen X, Xu P, Liu S. The Immediate Analgesic Effect of Acupuncture for Pain: A Systematic Review and Meta-Analysis. Evid Based Complement Alternat Med. 2017;2017:3837194. doi:10.1155/2017/3837194.
39. Yang A, Wu HM, Tang JL, Xu L, Yang M, Liu GJ. Acupuncture for stroke rehabilitation. Cochrane Database Syst Rev. 2016 Aug 26;8:CD004131. doi:10.1002/14651858.CD004131.pub3.
40. Ye Q, Xie Y, Shi J, Xu Z, Ou A, Xu N. Systematic Review on Acupuncture for Treatment of Dysphagia after Stroke. Evid Based Complement Alternat Med. 2017;2017:6421852. doi:10.1155/2017/6421852.
41. Zhan J, Pan R, Zhou M, et al. Electroacupuncture as an adjunctive therapy for motor dysfunction in acute stroke survivors: a systematic review and meta-analyses. BMJ Open. 2018;8(1):e017153. Published 2018 Jan 24. doi:10.1136/bmjopen-2017-017153.

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42. Zhang JH, Wang D, Liu M. Overview of systematic reviews and meta-analyses of acupuncture for stroke. Neuroepidemiology. 2014;42(1):50-8. doi:10.1159/000355435.
43. Zhao JG, Cao CH, Liu CZ, Han BJ, Zhang J, Li ZG, Yu T, Wang XH, Zhao H, Xu ZH. Effect of acupuncture treatment on spastic states of stroke patients. J Neurol Sci. 2009 Jan 15;276(1-2):143-7. doi:10.1016/j.jns.2008.09.018.
44. Zheng H, Cao N, Yin Y, Feng W. Stroke recovery and rehabilitation in 2016: a year in review of basic science and clinical science. Stroke and Vascular Neurology. 2017;2(4):222-229. doi:10.1136/svn-2017-000069.
45. Zheng J, Wu Q, Wang L, Guo T. A clinical study on acupuncture in combination with routine rehabilitation therapy for early pain recovery of post-stroke shoulder-hand syndrome. Exp Ther Med. 2018 Feb;15(2):2049-2053. doi:10.3892/etm.2017.5659.

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ACU-11.2: Fibromyalgia (Now Excluded)

- There is insufficient evidence that acupuncture is an effective treatment for Fibromyalgia.
- As such, acupuncture treatment for this condition does not meet medical necessity criteria.

Definition

- According to diagnostic criteria for Fibromyalgia Syndrome published by the 2016 American College of Rheumatology, fibromyalgia patients must have all of the following:
  - Widespread pain index (WPI) ≥7 and symptom severity scale (SSS) score ≥5 OR WPI 4–6 and SSS score ≥9.
  - Generalized pain, defined as pain in at least 4 of 5 regions, is present.
  - Symptoms have been present at a similar level for at least 3 months.
  - A diagnosis of fibromyalgia is valid irrespective of other diagnoses. A diagnosis of fibromyalgia does not exclude the presence of other clinically important illnesses.

Oriental Medicine Diagnoses

- Qi and Blood Stagnation
  - Stagnation results in pain; may have numerous causations; can be related to trauma or underlying syndromes.
- Spleen Qi Deficiency resulting in Damp
  - Causation by external pathogens, inappropriate lifestyle choices that result in damp and Qi Deficiency, stress.
- Yin Deficiency
  - Causation by external pathogens, inappropriate lifestyle choices that result in yin deficiency, stress.
- Kidney Yang, Essence and Yuan Qi Deficiency
  - Causation by long term illness, long term inappropriate lifestyle choices, congenital weakness in Kidney Yang, Essence, and Yuan Qi.

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History

Specific Aspects of History

- Fibromyalgia is a diagnosis of exclusion, and most patients presenting with this diagnosis will already have consulted with several MD's. If not, however, the patient should be directed to see their PCP at their earliest opportunity. There is a high incidence of clinical depression among fibromyalgia patients. The fatigue, pain, and depression typical of fibromyalgia may also be indications of several other serious conditions which should be ruled out. Several of these are listed in the Red Flag table and in the list of Differential Diagnoses below.
- Rule out red flags (require medical management).
- Identify co-morbidities requiring medical management, and those that affect acupuncture and Oriental Medicine management.
- Determine if trauma-related; determine nature and extent of traumatic event.

Red Flag	Possible Consequence or Cause	Action Required
Chronic fatigue	Systemic illnesses including cancer, hepatitis, lupus, Lyme Disease, viral or bacterial infection, allergies or sensitivities, cardiac disease, hypothyroidism, and psychological illness	Prompt referral to Primary Care Provider
Chronic pain	Infection, rheumatoid arthritis, lupus, Lyme Disease, and others	Prompt referral to Primary Care Provider
Depression	May be a symptom of fibromyalgia, or a response to the chronic illness. Can be life threatening in severe cases.	Prompt referral to Primary Care Provider
Digestive complaints	May be a symptom of fibromyalgia, or may be caused by celiac disease, food intolerance or sensitivities, chemical sensitivities, or cancer.	Prompt referral to Primary Care Provider
Chest pain	May be symptom of fibromyalgia, or a sign of cardiac disease.	Immediate referral to emergency department

Presentation

Often occurs in areas of muscles that previously experienced cumulative or sudden onset trauma. Subsequent acute manifestations are typically precipitated by exposure to cold, or by overstretching/overloading the same region of muscle frequently seen in people with poor posture.

Subjective Findings

- Dull aching pains in the muscle rather than the joints
- Patient may complain of a diffuse area of pain/stiffness covering an area adjacent to main area of complaint
- Pain should be documented as a numeric pain scale 0-10
- May report "knots" or "bumps" in the involved muscles
- There is a high incidence of clinical depression among fibromyalgia patients.

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Functional Assessment

- Documentation of a patient's level of function is an important aspect of patient care. This documentation is required in order to establish the medical necessity of ongoing acupuncture treatment. The Patient Specific Functional Scale (PSFS) is a patient reported outcome assessment that is easy and appropriate for acupuncturists to use. The PSFS has been studied in peer-reviewed scientific literature, and it has been proven to be a valid, reliable, and responsive measure for a variety of pain syndromes (neck, back, knee, etc.).

Objective Findings

Scope of Musculoskeletal Examination

- Inspection including Oriental Medicine inspection techniques
- Palpation of bony and soft tissue including Oriental Medicine palpation techniques
- Range of motion
- Orthopedic and neurologic testing if complaints radiate to extremities or signs/symptoms of cauda equina syndrome are present (where allowed by law)

Specific Aspects of Examination for Myositis

Examine the musculoskeletal system for possible causes or contributing factors to the complaint.

Findings of Myositis

- Involved muscle is generally resistant to stretching, limited by pain
- Tender nodules or areas of ropiness are noted in involved muscle group
- These nodular areas are tender to palpation and may elicit a "jump sign" or a "quickening reaction"
- Sensitized areas are generally called trigger points, and if active, palpation may lead to referral of pain

Differential Diagnoses

- Myofascial Pain Syndrome
- Chronic Fatigue Syndrome
- Radiculopathy
- Osteoarthritis
- Rheumatoid Arthritis
- Systemic lupus erythematosus
- Ankylosing spondylitis
- Hypothyroidism

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- Lupus
- Systemic illnesses including cancer
- Lyme Disease
- Viral or bacterial infection
- Mental illness, including depression
- Cardiac disease
- Sensitivity or intolerance to chemicals or foods

Oriental Medicine Management [20, 32]

There is insufficient evidence that acupuncture is an effective treatment for Fibromyalgia. As such, acupuncture treatment for this condition does not meet medical necessity criteria.

Alternatives to Oriental Medicine Management

(listed in alphabetical order)

- Chiropractic
- Dietary/Nutritional Medicine Counseling
- Injection therapy/Pain management
- Massage therapy
- Medication
- Occupational therapy
- Osteopathic Manipulation
- Pain management program
- Physical Therapy
- Physiatry
- Psychological counseling

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References

1. Aman MM, Jason Yong R, Kaye AD, Urman RD. Evidence-Based Non-Pharmacological Therapies for Fibromyalgia. Curr Pain Headache Rep. 2018 Apr 4;22(5):33. doi:10.1007/s11916-018-0688-2.
2. Amezaga Urruela M, Suarez-Almazor ME. Acupuncture in the treatment of rheumatic diseases. Curr Rheumatol Rep. 2012;14(6):589-597. doi:10.1007/s11926-012-0295-x.
3. Balshem H, Helfand M, Schunemann HJ, Oxman AD, Kunz R, Brozek J, et al. GRADE guidelines: 3. Rating the quality of evidence. J Clin Epidemiol. 2011 Apr;64(4):401-6. doi:10.1016/j.jclinepi.2010.07.015.
4. Cao H, Liu J, Lewith GT. Traditional Chinese Medicine for treatment of fibromyalgia: a systematic review of randomized controlled trials. J Altern Complement Med. 2010 Apr;16(4):397-409. doi:10.1089/acm.2009.0599.
5. Cheng X, Deng L. Chinese Acupuncture and Moxibustion. Beijing: Foreign Language Press; 2010.
6. Deare JC, Zheng Z, Xue CC, Liu JP, Shang J, Scott SW, et al. Acupuncture for treating fibromyalgia. Cochrane Database Syst Rev. 2013(5):Cd007070. doi:10.1002/14651858.CD007070.pub2.
7. Ernst E. Musculoskeletal conditions and complementary/alternative medicine. Best Practice & Research Clinical Rheumatology. 2004;18(4):539-556. doi:10.1016/j.berh.2004.03.005.
8. Hempel S, Taylor SL, Solloway MR, Miake-Lye IM, Beroes JM, Shanman R, et al. VA Evidence-based Synthesis Program Reports. Evidence Map of Acupuncture. Washington (DC): Department of Veterans Affairs; 2014.
9. Horn KK, Jennings S, Richardson G, Vliet DV, Hefford C, Abbott JH. The patient-specific functional scale: psychometrics, clinimetrics, and application as a clinical outcome measure. J Orthop Sports Phys Ther. 2012 Jan;42(1):30-42. doi:10.2519/jospt.2012.3727.
10. Kaptchuk T. The Web That Has No Weaver. Contemporary Books. 2000.
11. Kelly RB. Acupuncture for pain. Am Fam Physician. 2009 Sep 1;80(5):481-4.
12. Kligler B, Nielsen A, Kohrrer C, Schmid T, Waltermaurer E, Perez E, Merrell W. Acupuncture Therapy in a Group Setting for Chronic Pain. Pain Med. 2017 Jun 8. doi:10.1093/pm/pnx134.
13. Lauche R, Cramer H, Hauser W, Dobos G, Langhorst J. A Systematic Overview of Reviews for Complementary and Alternative Therapies in the Treatment of the Fibromyalgia Syndrome. Evid Based Complement Alternat Med. 2015;2015:610615. doi:10.1155/2015/610615.
14. Li X, Wang R, Xing X, et al. Acupuncture for Myofascial Pain Syndrome: A Network Meta-Analysis of 33 Randomized Controlled Trials. Pain Physician. 2017 Sep;20(6):E883-E902.
15. Maciocia, G; The Foundations of Chinese Medicine: A Comprehensive Text; Churchill Livingstone, 2005.
16. MacPherson H, Vertosick EA, Foster NE, Lewith G, Linde K, Sherman KJ, et al. The persistence of the effects of acupuncture after a course of treatment: A meta-analysis of patients with chronic pain. Pain. 2016 Oct 17. doi:10.1097/j.pain.0000000000000747.
17. Magee, David J., Orthopedic Physical Assessment, Second Edition, W.B. Saunders Company, 2007.
18. Martin-Sanchez E, Torralba E, Díaz-Domínguez E, Barriga A, Martin JL. Efficacy of acupuncture for the treatment of fibromyalgia: systematic review and meta-analysis of randomized trials. Open Rheumatol J. 2009 Jun 16;3:25-9. doi:10.2174/1874312900903010025.
19. Mayhew E, Ernst E. Acupuncture for fibromyalgia--a systematic review of randomized clinical trials. Rheumatology (Oxford). 2007 May;46(5):801-4. doi:10.1093/rheumatology/kel406.
20. McDonald J, Janz S. The Acupuncture Evidence Project: A Comparative Literature Review (Revised Edition). Brisbane: Australian Acupuncture and Chinese Medicine Association Ltd; 2017.
21. National Health and Medical Research Council. NHMRC additional levels of evidence and grades for recommendations for developers of guidelines. Table 3. NHMRC Evidence Hierarchy: designations of 'levels of evidence' according to type of research question (including explanatory notes). National Health and Medical Research Council; 2009.
22. O'Connor J, Bensky D. Acupuncture: A Comprehensive Text. Chicago: Eastland Press; 1981.
23. Olson WH, Brumback RA, Gascon G, Iyer V; Handbook of Symptom Oriented Neurology; Year Book Medical Publishers, Inc.; 2002.
24. Porter, R; The Merck Manual, Merck, 2011.
25. Roy, S., Irvin, R., and Iverson, D; Sports Medicine, Prevention, Education, Management, and Rehabilitation, Benjamin Cummings, 1998.

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26. Shen YF, Younger J, Goddard G, Mackey S. Randomized clinical trial of acupuncture for myofascial pain of the jaw muscles. J Orofac Pain. 2009 Fall;23(4):353-9.
27. Wang R, Li X, Zhou S, Zhang X, Yang K, Li X. Manual acupuncture for myofascial pain syndrome: a systematic review and meta-analysis. Acupunct Med. 2017 Aug;35(4):241-250. doi:10.1136/acupmed-2016-011176.
28. Weinstein, S, and Buckwalter, J. Orthopaedics Principles and Their Applications. Lippincott, Williams, & Wilkins, 2005.
29. Xiang A, Cheng K, Shen X, Xu P, Liu S. The Immediate Analgesic Effect of Acupuncture for Pain: A Systematic Review and Meta-Analysis. Evid Based Complement Alternat Med. 2017;2017:3837194. doi:10.1155/2017/3837194.
30. Yang B, Yi G, Hong W, Bo C, Wang Z, Liu Y, et al. Efficacy of acupuncture on fibromyalgia syndrome: a meta-analysis. J Tradit Chin Med. 2014 Aug;34(4):381-91.
31. Yuan J, Purepong N, Hunter RF, Kerr DP, Park J, Bradbury I, McDonough S. Different frequencies of acupuncture treatment for chronic low back pain: an assessor-blinded pilot randomised controlled trial. Complement Ther Med. 2009 Jun;17(3):131-40. doi:10.1016/j.ctim.2008.10.003.
32. Zhang XC, Chen H, Xu WT, Song YY, Gu YH, Ni GX. Acupuncture therapy for fibromyalgia: a systematic review and meta-analysis of randomized controlled trials. J Pain Res. 2019;12:527–542. Published 2019 Jan 30. doi:10.2147/JPR.S186227
33. Zhao HJ, Tan JY, Wang T, Jin L. Auricular therapy for chronic pain management in adults: A synthesis of evidence. Complement Ther Clin Pract. 2015 May;21(2):68-78. doi:10.1016/j.ctcp.2015.03.006.
34. Zotelli VL, Grillo CM, Gil ML, Wada RS, Sato JE, da Luz Rosário de Sousa M. Acupuncture Effect on Pain, Mouth Opening Limitation and on the Energy Meridians in Patients with Temporomandibular Dysfunction: A Randomized Controlled Trial. J Acupunct Meridian Stud. 2017 Oct;10(5):351-359. doi: 10.1016/j.jams.2017.08.005.

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ACU-11.3: Myalgia

Definition

Inflammation/irritation of muscle tissue, associated with focal points of tender nodules, which may refer pain to other areas of the body when palpated. Pain may be acute or chronic.

Oriental Medicine Diagnoses

- Qi and Blood Stagnation
  - Stagnation results in the painful condition; may have numerous causations; can be related to trauma or underlying syndromes.
- Spleen Qi Deficiency resulting in Damp
  - Causation by external pathogens, inappropriate lifestyle choices that result in damp and Qi deficiency, stress.
- Yin Deficiency resulting in Dampness
  - Causation by external pathogens, inappropriate lifestyle choices that result in damp and Yin Deficiency stress.
- Kidney Yang, Essence and Yuan Qi Deficiency
  - Causation by long term illness, long term inappropriate lifestyle choices, congenital weakness in Kidney Yang, Essence, and Yuan Qi.

Note: While the above pathways represent classical causations for a myalgia within the paradigm of Oriental Medicine diagnoses, they are not necessarily eligible for authorization or coverage under eviCore's acupuncture benefit plans. To be eligible for coverage and reimbursement, myalgia symptoms and/or a diagnosis of "myalgia" must be the direct result of a primary neuromusculoskeletal injury or illness.

History

Specific Aspects of History

- Rule out red flags (require medical management).
- Identify co-morbidities requiring medical management, and those that affect acupuncture and Oriental Medicine management.
- Determine if trauma-related; determine nature and extent of traumatic event.

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Red Flag	Possible Consequence or Cause	Action Required
Severe trauma	Fracture	Immediate referral to emergency department
Fever, severe pain	Possible infection	Immediate referral to emergency department
Unilateral edema	Possible deep vein thrombosis	Immediate referral to emergency department
Immune-compromised state	Infection	Prompt referral to Primary Care Provider
Cancer history	Cause of symptoms (metastatic or primary)	Prompt referral to Primary Care Provider
Discoloration of skin	Vascular occlusion, shunt emboli (dialysis patients)	Immediate referral to emergency department
Exertional symptoms, history of cardiac disease	Anginal equivalent	Immediate referral to emergency department
Multiple joint involvement, tophi	Rheumatological conditions, gout	Prompt referral to Primary Care Provider

Presentation

Often occurs in areas of muscles that previously experienced cumulative or sudden onset trauma. Subsequent acute manifestations are typically precipitated by exposure to cold, or by overstretching/overloading the same region of muscle frequently seen in people with poor posture.

Subjective Findings

- Dull aching pains in the muscle rather than the joints
- Patient may complain of a diffuse area of pain/stiffness covering an area adjacent to main area of complaint
- May report "knots" or "bumps" in the involved muscles
- Pain should be documented as a numeric pain scale 0-10

Functional Assessment

- Documentation of a patient's level of function is an important aspect of patient care. This documentation is required in order to establish the medical necessity of ongoing acupuncture treatment. The Patient Specific Functional Scale (PSFS) is a patient reported outcome assessment that is easy and appropriate for acupuncturists to use. The PSFS has been studied in peer-reviewed scientific literature, and it has been proven to be a valid, reliable, and responsive measure for a variety of pain syndromes (neck, back, knee, etc.).

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Objective Findings

Scope of Musculoskeletal Examination

- Inspection including Oriental Medicine inspection techniques
- Palpation of bony and soft tissue including Oriental Medicine palpation techniques
- Range of motion
- Orthopedic and neurologic testing if complaints radiate to extremities or signs/symptoms of cauda equina syndrome are present (where allowed by law)

Specific Aspects of Examination for Myositis

Examine the musculoskeletal system for possible causes or contributing factors to the complaint.

Findings of Myositis

- Involved muscle is generally resistant to stretching, limited by pain
- Tender nodules or areas of ropiness are noted in involved muscle group
- These nodular areas are tender to palpation and may elicit a "jump sign" or a “quickening reaction."
- Sensitized areas are generally called trigger points, and if active, palpation may lead to referral of pain

Differential Diagnoses

- Fibromyalgia
- Chronic Fatigue Syndrome
- Radiculopathy
- Osteoarthritis
- Rheumatoid Arthritis
- Systemic lupus erythematosus
- Ankylosing spondylitis

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Oriental Medicine Management [8, 19, 21]

- Oriental Medicine management goals are to resolve pain, restore the highest level of function possible, and educate patient to prevent recurrent symptoms.
- To be considered medically necessary, patient's symptoms must be the direct result of a primary neuromusculoskeletal injury or illness.
- Confirmation of appropriate medical co-management is always required when treating children age 14 and under.
- Treatment frequency should be commensurate with severity of the chief complaint.
- When significant improvements in patient's subjective findings and objective findings are demonstrated—continued treatment with decreased frequency is appropriate.
- As treatment progresses, one should see an increase in the active regimen of care, a decrease in the passive regimen of care, and a fading of treatment frequency.
- If the condition has not progressed towards resolution, refer the patient to an appropriate health care provider to explore other treatment alternatives.
- eviCore's consideration of requests for continued acupuncture treatment depends on updated clinical information submitted regarding patient's progress.
- Adequate and legible patient progress information that contains a history and examination, and/or eviCore's Acupuncture Treatment Request Form is required to determine medical necessity.
- In addition to the improvements in the table below, significant progress may be documented by increases in functional capacity and increasingly longer durations of pain relief.
- Discharge occurs when reasonable functional goals and expected outcomes have been achieved.
- The patient is discharged when the patient/care-giver can continue management of symptoms with an independent home program.
- Treatment is discontinued when the patient is unable to progress towards outcomes because of medical complications, psychosocial factors or other personal circumstances.
- If the member has been non-compliant with treatment as is evidenced by the clinical documentation, and/or the lack of demonstrated progress, treatment will be deemed to be not medically necessary and the member should be discharged from treatment.

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Week	Progress
0-1	◆ Some reduction of pain frequency and severity ◆ Some reduction of muscle spasm
2-4	◆ 50% decrease in pain severity and frequency ◆ 50% improvement in function
5-8	◆ 75% decrease in pain severity and frequency ◆ 75% improvement in function
9-12	◆ Gradual improvement leading toward resolution ◆ Reinforce self-management techniques ◆ Discharge patient to elective care, or to their primary care provider for alternative treatment options when a plateau is reached, or by week 12, whichever occurs first

Appropriate Procedures/Modalities

- Acupuncture
- Electro-acupuncture
- Cupping
- Moxibustion
- Gua Sha
- Myofascial release
- Acupressure
- Trigger point massage
- Tui Na (not to include osseous manipulation)
- Herbal formulas

Note: Not all of these modalities are covered by the patient's health-plan; review documentation regarding coverage. Acupuncture and herbs must be appropriate for covered diagnoses under the patient's insurance policy. Acupuncturist is responsible for determining which procedures/modalities are most appropriate for the patient's condition.

Inappropriate Procedures/Modalities

- Direct moxa
- Scarring moxa
- Applied kinesiology techniques
- Electro-acupuncture using more than 9 volts
- Any technique outside the scope of practice in your state.

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Self-Management Techniques

- Rest and reduce strenuous activities
- Ergonomics, Postural advice, postural exercises
- Appropriate exercises/stretching
- Tai Qi, Qi Gong, Yoga
- Stress management, meditation
- Joint protection
- Weight loss
- Self-massage, Self-acupressure
- Hot packs/cold packs, if needed, to relieve discomfort
- Dietary changes that would support treatment of underlying syndrome

Alternatives to Oriental Medicine Management

(listed in alphabetical order)

- Chiropractic
- Dietary/Nutritional Medicine Counseling
- Injection therapy/Pain management
- Massage therapy
- Medication
- Occupational therapy
- Osteopathic Manipulation
- Physical Therapy
- Psychological counseling

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References

1. Balshem H, Helfand M, Schunemann HJ, Oxman AD, Kunz R, Brozek J, et al. GRADE guidelines: 3. Rating the quality of evidence. J Clin Epidemiol. 2011 Apr;64(4):401-6. doi:10.1016/j.jclinepi.2010.07.015.
2. Cheng X, Deng L. Chinese Acupuncture and Moxibustion. Beijing: Foreign Language Press; 2010.
3. Hempel S, Taylor SL, Solloway MR, Miake-Lye IM, Beroes JM, Shanman R, et al. VA Evidence-based Synthesis Program Reports. Evidence Map of Acupuncture. Washington (DC): Department of Veterans Affairs; 2014.
4. Horn KK, Jennings S, Richardson G, Vliet DV, Hefford C, Abbott JH. The patient-specific functional scale: psychometrics, clinimetrics, and application as a clinical outcome measure. J Orthop Sports Phys Ther. 2012 Jan;42(1):30-42. doi:10.2519/jospt.2012.3727.
5. Kaptchuk T. The Web That Has No Weaver. Contemporary Books. 2000.
6. Kelly RB. Acupuncture for pain. Am Fam Physician. 2009 Sep 1;80(5):481-4.
7. Kligler B, Nielsen A, Kohrrer C, Schmid T, Waltermaurer E, Perez E, Merrell W. Acupuncture Therapy in a Group Setting for Chronic Pain. Pain Med. 2017 Jun 8. doi:10.1093/pm/pnx134.
8. Li X, Wang R, Xing X, et al. Acupuncture for Myofascial Pain Syndrome: A Network Meta-Analysis of 33 Randomized Controlled Trials. Pain Physician. 2017 Sep;20(6):E883-E902.
9. Maciocia, G; The Foundations of Chinese Medicine: A Comprehensive Text; Churchill Livingstone, 2005.
10. MacPherson H, Vertosick EA, Foster NE, Lewith G, Linde K, Sherman KJ, et al. The persistence of the effects of acupuncture after a course of treatment: A meta-analysis of patients with chronic pain. Pain. 2016 Oct 17. doi:10.1097/j.pain.0000000000000747.
11. Magee, David J., Orthopedic Physical Assessment, Second Edition, W.B. Saunders Company, 2007.
12. McDonald J, Janz S. The Acupuncture Evidence Project: A Comparative Literature Review (Revised Edition). Brisbane: Australian Acupuncture and Chinese Medicine Association Ltd; 2017. Date last accessed 01/15/18.
13. National Health and Medical Research Council. NHMRC additional levels of evidence and grades for recommendations for developers of guidelines. Table 3. NHMRC Evidence Hierarchy: designations of 'levels of evidence' according to type of research question (including explanatory notes). National Health and Medical Research Council; 2009.
14. O'Connor J, Bensky D. Acupuncture: A Comprehensive Text. Chicago: Eastland Press; 1981.
15. Olson WH, Brumback RA, Gascon G, Iyer V; Handbook of Symptom Oriented Neurology; Year Book Medical Publishers, Inc.; 2002.
16. Porter, R; The Merck Manual, Merck, 2011.
17. Roy, S., Irvin, R., and Iverson, D; Sports Medicine, Prevention, Education, Management, and Rehabilitation, Benjamin Cummings, 1998.
18. Shen YF, Younger J, Goddard G, Mackey S. Randomized clinical trial of acupuncture for myofascial pain of the jaw muscles. J Orofac Pain. 2009 Fall;23(4):353-9.
19. Wang R, Li X, Zhou S, Zhang X, Yang K, Li X. Manual acupuncture for myofascial pain syndrome: a systematic review and meta-analysis. Acupunct Med. 2017 Aug;35(4):241-250. doi:10.1136/acupmed-2016-011176.
20. Weinstein, S, and Buckwalter, J. Orthopaedics Principles and Their Applications. Lippincott, Williams, & Wilkins, 2005.
21. Xiang A, Cheng K, Shen X, Xu P, Liu S. The Immediate Analgesic Effect of Acupuncture for Pain: A Systematic Review and Meta-Analysis. Evid Based Complement Alternat Med. 2017;2017:3837194. doi:10.1155/2017/3837194.
22. Yuan J, Purepong N, Hunter RF, Kerr DP, Park J, Bradbury I, McDonough S. Different frequencies of acupuncture treatment for chronic low back pain: an assessor-blinded pilot randomised controlled trial. Complement Ther Med. 2009 Jun;17(3):131-40. doi:10.1016/j.ctim.2008.10.003.
23. Zhao HJ, Tan JY, Wang T, Jin L. Auricular therapy for chronic pain management in adults: A synthesis of evidence. Complement Ther Clin Pract. 2015 May;21(2):68-78. doi:10.1016/j.ctcp.2015.03.006.
24. Zotelli VL, Grillo CM, Gil ML, Wada RS, Sato JE, da Luz Rosário de Sousa M. Acupuncture Effect on Pain, Mouth Opening Limitation and on the Energy Meridians in Patients with Temporomandibular Dysfunction: A Randomized Controlled Trial. J Acupunct Meridian Stud. 2017 Oct;10(5):351-359. doi:10.1016/j.jams.2017.08.005.

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ACU-12.0: Non-Musculoskeletal Conditions

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ACU-12.1: Adjunct Cancer Care

Synonyms

- Cancer pain [15]
- Aromatase-inhibitor induced arthralgia [28]
- Cancer-related fatigue [42]
- Chemotherapy-related nausea

Definitions

Cancer pain: The type and stage of cancer are primary factors influencing cancer pain. Pain is most often caused by the cancer itself pressing on bones, nerves, or body organs. Pain may be acute or chronic. Breakthrough pain may occur despite use of pain medication. Pain may also be caused by cancer testing and treatment procedures including surgery, chemotherapy and radiation.

