

**Necessary Changes to Proposed New York State
Low Back Medical Treatment Guidelines¹**

Submitted to the New York State Workers' Compensation Board

by

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A. GENERAL SUMMARY OF RECOMMENDATIONS

The following is a general summary of the Low Back Pain (“LBP”) recommendations contained in this chapter:

- The initial assessment of patients with low back problems focuses on detecting indications of potentially serious disease, termed “red flags” (i.e., fever or major trauma).
- In the absence of red flags, imaging and other tests are not recommended in the first 4 to 6 weeks of low back symptoms as they almost never result in a

¹ Underlined text is new, recommended language. Strike-out text is language that we recommend be deleted from the draft guidelines.

meaningful change in clinical management. Nonprescription medication or an appropriately selected nonsteroidal anti-inflammatory drug (NSAID), appropriate adjustment of physical activity, and use of thermal modalities such as ice and/or heat can safely relieve discomfort.

- In the absence of red flags, low back problems can be effectively managed low conservatively.
- At the first visit, the physician should assure the patient that LBP is common, has a good prognosis, and is not debilitating in most cases on a long-term basis.
- To avoid undue back irritation and debilitation from inactivity, some activity or job modification may be helpful in the acute period. Bed rest is not generally recommended for patients with LB and radicular pain other than those with unstable fractures of cauda equine syndrome with pending neurological catastrophe. Maintaining ordinary activity, as tolerated, leads to the most rapid recovery.
- All patients should be encouraged to return to work as soon as possible, as evidence suggests this leads to the best outcomes. This process may be best facilitated with modified duty particularly when the job demands exceed the patient's capabilities. Full-duty work is a reasonable option for those with low physical job demands, and the ability to control their job demands and frequently alternate their posture, as well as for those with less severe presentations.
- For a minority of patients with persistent, chronic and/or debilitating neuropathic pain, return-to-work (full or partial) may not be feasible. For such patients, however, certain interventional and non-interventional approaches contained in this guideline may be successful in substantially alleviating pain and improving overall function and quality of life, even if full or partial return-to-work is not achieved.
- Aerobic exercise has the best evidence of efficacy among the exercise regimens, whether for acute, subacute, or chronic LBP patients.
- Specific types of stretching appear helpful while non-specific stretching is not recommended as it is not helpful. Strengthening exercises including lumbar stabilization exercises are recommended, but not until the acute period of LBP has subsided.
- Manipulation for treatment of non-specific LBP may have some efficacy.
- ~~Many invasive and noninvasive therapies are intended to cure or manage LBP, but no strong evidence exists that they accomplish this as successfully as therapies that focus on restoring functional ability without focusing on pain.~~
- Furthermore, patients should be aware that returning to normal activities most often aids functional recovery.
- Patients should be encouraged to accept responsibility for managing their recovery rather than expecting the provider to provide an easy "cure." This process will promote using activity rather than pain as a guide, and it will make the treatment goal of return to occupational and non-occupational activities more obvious.
- If symptoms persist without improvement, further evaluation is recommended.
- Within the first three months of low back symptoms, only patients with evidence of severe spinal disease or severe, debilitating symptoms, and physiologic

evidence of specific nerve root compromise confirmed by appropriate imaging studies, can be expected to potentially benefit from surgery.

- The vast majority of patients with symptoms of lumbosacral nerve root irritation due to herniated discs (nucleus pulposus) eventually recover with or without surgery. Quality evidence is present that those more severely affected and with sequestered disc fragments also benefit from conservative management.
- Nonphysical factors (such as psychiatric, psychosocial, workplace or socioeconomic problems) can be investigated and should be addressed in cases of delayed recovery or delayed return to work.

Physicians can greatly improve patient response to back symptoms by providing assurance, encouraging activity, and emphasizing that a significant majority ~~more than 90%~~ of LBP complaints resolve without any specific therapies. ~~While patients may be looking for a clear-cut diagnosis for their LBP, the risk to them of a suggested “cure” for this assumed diagnosis, resulting in failed expectations, may be worse than their symptoms.~~

Physicians should be aware that “abnormal” findings on x-rays, magnetic resonance images, and other diagnostic tests are frequently seen by age 40 even in asymptomatic individuals. Bulging discs continue to increase after that point and by approximately age 60, will be encountered in a majority of patients. This requires that a careful history and physical examination be conducted by a physician in order to correlate historical, clinical, and imaging findings prior to diagnosing and assigning the finding on imaging to a patient’s complaints. The focus of treatment should be improving symptoms and function, and not the correction of abnormalities on imaging studies.

