

CARE GUIDE for *Back Pain*

SUGGESTED GUIDELINES	PROCESS	IMPORTANT FINDINGS MEASUREMENTS AND VALUES	INTERVENTION	FOLLOW-UP
Patient Assessment (1,2,3)	<p>Initial visit* should include focused history (including psychosocial) and physical exam.</p> <p style="text-align: center;">History † ±:</p> <ul style="list-style-type: none"> • Pain: location, duration, frequency • History of previous symptoms, traumatic event(s), treatment response • Review of prior imaging studies when available • Risk factors (see findings) <p style="text-align: center;">Psychosocial history § ¥:</p> <ul style="list-style-type: none"> • Depression • Substance abuse • Passive coping skills • Job Dissatisfaction • Higher disability level • Disputed compensation claims • Somatization <p style="text-align: center;">Physical Exam:</p> <ul style="list-style-type: none"> • Straight-leg-raise testing • Posture, gait and range of motion • Palpation for spinal tenderness • Neuromuscular exam • Consider non-spinal causes of back pain (e.g., aortic aneurysm, pancreatic mass, nephrolithiasis, etc.) 	<ul style="list-style-type: none"> • Red flags: <ul style="list-style-type: none"> ➤ cauda equina syndrome or progressive neurologic defect <ul style="list-style-type: none"> ▪ saddle anesthesia ▪ recent onset of bladder dysfunction (urine retention, increased frequency, overflow incontinence) ▪ recent onset of fecal incontinence (loss of bowel control) ▪ major motor weakness ➤ history of or suspicion of cancer, osteoporosis, or osteoarthritis ➤ fever above 38° C (100.4° F) for greater than 48 hours ➤ immunosuppression ➤ serious accident or injury (fracture or suspected fracture) • Physical exam*** <ul style="list-style-type: none"> ➤ radicular pain <ul style="list-style-type: none"> ▪ straight leg raise test AND ▪ complete neurovascular exam ➤ without radicular pain <ul style="list-style-type: none"> ▪ straight leg raise test OR ▪ neurovascular exam OR ▪ clear notation of presence or absence of neurologic defects ▪ screen for leg-length 	<p>Categorize patient as having one of the following four types:</p> <ul style="list-style-type: none"> • Non-specific low back pain • Back pain potentially associated with radiculopathy or spinal stenosis • Back pain potentially associated with another specific spinal cause (e.g. cancer, infection, etc.) <p>Back pain from a non-spinal source</p> <p>Imaging info below</p> <p>Address mental health issues/yellow flags</p> <p>Educate patient on preventive care Consider blood work if cancer or infection is suspected If low back pain is possibly due to a work-related injury or Workers' Compensation claim, it is important to follow the Workers Compensation Treatment Guidelines</p>	<ul style="list-style-type: none"> • Refer emergent cases to ER: <ul style="list-style-type: none"> ➤ sudden loss of bowel/bladder function ➤ back pain secondary to trauma ➤ saddle numbness ➤ sudden unexplained bilateral leg weakness • Urgent referral (within 24 hours): <ul style="list-style-type: none"> ➤ fever above 38° C (100.4° F) for greater than 48 hours ➤ unrelenting night pain or pain at rest ➤ severe uncontrolled back or leg pain ➤ progressive pain with distal (below the knee) numbness or weakness of leg(s) ➤ progressive neurological deficit • Evaluation within 2 – 7 days <ul style="list-style-type: none"> ➤ moderate to severe new onset back pain or leg pain chronic back pain (≥ 6 weeks) ➤ unexplained weight loss (≥ 10 pounds in 6

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		<p>disparity, pelvic hip tilting, scoliosis</p> <ul style="list-style-type: none"> • Positive screening for depression, narcotic abuse, etc., or any of the following “yellow flags”: <ul style="list-style-type: none"> ➤ belief that pain and activity are harmful ➤ “sickness behaviors,” such as extended rest ➤ depressed or negative moods, social withdrawal ➤ treatment that does not fit best practice ➤ problems with claims and compensation ➤ history of back pain, time off or other claims ➤ problems at work or low job satisfaction ➤ heavy work ➤ overprotective family or lack of support 		<p>months)</p> <ul style="list-style-type: none"> ➤ over age 50 ➤ history of cancer • Refer for PT or to spine specialist: <ul style="list-style-type: none"> ➤ back/leg pain is disabling ➤ pt has functional or job limitations
Imaging * (1,2,3,5)	<ul style="list-style-type: none"> • Diagnostic imaging is not routinely recommended for non-specific low back pain. • For severe or progressive neurologic deficit or when cancer, cauda equina, or infection is suspected - MRI is preferred over CT. • For persistent (>1 month) low back pain and signs/symptoms of radiculopathy or spinal stenosis - MRI is preferred over CT, BUT only if the patient is a candidate for 	<ul style="list-style-type: none"> • See above for risk factors of cancer, cauda equina, & infection. 	<ul style="list-style-type: none"> • Ordering imaging studies as appropriate for findings on history and physical exam. 	<ul style="list-style-type: none"> • Treat specific cause if identified. • Refer as appropriate