Aromatase-inhibitor induced arthralgia: Aromatase inhibitors (AI) are often used in estrogen receptor-positive (ER+) breast cancer therapy. Up to half of women on AI therapy experience joint pain, and up to 20% are non-compliant due to the joint pain. Aromatase-inhibitor induced arthralgia generally presents as symmetrical joint pain in the wrists, hands and knees; there may be morning stiffness, myalgia, decreased grip strength, carpal tunnel syndrome or trigger finger. AI therapy is often continued up to 5 years. Time to symptom onset ranges from a few weeks up to 10 months. The median time to onset is 1.6 months, with symptoms generally peaking at about 6 months. Risk factors include obesity, osteoarthritis, history of hormone replacement therapy, or chemotherapy.

Cancer-related fatigue: Cancer-related fatigue is worse than everyday fatigue. It lasts longer and sleep doesn't make it better. Many people with cancer say fatigue is the most distressing side effect of cancer and its treatment. It can be overwhelming and affect every aspect of life. It may be accompanied by weakness, difficulty concentrating or remembering things, or depression. Cancer-related fatigue can continue even after cancer treatment ends. Factors contributing to cancer-related fatigue may include: changes in normal protein and hormone levels, excess of toxic substances and/or cellular waste, pain, stress, lack of sleep, lack of nourishment, anemia, dehydration, lack of exercise, medication side effects, or concurrent medical conditions. Any other medical causes of fatigue should be ruled out.

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Chemotherapy-related nausea: Acute nausea and vomiting is most common about 5-6 hours after chemotherapy and usually resolves within 24 hours. Delayed nausea and vomiting may occur for up to 5-7 days after chemotherapy. Anticipatory nausea and vomiting is a conditioned response in which nausea or vomiting occur before the chemotherapy due to previous experiences. Not everyone will experience chemotherapy related nausea and vomiting. The severity of these symptoms depends mostly on the type, dosage, method and frequency of the chemotherapy. Other risk factors include: history of motion sickness, history of morning sickness, history of previous chemotherapy, high levels of anxiety or nervousness. Anti-emetic drugs will be prescribed based on risk factors. If breakthrough nausea and vomiting occur, different or additional anti-emetic medication may be needed.

Oriental Medicine Diagnoses

Pain is caused by blockages, or Painful Obstruction, in Chinese Medicine. Commonly referred to as Bi Syndrome, pain conditions can be any combination of the following:

- Wind Bi, Moving (Wind) Painful Obstruction
  - Pain in the joints is widespread and moves from one area of the body to another.
- Damp Bi, Stationary (Damp) Painful Obstruction
  - Pain is localized and does not move.
- Cold Bi, Painful (Cold) Painful Obstruction
  - Severe pain in one part, or over one half of the body, which becomes worse when patient encounters cold and diminishes when patient is warm.
- Heat Bi, Heat Painful Obstruction
  - Flesh is hot, area of pain is red and swollen, pain increases upon contact.
  - Nausea related to chemotherapy is typically one of these patterns:
- Liver attacking Stomach
  - Liver Qi stagnation and Heat are caused by the chemotherapy drugs, causing the Liver to attack the Stomach, and leading to rebellious Stomach Qi. Causation is due to chemotherapy treatment.
- Yin Deficiency of Liver and Stomach
  - The Heat and Toxin inherent in the chemotherapy drugs dry out the Yin of the Liver and Stomach, leading to rebellious Stomach Qi. Causation is due to chemotherapy treatment.
- Stomach Heat
  - The Heat and Toxin inherent in the chemotherapy drugs cause heat to build up in the Stomach, leading to rebellious Stomach Qi. Causation is due to chemotherapy treatment.

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Cancer-related fatigue is often a complex combination of pathologies rooted in:

- Deficiency of Qi and/or Blood
  - Lack of nourishment, stress, insomnia, pain, toxicity, anemia and stagnation can all contribute to Deficient Qi and Blood patterns. This can be caused directly by the cancer, by cancer treatment and by lifestyle and coping mechanisms when dealing with cancer. Most cancer patients will have multiple pathologies contributing Qi and/or Blood Deficiency, which are mutually antagonizing conditions. Symptoms may be systemic, or correlate with specific organ pathologies according to the patient's underlying constitution, type of cancer and type of treatments.
- Spleen Qi Deficiency
  - The Spleen Qi transforms and transports food and fluids, replenishes Nutritive Qi and generates of Blood. Weakness of Spleen Qi can directly lead to deficiency of Qi and Blood and ultimately fatigue. Spleen Qi is damaged by worry, irregular diet, chemotherapy, and chronic disease.

History

Patients seeking acupuncture as an adjunct therapy should already be engaged in a comprehensive treatment program as directed by the oncologist and cancer care team. Common cancer treatments include: surgery, chemotherapy or targeted drug therapy, radiation therapy and immunotherapy. Other treatments include: stem cell therapy, blood transfusions, radiofrequency ablation and laser therapy. Symptoms experienced can vary widely according to the type and stage of cancer and treatments pursued. All cancer patients face the emotional challenges of cancer diagnosis, choosing and enduring a cancer treatment plan.

Additional Information Required

- Authorization requests for adjunct cancer care must include additional information. Patients seeking acupuncture as an adjunct therapy should already be engaged in a comprehensive treatment program as directed by the oncologist and cancer care team. While adjunctive acupuncture may ease symptoms during a cancer treatment program, it is not an equivalent or replacement for any aspect of the standard treatment program. Confirmation of participation in the cancer care program recommended by the oncologist and cancer care team is required. Acupuncture that may delay or replace needed medical care does not meet medical necessity criteria.
- Additional information must include:
- Confirmation of participation in the treatment program recommended by the oncologist and cancer care team
- Detailed current symptomatic evaluation of the symptom(s) treated with acupuncture
- Clear description of progress since the last authorization request
- Dates of previous and upcoming surgery, chemotherapy, radiation treatments should be noted

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Specific Aspects of History

- Rule out red flags (requires medical management).
- Identify co-morbidities requiring medical management, and those that affect acupuncture and Oriental Medicine management.
- Dates of previous and upcoming surgery, chemotherapy, radiation treatments should be noted
- Regardless of any red flags, confirmation of medical evaluation and appropriate medical co-management should be confirmed before initiating a course of acupuncture. Optimal levels of cancer recovery occur in the context of the comprehensive and multimodal care program designed by physicians and therapists specializing in cancer care. Acupuncture that may delay or replace needed medical care does not meet medical necessity criteria.

Red Flag	Possible Consequence or Cause	Action Required
New or worsening pain; new symptoms such as unable to walk, eat or urinate	Metastasis or recurrence	Prompt referral to Oncologist
Constipation, nausea, confusion, dizziness, unable to wake up or stay awake, unable to take prescribed medications, questions about how to take prescribed medications	Side effects of medication or change in medication	Prompt referral to Oncologist
Doesn't get pain relief from medication; relief doesn't last long enough; breakthrough pain; grimacing, moaning or reluctance to move	May need medication adjustment	Prompt referral to Oncologist
Fast heart rate, shortness of breath, trouble breathing with activity, dizziness, pale skin or nails beds, fatigue	Anemia	Prompt referral to Oncologist
Vomits more than 3 times per hour for 3 or more hours; cannot take in more than 4 cups of liquid in a day or can't eat for more than 2 days; loses 2 or more pounds in 1-2 days; decreased or dark urine; becomes dizzy, weak or confused	Dehydration	Prompt medical referral; Referral for immediate care for severe or prolonged dehydration
Swelling, pain, redness, cramping or soreness in the leg, especially the calf. Sudden shortness of breath, chest pain that worsens with cough or inhalation, rapid pulse, hemoptysis.	Deep Vein Thrombosis, Pulmonary Embolism	Immediate referral to emergency department

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Red Flag	Possible Consequence or Cause	Action Required
Impaired mobility, impaired gait, low muscle strength, poor balance, osteoporosis, older age, nutritional deficiency; severe pain, bruising, swelling	Fracture or other injury caused by fall	Immediate referral to emergency department if fracture is suspected and/or anticoagulant medication is used
Temporary confusion or staring spells, repetitive movements such as blinking or hand rubbing with or without loss of consciousness, sudden body twitching or jerking, collapse, loss of consciousness.	Seizure	Immediate referral to emergency department
Severe disability or pain, terminal illness, family history of psychiatric disorder, female, anxiety, lack of physical exercise, lack of motivation to participate in cancer care program	Depression	Prompt referral to Primary Care Provider National Suicide Prevention Lifeline is available 24 hours every day 1-800-273-8255.
Fever, immune compromised state, intravenous drug use	Infection	Prompt referral to Primary Care Provider
Headache associated with diastolic blood pressure greater than 110 mm/Hg, Exertional pain, history of CAD	Cardiac condition	Immediate referral to emergency department
Suspicion of drug or alcohol dependence	Side effect or withdrawal phenomenon	Immediate referral to emergency department

Subjective Findings

Cancer-related symptoms vary widely according to the type and location of malignancy and the cancer treatment plan. Symptoms may include:

- Pain, numbness or tingling
- Pain should be assessed using a **0-10 pain scale**
- Difficulty sleeping or getting comfortable
- Fatigue
- Nausea and/or vomiting
- Less ability to move around and/or do things
- Lack of interest in things previously enjoyed

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- **The Quality of Life Scale (QOLS)** is a reliable and valid instrument for measuring quality of life from the perspective of the patient with chronic illness. For populations with chronic disease, measurement of QOL provides a meaningful way to determine the impact of health care when cure is not possible. The QOLS is a 16 item questionnaire that can be completed in about 5 minutes. A seven-point response scale is used to answer each question; final score tally can range from 16-112. QOLS can respond to change as a result of specific treatments, and can be used for adults across gender, cultural and language groups.

Functional Assessment

- Documentation of a patient's level of function is an important aspect of patient care. This documentation is required in order to establish the medical necessity of ongoing acupuncture treatment. The **Patient Specific Functional Scale (PSFS)** is a patient reported outcome assessment that is easy and appropriate for acupuncturists to use. The PSFS has been studied in peer-reviewed scientific literature, and it has been proven to be a valid, reliable, and responsive measure for a variety of pain syndromes (neck, back, knee, etc.). The PSFS could be adapted to describe the level which pain, insomnia, fatigue or nausea affect specific activities.

Objective Findings

Scope of Exam:

- Inspection including Oriental Medicine inspection techniques
- Measure blood pressure, pulse rate, temperature
- Functional assessments corresponding to the subjective complaints treated with acupuncture

Specific Aspects of Examination for Cancer-related Symptoms

- Confirm current medical evaluation and diagnosis. Medical co-management with an MD is required. Acupuncture that may delay or replace needed medical care does not meet medical necessity criteria.
- Dates of previous and upcoming surgery, chemotherapy, radiation treatments should be noted
- Rule out other possible causes of symptoms (via medical co-management with MD).
- Referral back to MD if any red flags are present, if any symptoms worsen or new symptoms develop.

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Differential Diagnoses for Cancer-related Symptoms

- Metastasis
- Stroke
- Anemia
- Infection
- Musculoskeletal injury
- Dehydration or electrolyte imbalance
- Food-borne illness
- Reaction to medication
- Depression
- Other underlying conditions

*Patients seeking acupuncture for adjunctive cancer care should already have a confirmed diagnosis, and already be participating in a treatment program with cancer care specialists.

Oriental Medicine Management [5, 28, 41, 42, 45]

- Patients seeking acupuncture as an adjunct therapy should already be engaged in a comprehensive cancer care program as directed by the oncologist and cancer care team. While adjunctive acupuncture may ease the symptoms of a cancer care program, it is not an equivalent or replacement for any aspect of the standard cancer care program. Confirmation of participation in the cancer care program as recommended by the oncologist and care team is required.
- Acupuncture that may delay or replace needed medical care does not meet medical necessity criteria.
- Oriental Medicine management goals are to help reduce or resolve symptoms, help restore the highest level of function possible and help educate patient to reduce or prevent recurrent symptoms.
- Treatment frequency should be commensurate with the severity of the chief complaint, natural history of the condition, and expectation for functional improvement.
- When significant improvements in patient's subjective findings and objective findings are demonstrated—continued treatment with decreased frequency is appropriate.
- As treatment progresses, one should see an increase in the effective use of coping mechanisms, a decrease in the dependence on acupuncture services, and a fading of treatment frequency.
- If the condition has not progressed towards resolution, refer the patient to an appropriate health care provider to explore other treatment alternatives.

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- eviCore's consideration of requests for continued acupuncture treatment depends on updated clinical information submitted regarding patient's progress.
- Adequate and legible patient progress information that contains a history and examination, and/or eviCore's Treatment Request Form for each treatment is required to determine medical necessity.
- In addition to the improvements in the table below, significant progress may be documented by increases in functional capacity and increasingly longer durations of symptomatic relief.
- Discharge occurs when reasonable functional goals and expected outcomes have been achieved.
- The patient is discharged when the patient/care-giver can continue management of symptoms with an independent home program.
- Treatment is discontinued when the patient is unable to progress towards outcomes because of medical complications, psychosocial factors or other personal circumstances.
- If the member has been non-compliant with treatment as is evidenced by the clinical documentation, and/or the lack of demonstrated progress, treatment will be deemed to be not medically necessary and the member should be discharged from treatment.

Week	Progress
0-3	◆ Some reduction of symptom severity and frequency ◆ Ensure recent medical evaluation and appropriate co-management with oncologist and cancer care specialists
4-6	◆ At least 20-30% improvement in symptom severity and frequency ◆ Reinforce self-management techniques ◆ Reinforce continued medical co-management with oncologist and cancer care specialists
7-12	◆ At least 40-60% improvement in symptom severity and frequency ◆ Reinforce self-management techniques ◆ Reinforce continued medical co-management with oncologist and cancer care specialists
*13+	◆ *Cancer treatment and recovery time frame varies greatly depending on type, location and stage of cancer ◆ Continued acupuncture is merited with 20% progressive improvement monthly after cancer treatment has concluded ◆ Continued symptomatic relief until surgery / chemotherapy is completed ◆ If at least 20-30% symptomatic relief is not achieved, the patient should be referred back to the oncologist to explore more clinically significant treatment options ◆ Reinforce self-management techniques ◆ Reinforce continued medical co-management with oncologist and cancer care specialists

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Referral & Medical Co-Management Guidelines

- Refer patient to their Medical Doctor and/or Licensed Psychological Practitioner for evaluation of alternative treatment options if:
  - Confirmation of compliance with oncologist's current treatment plan is not provided.
  - There is refusal or inability to participate in other aspects of the cancer care program designed by the oncologist and care team.
  - There are signs of depression or ANY indication of thoughts or plans for self-harm. The National Suicide Prevention Lifeline is available 24 hours every day, call 1-800-273-8255.
  - There is significant worsening of the patient's complaint.
  - The patient shows additional complaints.
  - The patient has not responded positively to treatment after a couple of weeks.

Appropriate Procedures/Modalities

- Acupuncture
- Electro-acupuncture
- Herbal formulas

Note: Not all of these modalities are covered by patient's health-plan; review documentation regarding coverage. Acupuncture and herbs must be appropriate for covered diagnoses under the patient's insurance policy. Acupuncturist is responsible for determining which procedures/modalities are most appropriate for the patient's condition.

Inappropriate Procedures/Modalities

- Scarring moxa
- Electro-acupuncture using more than 9 volts
- Any techniques outside of the scope of practice in your state

Self-Management Techniques

- Relaxation / Stress Management
- Meditation
- Distraction
- Imagery
- Hot/Cold Packs, if recommended by your doctor
- Menthol or topical pain
- Transcutaneous electrical nerve stimulation (TENS)
- Good sleep hygiene

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- Adequate rest, short naps or breaks as needed
- Support Group
- Stay as active as possible
- Good nutrition and hydration
- Accept help from family and/or friends
- Self-hypnosis
- Progressive muscle relaxation
- Eat small but frequent meals
- Cold, bland, tart or sour foods, clear liquids or ice chips may be better during nausea

Alternatives to Oriental Medicine

(listed in alphabetical order)

- Biofeedback
- Counseling
- Massage Therapy
- Medication
- Occupational Therapy
- Oncology Care Plan
- Pain Management / Injection Therapy
- Physical Therapy
- Registered Dietician's Nutritional Plan
- Surgery

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References

1. Alimi D, Rubino C, Pichard-Leandri E, Fermand-Brule S, Dubreuil-Lemaire M, Hill C. Analgesic effect of auricular acupuncture for cancer pain: a randomized, blinded, controlled trial. J Clin Oncol. 2003 Nov 15;21(22):4120-6. doi:10.1200/JCO.2003.09.011.
2. American Cancer Society, Inc. Cancer Pain. 2018. https://www.cancer.org/treatment/treatments-and-side-effects/physical-side-effects/pain.html.
3. American Cancer Society, Inc. Cancer-Related Fatigue. 2018. https://www.cancer.org/treatment/treatments-and-side-effects/physical-side-effects/fatigue/what-is-cancer-related-fatigue.html.
4. American Cancer Society, Inc. Nausea and Vomiting. 2018. https://www.cancer.org/treatment/treatments-and-side-effects/physical-side-effects/nausea-and-vomiting.html.
5. Balk J, Day R, Rosenzweig M, Beriwal S. Pilot, randomized, modified, double-blind, placebo-controlled trial of acupuncture for cancer-related fatigue.
6. Balshem H, Helfand M, Schunemann HJ, Oxman AD, Kunz R, Brozek J, et al. GRADE guidelines: 3. Rating the quality of evidence. J Clin Epidemiol. 2011 Apr;64(4):401-6.
7. Bao T, Cai L, Giles JT, et al. A dual-center randomized controlled double blind trial assessing the effect of acupuncture in reducing musculoskeletal symptoms in breast cancer patients taking aromatase inhibitors. Breast Cancer Res Treat 2013 Feb;138(1):167-74. doi:10.1016/j.jclinepi.2010.07.015.
8. Burckhardt CS, Anderson KL. The Quality of Life Scale (QOLS): reliability, validity, and utilization. Health Qual Life Outcomes. 2003 Oct 23;1:60. doi:10.1007/s10549-013-2427-z.
9. Chen H, Liu TY, Kuai L, Zhu J, Wu CJ, Liu LM. Electroacupuncture treatment for pancreatic cancer pain: a randomized controlled trial. Pancreatology. 2013 Nov-Dec;13(6):594-7. doi:10.1186/1477-7525-1-60.
10. Chen L, Lin CC, Huang TW, Kuan YC, Huang YH, Chen HC, Kao CY, Su CM, Tam KW. Effect of acupuncture on aromatase inhibitor-induced arthralgia in patients with breast cancer: A meta-analysis of randomized controlled trials. Breast. 2017 Jun;33:132-138. doi:10.1016/j.pan.2013.10.007.
11. Chen ZJ, Guo YP, Wu ZC. [Observation on the therapeutic effect of acupuncture at pain points on cancer pain]. Zhongguo Zhen Jiu. 2008 Apr;28(4):251-3. doi:10.1016/j.breast.2017.03.015.
12. Cheng CS, Chen LY, Ning ZY, Zhang CY, Chen H, Chen Z, Zhu XY, Xie J. Acupuncture for cancer-related fatigue in lung cancer patients: a randomized, double blind, placebo-controlled pilot trial. Support Care Cancer. 2017 Dec;25(12):3807-3814.
13. Chien TJ, Liu CY, Chang YF, Fang CJ, Hsu CH. Acupuncture for treating aromatase inhibitor-related arthralgia in breast cancer: a systematic review and meta-analysis. J Altern Complement Med. 2015 May;21(5):251-60. doi:10.1007/s00520-017-3812-7.
14. Chiu HY, Hsieh YJ, Tsai PS. Systematic review and meta-analysis of acupuncture to reduce cancer-related pain. Eur J Cancer Care (Engl). 2017 Mar;26(2). doi:10.1089/acm.2014.0083.
15. Crew KD, Capodice JL, Greenlee H, et al. Pilot study of acupuncture for the treatment of joint symptoms related to adjuvant aromatase inhibitor therapy in postmenopausal breast cancer patients. J Cancer Surviv 2007 Dec;1(4):283-91. doi:10.1111/ecc.12457.
16. Crew KD, Capodice JL, Greenlee H, et al. Randomized, blinded, sham-controlled trial of acupuncture for the management of aromatase inhibitor-associated joint symptoms in women with early-stage breast cancer. J Clin Oncol 2010 Mar 1;28(7):1154-60. doi:10.1007/s11764-007-0034-x.
17. Dang W, Yang J. Clinical study on acupuncture treatment of stomach carcinoma pain. J Tradit Chin Med. 1998 Mar;18(1):31-8. doi:10.1200/JCO.2009.23.4708.
18. Deng G, Chan Y, Sjoberg D, et al. Acupuncture for the treatment of post-chemotherapy chronic fatigue: a randomized, blinded, sham-controlled trial. doi:10.1007/s00520-013-1720-z.
19. Filshie J, Hester J. Guidelines for providing acupuncture treatment for cancer patients - a peer-reviewed sample policy document. Acupunct Med. 2006 Dec;24(4):172-82. doi:10.1136/aim.24.4.172.
20. He XR, Wang Q, Li PP. Acupuncture and moxibustion for cancer-related fatigue: a systematic review and meta-analysis. Asian Pac J Cancer Prev. 2013;14(5):3067-74. doi:10.7314/apjcp.2013.14.5.3067
21. Hempel S, Taylor SL, Solloway MR, Miake-Lye IM, Beroes JM, Shanman R, et al. VA Evidence-based Synthesis Program Reports. Evidence Map of Acupuncture. Washington (DC): Department of Veterans Affairs; 2014. doi:10.7314/apjcp.2013.14.5.3067

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22. Horn KK, Jennings S, Richardson G, Vliet DV, Hefford C, Abbott JH. The patient-specific functional scale: psychometrics, clinimetrics, and application as a clinical outcome measure. J Orthop Sports Phys Ther. 2012 Jan;42(1):30-42. doi:10.2519/jospt.2012.3727.
23. Hseuh CC, and O'Connor. Acupuncture - A Comprehensive Text. Eastland Press, 1981.
24. Johnston MF, Hays RD, Subramanian SK, et al. Patient education integrated with acupuncture for relief of cancerrelated fatigue randomized controlled feasibility study. BMC Complement Altern Med. 2011 Jun 25;11:49. doi:10.1186/1472-6882-11-49.
25. Kaptchuk T. The Web That Has No Weaver. Contemporary Books. 2000.
26. Kelly RB. Acupuncture for pain. Am Fam Physician. 2009 Sep 1;80(5):481-4.
27. Kim TH, Kang JW, Lee TH. Therapeutic options for aromatase inhibitor-associated arthralgia in breast cancer survivors: A systematic review of systematic reviews, evidence mapping, and network meta-analysis. Maturitas. 2018 Dec;118:29-37. doi:10.1016/j.maturitas.2018.09.005.
28. Lu W, Matulonis UA, Dunn JE, Lee H, Doherty-Gilman A, Dean-Clower E, et al. The Feasibility and Effects of Acupuncture on Quality of Life Scores During Chemotherapy in Ovarian Cancer: Results from a Pilot, Randomized Sham-Controlled Trial. Med Acupunct. 2012 Dec;24(4):233-240. doi:10.1089/acu.2012.0904.
29. MacPherson H, Vertosick EA, Foster NE, Lewith G, Linde K, Sherman KJ, et al. The persistence of the effects of acupuncture after a course of treatment: A meta-analysis of patients with chronic pain. Pain. 2016 Oct 17. doi:10.1097/j.pain.0000000000000747.
30. Mao JJ, Xie SX, Farrar JT, et al. A randomised trial of electro-acupuncture for arthralgia related to aromatase inhibitor use. Eur J Cancer 2014 Jan;50(2):267-76. doi:10.1016/j.ejca.2013.09.022.
31. McDonald J, Janz S. The Acupuncture Evidence Project: A Comparative Literature Review (Revised Edition). Brisbane: Australian Acupuncture and Chinese Medicine Association Ltd; 2017.
32. Molassiotis A, Bardy J, Finnegan-John J, et al. A randomized, controlled trial of acupuncture self-needling as maintenance therapy for cancer-related fatigue after therapist-delivered acupuncture. Ann Oncol. 2013 Jun;24(6):1645-52. doi:10.1093/annonc/mdt034.
33. Molassiotis A, Bardy J, Finnegan-John J, Mackereth P, Ryder DW, Filshie J, Ream E, Richardson A. Acupuncture for cancer-related fatigue in patients with breast cancer: a pragmatic randomized controlled trial. J Clin Oncol. 2012 Dec 20;30(36):4470-6. doi:10.1093/annonc/mdt034.
34. Molassiotis A, Sylt P, Diggins H. The management of cancer-related fatigue after chemotherapy with acupuncture and acupressure: a randomised controlled trial. Complement Ther Med. 2007 Dec;15(4):228-37. doi:10.1016/j.ctim.2006.09.009.
35. National Health and Medical Research Council. NHMRC additional levels of evidence and grades for recommendations for developers of guidelines. Table 3. NHMRC Evidence Hierarchy: designations of 'levels of evidence' according to type of research question (including explanatory notes). National Health and Medical Research Council; 2009.
36. Niravath P. Aromatase inhibitor-induced arthralgia: a review. Ann Oncol. 2013 Jun;24(6):1443-9. doi:10.1093/annonc/mdt037.
37. Oh B, Kimble B, Costa DS, et al. Acupuncture for treatment of arthralgia secondary to aromatase inhibitor therapy in women with early breast cancer: pilot study. Acupunct Med 2013 Sep;31(3):264-71. doi:10.1136/acupmed-2012-010309.
38. Paley CA, Johnson MI, Tashani OA, Bagnall AM. Acupuncture for cancer pain in adults. Cochrane Database Syst Rev. 2015(10):Cd007753. doi:10.1002/14651858.CD007753.pub3.
39. Smith C, Carmady B, Thornton C, Perz J, Ussher JM. The effect of acupuncture on post-cancer fatigue and well-being for women recovering from breast cancer: a pilot randomised controlled trial. Acupunct Med. 2013 Mar;31(1):9-15. doi:10.1136/acupmed-2012-010228.
40. Wang XP, Zhang DJ, Wei XD, Wang JP, Zhang DZ. Acupuncture for the relief of hot flashes in breast cancer patients: A systematic review and meta-analysis of randomized controlled trials and observational studies. J Cancer Res Ther. 2018 Sep;14(Supplement):S600-S608. doi:10.4103/0973-1482.183174.
41. Wu C, Zheng Y, Duan Y, Lai X, Cui S, Xu N, Tang C, Lu L. Nonpharmacological Interventions for Cancer-Related Fatigue: A Systematic Review and Bayesian Network Meta-Analysis. Worldviews Evid Based Nurs. 2019 Apr;16(2):102-110. doi:10.1111/wvn.12352.
42. Yang GS, Kim HJ, Griffith KA, Zhu S, Dorsey SG, Renn CL. Interventions for the Treatment of Aromatase Inhibitor-Associated Arthralgia in Breast Cancer Survivors: A Systematic Review and Meta-analysis. Cancer Nurs. 2017 Jul/Aug;40(4):E26-E41. doi:10.1097/NCC.0000000000000409.

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43. Zeng Y, Luo T, Finnegan-John J, Cheng AS. Meta-Analysis of Randomized Controlled Trials of Acupuncture for Cancer-Related Fatigue. Integr Cancer Ther. 2014 May;13(3):193-200. doi:10.1177/1534735413510024.
44. Zhang X, Wang X, Zhang B, Yang S, Liu D. Effects of acupuncture on breast cancer-related lymphoedema: a systematic review and meta-analysis of randomised controlled trials. Acupunct Med. 2019 Mar 8:acupmed2018011668. doi:10.1136/acupmed-2018-011668.
45. Zhang Y, Lin L, Li H, Hu Y, Tian L. Effects of acupuncture on cancer-related fatigue: a meta-analysis. Support Care Cancer. 2018 Feb;26(2):415-425. doi:10.1007/s00520-017-3955-6.

