

Back Pain**Quality Indicators**  **CMS EP CQM Quality Indicators:**

Routine imaging is generally not required for patients with non-specific acute low back pain unless "red flag" indications are present

PQRS Quality Indicators:

Pain assessment should be performed using a standardized tool at each visit and a follow-up plan should be documented when pain is present

Cares**In-Clinic Assessments:**

Document patient's current disease/condition status

Complete pain assessment

Lifestyle Education: UpToDate UpToDate 

- *UpToDate recommends that patients remain active, and limit bedrest. UpToDate suggests patients be given evidence-based self-care information literature to supplement verbal advice. UpToDate suggests not advising patients to switch to a very firm mattress or other surface. UpToDate also suggests not advising routine use of lumbar supports. (UpToDate)*
- *UpToDate suggests home and supervised exercise therapy that includes an individualized regimen incorporating stretching and strengthening for motivated patients. Aerobic activities should be recommended for all patients, including patients with low back pain. (UpToDate)*

Provide disease/medical condition education

Vital Signs:

Obtain and document vital signs

Medications UpToDate  **Non-Opioid Analgesics:** 

- *UpToDate suggests short courses of nonopioid analgesic medications (acetaminophen or nonsteroidal antiinflammatory drugs) for acute exacerbations of subacute or chronic low back pain. (UpToDate)*

Acetaminophen 325 mg orally every 4 hours as needed for pain

Acetaminophen 1,000 mg orally every 6 hours as needed for pain (not to exceed 4 grams in 24 hours)

Ibuprofen 400 mg orally every 6 hours as needed for pain or inflammation

Naproxen sodium 220 mg orally 2 times per day as needed for pain and inflammation

Skeletal Muscle Relaxants: 

- *In general, short-term use of skeletal muscle relaxants may be considered as adjunctive therapy to analgesics in patients with acute exacerbations of chronic low back pain, but there is insufficient data to recommend their use for chronic stable low back pain. The lack of clear benefit, well known side effects including sedation, and the potential for dependence with some skeletal muscle relaxants suggest that this class of medication should not be recommended for prolonged use. (UpToDate)*

Cyclobenzaprine HCl 5 mg orally 3 times per day

Baclofen 5 mg orally 3 times per day

Carisoprodol 250 mg orally 4 times per day

Metaxalone 800 mg orally 3 times per day

Methocarbamol 1,500 mg orally 4 times per day for 48 hours *Step 1*.

Methocarbamol 1,000 mg orally 4 times per day *Step 2 - Maintenance dosing*.

Orphenadrine citrate extended release 12-hour tablet 100 mg orally 2 times per day

Diazepam 2 mg orally every 6 hours as needed for muscle tension *Because of limited evidence on efficacy and potential for addiction and abuse, benzodiazepines should not be used for long-term treatment of chronic low back pain, although a short course may be indicated for acute exacerbations of chronic low back pain in patients less vulnerable to abuse and addiction. (UpToDate)*

Tricyclic Antidepressants:

- *UpToDate* suggests a trial of tricyclic antidepressants for treatment of chronic low back pain in patients, with or without depression, who have not responded to other measures. (*UpToDate*)

Amitriptyline HCl 25 mg orally 1 time per day at bedtime

Opioid Analgesics:

- *UpToDate* suggests prescribing opioids for chronic low back pain only for short-term use in patients with low vulnerability for drug abuse who are experiencing severe acute exacerbations of back pain (Grade 2B). Rarely, opioids may also be appropriate for severely disabled patients with chronic low back pain who do not respond to other measures, and who are assessed to have low vulnerability for drug abuse. (*UpToDate*)

Acetaminophen-codeine 300-30 mg tablet 1 tablet orally every 4 hours

HYDROcodone-acetaminophen 5-300 mg tablet 1 tablet orally every 4 hours (not to exceed 4 grams of acetaminophen in 24 hours)

HYDROcodone-acetaminophen 5-325 mg tablet 1 tablet orally every 4 hours (not to exceed 4 grams of acetaminophen in 24 hours)

oxyCODONE-acetaminophen 5-325 mg tablet 1 tablet orally every 4 hours

traMADol HCl 50 mg orally every 6 hours as needed for pain

Laboratory UpToDate UpToDate UpToDate

- A history and physical exam alone are sufficient to evaluate most patients with back pain of less than four weeks duration. Patients with "red flags" for a serious underlying condition (eg, fracture, neoplasm, infection, cauda equina syndrome or other significant neurologic deficits), or those who are surgical candidates for persistent nerve-impingement symptoms, may warrant additional diagnostic studies. Red flags are recent significant trauma, or milder trauma in patients over age 50; unexplained weight loss; unexplained fever; immunosuppression; history of cancer; intravenous drug use; osteoporosis; prolonged use of glucocorticoids; age over 70; focal neurologic deficit or progressive or disabling neurologic symptoms. (*UpToDate*)

Chemistry:

- For patients in whom the possibility of multiple myeloma is considered, suggested by an elevated erythrocyte sedimentation rate (ESR), advanced age, or other clinical signs, a urine protein electrophoresis and serum protein electrophoresis should be obtained. (*UpToDate*)