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	surgery or epidural injection. <ul style="list-style-type: none"> For evaluation of ankylosing spondylitis: AP pelvis. For evaluation of vertebral compression fracture: LS plain x-rays. 			
Treatment (2,3,4,6)	<ul style="list-style-type: none"> Most patients improve with conservative therapy within six weeks. 	<ul style="list-style-type: none"> Documentation of recommended supervised OR therapeutic exercises in back pain lasting more than 12 weeks.* Cauda equina syndrome is a surgical emergency. 	Non-Invasive Treatment: Pharmacologic Therapy <ul style="list-style-type: none"> Acetaminophen Non-steroidal anti-inflammatories (NSAIDs) Skeletal muscle relaxants (for acute low back pain) Tri-cyclic antidepressants (for chronic low back pain) Corticosteroids Anticonvulsants Local anesthetics (topical or intraspinal) Opioids or tramadol (for severe, debilitating pain) Non-Invasive Treatment: Non-pharmacologic Therapy <ul style="list-style-type: none"> Spinal manipulation Interdisciplinary rehabilitation Exercise therapy Acupuncture Massage therapy Spinal manipulation Yoga Cognitive behavioral therapy Progressive relaxation Ice packs or heat for short 	<ul style="list-style-type: none"> Follow – up within 1-3weeks, if no improvement consider referral to spine specialist Assess pain and functional status as above Consider surgical referral when conservative management fails Monitor for response to therapy and for adverse outcomes

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			<p>periods of time document discussion of treatment options including natural history of low back pain, treatment options, alternatives to surgery, risks and benefits, and evidence of effectiveness (surgical and others)*</p> <ul style="list-style-type: none"> ➤ Written patient education** • NOTE: Transcutaneous electrical nerve stimulation (TENS) and traction have not proven effective 	
Activity (1,2,3)	<ul style="list-style-type: none"> • Discuss activity limitations on initial visit* • Work restrictions generally not recommended 	<ul style="list-style-type: none"> • Record date and recommendation on activity and bed rest* 	<ul style="list-style-type: none"> • Maintain or resume normal activity as early as possible* • Heavy lifting, trunk twisting and bodily vibrations should be avoided in the acute phase. • Bed rest is not recommended and should be limited to no more than two days. * 	<ul style="list-style-type: none"> • If pain better on follow – up, increase activity
Tobacco Use (3) *	<ul style="list-style-type: none"> • Smoking cessation 	<ul style="list-style-type: none"> • Tobacco use patterns • Prior quit attempts • Readiness assessment 	<p>5 A's</p> <ul style="list-style-type: none"> • Ask about smoking • Advise user to quit • Assess willingness to quit • Assist user to quit (i.e., refer to smoking cessation program and consider pharmacotherapy) • Arrange follow-up <p>Pharmacologic adjuvants:</p> <ul style="list-style-type: none"> • Nicotine replacement • Anti-depressants • Varenicline 	<ul style="list-style-type: none"> • Call on quit date or within 72 hrs. to boost self-efficacy <ul style="list-style-type: none"> • Assess each visit: smoking status, weight gain, nicotine withdrawal symptoms
Epidural Steroid Injections (2)*	<ul style="list-style-type: none"> • Consider referral before surgery 	<ul style="list-style-type: none"> • Persistent radicular symptoms in dermatomal distribution despite conservative therapy 	<ul style="list-style-type: none"> • Perform under fluoroscopy with contrast for best results • Perform under fluoroscopy 	

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			with contrast for best results Note: fluoroscopy is contraindicated in pregnancy	

Refer to patient's plan benefit design for coverage determinations

* Indicates a NCQA clinical measure for Back Pain Recognition Program (BPRP) (3)

Use of the following assessments satisfies requirements:

† - SF - 36, Oswestry Low Back Pain Disability Questionnaire, Roland - Morris Disability Questionnaire, Quebec Pain Disability Questionnaire, Sickness Impact Profile, or Multidimensional Pain Inventory,

McGill Pain Questionnaire, Visual analog scale, Brief pain inventory, Chronic pain grade, Neuropathic pain scale, Numerical rating scale, Verbal descriptive scale, Faces pain scale,

± - ADLs to document (in the absence of above questionnaires): eating, bathing, using the toilet, dressing, getting up from bed or a chair,

§ - PHQ -2/9, Distress and Risk Assessment Method, Zung Scale, Symptom Check List (SCL - 90 - R), Beck Depression Inventory, Millon Behavioral Health Inventory, Minnesota Multiphasic Personality Inventory,

¥ - CAGE - AID

** Indicates a NCQA structural standard for BPRP (3)

*** Must pass requirement BPRP (3)

REFERENCE LIST

<p>1. University of Michigan Health System. Acute Low Back Pain. Guidelines for Clinical Care. University of Michigan Health System. 2005. http://cme.med.umich.edu/pdf/guideline/backpain03.pdf</p>	<p>2. Institute for Clinical Systems Improvement Healthcare Guideline: Adult Low Back Pain. Institute for Clinical Systems Improvement (fourteenth edition, 1-75. November 2010 www.icsi.org/low_back_pain/adult_low_back_pain_8.html</p>
<p>3. National Committee for Quality Assurance. Back Pain Recognition Program. National Committee for Quality Assurance. 2007. 9-6-2010.</p>	<p>4. Chou R, Qaseem A, Snow V, Casey D, Cross T, Shekelle P, et.al., Guideline from the American College of Physicians and the American Pain Society. Ann Intern Med. 2007; 147:478-491. www.annals.org/content/147/7/478.full</p>
<p>5. American College of Radiology. ACR Appropriateness Criteria: Low Back Pain. 1 – 7. 2008. http://www.acr.org/SecondaryMainMenuCategories/quality_safety/app_criteria/pdf/ExpertPanelonNeurologicImaging/lowbackpainDoc7.aspx</p>	<p>6. Institute for Clinical Systems Improvement. Healthcare Guideline: Assessment and Management of Acute Pain. Institute for Clinical Systems Improvement. (Sixth edition) 1 – 59. 2008. 9-8-2010. http://www.icsi.org/pain_acute/pain__acute__assessment_and_management_of__3.html</p>