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ACU-12.2: Adjunct Care for Mental Health Conditions

- SynonymsAnxiety
- Depression
- Insomnia

Definitions

Anxiety disorders involve a state of nervousness that is inappropriately severe for the person's circumstances. Anxiety is a normal response to a threat or to psychological stress and is experienced occasionally by everyone. Normal anxiety has its root in fear and serves an important survival function. When someone is faced with a dangerous situation, anxiety triggers the fight-or-flight response. With this response, a variety of physical changes, such as increased blood flow to the heart and muscles, provide the body with the necessary energy and strength to deal with life-threatening situations, such as running from an aggressive animal or fighting off an attacker. However, when anxiety occurs at inappropriate times, occurs frequently, or is so intense and long-lasting that it interferes with a person's normal activities, it is considered a disorder. Anxiety disorders are the most common type of mental health disorder, believed to affect about 15% of adults in the United States. After anxiety, depression is the most common mental health disorder. People with an anxiety disorder are more likely than other people to have depression.

Depressive disorders are characterized by sadness severe enough or persistent enough to interfere with function and often by decreased interest or pleasure in activities. Exact cause is unknown but probably involves heredity, changes in neurotransmitter levels, altered neuroendocrine function, and psychosocial factors. It may follow a recent loss or other sad event but is out of proportion to that event and lasts beyond an appropriate length of time. An episode of depression, if untreated, typically lasts about 6 months but sometimes lasts for 2 years or more. Episodes tend to recur several times over a lifetime. Depression does not reflect a weakness of character and may not reflect a personality disorder, childhood trauma, or poor parenting. Social class, race, and culture do not appear to affect the chance that people will experience depression during their lifetime.

Insomnia symptoms may include difficulty falling asleep, difficulty staying asleep, waking too early, or not feeling rested after a night’s sleep. Acute insomnia is typically the result of stress or a traumatic event, and lasts for days or weeks. Chronic insomnia lasts a month or longer. It may occur as a stand-alone problem, or may be related to other conditions. Insomnia is often associated with anxiety, depression, and other mental health disorders. Insomnia can also be caused by underlying physical conditions or medications, so medical evaluation is important.

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Oriental Medicine Diagnoses

In Oriental Medicine, the Seven Emotions may be either the etiology or the symptom of disease. Anger, Fear, Fright, Grief, Joy and Worry/Pensiveness affect all of the Zang Organs, or may be a reflection of underlying dysfunction. There are often multiple Organ Systems involved. The list below includes only the most common patterns for anxiety and depression.

- Liver Qi Stagnation
  - Causation can be due to external pathogens, lifestyle choices, such as irregular or incorrect food choice, irregular eating times, lack of sleep, or stress. Emotional disharmony, especially repressed anger, resentment, frustration.
- Liver and Spleen Disharmony
  - Excessive contemplation and emotional dejection cause the Liver Qi to stagnate and the Spleen Qi fail to ascend. This leads to Phlegm which disturbs the mind.
- Gall Bladder Deficiency
  - May occur without specific etiology, but often combined with Liver Blood Deficiency. Severe Deficiency of Blood may result in fear and lack of courage. May result from childhood wounding, abuse, repressed anger.
- Heart Yin Deficiency
  - Chronic anxiety, worry, and a busy lifestyle can damage Yin and cause Yin Deficiency. Sadness weakens Lung Qi which can cause Heart Qi and Yin to become deficient.
- Heart Blood and Spleen Qi Deficiency
  - Chronic worry and anxiety, over-thinking, or dietary insufficiencies weaken Spleen Qi and disturb the Shen, which can lead to Heart Blood Deficiency. Dietary insufficiencies or hemorrhage can lead to Heart Blood Deficiency, which taxes and weakens the Spleen Qi.
- Liver Fire, Heart Fire, Phlegm Misting the Heart
  - Patients exhibiting these patterns may be suffering from mental health conditions beyond anxiety or depression. Appropriate medical co-management is critical for these patients. Please refer to the red flag recommendations chart below.

History

- There may be a family history of mental health disorder.
- Symptoms may develop in childhood, or later in adult life.
- Symptoms may be situational, acute, or chronic.
- Symptoms may be related to specific events or occur without cause.
- Symptoms may be caused by physical disorders including hormonal disorders, heart disorders, lung disorders, head injuries, some infectious diseases, and various chronic disorders
- Symptoms may be caused by drug use or drug withdrawal including alcohol, caffeine, weight loss products, sedatives, stimulants, and many prescription drugs

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Specific Aspects of History

- Rule out red flags (requires medical management).
- Identify co-morbidities requiring medical management, and those that affect acupuncture and Oriental Medicine management.
- Most patients with this diagnosis will already have consulted with their Primary Care Provider. If not, however, they should be directed to make an appointment with their MD at their earliest opportunity. Confirmation of appropriate medical co-management with an MD and/or Licensed Psychological Practitioner is required. Accurate diagnosis is important because the most appropriate treatment options vary from one anxiety/depressive/insomnia disorder to another. Additionally, anxiety/depressive/insomnia disorders must be distinguished from anxiety/depression/insomnia that occurs in many other physical disorders, which involve different treatment approaches.
- Acupuncture is not considered medically necessary if it may delay or replace needed medical care.

Red Flag	Possible Consequence or Cause	Action Required
Suicidal intent	Suicide	Prompt referral to emergency department AND National Suicide Prevention Lifeline is available 24 hours every day 1-800-273-8255.
Thoughts or plans of self-harm	Self-harm	Prompt referral to Primary Care Provider AND National Suicide Prevention Lifeline is available 24 hours every day 1-800-273-8255.
Thoughts or plans of isolation	Depression	Prompt referral to Primary Care Provider and/or Licensed Psychological Practitioner
Delusions, hallucinations, extreme mood change, confused thinking, dramatic change in eating or sleeping habits, highly risky behaviors, recurring thoughts of death	Other mental health disorders	Prompt referral to Primary Care Provider and/or Licensed Psychological Practitioner
Suspicion of drug or alcohol dependence	Side effect or withdrawal phenomenon	Immediate referral to emergency department

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Red Flag	Possible Consequence or Cause	Action Required
Head injury, widespread neurological symptoms, headaches that are new, progressive or persistent, vomiting without nausea, seizures, tremors, partial paralysis, dementia, cognitive changes such as confusion, drowsiness, giddiness	Brain and nervous system disorders	Prompt referral to Primary Care Provider
Cancer	Cause of symptoms (metastatic or primary)	Prompt referral to Primary Care Provider
Unexplained weight loss, Pain that is worse with recumbency or worse at night, Prior history of cancer	Malignancy	Prompt referral to Primary Care Provider
Fever, immune compromised state, intravenous drug use	Infection	Prompt referral to Primary Care Provider
Pleuritic pain, chronic cough, dyspnea	Pulmonary diseases	Prompt referral to Primary Care Provider
Fatigue, weakness, skin changes, stomach upset, constipation, fast heart rate, sweating, nervousness, depression	Potential for endocrine disorders	Prompt referral to Primary Care Provider
Associated dysphasia; unilateral weakness	Cerebrovascular accident	Immediate referral to emergency department
Headache associated with diastolic blood pressure greater than 110 mmHg, Exertional pain, history of CAD	Cardiac condition	Immediate referral to emergency department

Subjective Findings

- **Anxiety**:
  - Fear
  - Difficulty talking to or interacting with others
  - Avoidance of social situations
  - Difficulty establishing or keeping relationships
  - Blushing, sweating, or trembling
  - Increased muscle tension
  - Shortness of breath, dizziness, rapid heart rate, palpitations
  - Difficulty concentrating

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- **Depression:**
  - Sadness, sluggishness, irritability, anxiousness
  - Loss of interest or pleasure in activities that were previously enjoyed
  - Flat or lack of emotions
  - Sleeping difficulty
  - Overeating and weight gain
  - Aches and pains
  - Neglect of personal hygiene or neglect of loved ones
  - Any pain should be documented as a numeric pain scale 0-10
  - VAS may be used for other symptoms
  - Specific symptom frequency, duration and VAS or numeric scale should be documented
- **Insomnia:**
  - Difficulty falling asleep
  - Difficulty staying asleep
  - Waking too early
  - Not feeling rested after a night's sleep
  - Daytime tiredness or sleepiness
  - Difficulty focusing or remembering
  - Increased errors or accidents
  - Worry about getting enough sleep
  - Irritability, anxiety or depression
  - Specific symptom frequency, duration and VAS or numeric scale should be documented

Functional Assessment

- Documentation of a patient's level of function is an important aspect of patient care. This documentation is required in order to establish the medical necessity of ongoing acupuncture treatment. The **Patient Specific Functional Scale (PSFS)** is a patient reported outcome assessment that is easy and appropriate for acupuncturists to use. The PSFS has been studied in peer-reviewed scientific literature, and it has been proven to be a valid, reliable, and responsive measure for a variety of pain syndromes (neck, back, knee, etc.).
- Use of the **Hospital Anxiety and Depression Scale (HADS)** is recommended for acupuncturists, as it is a short questionnaire that can apply to either anxiety or depression. The HADS consists of 7 questions, resulting in a score of 0-21. Scores of 0-7 considered normal, 8-10 borderline, and 11 or over indicating clinical level of symptoms.
- Use of the **Pittsburg Sleep Quality Index (PSQI)** is recommended for acupuncturists. The PSQI is a self-rated questionnaire which assesses sleep quality and disturbances over a one-month time period. It consists of 10 questions, resulting in a score of 0-21. Scores of 0-5 considered good sleep; >5 considered poor sleep.

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Objective Findings

Scope of Exam

- Inspection including Oriental Medicine inspection techniques
- Palpation of areas of tension, tenderness, or trembling
- Measure blood pressure, pulse rate, temperature
- Question whether there are thoughts or plans for self-harm or suicide
- Use of questionnaires or outcome assessments to monitor anxiety/depression/insomnia
- There are many standardized questionnaires are used to help determine severity of anxiety, depression or insomnia
- Use of the Hospital Anxiety and Depression Scale (HADS) is recommended for acupuncturists, as it is a short questionnaire that can apply to either anxiety or depression. The HADS consists of 7 questions, resulting in a score of 0-21. Scores of 0-7 considered normal, 8-10 borderline, and 11 or over indicating clinical level of symptoms.
- Use of the Pittsburg Sleep Quality Index (PSQI) is recommended for acupuncturists. The PSQI is a self-rated questionnaire which assesses sleep quality and disturbances over a one-month time period. It consists of 10 questions, resulting in a score of 0-21. Scores of 0-5 considered good sleep; >5 considered poor sleep.

Specific Aspects of Examination for Anxiety/Depression/Insomnia

- Confirm current medical evaluation, diagnosis and treatment.
- Rule out other possible causes.
- Referral to an MD may be considered if any red flags are present.
- Medical co-management with an MD and/or Licensed Psychological Practitioner is required. Acupuncture is not considered medically necessary if it may delay or replace needed medical care.

Differential Diagnoses

- Generalized Anxiety Disorder
- Social Anxiety Disorders
- Panic Attacks and Panic Disorder
- Specific Phobic Disorders
- Trauma and Stress Related Disorders
- Major Depressive Disorder
- Persistent Depressive Disorder
- Premenstrual Dysphoric Disorder

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- Personality Disorders
- Sleep Apnea, Restless Leg Syndrome, Other Specific Sleeping Disorders
- Physical Disorders Including: Hormonal Disorders, Brain and Nervous System Disorders, Cancer, Infection, Substance Abuse

Oriental Medicine Management [1]

- Most patients with this diagnosis will already have consulted with their Primary Care Provider. If not, however, they should be directed to make an appointment with their MD at their earliest opportunity. Confirmation of appropriate medical co-management with an MD and/or Licensed Psychological Practitioner is required. Accurate diagnosis is important because the most appropriate treatment options vary from one anxiety/depressive/insomnia disorder to another. Additionally, anxiety/depressive/insomnia disorders must be distinguished from anxiety/depression/insomnia that occurs in many other physical disorders, which involve different treatment approaches.
- Acupuncture is not considered medically necessary if it may delay or replace needed medical care.
- Oriental Medicine management goals are to help reduce or resolve symptoms, help restore the highest level of function possible and help educate patient to reduce or prevent recurrent symptoms.
- Treatment frequency should be commensurate with the severity of the chief complaint, natural history of the condition, and expectation for functional improvement.
- When significant improvements in patient's subjective findings and objective findings are demonstrated—continued treatment with decreased frequency is appropriate.
- As treatment progresses, one should see an increase in the effective use of coping mechanisms, a decrease in the dependence on acupuncture services, and a fading of treatment frequency.
- If the condition has not progressed towards resolution, refer the patient to an appropriate health care provider to explore other treatment alternatives.
- eviCore's consideration of requests for continued acupuncture treatment depends on updated clinical information submitted regarding patient's progress.
- Adequate and legible patient progress information that contains a history and examination, and/or eviCore's Treatment Request Form for each treatment is required to determine medical necessity.
- In addition to the improvements in the table below, significant progress may be documented by increases in functional capacity and increasingly longer durations of symptomatic relief.
- Discharge occurs when reasonable functional goals and expected outcomes have been achieved.

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- The patient is discharged when the patient/care-giver can continue management of symptoms with an independent home program.
- Treatment is discontinued when the patient is unable to progress towards outcomes because of medical complications, psychosocial factors or other personal circumstances.
- If the member has been non-compliant with treatment as is evidenced by the clinical documentation, and/or the lack of demonstrated progress, treatment will be deemed to be not medically necessary and the member should be discharged from treatment.

Week	Progress
0-2	◆ Some reduction of symptom severity and frequency ◆ Ensure appropriate medical co-management is in place
3-4	◆ 10-15% improvement in symptom severity and frequency ◆ Reinforce self-management techniques ◆ Reinforce continued medical co-management
5-8	◆ 25% improvement in symptom severity and severity ◆ Reinforce self-management techniques ◆ Reinforce continued medical co-management
9-12	◆ 50% improvement in symptom severity and frequency ◆ Reinforce self-management techniques ◆ Reinforce continued medical co-management
13-16	◆ Condition is expected to have either resolved or reached a plateau stage by this time ◆ Reinforce self-management techniques ◆ Reinforce continued medical co-management ◆ Discharge patient to elective care or back to their MD or Licensed Psychological Practitioner for alternative treatment options, when a plateau is reached or by week 16, whichever occurs first

Referral & Medical Co-Management Guidelines

- Refer patient to their Medical Doctor and/or Licensed Psychological Practitioner for evaluation of alternative treatment options if:
  - Confirmation of current co-management with Medical Doctor and/or Licensed Psychological Practitioner is not provided.
  - There is ANY indication of thoughts or plans for self-harm. The National Suicide Prevention Lifeline is available 24 hours every day, call 1-800-273-8255.
  - There are signs or symptoms of mental health disorders beyond anxiety or depression.
  - There is significant worsening of the patient's complaint.
  - The patient shows additional complaints.
  - The patient has not responded positively to treatment after a couple of weeks.

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Appropriate Procedures/Modalities

- Acupuncture
- Electro-acupuncture
- Herbal formulas

Note: Not all of these modalities are covered by patient's health-plan; review documentation regarding coverage. Acupuncture and herbs must be appropriate for covered diagnoses under the patient's insurance policy. Acupuncturist is responsible for determining which procedures/modalities are most appropriate for the patient's condition.

Inappropriate Procedures/Modalities

- Scarring moxa
- Electro-acupuncture using more than 9 volts
- Any techniques outside of the scope of practice in your state

Self-Management Techniques

- Develop and implement coping strategies
- Appropriate exercises/stretching
- Tai Qi, Qi Gong, Yoga, Self-acupressure
- Stress management
- Meditation
- General self-care; Adequate nutrition and hydration; Good sleep hygiene
- Management of any underlying medical conditions
- Limit or eliminate caffeine, alcohol, nicotine
- Connecting with family and/or friends
- Journaling
- Engaging in hobbies

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Alternatives to Oriental Medicine

(listed in alphabetical order)

- Biofeedback
- Medication
- Psychiatry
- Psychological therapies, for example cognitive-behavioral therapy
- Talk to your doctor if your symptoms may be a side effect of medication
- Time management, conflict resolution, assertiveness training
- Stress Inoculation Therapy

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References

1. Amorim D, Amado J, Brito I, et al. Acupuncture and electroacupuncture for anxiety disorders: A systematic review of the clinical research. Complement Ther Clin Pract. 2018 May;31:31-37. doi:10.1016/j.ctcp.2018.01.008
2. Balshem H, Helfand M, Schunemann HJ, Oxman AD, Kunz R, Brozek J, et al. GRADE guidelines: 3. Rating the quality of evidence. J Clin Epidemiol. 2011 Apr;64(4):401-6. doi:10.1016/j.jclinepi.2010.07.015.
3. Bo A et al. Clinical Trial Research on Mongolian Medical Warm Acupuncture in Treating Insomnia. Evid Based Complement Alternat Med. 2016;2016:6190285. doi:10.1155/2016/6190285.
4. Bosch et al. Schizophrenia and Depression: A systematic review of the effectiveness and the working mechanisms behind acupuncture. Explore (NY). 2015 Jul-Aug;11(4):281-91. doi:10.1016/j.explore.2015.04.004.
5. Bosch et al. Sleep ameliorating effects of acupuncture in a psychiatric population. Evid Based Complement Alternat Med. 2013;2013:969032. doi:10.1155/2013/969032.
6. Buysse DJ, et al. The Pittsburgh Sleep Quality Index: a new instrument for psychiatric practice and research. Psychiatry Res. 1989 May;28(2):193-213.
7. Cheuk DKL, Yeung W-F, Chung K, Wong V. Acupuncture for insomnia. Cochrane Database of Systematic Reviews 2012, Issue 9. Art. No.: CD005472. doi:10.1002/14651858.CD005472.pub3.
8. Chung KF, Yeung WF, Yu BY, Leung FC, Zhang SP, Zhang ZJ, Ng RM, Yiu GC. Acupuncture with or without combined auricular acupuncture for insomnia: a randomised, waitlist-controlled trial. Acupunct Med. 2018 Feb;36(1):2-13. doi:10.1136/acupmed-2017-011371.
9. Dong B, Chen Z, Yin X, Li D, Ma J, Yin P, Cao Y, Lao L, Xu S. The Efficacy of Acupuncture for Treating Depression-Related Insomnia Compared with a Control Group: A Systematic Review and Meta-Analysis. Biomed Res Int. 2017;2017:9614810. doi:10.1155/2017/9614810.
10. Gao X, Xu C, Wang P, Ren S, Zhou Y, Yang X, Gao L. Curative effect of acupuncture and moxibustion on insomnia: a randomized clinical trial. J Tradit Chin Med. 2013 Aug;33(4):428-32.
11. Grant et al. Acupuncture for the Treatment of Adults with Posttraumatic Stress Disorder: A Systematic Review and Meta-Analysis. J Trauma Dissociation. 2018 Jan-Feb;19(1):39-58. doi:10.1080/15299732.2017.1289493.
12. Guo J, Wang LP, Liu CZ, Zhang J, Wang GL, Yi JH, Cheng JL. Efficacy of acupuncture for primary insomnia: a randomized controlled clinical trial. Evid Based Complement Alternat Med. 2013;2013:163850. doi:10.1155/2013/163850
13. Hayhoe, S. Insomnia: can acupuncture help? Pain Manag. 2017 Jan;7(1):49-57. doi:10.2217/pmt-2016-0025.
14. Hempel S, Taylor SL, Solloway MR, Miake-Lye IM, Beroes JM, Shanman R, et al. VA Evidence-based Synthesis Program Reports. Evidence Map of Acupuncture. Washington (DC): Department of Veterans Affairs; 2014.
15. Hollenbach D, Broker R, Herlehy S, Stuber K. Non-pharmacological interventions for sleep quality and insomnia during pregnancy: A systematic review. Can Chiropr Assoc. 2013 Sep;57(3):260-70.
16. Horn KK, Jennings S, Richardson G, Vliet DV, Hefford C, Abbott JH. The patient-specific functional scale: psychometrics, clinimetrics, and application as a clinical outcome measure. J Orthop Sports Phys Ther. 2012 Jan;42(1):30-42. doi:10.2519/jospt.2012.3727.
17. Hseuh CC, and O'Connor. Acupuncture - A Comprehensive Text. Eastland Press, 1981.
18. Huang HT, Lin SL, Lin CH, Tzeng DS. Comparison Between Acupuncture and Biofeedback as Adjunctive Treatments for Primary Insomnia Disorder. Altern Ther Health Med. 2017 Jul;23(4). pii: at5471.
19. Huang Y, Zheng Y. [Sleep disorder of schizophrenia treated with shallow needling: a randomized controlled trial]. Zhongguo Zhen Jiu. 2015 Sep;35(9):869-73.
20. Kaptchuk T. The Web That Has No Weaver. Contemporary Books. 2000.
21. Kelly RB. Acupuncture for pain. Am Fam Physician. 2009 Sep 1;80(5):481-4.
22. King HC, Spence DL, Hickey AH, Sargent P, Elesh R, Connelly CD. Auricular acupuncture for sleep disturbance in veterans with post-traumatic stress disorder: a feasibility study. Mil Med. 2015 May;180(5):582-90. doi:10.7205/MILMED-D-14-00451.
23. Lan et al. Auricular acupuncture with seed or pellet attachments for primary insomnia: a systematic review and meta-analysis. BMC Complement Altern Med. 2015 Apr 2;15:103. doi:10.1186/s12906-015-0606-7.

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24. Lee C, Crawford C, Wallerstedt D, et al. The effectiveness of acupuncture research across components of the trauma spectrum response (tsr): a systematic review of reviews. Syst Rev. 2012 Oct 15;1:46. doi:10.1186/2046-4053-1-46.
25. Lee SH, Lim SM. Acupuncture for insomnia after stroke: a systematic review and meta-analysis. BMC Complement Altern Med. 2016 Jul 19;16:228. doi:10.1186/s12906-016-1220-z.
26. MacPherson H, Vertosick EA, Foster NE, Lewith G, Linde K, Sherman KJ, et al. The persistence of the effects of acupuncture after a course of treatment: A meta-analysis of patients with chronic pain. Pain. 2016 Oct 17. doi:10.1097/j.pain.0000000000000747.
27. McDonald J, Janz S. The Acupuncture Evidence Project: A Comparative Literature Review (Revised Edition). Brisbane: Australian Acupuncture and Chinese Medicine Association Ltd; 2017.
28. National Health and Medical Research Council. NHMRC additional levels of evidence and grades for recommendations for developers of guidelines. Table 3. NHMRC Evidence Hierarchy: designations of 'levels of evidence' according to type of research question (including explanatory notes). National Health and Medical Research Council; 2009.
29. Reshef A, Bloch B, Vadas L, Ravid S, Kremer I, Haimov I. The Effects of Acupuncture Treatment on Sleep Quality and on Emotional Measures among Individuals Living with Schizophrenia: A Pilot Study. Sleep Disord. 2013;2013:327820. doi:10.1155/2013/327820.
30. Shen et al. Acupuncture for Schizophrenia. Cochrane Database Syst Rev. 2014 Oct 20;(10):CD005475. doi:10.1002/14651858.CD005475.pub2.
31. Shergis JL, Ni X, Jackson ML, Zhang AL, Guo X, Li Y, Lu C, Xue CC. A systematic review of acupuncture for sleep quality in people with insomnia. Complement Ther Med. 2016 Jun;26:11-20. doi:10.1016/j.ctim.2016.02.007
32. Tan HJ, Lan Y, Wu FS, Zhang HD, Wu L, Wu X, Liang FR. [Auricular acupuncture for primary insomnia: a systematic review based on GRADE system]. Zhongguo Zhen Jiu. 2014 Jul;34(7):726-30.
33. Tu JH, Chung WC, Yang CY, Tzeng DS. A comparison between acupuncture versus zolpidem in the treatment of primary insomnia. Asian J Psychiatr. 2012 Sep;5(3):231-5. doi:10.1016/j.ajp.2011.12.003.
34. van den Noort et al. Acupuncture as Add-On Treatment of the Positive, Negative, and Cognitive Symptoms of Patients with Schizophrenia: A Systematic Review. Medicines (Basel). 2018 Mar 30;5(2). pii: E29. doi:10.3390/medicines5020029.
35. van Ravesteyn LM, Lambregtse-van den Berg MP, Hoogendijk WJ, Kamperman AM. Interventions to treat mental disorders during pregnancy: A systematic review and multiple treatment meta-analysis. PLoS One. 2017 Mar 30;12(3):e0173397. doi:10.1371/journal.pone.0173397.
36. Wang J et al. [Senile insomnia treated with integrated acupuncture and medication therapy: a randomized controlled trial]. Zhongguo Zhen Jiu. 2015 Jun;35(6):544-8.
37. Yin X, Gou M, Xu J, Dong B, Yin P, Masquelin F, Wu J, Lao L, Xu S. Efficacy and safety of acupuncture treatment on primary insomnia: a randomized controlled trial. Sleep Med. 2017 Sep;37:193-200. doi:10.1016/j.sleep.2017.02.012.
38. Zhao K. Acupuncture for the treatment of insomnia. Int Rev Neurobiol. 2013;111:217-34. doi:10.1371/journal.pone.0173397.

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ACU-12.3: Allergic Rhinitis

Synonyms

Hay fever, nasal allergies, pollenosis.

Definition

Allergic rhinitis, also known as pollenosis or hay fever, is an allergic inflammation of the nasal airways. It occurs when an allergen, such as pollen, dust or animal dander (particles of shed skin and hair) is inhaled by an individual with a sensitized immune system. In such individuals, the allergen triggers the production of the antibody immunoglobulin E (IgE), which binds to mast cells and basophils containing histamine.

IgE bound to mast cells are stimulated by pollen and dust, causing the release of inflammatory mediators such as histamine (and other chemicals). This usually causes sneezing, itchy and watery eyes, swelling and inflammation of the nasal passages, and an increase in mucus production. Symptoms vary in severity between individuals.

All three are addressed similarly in terms of Traditional Chinese Medicine.

Oriental Medicine Diagnoses

- Liver Qi Stagnation
  - The Liver Qi becomes stagnated, causing the Liver to attack the Lungs. Causation can be due to external pathogens; lifestyle choices, such as, irregular or “incorrect” food choice, irregular eating times, lack of sleep, or stress.
- Kidney Qi Deficiency
  - May lead to an accumulation of Phlegm, Dampness and Deficiency affecting the Lung channel. Causation is from either congenital deficiency of Kidney Qi and/or lifestyle choices that lead to a depletion of Kidney Qi.
- Lung and Spleen Qi Deficiency
  - Weakness of the Lung and Spleen Qi may allow an accumulation of Dampness and Phlegm in the Lung channel. Causation may be congenital deficiency, or due to lifestyle factors, including poor diet and overwork.
- Spleen Qi Deficiency with Dampness
  - Much as in Lung and Spleen Qi Deficiency, above, but with greater manifestation of Dampness throughout the body systems. Causation may be congenital, or due to lifestyle factors such as poor diet and overwork.
- Wind-Cold attacking the Lungs
  - An external pathogen (termed “Wind-Cold”) attacks the Lung channel, causing obstruction of the Lung Qi, and an attendant increase in Dampness and Phlegm. Causation is an external attack, often exacerbated by pre-existing deficiency of the Lung Qi.

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History

- Symptoms may develop in childhood, or later in adult life
- Symptoms may be seasonal (for instance pollen in spring), or perennial (a dust allergy may be present year-round)
- Children will sometimes “outgrow” allergies as they mature

Specific Aspects of History

- Rule out red flags (requires medical management).
- Identify co-morbidities requiring medical management, and those that affect acupuncture and Oriental Medicine management.

Red Flag	Possible Consequence or Cause	Action Required
Fever, achiness	Viral or bacterial infection	Prompt referral to Primary Care Provider
Green or yellow mucus	Bacterial infection	Prompt referral to Primary Care Provider
Severe pain or burning in the nasal passages	Recent exposure to toxic inhalants	Immediate referral to emergency department
Complete blockage of nasal passage	Structural obstruction	Immediate referral to emergency department
Other recent changes in health or in healthcare	May indicate a systemic condition	Prompt referral to Primary Care Provider

Subjective Findings

- Rhinorrhea (runny nose)
- Nasal congestion and obstruction
- Itching in the nasal passages, throat, and/or eyes
- Swelling of the mucus membranes in the nose, throat, and/or eyes
- Difficulty in equalizing air pressure in the ears and/or hearing affected
- Pressure and/or pain in sinuses
- Pain should be documented as a numeric pain scale 0-10
- VAS may be used for other symptoms
- Headache and other symptom frequency, duration and numeric scale should be documented

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Functional Assessment

- Documentation of a patient's level of function is an important aspect of patient care. This documentation is required in order to establish the medical necessity of ongoing acupuncture treatment. The Patient Specific Functional Scale (PSFS) is a patient reported outcome assessment that is easy and appropriate for acupuncturists to use. The PSFS has been studied in peer-reviewed scientific literature, and it has been proven to be a valid, reliable, and responsive measure for a variety of pain syndromes (neck, back, knee, etc.).