C-reactive protein (serum)

Protein electrophoresis panel (serum)

Renal function panel (serum)

Protein electrophoresis panel (urine)

Hematology:

Erythrocyte sedimentation rate (blood)

WBC count (blood)

Immunology:

- HLA-B27 (blood) *The specificity of an HLA B27 antigen for ankylosing spondylitis is low; it should not be used as a screening test for this disorder but may be useful if x-ray findings are equivocal. (UpToDate)*

Urinalysis:

- Urinalysis (urine) *A urinalysis is not generally helpful in evaluating low back pain, but may be considered in patients with unexplained unilateral back pain, searching for subclinical pyelonephritis. (UpToDate)*

Imaging UpToDate UpToDate UpToDate

- A history and physical exam alone are sufficient to evaluate most patients with back pain of less than four weeks duration. Patients with "red flags" for a serious underlying condition (eg, fracture, neoplasm, infection, cauda equina syndrome or other significant neurologic deficits), or those who are surgical candidates for persistent nerve-impingement symptoms, may warrant additional diagnostic studies. Red flags are recent significant trauma, or milder trauma in patients over age 50; unexplained weight loss; unexplained fever; immunosuppression; history of cancer; intravenous drug use; osteoporosis; prolonged use of glucocorticoids; age over 70; focal neurologic deficit or progressive or disabling neurologic symptoms. (*UpToDate*)
- Imaging studies in the first four to six weeks are not necessary, unless there are progressive neurological findings or a high suspicion of a systemic etiology. A plain anteroposterior and lateral X-ray of the lumbar spine is appropriate if clinical improvement has not occurred after four to six weeks. (*UpToDate*)
- A magnetic resonance imaging (MRI) or computed tomography (CT) should be performed when the clinical exam suggests emergent conditions (cauda equina syndrome, infection, tumor, fracture with neurologic impingement, or other mass lesions or defects) or in patients with at least four to six weeks of radicular symptoms or a several month history of neurogenic claudication who would be appropriate surgical candidates for disc disease or spinal stenosis respectively. (*UpToDate*)

Computed Tomography:

- CT is superior to MRI for demonstrating bony abnormalities such as sacroiliac joint disease, fractures, spondylolisthesis, unstable fusions, abnormal facet joints, degenerative changes, and congenital abnormalities. CT may be helpful when radiographs of the spine are abnormal or non-diagnostic following trauma and can detect the sacroiliac changes of ankylosing spondylitis before these are apparent on plain radiographs. (*UpToDate*)

Lumbar spine CT scan today

Pelvis CT scan today

Thoracic spine CT scan today

Magnetic Resonance:

- *MRI is particularly useful in patients with suspected disc herniations, spinal stenosis, osteomyelitis, discitis, spinal epidural abscess, bone metastases, arachnoiditis, and neural tube defects. (UpToDate)*

Lumbar spine MRI today

Pelvis MRI today

Thoracic spine MRI today

X-Ray:

- *When x-rays are indicated, anteroposterior and lateral views are usually adequate. Oblique views substantially increase the risks of radiation exposure, particularly for women, and add little new diagnostic information. Flexion-extension views may be helpful in patients who have had surgical fusion procedures or in those with spondylolisthesis. A pelvic or hip x-ray should be considered for older patients in whom osteoarthritis of the hip may present as low back pain. If a patient's low back symptoms do not lateralize, a standing pelvis film will evaluate both hips for the presence of osteoarthritis; if symptoms lateralize, a two-view hip (standing frontal and frog-leg views) is appropriate. (UpToDate)*

Routine X-ray of the lumbar spine today

Routine X-ray of the pelvis today

Routine X-ray of the thoracic spine today

Referrals

- *Urgent referral is indicated for patients with suspected cauda equina syndrome or spinal cord compression. Surgical referral is also indicated for patients with progressive or severe neurologic deficits. Patients with persistent sciatica, sensory deficits, or reflex loss after four to six weeks, and who have consistent clinical findings, may also benefit from a specialist evaluation. (UpToDate)*
- *Many additional noninterventional treatment strategies have been advocated for patients with chronic low back pain. For patients interested in particular modalities, UpToDate suggests trials of Yoga (Viniyoga), spinal manipulation, massage therapy, or cognitive behavioral therapy, which are moderately more effective than sham or placebo treatment. UpToDate suggests functional restoration or interdisciplinary rehabilitation for patients who are more severely impaired by their back pain. UpToDate suggests that patients with chronic pain who are interested or open to acupuncture be referred for a trial of acupuncture when alternatives are limited. Acupuncture, as with other therapies, is likely to be most beneficial in patients who have high expectations of benefit. (UpToDate)*

Acupuncturist referral

Medical Oncology referral

Neurosurgery referral

Occupational Therapy referral

Orthopedic Surgery referral

Pain Management Clinic referral

Physical Therapy referral

Psychotherapy referral

Rheumatology referral

Disposition / Follow-up

Return to clinic for follow-up and then

Transfer