Objective Findings

Scope of Exam

- Inspection including Oriental Medicine inspection techniques
- Inspection of nose, ears, eyes, and back of throat
- Measure blood pressure, pulse rate, temperature
- Percussion of sinuses

Specific Aspects of Examination for Allergic Rhinitis

- Rule out other possible causes.
- A referral to an MD may be considered if other causes are a possibility.
- Referral to an MD may also be considered if skin tests are desired to confirm a diagnosis of allergic rhinitis.

Findings of Allergic Rhinitis

- Difficult respiration
- Sleep disturbances
- Irritability
- Fatigue
- Difficulty in concentration
- Possible injury to eardrums during air travel

Differential Diagnoses

- Infective rhinitis
- Irritant rhinitis
- Drug-induced rhinitis
- Hormonal rhinitis
- Non-allergic rhinitis with eosinophilia syndrome
- Nasal obstruction

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- Systemic conditions such as cystic fibrosis, Kartagener's syndrome, or Wegener's syndrome

Oriental Medicine Management [5]

- Most patients with this diagnosis will already have consulted with their Primary Care Provider. If not, however, they should be directed to make an appointment with their MD at their earliest opportunity.
- Confirmation of appropriate medical co-management is always required when treating children age 14 and under.
- Acupuncture is not considered medically necessary if it may delay or replace needed medical care.
- Oriental Medicine management goals are to reduce or resolve symptoms, restore the highest level of function possible and educate patient to reduce or prevent recurrent symptoms.
- Treatment frequency should be commensurate with severity of the chief complaint.
- When significant improvement in subjective findings and objective findings are demonstrated—continued treatment with decreased frequency is appropriate.
- If the condition has not progressed towards resolution, refer the patient to an appropriate health care provider to explore other treatment alternatives.
- eviCore's consideration of requests for continued acupuncture treatment depends on updated clinical information submitted regarding patient's progress.
- Adequate and legible patient progress information that contains a history and examination, and/or eviCore's Acupuncture Treatment Request Form is required to determine medical necessity.
- In addition to improvements in the table below, significant progress may be documented by increases in functional capacity and increasingly longer durations of symptom relief.
- Initiate two to four week trial of treatment.
- If severity or frequency of allergies decreases following the initial trial—continue treatment at a reduced frequency for a one month period.
- Recommendations depend on causation can include dietary recommendations, changes in daily routine and/or housekeeping routines (to reduce exposure to allergens), and possibly herbal formulas.
- If the patient does not improve with trial of Oriental Medicine treatment, or has reached a plateau, refer patient to an MD to explore other alternatives.
- Discharge occurs when reasonable functional goals and expected outcomes have been achieved.
- The patient is discharged when the patient/care-giver can continue management of symptoms with an independent home program.

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- Treatment is discontinued when the patient is unable to progress towards outcomes because of medical complications, psychosocial factors or other personal circumstances.
- If the member has been non-compliant with treatment as is evidenced by the clinical documentation, and/or the lack of demonstrated progress, treatment will be deemed to be not medically necessary and the member should be discharged from treatment.

Week	Progress
0-1	◆ Some reduction of symptom severity and frequency
2-4	◆ 30% improvement in symptom severity and frequency ◆ Reinforce self-management techniques
5-8	◆ 50% improvement in symptom severity and severity ◆ Reinforce self-management techniques
9-12	◆ 75% improvement in symptom severity and frequency ◆ Reinforce self-management techniques
13-16	◆ Condition is expected to have either resolved or reached a plateau stage by this time ◆ Reinforce self-management techniques ◆ Discharge patient to elective care, or to their primary care provider for alternative treatment options when a plateau is reached, or by week 16, whichever occurs first

Referral Guidelines (or co-management)

- Refer patient to their primary care provider for evaluation of alternative treatment options if:
  - There are signs or symptoms of a serious viral or bacterial infection, including but not limited to fever, or green or yellow phlegm or nasal drainage.
  - There is significant pain or burning in the nasal passages.
  - The nasal passages are entirely obstructed for more than a brief period of time.
  - The patient has not responded positively to treatment after a couple of weeks.
  - The condition appears to be worsening.

Appropriate Procedures/Modalities

- Acupuncture
- Electro-acupuncture
- Cupping
- Gua Sha
- Herbal formulas

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Note: Not all of these modalities are covered by patient's health-plan; review documentation regarding coverage. Acupuncture and herbs must be appropriate for covered diagnoses under the patient's insurance policy. Acupuncturist is responsible for determining which procedures/modalities are most appropriate for the patient's condition.

Inappropriate Procedures/Modalities

- Scarring moxa
- Applied kinesiology techniques
- Electro-acupuncture using more than 9 volts
- Any techniques outside of the scope of practice in your state

Self-Management Techniques

- Rest and reduce strenuous activities
- Appropriate exercises/stretching
- Tai Qi, Qi Gong, Yoga
- Stress management, meditation
- Self-massage, Self-acupressure
- Hot packs/cold packs, if needed, to relieve discomfort
- Avoid suspected or known allergic triggers:
  - Avoid outdoor activities during high-pollen hours
  - Remove allergens from the home environment to the extent possible (air purifiers, filter vacuums, proper dusting, clean HVAC filters, frequent washing of linens, etc
- Avoid suspected dietary triggers:
  - Excess dairy
  - Excess sugar
  - Excess fatty or fried foods
- Any known food sensitivities or allergies (wheat, gluten, etc, depending on the patient)
- Some patients may benefit from irrigation of the nasal passages (neti pot, etc)

Alternatives to Oriental Medicine

(listed in alphabetical order)

- Allergy shots
- Dietary/Nutritional Medicine Counseling
- Medication (oral and/or inhaled)
- Moving to an area with fewer allergens

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References

1. Balshem H, Helfand M, Schunemann HJ, Oxman AD, Kunz R, Brozek J, et al. GRADE guidelines: 3. Rating the quality of evidence. J Clin Epidemiol. 2011 Apr;64(4):401-6. doi:10.1016/j.jclinepi.2010.07.015.
2. Brinkhaus B, Witty CM, Jena S, Liecker B, Wegscheider K, Willich SN. Acupuncture in patients with allergic rhinitis: a pragmatic randomized trial. Ann Allergy Asthma Immunol. 2008 Nov;101(5):535-43. doi:10.1016/S1081-1206(10)60294-3.
3. Cheng X, Deng L. Chinese Acupuncture and Moxibustion. Beijing: Foreign Language Press; 2010.
4. Feng S, Han M, Fan Y, Yang G, Liao Z, Liao W, et al. Acupuncture for the treatment of allergic rhinitis: a systematic review and meta-analysis. Am J Rhinol Allergy. 2015 Jan-Feb;29(1):57-62. doi:10.2500/ajra.2015.29.4116.
5. Fu Q, Zhang L, Liu Y, et al. Effectiveness of Acupuncturing at the Sphenopalatine Ganglion Acupoint Alone for Treatment of Allergic Rhinitis: A Systematic Review and Meta-Analysis. Evid Based Complement Alternat Med. 2019;2019:6478102. Published 2019 Mar 12. doi:10.1155/2019/6478102
6. Hempel S, Taylor SL, Solloway MR, Miake-Lye IM, Beroes JM, Shanman R, et al. VA Evidence-based Synthesis Program Reports. Evidence Map of Acupuncture. Washington (DC): Department of Veterans Affairs; 2014.
7. Horn KK, Jennings S, Richardson G, Vliet DV, Hefford C, Abbott JH. The patient-specific functional scale: psychometrics, clinimetrics, and application as a clinical outcome measure. J Orthop Sports Phys Ther. 2012 Jan;42(1):30-42. doi:10.2519/jospt.2012.3727.
8. Kaptchuk T. The Web That Has No Weaver. Contemporary Books. 2000.
9. Kelly RB. Acupuncture for pain. Am Fam Physician. 2009 Sep 1;80(5):481-4.
10. Lee MS, Pittler MH, Shin BC, Kim JI, Ernst E. Acupuncture for allergic rhinitis: a systematic review. Ann Allergy Asthma Immunol. 2009 Apr;102(4):269-79; quiz 279-81, 307. doi:10.1016/S1081-1206(10)60330-4.
11. Maciocia, G; The Foundations of Chinese Medicine: A Comprehensive Text; Churchill Livingstone, 2005.
12. MacPherson H, Vertosick EA, Foster NE, Lewith G, Linde K, Sherman KJ, et al. The persistence of the effects of acupuncture after a course of treatment: A meta-analysis of patients with chronic pain. Pain. 2016 Oct 17. doi:10.1097/j.pain.0000000000000747.
13. McDonald J, Janz S. The Acupuncture Evidence Project: A Comparative Literature Review (Revised Edition). Brisbane: Australian Acupuncture and Chinese Medicine Association Ltd; 2017.
14. National Health and Medical Research Council. NHMRC additional levels of evidence and grades for recommendations for developers of guidelines. Table 3. NHMRC Evidence Hierarchy: designations of 'levels of evidence' according to type of research question (including explanatory notes). National Health and Medical Research Council; 2009.
15. O'Connor J, Bensky D. Acupuncture: A Comprehensive Text. Chicago: Eastland Press; 1981.
16. Porter, R; The Merck Manual, Merck, 2011.
17. Witt CM, Brinkhaus B. Efficacy, effectiveness and cost-effectiveness of acupuncture for allergic rhinitis - An overview about previous and ongoing studies. Auton Neurosci. 2010 Oct 28;157(1-2):42-5. doi:10.1016/j.autneu.2010.06.006.
18. Witt CM, Reinhold T, Jena S, Brinkhaus B, Willich SN. Cost-effectiveness of acupuncture in women and men with allergic rhinitis: a randomized controlled study in usual care. Am J Epidemiol. 2009 Mar 1;169(5):562-71. doi:10.1093/aje/kwn370.
19. Xue CC, Zhang AL, Zhang CS, DaCosta C, Story DF, Thien FC. Acupuncture for seasonal allergic rhinitis: a randomized controlled trial. Ann Allergy Asthma Immunol. 2015 Oct;115(4):317-24.e1. doi:10.1016/j.anai.2015.05.017.

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ACU-12.4: Chronic Functional Constipation

Synonyms

- Chronic Functional Constipation

Definitions and History

Functional constipation is a chronic condition that has various constipation-related symptoms, including infrequent bowel movements of less than three per week, with the presentation of some or all of the following associated symptoms at least 25% of the time: hard stool, feeling of incomplete evacuation, straining at defecation, need for manual maneuvers for defecation, and/or a blockage sensation during defecation. A diagnosis of functional constipation requires that symptoms do not meet the criteria for irritable bowel syndrome (IBS). There are three types of functional constipation, including **normal transit constipation, slow transit constipation, and defecation disorders.**

Normal transit constipation is the most common form. Waste travels through the colon at the correct speed, but it can be hard and difficult to move out. This type is often amenable to laxatives and a fiber-rich diet.

Slow transit constipation occurs when the colon isn't moving waste fast enough. The reason behind this is unclear but may have to do with the nerves not signaling the colon appropriately. Symptoms include lack of urge to go to the bathroom, less than one bowel movement per week, bowel movements with dry, hard stool, and bloated and/or painful abdomen.

Defecation disorders are caused by inadequate rectal propulsion and/or increased resistance to evacuation, such as anismus and pelvic floor dysfunction. The urge to go is likely present, but the bowel movement is often accomplished only after significant straining and pushing. There may be associated hemorrhoids, fissures and impacted stool.

Oriental Medicine Diagnoses

According to Oriental Medicine, symptoms associated with the digestive system can be caused by several factors, including internal, external, excess, and deficiency patterns, or a combination thereof. The most common pathologies involved include:

Excessive Heat, Large Intestine Qi Deficiency, and Kidney Deficiency can all lead constipation complaints. Excessive Heat, especially in the Large Intestine, can result in dry, hard stools. Deficiency of the Kidneys can result in dry stools which can be pellet-like. Large Intestine Qi Deficiency can result in difficult to pass stools that are not hard or dry.

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Additional Information Required

- Other conditions should be ruled out by a medical doctor before pursuing a course of acupuncture. Authorization requests for non-musculoskeletal conditions must include additional information. Medical necessity for treatment of these conditions cannot be established without confirmation of both appropriate medical co-management, and progressive improvement with acupuncture. Additional information must include:
- Confirm current medical evaluation, diagnosis and treatment.
- Detailed current symptomatic evaluation appropriate to the symptom(s) treated with acupuncture
- Clear description of progress since the last authorization request

Specific Aspects of History

- Rule out red flags (requires medical management).
- Identify co-morbidities requiring medical management, and those that affect acupuncture and Oriental Medicine management.
- Regardless of any red flags, confirmation of medical evaluation and appropriate medical co-management should be confirmed before initiating a course of acupuncture. Constipation may result from various etiologies. Acupuncture is not considered medically necessary if it may delay or replace needed medical care.

Red Flag	Possible Consequence or Cause	Action Required
Cancer	Cause of symptoms (metastatic or primary)	Prompt referral to Primary Care Provider
Unexplained weight loss, Pain that is worse with recumbency or worse at night, Prior history of cancer, rectal bleeding	Malignancy	Prompt referral to Primary Care Provider
Fever, immune compromised state, intravenous drug use	Infection	Prompt referral to Primary Care Provider
Cyclic pain, inability to have bowel movement, nausea, vomiting	Bowel Obstruction	Immediate referral to emergency department
Fatigue, weakness, skin changes, stomach upset, constipation, fast heart rate, sweating, nervousness, depression	Potential for endocrine disorders	Prompt referral to Primary Care Provider
Onset of IBS-like symptoms after age 50	Malignancy	Prompt referral to Primary Care Provider
Family history of bowel cancer or inflammatory bowel disease	Malignancy or inflammatory bowel disease	Prompt referral to Primary Care Provider
Systemic symptoms	Metabolic, endocrine, neurologic, etc. disorders	Prompt referral to Primary Care Provider

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Subjective Findings

- **Chronic functional constipation:** Chronic, infrequent bowel movements, generally less than three per week, hard stool, feeling of incomplete evacuation, straining at defecation, blockage sensation during defecation, and need for manual maneuvers for defecation.

Functional Assessment

- **Bowel diaries** are recommended for assessment of chronic functional constipation. The bowel diaries should include daily food, drink and medication intake, bowel frequency, bowel urgency rating, bowel pain rating, other symptom(s) with associated rating, and Bristol stool type.
- The key outcome measurement used to assess chronic functional constipation is the number of **weekly spontaneous bowel movements**.
- Documentation of a patient's level of function is an important aspect of patient care. This documentation is required in order to establish the medical necessity of ongoing acupuncture treatment. The **Patient Specific Functional Scale (PSFS)** is a patient reported outcome assessment that is easy and appropriate for acupuncturists to use. The PSFS has been studied in peer-reviewed scientific literature, and it has been proven to be a valid, reliable, and responsive measure for a variety of pain syndromes (neck, back, knee, etc.). The PSFS could be adapted to describe the level which constipation or irritable bowel symptoms are affecting specific activities.

Objective Findings

Scope of Exam

- Inspection including Oriental Medicine inspection techniques
- Measure blood pressure, pulse rate, temperature

Specific Aspects of Examination for Constipation Symptoms

- Confirm current medical evaluation and diagnosis.
- Rule out other possible causes (via medical co-management with MD).

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Differential Diagnoses for Chronic Functional Constipation & IBS

- Abdominal Angina
- Abdominal Hernias
- Acute Intermittent Porphyria
- Anxiety Disorders
- Appendicitis
- Bacterial Gastroenteritis
- Bacterial Overgrowth Syndrome
- Biliary Colic
- Biliary Disease
- Celiac Disease
- Chronic Mesenteric Ischemia
- Chronic Pancreatitis
- Collagenous and Lymphocytic Colitis
- Colon Cancer
- Colonic Obstruction
- Crohn Disease
- Depression
- Diverticulitis
- Endocrine Neoplasia
- Endometriosis
- Food Allergies
- Giardiasis
- Hypercalcemia
- Hypothyroidism
- Hyperthyroidism and Thyrotoxicosis
- Ileus
- Inflammatory Bowel Disease
- Intestinal Motility Disorders
- Lactose Intolerance
- Large-Bowel Obstruction
- Malignant Neoplasms of the Small Intestine
- Medication induced bowel changes
- Mesenteric Artery Thrombosis
- Mesenteric Venous Thrombosis
- Ogilvie Syndrome
- Other organic causes of constipation
- Pancreatic Cancer
- Peritonitis and Abdominal Sepsis
- Pheochromocytoma
- Postcholecystectomy Syndrome
- Somatostatinomas
- Toxic Megacolon
- Ulcerative Colitis
- Viral Gastroenteritis

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Oriental Medicine Management [22]

- Most patients with this diagnosis will already have consulted with their Primary Care Provider. If not, however, they should be directed to make an appointment with their MD at their earliest opportunity. Confirmation of medical evaluation and appropriate co-management is required. Accurate diagnosis is important because constipation symptoms may occur in many other physical disorders which require care beyond Acupuncture and Oriental Medicine management.
- Acupuncture that may delay or replace needed medical care does not meet medical necessity criteria.
- Oriental Medicine management goals are to help reduce or resolve symptoms, help restore the highest level of function possible and help educate patient to reduce or prevent recurrent symptoms.
- Treatment frequency should be commensurate with the severity of the chief complaint, natural history of the condition, and expectation for functional improvement.
- When significant improvements in patient's subjective findings and objective findings are demonstrated—continued treatment with decreased frequency is appropriate.
- As treatment progresses, one should see an increase in the effective use of coping mechanisms, a decrease in the dependence on acupuncture services, and a fading of treatment frequency.
- If the condition has not progressed towards resolution, refer the patient to an appropriate health care provider to explore other treatment alternatives.
- eviCore's consideration of requests for continued acupuncture treatment depends on updated clinical information submitted regarding patient's progress.
- Adequate and legible patient progress information that contains a history and examination, and/or eviCore's Treatment Request Form for each treatment is required to determine medical necessity.
- In addition to the improvements in the table below, significant progress may be documented by increases in functional capacity and increasingly longer durations of symptomatic relief.
- Discharge occurs when reasonable functional goals and expected outcomes have been achieved.
- The patient is discharged when the patient/care-giver can continue management of symptoms with an independent home program.
- Treatment is discontinued when the patient is unable to progress towards outcomes because of medical complications, psychosocial factors or other personal circumstances.

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- If the member has been non-compliant with treatment as is evidenced by the clinical documentation, and/or the lack of demonstrated progress, treatment will be deemed to be not medically necessary and the member should be discharged from treatment.

Week	Progress
0-1	◆ Some reduction of symptom severity and frequency ◆ Ensure recent medical evaluation and appropriate co-management is in place
2-4	◆ 20-25% improvement in symptom severity and frequency ◆ Reinforce self-management techniques ◆ Reinforce continued medical co-management
5-8	◆ 50% improvement in symptom severity and severity ◆ Reinforce self-management techniques ◆ Reinforce continued medical co-management
9-12	◆ 75% improvement in symptom severity and severity ◆ Reinforce self-management techniques ◆ Reinforce continued medical co-management
13-16	◆ Condition is expected to have either resolved or reached a plateau stage ◆ Reinforce self-management techniques ◆ Reinforce continued medical co-management ◆ Discharge patient to elective care or back to their MD for alternative treatment options, when a plateau is reached or by week 16, whichever occurs first

Referral & Medical Co-Management Guidelines

- Refer patient to their Medical Doctor and/or Licensed Psychological Practitioner for evaluation of alternative treatment options if:
  - Confirmation of current evaluation and diagnosis from Medical Doctor is not provided.
  - There is significant worsening of the patient's complaint.
  - The patient shows additional complaints.
  - The patient has not responded positively to treatment after a couple of weeks.

Appropriate Procedures/Modalities

- Acupuncture
- Electro-acupuncture
- Herbal formulas

Note: Not all of these modalities are covered by patient's health-plan; review documentation regarding coverage. Acupuncture and herbs must be appropriate for covered diagnoses under the patient's insurance policy. Acupuncturist is responsible for determining which procedures/modalities are most appropriate for the patient's condition.

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Inappropriate Procedures/Modalities

- Scarring moxa
- Electro-acupuncture using more than 9 volts
- Any techniques outside of the scope of practice in your state

Self-Management Techniques

- Sitz bath
- Stay hydrated
- Avoid tobacco, alcohol, caffeine, spicy food
- Avoid dietary triggers
- Eat a fiber rich diet and non-absorbable carbohydrates
- Weight loss
- Good sleep hygiene habits
- Appropriate exercises/stretching
- Tai Qi, Qi Gong, yoga, self-acupressure
- Stress management
- Meditation, relaxation training
- Over-the-counter products (bulking agents, magnesium salts, agents containing polyethylene glycol, probiotics)
- Laxatives, enemas, suppositories

Alternatives to Oriental Medicine

(listed in alphabetical order)

- Prescription medications
- Psychological interventions and behavioral therapy including cognitive-behavioral therapy, hypnotherapy, and biofeedback therapy

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References

1. Balshem H, Helfand M, Schunemann HJ, Oxman AD, Kunz R, Brozek J, et al. GRADE guidelines: 3. Rating the quality of evidence. J Clin Epidemiol. 2011 Apr;64(4):401-6. doi:10.1016/j.jclinepi.2010.07.015.
2. Camilleri M. Functional Gastrointestinal Disorders: Novel Insights and Treatments. MedGenMed 1(3), 1999. https://www.medscape.com/viewarticle/717346_3
3. Chen CY, Ke MD, Kuo CD, Huang CH, Hsueh YH, Chen JR. The influence of electro-acupuncture stimulation to female constipation patients. Am J Chin Med. 2013;41(2):301-13. doi:10.1142/S0192415X13500225.
4. Chen L, Jin X, Jiang X, Wang C, Shi Y, Wang L. [Acupoint embedding for female functional constipation:a randomized controlled trial]. Zhongguo Zhen Jiu. 2017 Jul 12;37(7):717-721. doi:10.13703/j.0255-2930.2017.07.009.
5. Hempel S, Taylor SL, Solloway MR, Miake-Lye IM, Beroes JM, Shanman R, et al. VA Evidence-based Synthesis Program Reports. Evidence Map of Acupuncture. Washington (DC): Department of Veterans Affairs; 2014.
6. Horn KK, Jennings S, Richardson G, Vliet DV, Hefford C, Abbott JH. The patient-specific functional scale: psychometrics, clinimetrics, and application as a clinical outcome measure. J Orthop Sports Phys Ther. 2012 Jan;42(1):30-42. doi:10.2519/jospt.2012.3727.
7. Hseuh CC, and O'Connor. Acupuncture - A Comprehensive Text. Eastland Press, 1981.
8. Kaptchuk T. The Web That Has No Weaver. Contemporary Books. 2000.
9. Kelly RB. Acupuncture for pain. Am Fam Physician. 2009 Sep 1;80(5):481-4.
10. Lee HY, Kwon OJ, Kim JE, Kim M, Kim AR, Park HJ, Cho JH, Kim JH, Choi SM. Efficacy and safety of acupuncture for functional constipation: a randomised, sham-controlled pilot trial. BMC Complement Altern Med. 2018 Jun 15;18(1):186. doi:10.1186/s12906-018-2243-4.
11. Liu Z, Yan S, Wu J, He L, Li N, Dong G, et al. Acupuncture for Chronic Severe Functional Constipation: A Randomized Trial. Ann Intern Med. 2016 Dec 6;165(11):761-769. doi:10.7326/M15-3118.
12. Longstreth GF, Thompson WG, Chey WD, Houghton LA, Mearin F, Spiller RC. Functional bowel disorders. Gastroenterology. 2006 Apr;130(5):1480-91. doi:10.1053/j.gastro.2005.11.061.
13. MacPherson H, Vertosick EA, Foster NE, Lewith G, Linde K, Sherman KJ, et al. The persistence of the effects of acupuncture after a course of treatment: A meta-analysis of patients with chronic pain. Pain. 2016 Oct 17. doi:10.1097/j.pain.0000000000000747.
14. McDonald J, Janz S. The Acupuncture Evidence Project: A Comparative Literature Review (Revised Edition). Brisbane: Australian Acupuncture and Chinese Medicine Association Ltd; 2017.
15. National Health and Medical Research Council. NHMRC additional levels of evidence and grades for recommendations for developers of guidelines. Table 3. NHMRC Evidence Hierarchy: designations of 'levels of evidence' according to type of research question (including explanatory notes). National Health and Medical Research Council; 2009.
16. Shin JE, Jung HK, Lee TH, et al. Guidelines for the Diagnosis and Treatment of Chronic Functional Constipation in Korea, 2015 Revised Edition. J Neurogastroenterol Motil. 2016 Jul 30;22(3):383-411. doi:10.5056/jnm15185.
17. Wang CW, Li N, He HB, Lü JQ, Liu ZS. [Effect of electroacupuncture of Tianshu (ST 25) on the rational symptoms of functional constipation patients and evaluation on its efficacy satisfaction: a single-center, prospective, practical and randomized control trial]. Zhen Ci Yan Jiu. 2010 Oct;35(5):375-9.
18. Wang X, Yin J. Complementary and Alternative Therapies for Chronic Constipation. Evid Based Complement Alternat Med. 2015;2015:396396. doi:10.1155/2015/396396.
19. Wu JN, Zhang BY, Zhu WZ, Du RS, Liu ZS. [Comparison of efficacy on functional constipation treated with electroacupuncture of different acupoint prescriptions: a randomized controlled pilot trial]. Zhongguo Zhen Jiu. 2014 Jun;34(6):521-8.
20. Wu X, Zheng C, Xu X, Ding P, Xiong F, Tian M, Wang Y, Dong H, Zhang M, Wang W, Xu S, Xie M, Huang G. Electroacupuncture for Functional Constipation: A Multicenter, Randomized, Control Trial. Evid Based Complement Alternat Med. 2017;2017:1428943. doi:10.1155/2017/1428943.
21. Zhang ZL, Ji XQ, Zhao SH, Li P, Zhang WZ, Yu SH, Wang CM, Liu ZF. [Multi-central randomized controlled trials of electroacupunture at Zhigou (TE 6) for treatment of constipation induced by stagnation or deficiency of qi]. Zhongguo Zhen Jiu. 2007 Jul;27(7):475-8.

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22. Zheng H, Chen Q, Chen M, Wu X, She TW, Li J, Huang DQ, Yue L, Fang JQ. Nonpharmacological conservative treatments for chronic functional constipation: A systematic review and network meta-analysis. Neurogastroenterol Motil. 2019 Jan;31(1):e13441. doi:10.1111/nmo.13441.
23. Zheng H, Liu ZS, Zhang W, Chen M, Zhong F, Jing XH, Rong PJ, Zhu WZ, Wang FC, Liu ZB, Tang CZ, Wang SJ, Zhou MQ, Li Y, Zhu B. Acupuncture for patients with chronic functional constipation: A randomized controlled trial. Neurogastroenterol Motil. 2018 Feb 2. doi:10.1111/nmo.13307.
24. Zhou SL, Zhang XL, Wang JH. Comparison of electroacupuncture and medical treatment for functional constipation: a systematic review and meta-analysis. Acupunct Med. 2017 Oct;35(5):324-331. doi:10.1136/acupmed-2016-011127.

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ACU-12.5: Chronic Prostatitis

Definitions and History

Chronic prostatitis and chronic pelvic pain syndrome typically affects young to middle-aged men with variable symptoms. It is generally characterized by pelvis, lower back, lower abdominal, perineum, or genitalia pain without evidence of urinary tract infection. This condition must last longer than 3 months, with symptoms that often wax and wane. Pain can range from mild to severe. Dysuria, arthralgia, myalgia, abdominal pain, burning pain in the penis, urinary frequency, urinary urgency and weak or interrupted urine stream are common symptoms. Symptoms parallel those experienced by persons with chronic bacterial and nonbacterial prostatitis. In addition, pain during or after ejaculation is common and helps to distinguish this condition from benign prostatic hyperplasia (BPH). Additional symptoms may include low libido, sexual dysfunction and erectile dysfunction. Individuals with this condition are at risk of developing mental health disorders, such as anxiety and depression.

Oriental Medicine Diagnoses

In Oriental Medicine, chronic prostatitis and chronic pelvic pain symptoms are generally related to an accumulation or downward transmission of Dampness and Heat. It may also be related to a Deficiency of the Kidney and/or Spleen. Irregular dietary choices may allow for the development of Dampness and Heat. When this Dampness and Heat accumulates in the bladder, it gives rise to urinary symptoms such as urgency, frequency, intermittency, and painful urination. Liver Qi Stagnation may suppress the Urinary Bladder Qi mechanism and Blood Stasis may further disrupt normal bladder function and result in severe pain. Deficiency of the Spleen and or Kidneys will result in insufficient Qi to both hold and contain bladder fluids, giving rise to intermittent urination with post void dribbling. Over working, over thinking, excessive worry and irregular diet may contribute to this condition. The Oriental Medicine pattern may present as Deficiency, Excess, or a combination of both Deficiency and Excess patterns:

- Blood Stasis
- Damp Heat Accumulation
- Kidney Yin Deficiency
- Kidney Yang Deficiency & Dampness
- Kidney Yin Deficiency & Kidney Yang Deficiency
- Spleen Qi & Kidney Qi Deficiency
- Toxic Heat Accumulation & Qi Stagnation
- Qi and Yin Deficiency

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Additional Information Required

- Other conditions should be ruled out by a medical doctor before pursuing a course of acupuncture. Authorization requests for non-musculoskeletal conditions must include additional information. Medical necessity for treatment of these conditions cannot be established without confirmation of both appropriate medical co-management, and progressive improvement with acupuncture. Additional information must include:
- Confirm current medical evaluation, diagnosis and treatment.
- Detailed current symptomatic evaluation appropriate to the symptom(s) treated with acupuncture
- Clear description of progress since the last authorization request

Specific Aspects of History

- Rule out red flags (requires medical management).
- Identify co-morbidities requiring medical management, and those that affect acupuncture and Oriental Medicine management.
- Regardless of any red flags, confirmation of medical evaluation and appropriate medical co-management should be confirmed before initiating a course of acupuncture. Chronic prostatitis and chronic pelvic pain symptoms may result from various etiologies Acupuncture is not considered medically necessary if it may delay or replace needed medical care.

Red Flag	Possible Consequence or Cause	Action Required
Cancer	Cause of symptoms (metastatic or primary)	Prompt referral to Primary Care Provider
Painless blood in urine, Unexplained weight loss, Pain that is worse with recumbency or worse at night, Prior history of cancer	Malignancy	Prompt referral to Primary Care Provider
Fever, chills, flank pain, painful, frequent, and urgent urination, nausea, vomiting	Infection, possibly kidney stones	Immediate referral to urgent care or emergency department
Complete inability to urinate	Rupture of bladder	Immediate referral to emergency department
Fatigue, weakness, skin changes, stomach upset, constipation, fast heart rate, sweating, nervousness, depression	Potential for endocrine disorders	Prompt referral to Primary Care Provider
Penile discharge, genital lesions, history of unprotected sexual contact	Sexually transmitted disease	Prompt referral to Primary Care Provider

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Red Flag	Possible Consequence or Cause	Action Required
Acute onset of urinary and genital symptoms	Infection or kidney stones	Immediate referral to urgent care or emergency department
Arthritis, conjunctivitis/iritis, urethritis (multisystem, inflammatory disorder classically involving joints, the eye, and the lower genitourinary region)	Reactive arthritis (Reiter syndrome)	Prompt referral to Primary Care Provider
Thoughts or plans of self-harm	Self-harm, Suicide	Prompt referral to Primary Care Provider AND National Suicide Prevention Lifeline is available 24 hours every day 1-800-273-8255.
Thoughts or plans of isolation	Depression	Prompt referral to Primary Care Provider and/or Licensed Psychological Practitioner
Delusions, hallucinations, extreme mood change, confused thinking, dramatic change in eating or sleeping habits, high risk behaviors, recurring thoughts of death	Other mental health disorders	Prompt referral to Primary Care Provider and/or Licensed Psychological Practitioner
Suspicion of drug or alcohol dependence	Side effect or withdrawal phenomenon	Immediate referral to emergency department

Subjective Findings

- Pelvis, lower back, lower abdominal, perineum, or genitalia pain that generally waxes and wanes, ranging from mild to severe in intensity. Condition has been present for at least 3 months. Frequently dysuria, arthralgia, myalgia, abdominal pain, burning pain in the penis, urinary frequency, urinary urgency and weak or interrupted urine stream will be present. Pain during or after ejaculation may also be reported. Additional symptoms include low libido, sexual dysfunction, erectile dysfunction, anxiety, and depression.

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Functional Assessment

- **Daily diaries** are recommended for assessment of chronic prostatitis and chronic pelvic pain syndrome. The daily diaries could include frequency, severity and/or duration of each reported symptom.
- Documentation of a patient's level of function is an important aspect of patient care. This documentation is required in order to establish the medical necessity of ongoing acupuncture treatment. The **Patient Specific Functional Scale (PSFS)** is a patient reported outcome assessment that is easy and appropriate for acupuncturists to use. The PSFS has been studied in peer-reviewed scientific literature, and it has been proven to be a valid, reliable, and responsive measure for a variety of pain syndromes (neck, back, knee, etc.). The PSFS could be adapted to describe the level which the chronic prostatitis and chronic pelvic pain syndrome are affecting specific activities.
- The **Chronic Prostatitis Symptom Index** (NIH-CPSI) is another patient reported outcome assessment that uses nine questions, containing 21 items, to assess patient history in a consistent and quantifiable format. The questions cover pain, urinary symptoms, and impact of symptoms on quality of life. Each category generates separate scores and a total score is also calculated. In addition to the Patient Specific Functional Scale (PSFS), the Chronic Prostatitis Symptom Index can also be utilized to demonstrate improvement over the course of care.

Objective Findings

Scope of Exam

- Inspection including Oriental Medicine inspection techniques
- Measure blood pressure, pulse rate, temperature

Specific Aspects of Examination for Chronic Prostatitis and Chronic Pelvic Pain Symptoms

- Confirm current medical evaluation and diagnosis. Medical co-management with an MD is required. Acupuncture is not considered medically necessary if it may delay or replace needed medical care.
- Rule out other possible causes (via medical co-management with MD).
- Referral back to MD if any red flags are present.

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Differential Diagnoses for Chronic Prostatitis and Chronic Pelvic Pain Symptoms

- Acute bacterial prostatitis
- Benign prostatic hyperplasia (BPH)
- Carcinoma in situ of the urinary bladder
- Chronic urethritis
- Coccydynia
- Congenital or acquired abnormalities of the urethra
- Inflammatory bowel disease
- Interstitial cystitis
- Kidney Infection
- Kidney Stones
- Myofascial pain syndrome
- Nonbacterial prostatitis
- Pelvic joint dysfunction
- Prostate cancer
- Prostatic abscess
- Prostatic cyst
- Reactive arthritis
- Seminal vesiculitis
- Sexually transmitted diseases
- Tuberculosis of the genitourinary system
- Tuberculous prostatitis
- Urethral cancer
- Urethral diverticula
- Urethritis
- Urinary retention

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Oriental Medicine Management [2]

- Most patients with this diagnosis will already have consulted with their Primary Care Provider. If not, however, they should be directed to make an appointment with their MD at their earliest opportunity. Confirmation of medical evaluation and appropriate co-management is required. Accurate diagnosis is important because chronic prostatitis and chronic pelvic pain symptoms may occur in many other physical disorders which require care beyond Acupuncture and Oriental Medicine management.
- Acupuncture that may delay or replace needed medical care does not meet medical necessity criteria.
- Oriental Medicine management goals are to help reduce or resolve symptoms, help restore the highest level of function possible and help educate patient to reduce or prevent recurrent symptoms.
- Treatment frequency should be commensurate with the severity of the chief complaint, natural history of the condition, and expectation for functional improvement.
- When significant improvements in patient's subjective findings and objective findings are demonstrated—continued treatment with decreased frequency is appropriate.
- As treatment progresses, one should see an increase in the effective use of coping mechanisms, a decrease in the dependence on acupuncture services, and a fading of treatment frequency.
- If the condition has not progressed towards resolution, refer the patient to an appropriate health care provider to explore other treatment alternatives.
- eviCore's consideration of requests for continued acupuncture treatment depends on updated clinical information submitted regarding patient's progress.
- Adequate and legible patient progress information that contains a history and examination, and/or eviCore's Treatment Request Form for each treatment is required to determine medical necessity.
- In addition to the improvements in the table below, significant progress may be documented by increases in functional capacity and increasingly longer durations of symptomatic relief.
- Discharge occurs when reasonable functional goals and expected outcomes have been achieved.
- The patient is discharged when the patient/care-giver can continue management of symptoms with an independent home program.
- Treatment is discontinued when the patient is unable to progress towards outcomes because of medical complications, psychosocial factors or other personal circumstances.

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- If the member has been non-compliant with treatment as is evidenced by the clinical documentation, and/or the lack of demonstrated progress, treatment will be deemed to be not medically necessary and the member should be discharged from treatment.

Week	Progress
0-1	◆ Some reduction of symptom severity and frequency ◆ Ensure recent medical evaluation and appropriate co-management is in place
2-4	◆ 10-40% improvement in pain and/or urinary symptoms ◆ Reinforce self-management techniques ◆ Reinforce continued medical co-management
5-8	◆ 20-80% improvement in pain and/or urinary symptoms ◆ Reinforce self-management techniques ◆ Reinforce continued medical co-management
9-12	◆ 30-100% improvement in pain and/or urinary symptoms ◆ Reinforce self-management techniques ◆ Reinforce continued medical co-management
13-16	◆ Condition is expected to have either resolved or reached a plateau stage ◆ Reinforce self-management techniques ◆ Reinforce continued medical co-management ◆ Discharge patient to elective care or back to their MD for alternative treatment options, when a plateau is reached or by week 16, whichever occurs first

Referral & Medical Co-Management Guidelines

- Refer patient to their Medical Doctor and/or Licensed Psychological Practitioner for evaluation of alternative treatment options if:
  - Confirmation of current evaluation and diagnosis from Medical Doctor is not provided.
  - There is ANY indication of thoughts or plans for self-harm. The National Suicide Prevention Lifeline is available 24 hours every day, call 1-800-273-8255.
  - There are signs or symptoms of mental health disorders beyond anxiety or depression.
  - There is significant worsening of the patient's complaint.
  - The patient shows additional complaints.
  - The patient has not responded positively to treatment after a couple of weeks.

Appropriate Procedures/Modalities

- Acupuncture
- Electro-acupuncture
- Herbal formulas

Note: Not all of these modalities are covered by patient's health-plan; review documentation regarding coverage. Acupuncture and herbs must be appropriate for covered diagnoses under the patient's insurance policy. Acupuncturist is responsible for determining which procedures/modalities are most appropriate for the patient's condition.

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Inappropriate Procedures/Modalities

- Scarring moxa
- Electro-acupuncture using more than 9 volts
- Any techniques outside of the scope of practice in your state

Self-Management Techniques

- Sitz baths
- Avoid tobacco, alcohol, caffeine, spicy food
- Avoid dietary triggers
- Weight loss
- Good sleep hygiene habits
- Appropriate exercises/stretching
- Tai Qi, Qi Gong, yoga, self-acupressure
- Stress management
- Meditation, relaxation training

Alternatives to Oriental Medicine

(listed in alphabetical order)

- Medication therapy
- Physical therapy
- Psychological interventions including cognitive-behavioral therapy, hypnotherapy, biofeedback
- Surgical intervention

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References

1. Balshem H, Helfand M, Schunemann HJ, Oxman AD, Kunz R, Brozek J, et al. GRADE guidelines: 3. Rating the quality of evidence. J Clin Epidemiol. 2011 Apr;64(4):401-6. doi:10.1016/j.jclinepi.2010.07.015
2. Franco JVA, Turk T, Jung JH, Xiao YT, Iakhno S, Garrote V, Vietto V. Non-pharmacological interventions for treating chronic prostatitis/chronic pelvic pain syndrome. Cochrane Database of Systematic Reviews 2018, Issue 1. Art. No.: CD012551. doi:10.1002/14651858.CD012551.pub2
3. Hempel S, Taylor SL, Solloway MR, Miake-Lye IM, Beroes JM, Shanman R, et al. VA Evidence-based Synthesis Program Reports. Evidence Map of Acupuncture. Washington (DC): Department of Veterans Affairs; 2014. Date last accessed 01/15/18.
4. Horn KK, Jennings S, Richardson G, Vliet DV, Hefford C, Abbott JH. The patient-specific functional scale: psychometrics, clinimetrics, and application as a clinical outcome measure. J Orthop Sports Phys Ther. 2012 Jan;42(1):30-42. doi:10.2519/jospt.2012.3727.
5. Hseuh CC, and O'Connor. Acupuncture - A Comprehensive Text. Eastland Press, 1981.
6. Kaptchuk T. The Web That Has No Weaver. Contemporary Books. 2000.
7. Kelly RB. Acupuncture for pain. Am Fam Physician. 2009 Sep 1;80(5):481-4.
8. Küçük EV, Suçeken FY, Bindayı A, Boylu U, Onol FF, Gümüş E. Effectiveness of acupuncture on chronic prostatitis-chronic pelvic pain syndrome category IIIB patients: a prospective, randomized, nonblinded, clinical trial. Urology. 2015 Mar;85(3):636-40. doi:10.1016/j.urology.2014.11.004.
9. Lee SH, Lee BC. Electroacupuncture relieves pain in men with chronic prostatitis/chronic pelvic pain syndrome: three-arm randomized trial. Urology. 2009 May;73(5):1036-41. doi:10.1016/j.urology.2008.10.047.
10. Lee SW, Liong ML, Yuen KH, Leong WS, Chee C, Cheah PY, Choong WP, Wu Y, Khan N, Choong WL, Yap HW, Krieger JN. Acupuncture versus sham acupuncture for chronic prostatitis/chronic pelvic pain. Am J Med. 2008 Jan;121(1):79.e1-7. doi:10.1016/j.amjmed.2007.07.033.
11. Litwin MS, McNaughton-Collins M, Fowler Jr. FL, Nickel JC, Calhoun EA, Pontari MA, Alexander RB, Farrar JT, O'Leary MP, and the Chronic Prostatitis Collaborative Research Network (Presented by Dr. Litwin). The National Institutes of Health Chronic Prostatitis Symptoms Index (NIH-CPSI). 1999. https://www.prostatitis.org/nih-cpsi.html.
12. Liu BP, Wang YT, Chen SD. Effect of acupuncture on clinical symptoms and laboratory indicators for chronic prostatitis/chronic pelvic pain syndrome: a systematic review and meta-analysis. Int Urol Nephrol. 2016 Dec;48(12):1977-1991. doi:10.1007/s11255-016-1403-z.
13. MacPherson H, Vertosick EA, Foster NE, Lewith G, Linde K, Sherman KJ, et al. The persistence of the effects of acupuncture after a course of treatment: A meta-analysis of patients with chronic pain. Pain. 2016 Oct 17. doi:10.1097/j.pain.0000000000000747.
14. McDonald J, Janz S. The Acupuncture Evidence Project: A Comparative Literature Review (Revised Edition). Brisbane: Australian Acupuncture and Chinese Medicine Association Ltd; 2017.
15. Murphy AB, Macejko A, Taylor A, Nadler RB. Chronic prostatitis: management strategies. Drugs. 2009;69(1):71–84. doi:10.2165/00003495-200969010-00005.
16. National Health and Medical Research Council. NHMRC additional levels of evidence and grades for recommendations for developers of guidelines. Table 3. NHMRC Evidence Hierarchy: designations of 'levels of evidence' according to type of research question (including explanatory notes). National Health and Medical Research Council; 2009.
17. Qin Z, Wu J, Tian J, Zhou J, Liu Y, Liu Z. Network Meta-Analysis of the Efficacy of Acupuncture, Alpha-blockers and Antibiotics on Chronic Prostatitis/Chronic Pelvic Pain Syndrome. Sci Rep. 2016 Oct 19;6:35737. doi:10.1038/srep35737.
18. Qin Z, Wu J, Zhou J, Liu Z. Systematic Review of Acupuncture for Chronic Prostatitis/Chronic Pelvic Pain Syndrome. Medicine (Baltimore). 2016 Mar;95(11):e3095. doi:10.1097/MD.0000000000003095.
19. Qin Z, Zang Z, Zhou K, Wu J, Zhou J, Kwong JSW, Liu Z. Acupuncture for chronic prostatitis/chronic pelvic pain syndrome: a randomized, sham acupuncture-controlled trial. J Urol. 2018 May 4. pii: S0022-5347(18)43097-2. doi:10.1016/j.juro.2018.05.001.
20. Richard A Watson, MD; Chief Editor: Edward David Kim, MD, FACS. Chronic Pelvic Pain in Men. May 22, 2017. https://emedicine.medscape.com/article/437745-overview
21. Sahin S, Bicer M, Eren GA, Tas S, Tugcu V, Tasci AI, Cek M. Acupuncture relieves symptoms in chronic prostatitis/chronic pelvic pain syndrome: a randomized, sham-controlled trial. Prostate Cancer Prostatic Dis. 2015 Sep;18(3):249-54. doi:10.1038/pcan.2015.13.

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22. The National Institute of Diabetes and Digestive and Kidney Diseases. Prostatitis: Inflammation of the Prostate. July 2014. https://www.niddk.nih.gov/health-information/urologic-diseases/prostate-problems/prostatitis-inflammation-prostate.

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ACU-12.6: Dry Eye Syndrome

Definitions

Dry Eye Syndrome is a condition that occurs when the quantity and/or quality of tears fails to adequately lubricate and nourish the eye. Tears are a mixture of fatty oils, water, and mucus and are necessary for maintaining the health of the eye and providing clear vision. An inadequate quantity of tears can occur due to several factors, including aging, various medical conditions, side effect to medications, and environmental conditions. Poor quality of tears occurs when one or more of the three layers (oil, water, and mucin layers) of tears is deficient. The most common form of Dry Eye occurs when there is a deficiency of the water layer of the tears. This is known as Keratoconjunctivitis Sicca (KSC) or Dry Eye Syndrome. Excess tears drain through small ducts in the inner corners of the eyelid. Dry eyes can also occur when tear production and tear drainage is not in balance.

Oriental Medicine Diagnoses

In Oriental Medicine, Dry Eye is most often due to a deficiency of nourishing agents, such as Yin, or an excess of drying properties, such as Wind and Heat. Excess Heat, combined with a Yin and Yang imbalance can lead to insufficient nourishment along with inflammation of the eyes and eyelids. Environmental pathogen factors, such as Dryness, Heat, Summer Heat and Wind, can lead to Dry Eye. The Oriental Medicine pattern may present as a deficiency, excess or combination of both deficiency and excess:

- Deficiency of Liver and Kidney Yin
- Deficiency of Lung Yin
- Heart Heat induced Dry Eye
- Liver Heat induced Dry Eye
- Wind and Heat induced Dry Eye
- Environmental Dryness, Heat, Summer Heat and/or Wind induced Dry Eye

History

- Dry Eye occurs due to multiple factors and is generally a part of the natural aging process. Women are more likely to develop Dry Eye due to hormonal changes associated with pregnancy, oral contraceptive use, and menopause. Certain medications can reduce tear production and various medical conditions, such as Rheumatoid Arthritis, diabetes and thyroid problems increase the risk for Dry Eye. Exposure to environmental conditions such as dry climates, wind, and smoke can lead to increased tear evaporation rates, resulting in Dry Eye. In addition, long-term use of contact lenses can increase the risk of Dry Eye and refractive eye surgeries can result in diminished tear production, again leading to Dry Eye.

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Additional Information Required

- Other conditions should be ruled out by a medical doctor before pursuing a course of acupuncture. Authorization requests for non-musculoskeletal conditions must include additional information. Medical necessity for treatment of these conditions cannot be established without confirmation of both appropriate medical co-management, and progressive improvement with acupuncture. Additional information must include:
- Confirm current medical evaluation, diagnosis and treatment.
- Detailed current symptomatic evaluation appropriate to the symptom(s) treated with acupuncture
- Clear description of progress since the last authorization request

Specific Aspects of History

- Rule out red flags (requires medical management).
- Identify co-morbidities requiring medical management, and those that affect acupuncture and Oriental Medicine management.
- Regardless of any red flags, confirmation of medical evaluation and appropriate medical co-management should be confirmed before initiating a course of acupuncture. Dry eye symptoms may result from various etiologies. Acupuncture is not considered medically necessary if it may delay or replace needed medical care

Red Flag	Possible Consequence or Cause	Action Required
Persistent red eyes with associated pain, itching, discharge, swelling, especially of one eye	Keratitis, pink eye, corneal scratch	Prompt referral to Primary Care Provider/Eye doctor
Persistent watery eyes	Eyelid/tear-duct issue	Prompt referral to Primary Care Provider/Eye doctor
Frequent eye floaters, eye pain, flashes of light, loss of peripheral vision	Eye Stroke	Immediate referral to emergency department
Persistent drooping eyelid	Ptosis	Prompt referral to Primary Care Provider/Eye doctor
Acute onset of drooping of ½ of the face, weakness of ½ the body, slurred speech	Stroke	Immediate referral to emergency department
Transient loss of vision as though a window shade has been pulled over eyes, transient slurred speech, blurred vision, lack of coordination	Transient ischemic stroke (TIA) or other transient emboli	Immediate referral to emergency department
Pain or redness of eye after a foreign body has been removed	Infection, retained foreign body, damage to eye surface	Immediate referral to urgent care/eye doctor

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Red Flag	Possible Consequence or Cause	Action Required
Small, red, painful lump at base of eyelash	Stye	Prompt referral to Primary Care Provider/Eye doctor
Discharge	Infection/underlying disease	Prompt referral to Primary Care Provider/Eye doctor
Blood in eye, especially following head injury	Eye and/or brain injury	Immediate referral to emergency department
Signs of systemic ill health, weight loss, fever	Malignancy	Prompt referral to Primary Care Provider
Sudden, severe eye pain, redness of eye, reduced or blurry vision	Glaucoma	Immediate referral to emergency department

Subjective Findings

- Dry Eye may present as a painful, irritated, scratchy, and burning sensation in the eyes. There may be the sensation of grit or sand in the eyes, along with redness of the eyes. In addition, blurry vision may occur. Episodes of excessive tearing alternating with periods of dryness often ensues. In addition, there may be an excess of mucus in or around the eyes.

Functional Assessment

- Documentation of a patient's level of function is an important aspect of patient care. This documentation is required in order to establish the medical necessity of ongoing acupuncture treatment. The **Patient Specific Functional Scale (PSFS)** is a patient reported outcome assessment that is easy and appropriate for acupuncturists to use. The PSFS has been studied in peer-reviewed scientific literature, and it has been proven to be a valid, reliable, and responsive measure for a variety of pain syndromes (neck, back, knee, etc.). The PSFS could be adapted to describe the level that eye dryness is affecting specific activities.
- The **Ocular Surface Disease Index (OSDI)** is a 12-item scale for the assessment of symptoms related to Dry Eye Disease and its effect on vision. This index allows for assessment of symptoms, functional limitations, and environmental factors related to Dry Eye.

Objective Findings

Scope of Exam

- Inspection including Oriental Medicine inspection techniques
- Measure blood pressure, pulse rate, temperature

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Specific Aspects of Examination for Dry Eye Symptoms

- Confirm current medical evaluation and diagnosis. Medical co-management with an MD is required. Acupuncture is not considered medically necessary if it may delay or replace needed medical care.
- Rule out other possible causes (via medical co-management with MD).
- Referral back to MD if any red flags are present.

Differential Diagnoses for Dry Eye Syndrome

- Blepharitis
- Diabetes
- Hypertension
- Lupus
- Medication side effects
- Parkinson's disease
- Rheumatoid arthritis
- Rosacea
- Scleroderma
- Sjögren's syndrome
- Thyroid disorders
- Vitamin A deficiency

Oriental Medicine Management

- Many patients with this diagnosis may not have consulted with their Primary Care Provider. As such, they should be directed to make an appointment with their MD at their earliest opportunity. Confirmation of medical evaluation and appropriate co-management is required. Accurate diagnosis is important because dry eye symptoms may occur in many other physical disorders which require care beyond Acupuncture and Oriental Medicine management.
- Acupuncture that may delay or replace needed medical care does not meet medical necessity criteria.
- Oriental Medicine management goals are to help reduce or resolve symptoms, help restore the highest level of function possible and help educate patient to reduce or prevent recurrent symptoms.
- Treatment frequency should be commensurate with the severity of the chief complaint, natural history of the condition, and expectation for functional improvement.
- When significant improvements in patient's subjective findings and objective findings are demonstrated—continued treatment with decreased frequency is appropriate.

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- As treatment progresses, one should see an increase in the effective use of coping mechanisms, a decrease in the dependence on acupuncture services, and a fading of treatment frequency.
- If the condition has not progressed towards resolution, refer the patient to an appropriate health care provider to explore other treatment alternatives.
- eviCore's consideration of requests for continued acupuncture treatment depends on updated clinical information submitted regarding patient's progress.
- Adequate and legible patient progress information that contains a history and examination, and/or eviCore's Treatment Request Form for each treatment is required to determine medical necessity.
- In addition to the improvements in the table below, significant progress may be documented by increases in functional capacity and increasingly longer durations of symptomatic relief.
- Discharge occurs when reasonable functional goals and expected outcomes have been achieved.
- The patient is discharged when the patient/care-giver can continue management of symptoms with an independent home program.
- Treatment is discontinued when the patient is unable to progress towards outcomes because of medical complications, psychosocial factors or other personal circumstances.
- If the member has been non-compliant with treatment as is evidenced by the clinical documentation, and/or the lack of demonstrated progress, treatment will be deemed to be not medically necessary and the member should be discharged from treatment.

Week	Progress
0-1	◆ Some reduction of symptom severity and frequency ◆ Ensure recent medical evaluation and appropriate co-management is in place
2-4	◆ 30% improvement in symptom severity and frequency ◆ Reinforce self-management techniques ◆ Reinforce continued medical co-management
5-8	◆ 60% improvement in symptom severity and severity ◆ Reinforce self-management techniques ◆ Reinforce continued medical co-management
9-12	◆ 90-100% improvement in symptom severity and frequency ◆ Condition is expected to have either resolved or reached a plateau stage by this time ◆ Reinforce self-management techniques ◆ Reinforce continued medical co-management ◆ Discharge patient to elective care or back to their MD for alternative treatment options when a plateau is reached or by week 12, whichever occurs first

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Referral & Medical Co-Management Guidelines

- Refer patient to their Medical Doctor for evaluation of alternative treatment options if:
  - Confirmation of current evaluation and diagnosis from Medical Doctor is not provided.
  - There is significant worsening of the patient's complaint.
  - The patient shows additional complaints.
  - The patient has not responded positively to treatment after a couple of weeks.
  - The patient develops any visual or cognitive changes

Appropriate Procedures/Modalities

- Acupuncture
- Electro-acupuncture
- Herbal formulas

Note: Not all of these modalities are covered by patient's health-plan; review documentation regarding coverage. Acupuncture and herbs must be appropriate for covered diagnoses under the patient's insurance policy. Acupuncturist is responsible for determining which procedures/modalities are most appropriate for the patient's condition.

Inappropriate Procedures/Modalities

- Scarring moxa
- Electro-acupuncture using more than 9 volts
- Any techniques outside of the scope of practice in your state

Self-Management Techniques

- Avoid dietary triggers
- Blink Regularly
- Eyelid Cleaner
- Good sleep hygiene habits
- Increase humidity at work and home
- Maintain adequate hydration
- Omega-3 fatty acid nutritional supplementation
- Over-the-counter artificial tear solutions
- Reduce electronic screen time
- Reduce environmental triggers
- Warm compresses
- Wear sunglasses

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Alternatives to Oriental Medicine

(listed in alphabetical order)

- Autologous blood serum drops
- Hydroxypropyl cellulose inserts
- Prescription medications
- Punctal plugs
- Scleral/bandage lenses
- Surgery to correct anatomical defects
- Treatment of other medical conditions that may contribute to dry eyes

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References

1. American Optometric Association. Dry Eye. 2018. https://www.aoa.org/patients-and-public/eye-and-vision-problems/glossary-of-eye-and-vision-conditions/dry-eye#top.
2. Balshem H, Helfand M, Schunemann HJ, Oxman AD, Kunz R, Brozek J, et al. GRADE guidelines: 3. Rating the quality of evidence. J Clin Epidemiol. 2011 Apr;64(4):401-6. doi:10.1016/j.jclinepi.2010.07.015.
3. Grönlund MA, Stenevi U, Lundeberg T. Acupuncture treatment in patients with keratoconjunctivitis sicca: a pilot study. Acta Ophthalmol Scand. 2004 Jun;82(3 Pt 1):283-90. doi:10.1111/j.1600-0420.2004.00254.x.
4. He HQ, Wang ZL, Hu HL, and Liu R. Effect of acupuncture on lacrimal film of Xeroma patients. Journal of Nanjing TCM University, vol. 20, no. 3, pp. 158–159, 2004.
5. Hempel S, Taylor SL, Solloway MR, Miake-Lye IM, Beroes JM, Shanman R, et al. VA Evidence-based Synthesis Program Reports. Evidence Map of Acupuncture. Washington (DC): Department of Veterans Affairs; 2014. Date last accessed 01/15/18.
6. Horn KK, Jennings S, Richardson G, Vliet DV, Hefford C, Abbott JH. The patient-specific functional scale: psychometrics, clinimetrics, and application as a clinical outcome measure. J Orthop Sports Phys Ther. 2012 Jan;42(1):30-42. doi:10.2519/jospt.2012.3727.
7. Hseuh CC, and O'Connor. Acupuncture - A Comprehensive Text. Eastland Press, 1981.
8. Kaptchuk T. The Web That Has No Weaver. Contemporary Books. 2000.
9. Kelly RB. Acupuncture for pain. Am Fam Physician. 2009 Sep 1;80(5):481-4.
10. Kim BH, Kim MH, Kang SH, Nam HJ. Optimizing acupuncture treatment for dry eye syndrome: a systematic review. BMC Complement Altern Med. 2018 May 3;18(1):145. doi:10.1186/s12906-018-2202-0.
11. Kim TH, Kang JW, Kim KH, Kang KW, Shin MS, Jung SY, Kim AR, Jung HJ, Choi JB, Hong KE, Lee SD, Choi SM. Acupuncture for the treatment of dry eye: a multicenter randomised controlled trial with active comparison intervention (artificial teardrops). PLoS One. 2012;7(5):e36638. doi:10.1371/journal.pone.0036638.
12. Lee MS, Shin BC, Choi TY, Ernst E. Acupuncture for treating dry eye: a systematic review. Acta Ophthalmol. 2011 Mar;89(2):101-6. doi:10.1111/j.1755-3768.2009.01855.x.
13. MacPherson H, Vertosick EA, Foster NE, Lewith G, Linde K, Sherman KJ, et al. The persistence of the effects of acupuncture after a course of treatment: A meta-analysis of patients with chronic pain. Pain. 2016 Oct 17. doi:10.1097/j.pain.0000000000000747.
14. Mayo Foundation for Medical Education and Research (MFMER). Dry Eye. 1998-2018. https://www.mayoclinic.org/diseases-conditions/dry-eyes/symptoms-causes/syc-20371863.
15. McDonald J, Janz S. The Acupuncture Evidence Project: A Comparative Literature Review (Revised Edition). Brisbane: Australian Acupuncture and Chinese Medicine Association Ltd; 2017.
16. Miller KL, Walt JG, Mink DR, Satram-Hoang S, Wilson SE, Perry HD, Asbell PA, Pflugfelder SC. Minimal clinically important difference for the ocular surface disease index. Arch Ophthalmol. 2010 Jan;128(1):94-101. doi:10.1001/archophthalmol.2009.356.
17. National Health and Medical Research Council. NHMRC additional levels of evidence and grades for recommendations for developers of guidelines. Table 3. NHMRC Evidence Hierarchy: designations of 'levels of evidence' according to type of research question (including explanatory notes). National Health and Medical Research Council; 2009.
18. Nepp J, Wedrich A, Akramian J, Derbolav A, Mudrich C, Ries E, Schauersberger J. Dry eye treatment with acupuncture. A prospective, randomized, double-masked study. Adv Exp Med Biol. 1998;438:1011-6. doi:10.1007/978-1-4615-5359-5_146.
19. Schiffman RM, Christianson MD, Jacobsen G, Hirsch JD, Reis BL. Reliability and validity of the Ocular Surface Disease Index. Arch Ophthalmol. 2000 May;118(5):615-21.
20. Shi JL, Miao WH. [Effects of acupuncture on lactoferrin content in tears and tear secretion in patients suffering from dry eyes: a randomized controlled trial]. Zhong Xi Yi Jie He Xue Bao. 2012 Sep;10(9):1003-8. doi:10.1136/bmjophth-2018-000150.
21. Shin MS, Kim JI, Lee MS, Kim KH, Choi JY, Kang KW, Jung SY, Kim AR, Kim TH. Acupuncture for treating dry eye: a randomized placebo-controlled trial. Acta Ophthalmol. 2010 Dec;88(8):e328-33. doi:10.1111/j.1755-3768.2010.02027.x.

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22. Tseng KL, Liu HJ, Tso KY, Woung LC, Su YC, Lin JG. A clinical study of acupuncture and SSP (silver spike point) electro-therapy for dry eye syndrome. Am J Chin Med. 2006;34(2):197-206. doi:10.1142/S0192415X0600376X.
23. Wang ZL, He HQ, Huang D, Shi CG. [Effect of integral syndrome differentiation acupuncture on the tear film stability in the patient of xerophthalmia]. Zhongguo Zhen Jiu. 2005 Jul;25(7):460-3.
24. Yang L, Yang Z, Yu H, Song H. Acupuncture therapy is more effective than artificial tears for dry eye syndrome: evidence based on a meta-analysis. Evid Based Complement Alternat Med. 2015;2015:143858. doi:10.1155/2015/143858.

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ACU-12.7: Extrinsic Asthma

Synonyms

Allergic asthma, atopic asthma, childhood asthma.

Definition

Asthma is a common chronic inflammatory disease of the airways characterized by variable and recurring symptoms, reversible airflow obstruction, and bronchospasm. Symptoms include wheezing, coughing, chest tightness, and shortness of breath. Asthma is clinically classified according to the frequency of symptoms, forced expiratory volume in 1 second (FEV1), and peak expiratory flow rate. Asthma may also be classified as atopic (extrinsic) or non-atopic (intrinsic). Extrinsic asthma is triggered by external allergenic factors.

It is thought to be caused by a combination of genetic and environmental factors.

Oriental Medicine Diagnoses

- Liver Qi Stagnation
  - The Liver Qi becomes stagnated, causing the Liver to attack the Lungs. Causation can be due to external pathogens (such as allergens or toxins); or internal causes, including poor diet, lack of sleep, or stress.
- Kidneys Not Grasping the Lung Qi
  - A deficiency of Kidney Qi may cause weakness affecting the Lung channel. Causation is from either congenital deficiency of Kidney Qi and/or lifestyle factors that lead to a depletion of Kidney Qi.
- Lung Qi Deficiency
  - Weakness of the Lung Qi leads to obstruction in the Lung channel. Causation may be congenital deficiency, or due to lifestyle factors, including poor diet and overwork.
- Phlegm-Heat in the Lung
  - Lung and Spleen Q Deficiency leads to an accumulation of Dampness and Phlegm, which combined with an accumulation of Heat (secondary to stagnation), creates Phlegm-Heat obstructing the channels of the Lung. Causation may be congenital, or due to lifestyle factors such as poor diet and overwork.
- Wind-Cold attacking the Lungs
  - An external pathogen (termed “Wind-Cold”) attacks the Lung channel, causing obstruction of the Lung Qi. Causation is an external attack, often exacerbated by pre-existing deficiency in the Lung Qi.

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History

- Symptoms may develop in childhood, or later in adult life
- Symptoms may be seasonal (for instance pollen in spring), or perennial (a dust allergy may be present year-round).
- Children will sometimes “outgrow” asthma as they mature

Specific Aspects of History

- Rule out red flags (requires medical management).
- Identify co-morbidities requiring medical management, and those that affect acupuncture and Oriental Medicine management.

Red Flag	Possible Consequence or Cause	Action Required
Severe, life-threatening asthma attacks	Requires medical co-management	Immediate referral to emergency department
Any cardiac abnormalities	Requires medical co-management	Immediate referral to emergency department
Very sudden onset without previous history	Possible airway obstruction	Immediate referral to emergency department
Worsens after recent change in medication	Requires medical co-management	Prompt referral to Primary Care Provider
Other recent changes in health or in healthcare	May indicate a systemic condition	Prompt referral to Primary Care Provider

Subjective Findings

- Recurrent difficulty in breathing
- Recurrent chest tightness
- Recurrent wheezing
- Chronic cough, especially at night
- Sensation of “not being able to take a full breath”
- Worse with exposure to allergens, weather changes, or emotional or physical stress.
- Pain should be documented as a numeric pain scale 0-10
- VAS may be used for other symptoms
- Specific symptom frequency, duration and VAS or numeric scale should be documented

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Functional Assessment

- Documentation of a patient's level of function is an important aspect of patient care. This documentation is required in order to establish the medical necessity of ongoing acupuncture treatment. The Patient Specific Functional Scale (PSFS) is a patient reported outcome assessment that is easy and appropriate for acupuncturists to use. The PSFS has been studied in peer-reviewed scientific literature, and it has been proven to be a valid, reliable, and responsive measure for a variety of pain syndromes (neck, back, knee, etc.).

Objective Findings

Scope of Exam

- Inspection including Oriental Medicine inspection techniques
- Inspection of nose, ears, eyes, and back of throat
- Measure blood pressure, pulse rate, temperature
- Wheezing may or may not be heard at the time of the office visit

Specific Aspects of Examination for Extrinsic Asthma

- Rule out other possible causes.
- A referral to an MD may be considered if other causes are a possibility.
- Most patients will already have seen one or more MD's for this condition; if not, referral is recommended.

Findings of Extrinsic Asthma

- Difficult respiration
- If severe, may be life-threatening
- Sleep disturbances
- Irritability
- Fatigue
- Difficulty in concentration

Differential Diagnoses

- Allergic rhinitis and allergic sinusitis
- Obstructions involving large airways
- Vocal cord dysfunction
- Vascular rings or laryngeal webs
- Laryngotracheomalacia, tracheal stenosis, or bronchostenosis
- Enlarged lymph nodes or tumor

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- Airway obstructions (foreign objects, tumors)
- Viral bronchiolitis or obliterative bronchiolitis
- Cystic fibrosis
- Bronchopulmonary dysplasia
- Heart disease
- Recurrent cough not due to asthma
- Aspiration from swallowing mechanism dysfunction or gastroesopageal reflux
- Medication induced
- COPD (e.g., chronic bronchitis or emphysema)
- Congestive heart failure
- Pulmonary embolism
- Pulmonary infiltration with eosinophilia
- Cough secondary to drugs (e.g., angiotensin-converting enzyme (ACE) inhibitors)

Oriental Medicine Management [5]

- Most patients with this diagnosis will already have consulted with their Primary Care Provider. If not, however, they should be directed to make an appointment with their MD at their earliest opportunity.
- Confirmation of appropriate medical co-management is always required when treating children age 14 and under.
- Acupuncture is not considered medically necessary if it may delay or replace needed care.
- Oriental Medicine management goals are to reduce or resolve symptoms, restore the highest level of function possible and educate patient to reduce or prevent recurrent symptoms.
- Treatment frequency should be commensurate with severity of the chief complaint.
- When significant improvement in subjective findings and objective findings are demonstrated—continued treatment with decreased frequency is appropriate.
- If the condition has not progressed towards resolution, refer the patient to an appropriate health care provider to explore other treatment alternatives.
- eviCore's consideration of requests for continued acupuncture treatment depends on updated clinical information submitted regarding patient's progress.
- Adequate and legible patient progress information that contains a history and examination, and/or eviCore's Acupuncture Treatment Request Form is required to determine medical necessity.

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- In addition to improvements in the table below, significant progress may be documented by increases in functional capacity and increasingly longer durations of symptom relief.
- Initiate two to four week trial of treatment.
- If severity or frequency of asthma decreases following the initial trial—continue treatment at a reduced frequency for a one month period.
- Recommendations depend on causation can include dietary recommendations, changes in daily routine and/or housekeeping routines (to reduce exposure to allergens), and possibly herbal formulas.
- If the patient does not improve with trial of Oriental Medicine treatment, or has reached a plateau, refer patient to an MD to explore other alternatives.
- Discharge occurs when reasonable functional goals and expected outcomes have been achieved.
- The patient is discharged when the patient/care-giver can continue management of symptoms with an independent home program.
- Treatment is discontinued when the patient is unable to progress towards outcomes because of medical complications, psychosocial factors or other personal circumstances.
- If the member has been non-compliant with treatment as is evidenced by the clinical documentation, and/or the lack of demonstrated progress, treatment will be deemed to be not medically necessary and the member should be discharged from treatment.

Week	Progress
0-1	◆ Some reduction of symptom severity and frequency
2-4	◆ 25% improvement in symptom severity and frequency ◆ Reinforce self-management techniques
5-8	◆ 50% improvement in symptom severity and severity ◆ Reinforce self-management techniques
9-12	◆ 75% improvement in symptom severity and frequency ◆ Reinforce self-management techniques
13-16	◆ Condition is expected to have either resolved or reached a plateau stage by this time ◆ Reinforce self-management techniques ◆ Discharge patient to elective care, or to their primary care provider for alternative treatment options when a plateau is reached, or by week 16, whichever occurs first

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Referral Guidelines (or co-management)

- Refer patient to their primary care provider for evaluation of alternative treatment options if:
  - Most patients with severe asthma will already be under the care of an MD. If not, they should be advised to seek medical co-management.
  - There are any cardiac abnormalities.
  - The condition has arisen suddenly and severely, without previous history.
  - There have been any significant recent changes in their overall health, or in their medication regimen.
  - The patient has not responded positively to treatment after a couple of weeks.
  - The condition appears to be worsening.

Appropriate Procedures/Modalities

- Acupuncture
- Electro-acupuncture
- Cupping
- Gua Sha
- Acupressure
- Herbal formulas

Note: Not all of these modalities are covered by patient's health-plan; review documentation regarding coverage. Acupuncture and herbs must be appropriate for covered diagnoses under the patient's insurance policy. Acupuncturist is responsible for determining which procedures/modalities are most appropriate for the patient's condition.

Inappropriate Procedures/Modalities

- Scarring moxa
- Applied kinesiology techniques
- Electro-acupuncture using more than 9 volts
- Any techniques outside of the scope of practice in your state

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Self-Management Techniques

- Rest and reduce strenuous activities
- Appropriate exercises/stretching
- Tai Qi, Qi Gong, Yoga
- Stress management, meditation
- Self-massage, Self-acupressure
- Avoid suspected or known allergic triggers:
  - Avoid outdoor activities during high-pollen hours
  - Remove allergens from the home environment to the extent possible (air purifiers, filter vacuums, proper dusting, clean HVAC filters, frequent washing of linens, etc
- Avoid suspected dietary triggers:
  - Excess dairy
  - Excess sugar
  - Excess fatty or fried foods
  - Any known food sensitivities (wheat, gluten, etc, depending on the patient)
  - Some patients may benefit from irrigation of the nasal passages (neti pot, etc)

Alternatives to Oriental Medicine

(listed in alphabetical order)

- Allergy shots
- Dietary/Nutritional Medicine Counseling
- Medication (oral and/or inhaled)
- Moving to an area with fewer allergens

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References

1. Balshem H, Helfand M, Schunemann HJ, Oxman AD, Kunz R, Brozek J, et al. GRADE guidelines: 3. Rating the quality of evidence. J Clin Epidemiol. 2011 Apr;64(4):401-6. doi:10.1016/j.jclinepi.2010.07.015.
2. Cheng X, Deng L. Chinese Acupuncture and Moxibustion. Beijing: Foreign Language Press; 2010.
3. Hempel S, Taylor SL, Solloway MR, Miake-Lye IM, Beroes JM, Shanman R, et al. VA Evidence-based Synthesis Program Reports. Evidence Map of Acupuncture. Washington (DC): Department of Veterans Affairs; 2014.
4. Horn KK, Jennings S, Richardson G, Vliet DV, Hefford C, Abbott JH. The patient-specific functional scale: psychometrics, clinimetrics, and application as a clinical outcome measure. J Orthop Sports Phys Ther. 2012 Jan;42(1):30-42. doi:10.2519/jospt.2012.3727.
5. Jiang C, Jiang L, Qin Q. Conventional Treatments plus Acupuncture for Asthma in Adults and Adolescent: A Systematic Review and Meta-Analysis. Evid Based Complement Alternat Med. 2019;2019:9580670. Published 2019 Jan 17. doi:10.1155/2019/9580670
6. Kaptchuk T. The Web That Has No Weaver. Contemporary Books. 2000.
7. Kelly RB. Acupuncture for pain. Am Fam Physician. 2009 Sep 1;80(5):481-4.
8. Maciocia, G; The Foundations of Chinese Medicine: A Comprehensive Text; Churchill Livingstone, 2005.
9. MacPherson H, Vertosick EA, Foster NE, Lewith G, Linde K, Sherman KJ, et al. The persistence of the effects of acupuncture after a course of treatment: A meta-analysis of patients with chronic pain. Pain. 2016 Oct 17. doi:10.1097/j.pain.0000000000000747.
10. McDonald J, Janz S. The Acupuncture Evidence Project: A Comparative Literature Review (Revised Edition). Brisbane: Australian Acupuncture and Chinese Medicine Association Ltd; 2017.
11. National Health and Medical Research Council. NHMRC additional levels of evidence and grades for recommendations for developers of guidelines. Table 3. NHMRC Evidence Hierarchy: designations of 'levels of evidence' according to type of research question (including explanatory notes). National Health and Medical Research Council; 2009.
12. O'Connor J, Bensky D. Acupuncture: A Comprehensive Text. Chicago: Eastland Press; 1981.
13. Pai HJ, Azevedo RS, Braga AL, Martins LC, Saraiva-Romanholo BM, Martins Mde A, Lin CA. A randomized, controlled, crossover study in patients with mild and moderate asthma undergoing treatment with traditional Chinese acupuncture. Clinics (Sao Paulo). 2015 Oct;70(10):663-9. doi:10.6061/clinics/2015(10)01.
14. Porter, R; The Merck Manual, Merck, 2011.
15. Su L, Meng L, Chen R, Wu W, Peng B, Man L. Acupoint Application for Asthma Therapy in Adults: A Systematic Review and Meta-Analysis of Randomized Controlled Trials. Forsch Komplementmed. 2016;23(1):16-21. doi:10.1159/000443813.

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ACU-12.8: Intrinsic Asthma

Synonyms

Immunological asthma, late onset asthma.

Definition

Asthma is a common chronic inflammatory disease of the airways characterized by variable and recurring symptoms, reversible airflow obstruction, and bronchospasm. Symptoms include wheezing, coughing, chest tightness, and shortness of breath. Asthma is clinically classified according to the frequency of symptoms, forced expiratory volume in 1 second (FEV1), and peak expiratory flow rate. Asthma may also be classified as atopic (extrinsic) or non-atopic (intrinsic). Intrinsic asthma is triggered by internal immunologic factors.

It is thought to be caused by a combination of genetic and environmental factors.

Oriental Medicine Diagnoses

- Liver Qi Stagnation
  - The Liver Qi becomes stagnated, causing the Liver to attack the Lungs. Causation can be due to external pathogens (such as viruses or toxins); or internal causes, including poor diet, lack of sleep, or stress.
- Kidneys Not Grasping the Lung Qi
  - A deficiency of Kidney Qi may cause weakness affecting the Lung channel. Causation is from either congenital deficiency of Kidney Qi and/or lifestyle factors that lead to a depletion of Kidney Qi.
- Lung Qi Deficiency
  - Weakness of the Lung Qi leads to obstruction in the Lung channel. Causation may be congenital deficiency, or due to lifestyle factors, including poor diet and overwork.
- Phlegm-Heat in the Lung
  - Lung and Spleen Qi deficiency leads to an accumulation of Dampness and Phlegm, which combined with an accumulation of Heat (secondary to stagnation and attack of external pathogens), creates Phlegm-Heat obstructing the channels of the Lung. Causation may be congenital, or due to lifestyle factors such as poor diet and overwork.
- Wind-Cold attacking the Lungs
  - An external pathogen (termed “Wind-Cold”) attacks the Lung channel, causing obstruction of the Lung Qi. Causation is an external attack, often exacerbated by pre-existing deficiency in the Lung Qi.

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History

- Symptoms may develop in childhood, but more commonly, later in adult life
- Symptoms generally develop after chronic, recurrent, or severe viral or bacterial infections of the respiratory system

Specific Aspects of History

- Rule out red flags (requires medical management).
- Identify co-morbidities requiring medical management, and those that affect acupuncture and Oriental Medicine management.

Red Flag	Possible Consequence or Cause	Action Required
Severe, life-threatening asthma attacks	Requires medical co-management	Immediate referral to emergency department
Any cardiac abnormalities	Requires medical co-management	Immediate referral to emergency department
Fever, yellow discharge, or other signs of active viral or bacterial infection	May require medical co-management	Prompt referral to Primary Care Provider
Very sudden onset without previous history	Possible airway obstruction	Immediate referral to emergency department
Worsens after recent change in medication	Requires medical co-management	Prompt referral to Primary Care Provider
Other recent changes in health or in healthcare	May indicate a systemic condition	Prompt referral to Primary Care Provider

Subjective Findings

- Recurrent difficulty in breathing
- Recurrent chest tightness
- Recurrent wheezing
- Chronic cough, especially at night
- Sensation of “not being able to take a full breath”
- Worse with exposure to allergens, weather changes, or emotional or physical stress.
- Pain should be documented as a numeric pain scale 0-10
- VAS may be used for other symptoms
- Specific symptom frequency, duration and VAS or numeric scale should be documented

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Functional Assessment

- Documentation of a patient's level of function is an important aspect of patient care. This documentation is required in order to establish the medical necessity of ongoing acupuncture treatment. The Patient Specific Functional Scale (PSFS) is a patient reported outcome assessment that is easy and appropriate for acupuncturists to use. The PSFS has been studied in peer-reviewed scientific literature, and it has been proven to be a valid, reliable, and responsive measure for a variety of pain syndromes (neck, back, knee, etc.).

Objective Findings

Scope of Exam

- Inspection including Oriental Medicine inspection techniques
- Inspection of nose, ears, eyes, and back of throat
- Measure blood pressure, pulse rate, temperature
- Wheezing may or may not be heard at the time of the office visit

Specific Aspects of Examination for Intrinsic Asthma

- Rule out other possible causes.
- A referral to an MD may be considered if other causes are a possibility.
- Most patients will already have seen one or more MD's for this condition; if not, referral is recommended.

Findings of Intrinsic Asthma

- Difficult respiration
- If severe, may be life-threatening
- Sleep disturbances
- Irritability
- Fatigue
- Difficulty in concentration

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Differential Diagnoses

- Allergic rhinitis and allergic sinusitis
- Obstructions involving large airways
- Vocal cord dysfunction
- Vascular rings or laryngeal webs
- Laryngotracheomalacia, tracheal stenosis, or bronchostenosis
- Enlarged lymph nodes or tumor
- Airway obstructions (foreign objects, tumors)
- Viral bronchiolitis or obliterative bronchiolitis
- Cystic fibrosis
- Bronchopulmonary dysplasia
- Heart disease
- Recurrent cough not due to asthma
- Aspiration from swallowing mechanism dysfunction or gastroesopageal reflux
- Medication induced
- COPD (e.g., chronic bronchitis or emphysema)
- Congestive heart failure
- Pulmonary embolism
- Pulmonary infiltration with eosinophilia
- Cough secondary to drugs (e.g., angiotensin-converting enzyme (ACE) inhibitors)

Oriental Medicine Management [7]

- Most patients with this diagnosis will already have consulted with their Primary Care Provider. If not, however, they should be directed to make an appointment with their MD at their earliest opportunity.
- Confirmation of appropriate medical co-management is always required when treating children age 14 and under.
- Acupuncture is not considered medically necessary if it may delay or replace needed care.
- Oriental Medicine management goals are to reduce or resolve symptoms, restore the highest level of function possible and educate patient to reduce or prevent recurrent symptoms.
- Treatment frequency should be commensurate with severity of the chief complaint.
- When significant improvement in subjective findings and objective findings are demonstrated—continued treatment with decreased frequency is appropriate.

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- If the condition has not progressed towards resolution, refer the patient to an appropriate health care provider to explore other treatment alternatives.
- eviCore's consideration of requests for continued acupuncture treatment depends on updated clinical information submitted regarding patient's progress.
- Adequate and legible patient progress information that contains a history and examination, and/or eviCore's Acupuncture Treatment Request Form is required to determine medical necessity.
- In addition to improvements in the table below, significant progress may be documented by increases in functional capacity and increasingly longer durations of symptom relief.
- Initiate two to four week trial of treatment.
- If severity or frequency of asthma decreases following the initial trial—continue treatment at a reduced frequency for a one month period.
- Recommendations depend on causation can include dietary recommendations, changes in daily routine and/or housekeeping routines (to reduce exposure to allergens), and possibly herbal formulas.
- If the patient does not improve with trial of Oriental Medicine treatment, or has reached a plateau, refer patient to an MD to explore other alternatives.
- Discharge occurs when reasonable functional goals and expected outcomes have been achieved.
- The patient is discharged when the patient/care-giver can continue management of symptoms with an independent home program.
- Treatment is discontinued when the patient is unable to progress towards outcomes because of medical complications, psychosocial factors or other personal circumstances.
- If the member has been non-compliant with treatment as is evidenced by the clinical documentation, and/or the lack of demonstrated progress, treatment will be deemed to be not medically necessary and the member should be discharged from treatment.

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Week	Progress
0-1	◆ Some reduction of symptom severity and frequency
2-4	◆ 25% improvement in symptom severity and frequency ◆ Reinforce self-management techniques
5-8	◆ 50% improvement in symptom severity and severity ◆ Reinforce self-management techniques
9-12	◆ 75% improvement in symptom severity and frequency ◆ Reinforce self-management techniques
13-16	◆ Condition is expected to have either resolved or reached a plateau stage by this time ◆ Reinforce self-management techniques ◆ Discharge patient to elective care, or to their primary care provider for alternative treatment options when a plateau is reached, or by week 16, whichever occurs first

Referral Guidelines (or co-management)

- Refer patient to their primary care provider for evaluation of alternative treatment options if:
  - Most patients with severe asthma will already be under the care of an MD. If not, they should be advised to seek medical co-management.
  - There are any cardiac abnormalities.
  - There are signs of an active and severe viral or bacterial infection.
  - The condition has arisen suddenly and severely, without previous history.
  - There have been any significant recent changes in their overall health, or in their medication regimen.
  - The patient has not responded positively to treatment after a couple of weeks.
  - The condition appears to be worsening.

Appropriate Procedures/Modalities

- Acupuncture
- Electro-acupuncture
- Cupping
- Gua sha
- Acupressure
- Herbal formulas

Note: Not all of these modalities are covered by patient's health-plan; review documentation regarding coverage. Acupuncture and herbs must be appropriate for covered diagnoses under the patient's insurance policy. Acupuncturist is responsible for determining which procedures/modalities are most appropriate for the patient's condition.

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Inappropriate Procedures/Modalities

- Scarring moxa
- Applied kinesiology techniques
- Electro-acupuncture using more than 9 volts
- Any techniques outside of the scope of practice in your state

Self-Management Techniques

- Rest and reduce strenuous activities
- Appropriate exercises/stretching
- Tai Qi, Qi Gong, Yoga
- Stress management, meditation
- Self-massage, Self-acupressure
- Cupping the upper back with assistance of a partner

Alternatives to Oriental Medicine

- Medication (oral and/or inhaled)

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References

1. Balshem H, Helfand M, Schunemann HJ, Oxman AD, Kunz R, Brozek J, et al. GRADE guidelines: 3. Rating the quality of evidence. J Clin Epidemiol. 2011 Apr;64(4):401-6. doi:10.1016/j.jclinepi.2010.07.015.
2. Cheng X, Deng L. Chinese Acupuncture and Moxibustion. Beijing: Foreign Language Press; 2010.
3. Hempel S, Taylor SL, Solloway MR, Miake-Lye IM, Beroes JM, Shanman R, et al. VA Evidence-based Synthesis Program Reports. Evidence Map of Acupuncture. Washington (DC): Department of Veterans Affairs; 2014.
4. Horn KK, Jennings S, Richardson G, Vliet DV, Hefford C, Abbott JH. The patient-specific functional scale: psychometrics, clinimetrics, and application as a clinical outcome measure. J Orthop Sports Phys Ther. 2012 Jan;42(1):30-42. doi:10.2519/jospt.2012.3727.
5. Kaptchuk T. The Web That Has No Weaver. Contemporary Books. 2000.
6. Kelly RB. Acupuncture for pain. Am Fam Physician. 2009 Sep 1;80(5):481-4.
7. Jiang C, Jiang L, Qin Q. Conventional Treatments plus Acupuncture for Asthma in Adults and Adolescent: A Systematic Review and Meta-Analysis. Evid Based Complement Alternat Med. 2019;2019:9580670. Published 2019 Jan 17. doi:10.1155/2019/9580670.
8. Maciocia, G; The Foundations of Chinese Medicine: A Comprehensive Text; Churchill Livingstone, 2005.
9. MacPherson H, Vertosick EA, Foster NE, Lewith G, Linde K, Sherman KJ, et al. The persistence of the effects of acupuncture after a course of treatment: A meta-analysis of patients with chronic pain. Pain. 2016 Oct 17. doi:10.1097/j.pain.0000000000000747.
10. McDonald J, Janz S. The Acupuncture Evidence Project: A Comparative Literature Review (Revised Edition). Brisbane: Australian Acupuncture and Chinese Medicine Association Ltd; 2017.
11. National Health and Medical Research Council. NHMRC additional levels of evidence and grades for recommendations for developers of guidelines. Table 3. NHMRC Evidence Hierarchy: designations of 'levels of evidence' according to type of research question (including explanatory notes). National Health and Medical Research Council; 2009.
12. O'Connor J, Bensky D. Acupuncture: A Comprehensive Text. Chicago: Eastland Press; 1981.
13. Pai HJ, Azevedo RS, Braga AL, Martins LC, Saraiva-Romanholo BM, Martins Mde A, Lin CA. A randomized, controlled, crossover study in patients with mild and moderate asthma undergoing treatment with traditional Chinese acupuncture. Clinics (Sao Paulo). 2015 Oct;70(10):663-9. doi:10.6061/clinics/2015(10)01.
14. Porter, R; The Merck Manual, Merck, 2011.
15. Su L, Meng L, Chen R, Wu W, Peng B, Man L. Acupoint Application for Asthma Therapy in Adults: A Systematic Review and Meta-Analysis of Randomized Controlled Trials. Forsch Komplementmed. 2016;23(1):16-21. doi:10.1159/000443813.

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ACU-12.9: Irritable Bowel Syndrome

Synonyms

- Irritable Bowel Syndrome

Definitions and History

Irritable bowel syndrome is a group of symptoms, including abdominal cramping, abdominal pain, bloating, and gas, which is associated with changes in bowel movements. These changes may include diarrhea, constipation, or both. With IBS, there are no signs of damage or disease to the digestive tract. To be classified as irritable bowel syndrome, there must be recurrent abdominal pain or discomfort at least three days per month in the last three months associated with two of more of the following: improvement with defecation, onset associated with a change in frequency of stool, and onset associated with change in form of stool. Irritable bowel syndrome can be divided into three types, including constipation-predominant, diarrhea-predominant or mixed. The symptoms of IBS often wax and wane and are typically relieved or partially relieved by passing a bowel movement. The symptoms may be triggered by food, stress, and hormones. In addition, signs and symptoms of IBS can lead to depression and/or anxiety, and depression and anxiety can also make IBS worse.

Oriental Medicine Diagnoses

According to Oriental Medicine, symptoms associated with the digestive system can be caused by several factors, including internal, external, excess, and deficiency patterns, or a combination thereof. The most common pathologies involved include:

Damp Heat in the Large Intestine: Over consumption of fatty, greasy and hot foods can cause Damp-Heat in the Large Intestine. External climatic damp-heat and well as chronic sadness and/or worry can also lead to Damp-Heat in the Large Intestine. This pattern of irritable bowel syndrome presents with abdominal pain and diarrhea with a sense of urgency and a burning sensation. Generally, relief will be felt after having a bowel movement.

Disharmony between the Liver and Spleen: Emotional problems can cause the Liver Qi to stagnate, which, over time may invade the Spleen. Overwork or irregular diet can cause the Spleen Qi to become weak and deficient. Stagnation of Qi in the abdomen will disrupt the Spleen's function of transformation and transportation. This pattern of irritable bowel syndrome will often have symptom of alternating constipation and diarrhea. Stress, frustration, and anger aggravate this condition.

Liver Qi Stagnation: The Liver is responsible for ensuring a smooth flow of Qi throughout the body. The most common cause of Qi Stagnation is stress and emotional problems. This pattern will result in stools that may be pellet like, difficult to move, and may be associated with an incomplete bowel movement sensation. Additional symptoms may include nausea, acid reflux, abdominal bloating and cramping, and belching. Stress and emotions easily aggravate this pattern.

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Spleen Qi Deficiency: Poor dietary choices, multitasking, overworking, overthinking, and having a propensity to worry damages the Spleen. This pattern of irritable bowel syndrome presents predominantly with fatigue, gas, bloating, and abdominal pain relieved by pressure. In addition, hemorrhoids may be present. This pattern often becomes worse in times of overwork or worry.

Spleen Dampness: This generally is an extension of Spleen Qi Deficiency that has developed Dampness, often due to over consumption of sweet, greasy, fried, and processed foods. Generally, all symptoms of Spleen Qi Deficiency will be present, in addition to Damp signs and symptoms, such as mucus, phlegm, and a sense of heaviness.

Spleen and Kidney Yang Deficiency or Excess Cold: Yang Deficiency can result from unchecked Qi Deficiency, doing too much without adequate rest and recuperation, severe illness, and use of stimulants. This irritable bowel syndrome will be similar to Spleen Qi Deficiency and Damp patterns except symptoms of Coldness and Kidney Deficiency will be present. Often patients will have loose stool first thing in the morning, potentially containing undigested food. If excess Cold is present, there will be severe pain, possibly accompanied by constipation.

Additional Information Required

- Other conditions should be ruled out by a medical doctor before pursuing a course of acupuncture. Authorization requests for non-musculoskeletal conditions must include additional information. Medical necessity for treatment of these conditions cannot be established without confirmation of both appropriate medical co-management, and progressive improvement with acupuncture. Additional information must include:
- Confirm current medical evaluation, diagnosis and treatment.
- Detailed current symptomatic evaluation appropriate to the symptom(s) treated with acupuncture
- Clear description of progress since the last authorization request

Specific Aspects of History

- Rule out red flags (requires medical management).
- Identify co-morbidities requiring medical management, and those that affect acupuncture and Oriental Medicine management.
- Regardless of any red flags, confirmation of medical evaluation and appropriate medical co-management should be confirmed before initiating a course of acupuncture. Irritable bowel symptoms may result from various etiologies. Acupuncture is not considered medically necessary if it may delay or replace needed medical care.

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Red Flag	Possible Consequence or Cause	Action Required
Cancer	Cause of symptoms (metastatic or primary)	Prompt referral to Primary Care Provider
Unexplained weight loss, Pain that is worse with recumbency or worse at night, Prior history of cancer, rectal bleeding	Malignancy	Prompt referral to Primary Care Provider
Fever, immune compromised state, intravenous drug use	Infection	Prompt referral to Primary Care Provider
Cyclic pain, inability to have bowel movement, nausea, vomiting	Bowel Obstruction	Immediate referral to emergency department
Fatigue, weakness, skin changes, stomach upset, constipation, fast heart rate, sweating, nervousness, depression	Potential for endocrine disorders	Prompt referral to Primary Care Provider
Onset of IBS-like symptoms after age 50	Malignancy	Prompt referral to Primary Care Provider
Family history of bowel cancer or inflammatory bowel disease	Malignancy or inflammatory bowel disease	Prompt referral to Primary Care Provider
Systemic symptoms	Metabolic, endocrine, neurologic, etc. disorders	Prompt referral to Primary Care Provider

Subjective Findings

- **Irritable bowel syndrome:** Chronic, intermittent, abdominal cramping, abdominal pain, bloating, and gas, with associated changes in bowel movements, including diarrhea, constipation, or both.

Functional Assessment

- **Bowel diaries** are recommended for assessment of constipation and irritable bowel syndrome. The bowel diaries should include daily food, drink and medication intake, bowel frequency, bowel urgency rating, bowel pain rating, other symptom(s) with associated rating, and Bristol stool type.
- The **Irritable Bowel Syndrome Symptom Severity Scale (IBS-SSS)** is a validated scale for measuring severity and clinical changes in IBS symptoms. It consists of five questions that are scored on a scale of 0-100, with total score ranging from 0-500.
- Documentation of a patient's level of function is an important aspect of patient care. This documentation is required in order to establish the medical necessity of ongoing acupuncture treatment. The **Patient Specific Functional Scale (PSFS)** is a patient reported outcome assessment that is easy and appropriate for acupuncturists to use. The PSFS has been studied in peer-reviewed scientific literature, and it has been proven to be a valid, reliable, and responsive measure for a variety of pain syndromes (neck, back, knee, etc.). The PSFS could be adapted to describe the level which constipation or irritable bowel symptoms are affecting specific activities.

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Objective Findings

Scope of Exam

- Inspection including Oriental Medicine inspection techniques
- Measure blood pressure, pulse rate, temperature

Specific Aspects of Examination for Constipation Symptoms

- Confirm current medical evaluation and diagnosis.
- Rule out other possible causes (via medical co-management with MD).

Differential Diagnoses for Chronic Functional Constipation & IBS

- Abdominal Angina
- Abdominal Hernias
- Acute Intermittent Porphyria
- Anxiety Disorders
- Appendicitis
- Bacterial Gastroenteritis
- Bacterial Overgrowth Syndrome
- Biliary Colic
- Biliary Disease
- Celiac Disease
- Chronic Mesenteric Ischemia
- Chronic Pancreatitis
- Collagenous and Lymphocytic Colitis
- Colon Cancer
- Colonic Obstruction
- Crohn Disease
- Depression
- Diverticulitis
- Endocrine Neoplasia
- Endometriosis
- Food Allergies
- Giardiasis
- Hypercalcemia
- Hypothyroidism
- Hyperthyroidism and Thyrotoxicosis
- Ileus
- Inflammatory Bowel Disease
- Intestinal Motility Disorders
- Lactose Intolerance
- Large-Bowel Obstruction
- Malignant Neoplasms of the Small Intestine
- Medication induced bowel changes
- Mesenteric Artery Thrombosis
- Mesenteric Venous Thrombosis
- Ogilvie Syndrome
- Other organic causes of constipation
- Pancreatic Cancer
- Peritonitis and Abdominal Sepsis
- Pheochromocytoma
- Postcholecystectomy Syndrome
- Somatostatinomas
- Toxic Megacolon
- Ulcerative Colitis
- Viral Gastroenteritis

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Oriental Medicine Management

- Most patients with this diagnosis will already have consulted with their Primary Care Provider. If not, however, they should be directed to make an appointment with their MD at their earliest opportunity. Confirmation of medical evaluation and appropriate co-management is required. Accurate diagnosis is important because constipation symptoms may occur in many other physical disorders which require care beyond Acupuncture and Oriental Medicine management.
- Acupuncture that may delay or replace needed medical care does not meet medical necessity criteria.
- Oriental Medicine management goals are to help reduce or resolve symptoms, help restore the highest level of function possible and help educate patient to reduce or prevent recurrent symptoms.
- Treatment frequency should be commensurate with the severity of the chief complaint, natural history of the condition, and expectation for functional improvement.
- When significant improvements in patient's subjective findings and objective findings are demonstrated—continued treatment with decreased frequency is appropriate.
- As treatment progresses, one should see an increase in the effective use of coping mechanisms, a decrease in the dependence on acupuncture services, and a fading of treatment frequency.
- If the condition has not progressed towards resolution, refer the patient to an appropriate health care provider to explore other treatment alternatives.
- eviCore's consideration of requests for continued acupuncture treatment depends on updated clinical information submitted regarding patient's progress.
- Adequate and legible patient progress information that contains a history and examination, and/or eviCore's Treatment Request Form for each treatment is required to determine medical necessity.
- In addition to the improvements in the table below, significant progress may be documented by increases in functional capacity and increasingly longer durations of symptomatic relief.
- Discharge occurs when reasonable functional goals and expected outcomes have been achieved.
- The patient is discharged when the patient/care-giver can continue management of symptoms with an independent home program.
- Treatment is discontinued when the patient is unable to progress towards outcomes because of medical complications, psychosocial factors or other personal circumstances.

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- If the member has been non-compliant with treatment as is evidenced by the clinical documentation, and/or the lack of demonstrated progress, treatment will be deemed to be not medically necessary and the member should be discharged from treatment.

Week	Progress
0-4	◆ Ensure recent medical evaluation and appropriate co-management is in place ◆ At least 10% improvement in symptom severity and frequency ◆ Reinforce self-management techniques ◆ Reinforce continued medical co-management
5-8	◆ At least 20% improvement in symptom severity and frequency ◆ Reinforce self-management techniques ◆ Reinforce continued medical co-management
9-12	◆ At least 30% improvement in symptom severity and frequency ◆ Reinforce self-management techniques ◆ Reinforce continued medical co-management
13-16	◆ At least 40% improvement in symptom severity and frequency ◆ Reinforce self-management techniques ◆ Reinforce continued medical co-management
17-40	◆ Condition is expected to have either resolved or reached a plateau stage within this timeframe ◆ Continued acupuncture is merited with at least 10% progressive improvement monthly ◆ Reinforce self-management techniques ◆ Reinforce continued medical co-management ◆ Discharge patient to elective care or back to their MD for alternative treatment options when a plateau is reached or by week 40, whichever occurs first

Referral & Medical Co-Management Guidelines

- Refer patient to their Medical Doctor and/or Licensed Psychological Practitioner for evaluation of alternative treatment options if:
  - Confirmation of current evaluation and diagnosis from Medical Doctor is not provided.
  - There is significant worsening of the patient's complaint.
  - The patient shows additional complaints.
  - The patient has not responded positively to treatment after a couple of weeks.

Appropriate Procedures/Modalities

- Acupuncture
- Electro-acupuncture
- Herbal formulas

Note: Not all of these modalities are covered by patient's health-plan; review documentation regarding coverage. Acupuncture and herbs must be appropriate for covered diagnoses under the patient's insurance policy. Acupuncturist is responsible for determining which procedures/modalities are most appropriate for the patient's condition.

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Inappropriate Procedures/Modalities

- Scarring moxa
- Electro-acupuncture using more than 9 volts
- Any techniques outside of the scope of practice in your state

Self-Management Techniques

- Sitz bath
- Stay hydrated
- Avoid tobacco, alcohol, caffeine, spicy food
- Avoid dietary triggers
- Eat a fiber rich diet and non-absorbable carbohydrates
- Low FODMAP diet (FODMAP is an acronym for fermentable oligosaccharides, disaccharides, monosaccharides, and polyols)
- Weight loss
- Good sleep hygiene habits
- Appropriate exercises/stretching
- Tai Qi, Qi Gong, yoga, self-acupressure
- Stress management
- Meditation, relaxation training
- Over-the-counter products (bulking agents, magnesium salts, agents containing polyethylene glycol, probiotics)

Alternatives to Oriental Medicine

(listed in alphabetical order)

- Prescription medications
- Psychological interventions and behavioral therapy including cognitive-behavioral therapy, hypnotherapy, and biofeedback therapy

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References

1. Anastasi JK, McMahon DJ, Kim GH. Symptom management for irritable bowel syndrome: a pilot randomized controlled trial of acupuncture/moxibustion. Gastroenterol Nurs. 2009 Jul-Aug;32(4):243-55. doi:10.1097/SGA.0b013e3181b2c920.
2. Balshem H, Helfand M, Schunemann HJ, Oxman AD, Kunz R, Brozek J, et al. Rating the quality of evidence. J Clin Epidemiol. 2011 Apr;64(4):401-6. doi:10.1016/j.jclinepi.2010.07.015.
3. Camilleri M. Functional Gastrointestinal Disorders: Novel Insights and Treatments. MedGenMed 1(3), 1999. https://www.medscape.com/viewarticle/717346_3
4. Chao GQ, Zhang S. Effectiveness of acupuncture to treat irritable bowel syndrome: A meta-analysis. World J Gastroenterol. 2014 Feb 21;20(7):1871-7. doi:10.3748/wjg.v20.i7.1871.
5. Deng et al. [Acupuncture for diarrhea-predominant irritable bowel syndrome:a meta-analysis]. Zhongguo Zhen Jiu. 2017 Aug 12;37(8):907-912. doi:10.13703/j.0255-2930.2017.08.027.
6. Francis CY, Morris J, Whorwell PJ. The irritable bowel severity scoring system: a simple method of monitoring irritable bowel syndrome and its progress. Aliment Pharmacol Ther. 1997 Apr;11(2):395-402.
7. Hempel S, Taylor SL, Solloway MR, Miake-Lye IM, Beroes JM, Shanman R, et al. VA Evidence-based Synthesis Program Reports. Evidence Map of Acupuncture. Washington (DC): Department of Veterans Affairs; 2014. Date last accessed 01/15/18.
8. Horn KK, Jennings S, Richardson G, Vliet DV, Hefford C, Abbott JH. The patient-specific functional scale: psychometrics, clinimetrics, and application as a clinical outcome measure. J Orthop Sports Phys Ther. 2012 Jan;42(1):30-42. doi:10.2519/jospt.2012.3727.
9. Hseuh CC, and O'Connor. Acupuncture - A Comprehensive Text. Eastland Press, 1981.
10. Kaptchuk T. The Web That Has No Weaver. Contemporary Books. 2000.
11. Kelly RB. Acupuncture for pain. Am Fam Physician. 2009 Sep 1;80(5):481-4.
12. Lembo AJ, Conboy L, Kelley JM, et al. A treatment trial of acupuncture in IBS patients. Am J Gastroenterol. 2009 Jun;104(6):1489-97. doi:10.1038/ajg.2009.156.
13. Longstreth GF, Thompson WG, Chey WD, Houghton LA, Mearin F, Spiller RC. Functional bowel disorders. Gastroenterology. 2006 Apr;130(5):1480-91. doi:10.1053/j.gastro.2005.11.061
14. MacPherson H, Tilbrook H, Agbedjro D, Buckley H, Hewitt C, Frost C. Acupuncture for irritable bowel syndrome: 2-year follow-up of a randomised controlled trial. Acupunct Med. 2017 Mar;35(1):17-23. doi:10.1136/acupmed-2015-010854.
15. MacPherson H, Vertosick EA, Foster NE, Lewith G, Linde K, Sherman KJ, et al. The persistence of the effects of acupuncture after a course of treatment: A meta-analysis of patients with chronic pain. Pain. 2016 Oct 17. doi:10.1097/j.pain.0000000000000747.
16. Manheimer E, Wieland LS, Cheng K, Li SM, Shen X, Berman BM, Lao L. Acupuncture for irritable bowel syndrome: systematic review and meta-analysis. Am J Gastroenterol. 2012 Jun;107(6):835-47; quiz 848. doi:10.1038/ajg.2012.66.
17. McDonald J, Janz S. The Acupuncture Evidence Project: A Comparative Literature Review (Revised Edition). Brisbane: Australian Acupuncture and Chinese Medicine Association Ltd; 2017.
18. National Health and Medical Research Council. NHMRC additional levels of evidence and grades for recommendations for developers of guidelines. Table 3. NHMRC Evidence Hierarchy: designations of 'levels of evidence' according to type of research question (including explanatory notes). National Health and Medical Research Council; 2009.
19. Qin Y, Yi W, Lin S, Yang C, Zhuang Z. [Clinical effect of abdominal acupuncture for diarrhea irritable bowel syndrome]. Zhongguo Zhen Jiu. 2017 Dec 12;37(12):1265-8. doi:10.13703/j.0255-2930.2017.12.003.
20. Reynolds JA, Bland JM, MacPherson H. Acupuncture for irritable bowel syndrome an exploratory randomised controlled trial. Acupunct Med. 2008 Mar;26(1):8-16. doi:10.1136/aim.26.1.8.
21. Sun JH, Wu XL, Xia C, et al. Clinical evaluation of Soothing Gan and invigorating Pi acupuncture treatment on diarrhea-predominant irritable bowel syndrome. Chin J Integr Med. 2011 Oct;17(10):780-5. doi:10.1007/s11655-011-0875-z.
22. Zheng H, Li Y, Zhang W, et al. Electroacupuncture for patients with diarrhea-predominant irritable bowel syndrome or functional diarrhea: A randomized controlled trial. Medicine (Baltimore). 2016 Jun;95(24):e3884. doi:10.1097/MD.0000000000003884.

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ACU-12.10: Menopausal Symptoms

Synonyms

- Menopausal hot flashes
- Insomnia related to menopausal hot flashes and night sweats

Definitions

Menopause is the biological process when the ovaries stop releasing eggs, ovarian function decreases, and menstrual periods stop. Menopause occurs naturally during the fourth or fifth decade. In the United States fifty-one is the average age for menopause, or 12 months without a menstrual period. Although some women go through the menopausal transition without symptoms, others experience symptoms. The most common symptom experienced is hot flashes.

Hot flashes are reported as intense feelings of warmth along with sweating, flushing and chills. Sweating is generally reported in the face, neck and chest. Hot flashes usually last for one to five minutes, with some lasting as long as one hour. The most bothersome symptoms typically begin about one year before the final menstrual period, and decline thereafter. Hot flashes may persist four to five years. Some women experience symptoms five or more years after menopause.

Nocturnal hot flashes and night sweats may contribute to insomnia and sleeping difficulty during menopause. Sleep quality generally deteriorates with aging, and menopause may add an additional acute layer of complexity to that natural gradual process. Hormonal changes alone do not likely provide a complete explanation for the relationship between sleeping difficulty and menopause, as hormones are not always successful in treating sleep problems in midlife and beyond. Treatment of sleep complaints depends on the clinical findings and underlying diagnosis, if any. Insomnia may be primary or secondary. Chronic poor sleep hygiene and mood disorders may further contribute to sleep problems. Chronic insomnia is also a risk factor for development of other medical and mental health disorders.

Oriental Medicine Diagnoses

In Oriental Medicine, menopausal symptoms are generally related to the natural decline of Kidney Essence. This deficiency pattern may present with several variations according to dietary habits, lifestyle and underlying conditions. Overwork, irregular diet, and having too many children or births too close together contribute to weakening the Kidneys. A history of excessive worry, anxiety and fear also contribute to weakening the Kidneys. The same lifestyle factors that contribute to weakening the Kidneys may also lead to Dampness, Qi Stagnation or Blood Stasis. The Oriental Medicine pattern may present as Deficiency, Excess, or a combination of both Deficiency and Excess patterns:

- Kidney Yin Deficiency
- Kidney Yang Deficiency

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- Kidney Yin and Yang Deficiency
- Kidney and Liver Yin Deficiency with Liver Yang Rising
- Kidney and Heart Not Harmonized
- Phlegm Accumulation & Qi Stagnation
- Blood Stasis

History

- Natural part of the aging process that usually occurs in fourth or fifth decade.
- In the months or years prior to total cessation of the menstrual period, decline of estrogen and progesterone may lead to symptoms including: irregular periods, hot flashes, chills, night sweats, sleeping problems. Women may also experience: vaginal dryness, dry skin, thinning hair, weight gain, or mood problems.
- Menopausal symptoms may also be caused by: oophorectomy (removal of ovaries), chemotherapy, radiation therapy, or primary ovarian insufficiency.
- Hot flashes are more common in women with high body mass index, low education and income, smokers, and African-Americans.
- After menopause, women are at increased risk for cardiovascular disease, osteoporosis, urinary incontinence and weight gain.
- Both insomnia and menopausal-type symptoms may result from various etiologies. Other conditions should be ruled out by a medical doctor before pursuing a course of acupuncture. Acupuncture is not considered medically necessary if it may delay or replace needed medical care.

Additional Information Required

- Other conditions should be ruled out by a medical doctor before pursuing a course of acupuncture. Authorization requests for non-musculoskeletal conditions must include additional information. Medical necessity for treatment of these conditions cannot be established without confirmation of both appropriate medical co-management, and progressive improvement with acupuncture. Additional information must include:
- Confirm current medical evaluation, diagnosis and treatment.
- Detailed current symptomatic evaluation appropriate to the symptom(s) treated with acupuncture
- Clear description of progress since the last authorization request

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Specific Aspects of History

- Rule out red flags (requires medical management).
- Identify co-morbidities requiring medical management, and those that affect acupuncture and Oriental Medicine management.
- Regardless of any red flags, confirmation of medical evaluation and appropriate medical co-management should be confirmed before initiating a course of acupuncture. Menopausal-type symptoms may result from various etiology. Acupuncture is not considered medically necessary if it may delay or replace needed medical care.
- Hot flashes are more common in women with high body mass index, low education and income, smokers, and African-Americans.

Red Flag	Possible Consequence or Cause	Action Required
Cancer	Cause of symptoms (metastatic or primary)	Prompt referral to Primary Care Provider
Unexplained weight loss, Pain that is worse with recumbency or worse at night, Prior history of cancer	Malignancy	Prompt referral to Primary Care Provider
Fever, immune compromised state, intravenous drug use	Infection	Prompt referral to Primary Care Provider
Pleuritic pain, chronic cough, dyspnea	Pulmonary diseases	Prompt referral to Primary Care Provider
Fatigue, weakness, skin changes, stomach upset, constipation, fast heart rate, sweating, nervousness, depression	Potential for endocrine disorders	Prompt referral to Primary Care Provider
Associated dysphasia; unilateral weakness	Cerebrovascular accident	Immediate referral to emergency department
Headache associated with diastolic blood pressure greater than 110 mmHg, Exertional pain, history of CAD	Cardiac condition	Immediate referral to emergency department
Thoughts or plans of self-harm	Self-harm, Suicide	Prompt referral to Primary Care Provider AND National Suicide Prevention Lifeline is available 24 hours every day 1-800-273-8255.
Thoughts or plans of isolation	Depression	Prompt referral to Primary Care Provider and/or Licensed Psychological Practitioner

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Red Flag	Possible Consequence or Cause	Action Required
Delusions, hallucinations, extreme mood change, confused thinking, dramatic change in eating or sleeping habits, high risk behaviors, recurring thoughts of death	Other mental health disorders	Prompt referral to Primary Care Provider and/or Licensed Psychological Practitioner
Suspicion of drug or alcohol dependence	Side effect or withdrawal phenomenon	Immediate referral to emergency department
Head injury, widespread neurological symptoms, headaches that are new, progressive or persistent, vomiting without nausea, seizures, tremors, partial paralysis, dementia, cognitive changes such as confusion, drowsiness, giddiness	Brain and nervous system disorders	Prompt referral to Primary Care Provider

Subjective Findings

- **Menopausal hot flashes:** Intermittent intense feelings of warmth along with sweating, flushing and/or chills. Sweating is generally reported in the face, neck and chest. Hot flashes usually last for one to five minutes, with some lasting as long as one hour.
- **Menopausal insomnia:** Difficulty falling asleep, staying asleep or waking too early associated with nocturnal hot flashes or night sweats during menopause. Feeling that amount of sleep is inadequate. Day time sleepiness, fatigue and irritability are common symptoms of clinical insomnia.

Functional Assessment

- **Daily diaries** are recommended for assessment of hot flashes and night sweats. The daily diaries could include frequency, severity and/or duration of hot flash episodes. The daily diaries could also include hours slept and number of times woken during the night.
- Use of the **Pittsburg Sleep Quality Index (PSQI)** is recommended for acupuncturists to assess insomnia. The PSQI is a self-rated questionnaire which assesses sleep quality and disturbances over a one-month time period. It consists of 10 questions, resulting in a score of 0-21. Scores of 0-5 considered good sleep; >5 considered poor sleep.
- Documentation of a patient's level of function is an important aspect of patient care. This documentation is required in order to establish the medical necessity of ongoing acupuncture treatment. The **Patient Specific Functional Scale (PSFS)** is a patient reported outcome assessment that is easy and appropriate for acupuncturists to use. The PSFS has been studied in peer-reviewed scientific literature, and it has been proven to be a valid, reliable, and responsive measure for a variety of pain

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syndromes (neck, back, knee, etc.). The PSFS could be adapted to describe the level which hot flashes or night sweats are affecting specific activities.

Objective Findings

Scope of Exam

- Inspection including Oriental Medicine inspection techniques
- Measure blood pressure, pulse rate, temperature

Specific Aspects of Examination for Menopausal Symptoms

- Confirm current medical evaluation and diagnosis. Medical co-management with an MD is required. Acupuncture is not considered medically necessary if it may delay or replace needed medical care.
- Rule out other possible causes (via medical co-management with MD).
- Referral back to MD if any red flags are present.
- Hot flashes are more common in women with high body mass index, low education and income, smokers, and African-Americans.

Differential Diagnoses for Hot Flashes and/or Insomnia

- Carcinoid syndrome
- Systemic mast cell disease
- Pheochromocytoma
- Medullary carcinoma of the thyroid
- Pancreatic islet-cell tumors
- Renal cell carcinoma, chronic renal failure
- Hyperthyroidism, diabetes
- Congestive heart failure, arrhythmia, coronary artery disease
- COPD, asthma
- Spinal Cord Injury, traumatic brain injury, stroke
- Reaction related to alcohol, drugs or medication
- Reaction associated with food additives and eating
- Neurological flushing, emotional flushing
- Sleep apnea, restless leg syndrome, circadian rhythm sleep disorders
- Anxiety, panic disorder, post-traumatic stress disorder

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Oriental Medicine Management [4]

- Most patients with this diagnosis will already have consulted with their Primary Care Provider. If not, however, they should be directed to make an appointment with their MD at their earliest opportunity. Confirmation of medical evaluation and appropriate co-management is required. Accurate diagnosis is important because menopausal symptoms may occur in many other physical disorders which require care beyond Acupuncture and Oriental Medicine management.
- Acupuncture that may delay or replace needed medical care does not meet medical necessity criteria.
- Oriental Medicine management goals are to help reduce or resolve symptoms, help restore the highest level of function possible and help educate patient to reduce or prevent recurrent symptoms.
- Treatment frequency should be commensurate with the severity of the chief complaint, natural history of the condition, and expectation for functional improvement.
- When significant improvements in patient's subjective findings and objective findings are demonstrated—continued treatment with decreased frequency is appropriate.
- As treatment progresses, one should see an increase in the effective use of coping mechanisms, a decrease in the dependence on acupuncture services, and a fading of treatment frequency.
- If the condition has not progressed towards resolution, refer the patient to an appropriate health care provider to explore other treatment alternatives.
- eviCore's consideration of requests for continued acupuncture treatment depends on updated clinical information submitted regarding patient's progress.
- Adequate and legible patient progress information that contains a history and examination, and/or eviCore's Treatment Request Form for each treatment is required to determine medical necessity.
- In addition to the improvements in the table below, significant progress may be documented by increases in functional capacity and increasingly longer durations of symptomatic relief.
- Discharge occurs when reasonable functional goals and expected outcomes have been achieved.
- The patient is discharged when the patient/care-giver can continue management of symptoms with an independent home program.
- Treatment is discontinued when the patient is unable to progress towards outcomes because of medical complications, psychosocial factors or other personal circumstances.
- If the member has been non-compliant with treatment as is evidenced by the clinical documentation, and/or the lack of demonstrated progress, treatment will be deemed

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to be not medically necessary and the member should be discharged from treatment.

Week	Progress
0-2	◆ Some reduction of symptom severity and frequency ◆ Ensure recent medical evaluation and appropriate co-management is in place
3-4	◆ At least 20-30% improvement in symptom severity and frequency ◆ Reinforce self-management techniques ◆ Reinforce continued medical co-management
5-8	◆ At least 40% improvement in symptom severity and severity ◆ Reinforce self-management techniques ◆ Reinforce continued medical co-management
9-12	◆ At least 50% improvement in symptom severity and frequency ◆ Reinforce self-management techniques ◆ Reinforce continued medical co-management
13-16	◆ Condition is expected to have either resolved or reached a plateau stage by this time ◆ Reinforce self-management techniques ◆ Reinforce continued medical co-management ◆ Discharge patient to elective care or back to their MD for alternative treatment options, when a plateau is reached or by week 16, whichever occurs first

Referral & Medical Co-Management Guidelines

- Refer patient to their Medical Doctor and/or Licensed Psychological Practitioner for evaluation of alternative treatment options if:
  - Confirmation of current evaluation and diagnosis from Medical Doctor is not provided.
  - There is ANY indication of thoughts or plans for self-harm. The National Suicide Prevention Lifeline is available 24 hours every day, call 1-800-273-8255.
  - There are signs or symptoms of mental health disorders beyond anxiety or depression.
  - There is significant worsening of the patient's complaint.
  - The patient shows additional complaints.
  - The patient has not responded positively to treatment after a couple of weeks.

Appropriate Procedures/Modalities

- Acupuncture
- Electro-acupuncture
- Herbal formulas

Note: Not all of these modalities are covered by patient's health-plan; review documentation regarding coverage. Acupuncture and herbs must be appropriate for covered diagnoses under the patient's insurance policy. Acupuncturist is responsible for determining which procedures/modalities are most appropriate for the patient's condition.

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Inappropriate Procedures/Modalities

- Scarring moxa
- Electro-acupuncture using more than 9 volts
- Any techniques outside of the scope of practice in your state

Self-Management Techniques

- Wear layered clothing
- Lower room temperature, use portable fan
- Stay hydrated, drink cool drinks
- Avoid tobacco, alcohol, caffeine, spicy food
- Avoid dietary triggers
- Weight loss
- Good sleep hygiene habits
- Appropriate exercises/stretching
- Tai Qi, Qi Gong, yoga, self-acupressure
- Stress management
- Meditation, relaxation training

Alternatives to Oriental Medicine

(listed in alphabetical order)

- Hormone replacement therapy
- Non-hormonal prescription medications
- Psychological interventions including cognitive-behavioral therapy, hypnotherapy
- Treatment of other medical conditions that may contribute to menopausal hot flashes or insomnia

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References

1. Avis NE, Legault C, Coeytaux RR, Pian-Smith M, Shifren JL, Chen W, Valaskatgis P. A randomized, controlled pilot study of acupuncture treatment for menopausal hot flashes. Menopause. 2008 Nov-Dec;15(6):1070-8. doi:10.1097/gme.0b013e31816d5b03.
2. Baccetti S, Da Frè M, Becorpi A, Faedda M, Guerrera A, Monechi MV, Munizzi RM, Parazzini F. Acupuncture and traditional Chinese medicine for hot flushes in menopause: a randomized trial. J Altern Complement Med. 2014 Jul;20(7):550-7. doi:10.1089/acm.2012.0499.
3. Balshem H, Helfand M, Schunemann HJ, Oxman AD, Kunz R, Brozek J, et al. GRADE guidelines: 3. Rating the quality of evidence. J Clin Epidemiol. 2011 Apr;64(4):401-6.
4. Befus D, Coeytaux RR, Goldstein KM, et al. Management of Menopause Symptoms with Acupuncture: An Umbrella Systematic Review and Meta-Analysis. J Altern Complement Med. 2018 Apr;24(4):314-323. doi:10.1089/acm.2016.0408.
5. Bezerra AG, Pires GN, Andersen ML, Tufik S, Hachul H. Acupuncture to Treat Sleep Disorders in Postmenopausal Women: A Systematic Review. Evid Based Complement Alternat Med. 2015;2015:563236. doi:10.1155/2015/563236.
6. Borud EK, Alraek T, White A, Fonnebo V, Eggen AE, Hammar M, Astrand LL, Theodorsson E, Grimsgaard S. The Acupuncture on Hot Flushes Among Menopausal Women (ACUFLASH) study, a randomized controlled trial. Menopause. 2009 May-Jun;16(3):484-93. doi:10.1155/2015/563236.
7. Borud EK, Alraek T, White A, Grimsgaard S. The Acupuncture on Hot Flashes Among Menopausal Women study: observational follow-up results at 6 and 12 months. Menopause. 2010 Mar;17(2):262-8. doi:10.1097/gme.0b013e3181c07275.
8. Buysse DJ. Insomnia. JAMA. 2013 Feb 20;309(7):706-16. doi:10.1001/jama.2013.193.
9. Chien TJ, Hsu CH, Liu CY, Fang CJ. Effect of acupuncture on hot flush and menopause symptoms in breast cancer- A systematic review and meta-analysis. PLoS One. 2017 Aug 22;12(8):e0180918. doi:10.1371/journal.pone.0180918.
10. Deng G, Vickers A, Yeung S, D'Andrea GM, Xiao H, Heerdt AS, Sugarman S, Troso-Sandoval T, Seidman AD, Hudis CA, Cassileth B. Randomized, controlled trial of acupuncture for the treatment of hot flashes in breast cancer patients. J Clin Oncol. 2007 Dec 10;25(35):5584-90. doi:10.1200/JCO.2007.12.0774.
11. Dodin S, Blanchet C, Marc I, Ernst E, Wu T, Vaillancourt C, Paquette J, Maunsell E. Acupuncture for menopausal hot flushes. Cochrane Database Syst Rev. 2013 Jul 30;(7):CD007410. doi:10.1002/14651858.CD007410.pub2.
12. Freedman RR. Menopausal hot flashes: mechanisms, endocrinology, treatment. J Steroid Biochem Mol Biol. 2014 Jul;142:115-20. doi:10.1016/j.jsbmb.2013.08.010.
13. Fu C, Zhao N, Liu Z, Yuan LH, Xie C, Yang WJ, Yu XT, Yu H, Chen YF. Acupuncture Improves Peri-menopausal Insomnia: A Randomized Controlled Trial. Sleep. 2017 Nov 1;40(11). doi:10.1093/sleep/zsx153.
14. Garland SN, Xie SX, Li Q, Seluzicki C, Basal C, Mao JJ. Comparative effectiveness of electro-acupuncture versus gabapentin for sleep disturbances in breast cancer survivors with hot flashes: a randomized trial. Menopause. 2017 May;24(5):517-523. doi:10.1097/GME.0000000000000779.
15. Greenlee H, DuPont-Reyes MJ, Balneaves LG, Carlson LE, Cohen MR, Deng G, Johnson JA, Mumber M, Seely D, Zick SM, Boyce LM, Tripathy D. Clinical practice guidelines on the evidence-based use of integrative therapies during and after breast cancer treatment. CA Cancer J Clin. 2017 May 6;67(3):194-232. doi:10.3322/caac.21397.
16. Hachul H, Garcia TK, Maciel AL, Yagihara F, Tufik S, Bittencourt L. Acupuncture improves sleep in postmenopause in a randomized, double-blind, placebo-controlled study. Climacteric. 2013 Feb;16(1):36-40. doi:10.3109/13697137.2012.698432.
17. Hempel S, Taylor SL, Solloway MR, Miake-Lye IM, Beroes JM, Shanman R, et al. VA Evidence-based Synthesis Program Reports. Evidence Map of Acupuncture. Washington (DC): Department of Veterans Affairs; 2014. Date last accessed 01/15/18.
18. Hervik J, Mjåland O. Acupuncture for the treatment of hot flashes in breast cancer patients, a randomized, controlled trial. Breast Cancer Res Treat. 2009 Jul;116(2):311-6. doi:10.1007/s10549-008-0210-3.
19. Hill DA, Crider M, Hill SR. Hormone Therapy and Other Treatments for Symptoms of Menopause. Am Fam Physician. 2016 Dec 1;94(11):884-889.

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20. Horn KK, Jennings S, Richardson G, Vliet DV, Hefford C, Abbott JH. The patient-specific functional scale: psychometrics, clinimetrics, and application as a clinical outcome measure. J Orthop Sports Phys Ther. 2012 Jan;42(1):30-42. doi:10.2519/jospt.2012.3727.
21. Hseuh CC, and O'Connor. Acupuncture - A Comprehensive Text. Eastland Press, 1981.
22. Huang MI, Nir Y, Chen B, Schnyer R, Manber R. A randomized controlled pilot study of acupuncture for postmenopausal hot flashes: effect on nocturnal hot flashes and sleep quality. Fertil Steril. 2006 Sep;86(3):700-10. doi:10.1016/j.fertnstert.2006.02.100.
23. Kaptchuk T. The Web That Has No Weaver. Contemporary Books. 2000.
24. Kaunitz AM, Manson JE. Management of Menopausal Symptoms. Obstet Gynecol. 2015 Oct;126(4):859-76. doi:10.1097/AOG.0000000000001058.
25. Kelly RB. Acupuncture for pain. Am Fam Physician. 2009 Sep 1;80(5):481-4.
26. Kim DI, Jeong JC, Kim KH, Rho JJ, Choi MS, Yoon SH, Choi SM, Kang KW, Ahn HY, Lee MS. Acupuncture for hot flushes in perimenopausal and postmenopausal women: a randomised, sham-controlled trial. Acupunct Med. 2011 Dec;29(4):249-56. doi:10.1136/aim.2011.004085.
27. Kim KH, Kang KW, Kim DI, Kim HJ, Yoon HM, Lee JM, Jeong JC, Lee MS, Jung HJ, Choi SM. Effects of acupuncture on hot flashes in perimenopausal and postmenopausal women--a multicenter randomized clinical trial. Menopause. 2010 Mar;17(2):269-80. doi:10.1097/gme.0b013e3181bfac3b.
28. MacPherson H, Vertosick EA, Foster NE, Lewith G, Linde K, Sherman KJ, et al. The persistence of the effects of acupuncture after a course of treatment: A meta-analysis of patients with chronic pain. Pain. 2016 Oct 17. doi:10.1097/j.pain.0000000000000747.
29. Maness DL, Khan M. Nonpharmacologic Management of Chronic Insomnia. Am Fam Physician. 2015 Dec 15;92(12):1058-64.
30. McDonald J, Janz S. The Acupuncture Evidence Project: A Comparative Literature Review (Revised Edition). Brisbane: Australian Acupuncture and Chinese Medicine Association Ltd; 2017.
31. National Health and Medical Research Council. NHMRC additional levels of evidence and grades for recommendations for developers of guidelines. Table 3. NHMRC Evidence Hierarchy: designations of 'levels of evidence' according to type of research question (including explanatory notes). National Health and Medical Research Council; 2009.
32. Nir Y, Huang MI, Schnyer R, Chen B, Manber R. Acupuncture for postmenopausal hot flashes. Maturitas. 2007 Apr 20;56(4):383-95. doi:10.1016/j.maturitas.2006.11.001.
33. Painovich JM, Shufelt CL, Azziz R, Yang Y, Goodarzi MO, Braunstein GD, Karlan BY, Stewart PM, Merz CN. A pilot randomized, single-blind, placebo-controlled trial of traditional acupuncture for vasomotor symptoms and mechanistic pathways of menopause. Menopause. 2012 Jan;19(1):54-61. doi:10.1097/gme.0b013e31821f9171.
34. Santoro N, Epperson CN, Mathews SB. Menopausal Symptoms and Their Management. Endocrinol Metab Clin North Am. 2015 Sep;44(3):497-515. doi:10.1016/j.ecl.2015.05.001
35. Selva Olid A, Martínez Zapata MJ, Solà I, Stojanovic Z, Uriona Tuma SM, Bonfill Cosp X. Efficacy and Safety of Needle Acupuncture for Treating Gynecologic and Obstetric Disorders: An Overview. Med Acupunct. 2013 Dec 1;25(6):386-397. doi:10.1089/acu.2013.0976.
36. Tao WW, Tao XM, Song CL. Effects of non-pharmacological supportive care for hot flushes in breast cancer: a meta-analysis. Support Care Cancer. 2017 Jul;25(7):2335-2347. doi:10.1007/s00520-017-3691-y.
37. Venzke L, Calvert JF Jr, Gilbertson B. A randomized trial of acupuncture for vasomotor symptoms in post-menopausal women. Complement Ther Med. 2010 Apr;18(2):59-66. doi:10.1016/j.ctim.2010.02.002.
38. Vincent A, Barton DL, Mandrekar JN, Cha SS, Zais T, Wahner-Roedler DL, Keppler MA, Kreitzer MJ, Loprinzi C. Acupuncture for hot flashes: a randomized, sham-controlled clinical study. Menopause. 2007 Jan-Feb;14(1):45-52. doi:10.1097/01.gme.0000227854.27603.7d.
39. Wyon Y, Wijma K, Nedstrand E, Hammar M. A comparison of acupuncture and oral estradiol treatment of vasomotor symptoms in postmenopausal women. Climacteric. 2004 Jun;7(2):153-64.

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ACU-12.11: Mild Hyperemesis Gravidarum (Now Excluded)

- There is insufficient evidence that acupuncture is an effective treatment for Hyperemesis Gravidarum or Nausea in Pregnancy.
- As such, acupuncture treatment for this condition does not meet medical necessity criteria.

Synonyms

Morning sickness, nausea and vomiting due to pregnancy, nausea gravidarum, hyperemesis gravidarum, pregnancy sickness.

Definition

Morning sickness is a condition that affects more than half of all pregnant women. Related to increased estrogen levels, a similar form of nausea is also seen in some women who use hormonal contraception or hormone replacement therapy. Sometimes it is present in the early hours of the morning and reduces as the day progresses. The nausea can be mild or induce actual vomiting, however, not severe enough to cause metabolic derangement. In more severe cases, vomiting may cause dehydration, weight loss, alkalosis and hypokalemia. This condition is known as hyperemesis gravidarum and occurs in about 1% of all pregnancies. Nausea and vomiting can be one of the first signs of pregnancy and usually begins around the 6th week of pregnancy (counting gestational age from 14 days before conception). In spite of its common name, it can occur at any time of the day, and for most women it may stop around the 12th week of pregnancy.

Oriental Medicine Diagnoses

- Liver Attacking Stomach
  - Liver Blood is redirected toward the fetus, resulting in a relative excess of Liver Qi, which flows upward, disturbing the Stomach, and causing rebellious Stomach Qi. Causation is due to pregnancy.
- Spleen and Stomach Deficiency
  - A relative excess of Blood during normal pregnancy may couple with a pre-existing Spleen and Stomach Qi deficiency to cause rebellious Stomach Qi. Causation is due to pregnancy.

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History

- Commonly begins about the sixth week of pregnancy
- Usually ends about the twelfth week of pregnancy

Specific Aspects of History

- Rule out red flags (requires medical management).
- Identify co-morbidities requiring medical management, and those that affect acupuncture and Oriental Medicine management.
- Regardless of any red flags, all pregnant patients should be under the care of an MD, or a licensed professional midwife (where allowed by law).

Red Flag	Possible Consequence or Cause	Action Required
Extremely severe nausea and vomiting	Dehydration, exhaustion; medical co-management recommended	Immediate referral to emergency department
Fever, achiness	Viral or bacterial infection; medical co-management recommended	Immediate referral to emergency department
Sudden onset after meal	Food poisoning; medical co-management recommended	Immediate referral to emergency department
History of drug use and/or withdrawal	Requires medical co-management	Immediate referral to emergency department

Subjective Findings

- Nausea and vomiting during (roughly) the first trimester of pregnancy
- May be worse in the morning (but not always)
- Generally a self-limiting condition

Functional Assessment

- Documentation of a patient's level of function is an important aspect of patient care. This documentation is required in order to establish the medical necessity of ongoing acupuncture treatment. The Patient Specific Functional Scale (PSFS) is a patient reported outcome assessment that is easy and appropriate for acupuncturists to use. The PSFS has been studied in peer-reviewed scientific literature, and it has been proven to be a valid, reliable, and responsive measure for a variety of pain syndromes (neck, back, knee, etc.).

Objective Findings

Scope of Exam

- Inspection including Oriental Medicine inspection techniques
- Measure blood pressure, pulse rate, temperature

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Specific Aspects of Examination for Morning Sickness

- Rule out other possible causes, such as viral infection or food poisoning.
- Ensure that the patient is receiving prenatal medical care.

Findings of Morning Sickness

- Nausea
- Vomiting
- Loss of appetite
- Sensitivity to odors
- Fatigue
- Possible dehydration or weight loss

Differential Diagnoses

- Viral or bacterial infection
- Food poisoning

Oriental Medicine Management [2, 3, 12, 17]

- There is insufficient evidence that acupuncture is an effective treatment for Hyperemesis Gravidarum and Nausea in Pregnancy. As such, acupuncture treatment for this condition does not meet medical necessity criteria.

Self-Management Techniques

- Rest and reduce strenuous activities
- Tai Qi, Qi Gong, Yoga
- Stress management, meditation
- Self-massage, Self-acupressure
- Self-acupressure (Pericardium 6; “wrist bands”)
- Drinking fluids to stay hydrated
- Ice cubes (to melt in mouth) if fluids won’t stay down
- Ginger (as capsules, tea, ingredient in food) to quell nausea
- Eating bland food such as crackers, applesauce, or bananas

Alternatives to Oriental Medicine

- Medication

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References

1. Balshem H, Helfand M, Schunemann HJ, Oxman AD, Kunz R, Brozek J, et al. GRADE guidelines: 3. Rating the quality of evidence. J Clin Epidemiol. 2011 Apr;64(4):401-6. doi:10.1016/j.jclinepi.2010.07.015.
2. Boelig RC, Barton SJ, Saccone G, Kelly AJ, Edwards SJ, Berghella V. Interventions for treating hyperemesis gravidarum: a Cochrane systematic review and meta-analysis. J Matern Fetal Neonatal Med. 2018 Sep;31(18):2492-2505. doi:10.1080/14767058.2017.1342805.
3. Boelig RC, Barton SJ, Saccone G, Kelly AJ, Edwards SJ, Berghella V. Interventions for treating hyperemesis gravidarum. Cochrane Database Syst Rev. 2016(5):Cd010607. doi:10.1002/14651858.CD010607.pub2
4. Cheng X, Deng L. Chinese Acupuncture and Moxibustion. Beijing: Foreign Language Press; 2010.
5. Hempel S, Taylor SL, Solloway MR, Miake-Lye IM, Beroes JM, Shanman R, et al. VA Evidence-based Synthesis Program Reports. Evidence Map of Acupuncture. Washington (DC): Department of Veterans Affairs; 2014.
6. Horn KK, Jennings S, Richardson G, Vliet DV, Hefford C, Abbott JH. The patient-specific functional scale: psychometrics, clinimetrics, and application as a clinical outcome measure. J Orthop Sports Phys Ther. 2012 Jan;42(1):30-42. doi:10.2519/jospt.2012.3727.
7. Kaptchuk T. The Web That Has No Weaver. Contemporary Books. 2000.
8. Kelly RB. Acupuncture for pain. Am Fam Physician. 2009 Sep 1;80(5):481-4.
9. Maciocia, G; The Foundations of Chinese Medicine: A Comprehensive Text; Churchill Livingstone, 2005.
10. MacPherson H, Vertosick EA, Foster NE, Lewith G, Linde K, Sherman KJ, et al. The persistence of the effects of acupuncture after a course of treatment: A meta-analysis of patients with chronic pain. Pain. 2016 Oct 17. doi:10.1097/j.pain.0000000000000747.
11. Matthews A, Haas DM, O'Mathuna DP, Dowswell T. Interventions for nausea and vomiting in early pregnancy. Cochrane Database Syst Rev. 2015(9):Cd007575. doi:10.1002/14651858.CD007575.pub4
12. McDonald J, Janz S. The Acupuncture Evidence Project: A Comparative Literature Review (Revised Edition). Brisbane: Australian Acupuncture and Chinese Medicine Association Ltd; 2017.
13. National Health and Medical Research Council. NHMRC additional levels of evidence and grades for recommendations for developers of guidelines. Table 3. NHMRC Evidence Hierarchy: designations of 'levels of evidence' according to type of research question (including explanatory notes). National Health and Medical Research Council; 2009.
14. O'Connor J, Bensky D. Acupuncture: A Comprehensive Text. Chicago: Eastland Press; 1981.
15. Porter, R; The Merck Manual, Merck, 2011.
16. Smith CA, Cochrane S. Does acupuncture have a place as an adjunct treatment during pregnancy? A review of randomized controlled trials and systematic reviews. Birth. 2009 Sep;36(3):246-53. doi:10.1111/j.1523-536X.2009.00329.x.
17. Sridharan K, Sivaramakrishnan G. Interventions for treating nausea and vomiting in pregnancy: a network meta-analysis and trial sequential analysis of randomized clinical trials. Expert Rev Clin Pharmacol. 2018 Nov;11(11):1143-1150. doi:10.1080/17512433.2018.1530108.

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ACU-13.0: Diagnosis Codes

Headaches	ICD-10 Codes
Cervicocranial Syndrome	M53.0
Headache, Cephalgia	R51
Migraine With Aura	G43.101, G43.109, G43.111, G43.119, G43.501, G43.509, G43.511, G43.519
Migraine Without Aura	G43.001, G43.009, G43.011, G43.019, G43.701, G43.709, G43.711, G43.719
Unspecified Migraine Headache	G43.901, G43.909, G43.911, G43.919, G43.801, G43.809, G43.811, G43.819
Cervical Conditions (Disc Radicular)	**ICD-10 Codes**
Brachial Neuritis	M54.11, M54.12, M54.13
Cervical Degeneration of Intervertebral Disc	M50.30, M50.31, M50.32, M50.33
Cervical Post Laminectomy Syndrome	M96.1
Cervical Stenosis	M48.01, M48.02, M48.03, M99.51
Cervicobrachial Syndrome	M53.1
Cervical Conditions (Non-Specific)	**ICD-10 Codes**
Cervical Spondylosis	M47.811, M47.812, M47.813
Cervical Sprain Strain	S13.4XXA, S13.4XXD, S13.4XXS, S13.8XXA, S13.8XXD, S13.8XXS, S13.9XXA, S13.9XXD, S13.9XXS, S16.1XXA, S16.1XXD, S16.1XXS
Cervicalgia	M54.2
Thoracic Conditions	**ICD-10 Codes**
Thoracic Intervertebral Disc Syndrome without Myelopathy	M51.84, M51.14, M54.14
Thoracic Outlet Syndrome	G54.0
Pain in thoracic spine	M54.6
Lumbosacral Conditions (Disc Radicular)	**ICD-10 Codes**
Lumbar Degenerative Disc Disease	M51.36, M51.37
Lumbar Post Laminectomy Syndrome	M96.1
Lumbar Radiculopathy and Sciatica	M54.15, M54.16, M54.17, M51.15, M51.16, M51.17, M54.30, M54.31, M54.32, M54.40, M54.41, M54.42
Lumbosacral Conditions (Non-Specific)	**ICD-10 Codes**
Lumbago Backache NOS	M54.5
Lumbar Spondylosis	M47.816, M47.817
Lumbar Sprain Strain	S33.5XXA, S39.012A
Lumbosacral (joint), Sprain Strain	S33.8XXA
Sacroiliac Sprain Strain	S33.6XXA

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Upper Extremity Conditions	ICD-10 Codes
Bursitis of the Shoulder and Rotator Cuff Syndrome	M75.51, M75.52, S43.421A, S43.422A, S46.012A, S46.011A
Carpal Tunnel Syndrome	G56.01, G56.02
Forearm, Joint Pain and Osteoarthrosis	M79.631, M79.632
Hand, Joint Pain and Osteoarthrosis	M79.641, M79.642, M19.041, M19.042
Lateral Epicondylitis	M77.11, M77.12
Medial Epicondylitis	M77.01, M77.02
Radial Nerve Entrapment	G56.31, G56.32
Shoulder, Adhesive Capsulitis	M75.01, M75.02
Shoulder, Joint Pain and Osteoarthrosis	M25.511, M25.512, M19.011, M19.012
Wrist, Sprain Strain	S63.8X1A, S63.8X2A
Lower Extremity Conditions	**ICD-10 Codes**
Ankle and Foot, Joint Pain and Osteoarthrosis	M25.571, M25.572, M79.671, M79.672, M19.071, M19.072
Ankle Sprain	S93.432A, S93.431A, S93.492A, S93.491A, S96.812A, S96.811A
Chrondromalacia	M22.41, M22.42
Hip, Joint Pain and Osteoarthrosis	M25.551, M25.552, M16.11, M16.12
Knee Joint Pain and Osteoarthrosis	M25.561, M25.562, M19.071, M19.072, M17.11, M17.12
Knee Tear, Medial Meniscus	S83.221A, S83.222A
Piriformis Syndrome	G57.01, G57.02
Plantar Fasciitis	M72.2
Thigh Sprain Strain Unspecified Site of Hip and Thigh	M25.551, M25.552, S76.012A, S76.0111A
Neuromusculoskeletal Conditions (Non-Specific)	**ICD-10 Codes**
Fibromyalgia	M79.7
Jaw Pain, Unspecified	R68.84
Myalgia	M79.1
Internal Medical Conditions	**ICD-10 Codes**
Adjunct Cancer Care	G89.3, Z79.811, Z29.8, R53.0, R53.83, R11.0, R11.11, R11.2
Adjunct Care for Mental Health Conditions	F41.-, F32.-, F33.-, F34.1, F43.1, F50.0-
Adjunct Care for Post-Stroke Rehabilitation	I69.-
Allergic Rhinitis	J30.1, J30.2, J30.81
Dry Eye Syndrome	H04.12-
Chronic Functional Constipation	K59.04
Chronic Prostatitis Pain	N41.1
Extrinsic Asthma	J45.20, J45.30, J45.40, J45.990
Intrinsic Asthma	
Irritable Bowel Syndrome	K58.9
Mild Hyperemesis Gravidarum	R11.0, R11.11, R11.2, O21.9
Menopausal Symptoms	N95.1

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