B. ANATOMICAL TESTS

Fluoroscopy

1. Recommendation: Acute, Subacute or Chronic LBP

~~Fluoroscopy is not recommended for the evaluation of acute, subacute, and chronic LBP.~~

~~Strength of Evidence: Not Recommended, Insufficient Evidence (I)~~

The standard of care for all transforaminal epidural injections for chronic pain, paravertebral facet joint/nerve injection and denervation, and sacroiliac joint injections requires that these procedures be performed under fluoroscopic- or CT-guided imaging. Therefore, injections performed without imaging guidance will be considered inappropriate and not reasonable or necessary.

Since multi-planar fluoroscopy during procedures is required to document technique and needle placement, an experienced physician should perform the procedure. Permanent images are required to verify needle placement. The subspecialty disciplines of the

physicians performing the injections may be varied, including, but not limited to: anesthesiology, radiology, surgery, or physiatry. The practitioner should document hands-on training through workshops of the type offered by organizations such as the International Spine Intervention Society (ISIS) and/or completed fellowship training with interventional training. They must also be knowledgeable in radiation safety.

For applicability within this guideline, see *Section J, Injection Therapies - Lumbar, Transforaminal, Epidural.*

Strength of Evidence: Recommended, Evidence (B)

Lumbar Discography

1. Recommendation: Acute, Subacute, Chronic LBP or Radicular Pain Syndromes

~~Discography, whether performed as a solitary test or when paired with imaging (e.g., MRI), is not recommended for acute, subacute, chronic LBP or radicular pain syndromes.~~

~~Strength of Evidence: Moderately Not Recommended, Evidence (B)~~

Discography is an accepted diagnostic procedure to identify or refute a discogenic source of pain for patients who are surgical candidates. Discography should only be performed by physicians who are experienced and have been proctored in the technique. It is essential that all indications, pre-conditions, special considerations, procedures, reporting requirements, and results are carefully and specifically followed. Results should be interpreted judiciously.

Lumbar provocative discography is considered medically necessary for evaluation of disc pathology in persons with persistent, severe low back pain (LBP) and abnormal interspaces on magnetic resonance imaging (MRI), where other diagnostic tests have failed to reveal clear confirmation of a suspected disc as the source of pain, and surgical intervention is being considered.

Strength of Evidence: Moderately Recommended, Evidence (C)

J. INJECTION THERAPIES

~~Diagnostic Facet Joint Injections (Intra-articular and Nerve Blocks)~~

Diagnostic Paravertebral Facet Joint/Nerve Block

1. Recommendation: Chronic LBP

~~One fluoroscopically guided diagnostic facet joint injection per side per level may be recommended for patients with chronic LBP that is significantly exacerbated by extension and rotation or associated with lumbar rigidity, and not alleviated with other conservative treatments (e.g., medication, aerobic exercise, other exercise,~~

manipulation) in order to determine whether specific interventions targeting the facet joint are recommended. Repeated diagnostic injections in the same location(s) are not recommended.

Diagnostic paravertebral facet joint/nerve block is appropriate for the following conditions:

- Hypertrophic arthropathy of the facet joints causing back and/or neck pain;
- Back or neck pain following whiplash/post-traumatic injury;
- Back pain greater than leg pain;
- Neck pain greater than arm pain;
- Thoracic pain greater than chest wall pain;
- Back or neck pain associated with suspected motion segment instability/hypermobility or pseudoarthrosis following fusion.

Repeat injection would be considered medically necessary only upon subsequent return of pain and deterioration in functional status. As noted in the above, if pain returns after a satisfactory response it may be necessary to give a second injection on a different date of service to determine the etiology of the pain and effectiveness of the injection. Two-to-three adjacent joint levels may need to be injected before the level(s) is (are) determined.

Radiofrequency Neurotomy, Neurotomy, and Facet Rhizotomy

1. Recommendation: Procedure of Last Resort Radiofrequency Neurotomy, Neurotomy, and Facet Rhizotomy

Radiofrequency neurotomy, neurotomy, and facet rhizotomy is indicated in patients who have had successful diagnostic facet injections, as delineated in the foregoing section, **Diagnostic Paravertebral Facet Joint/Nerve Block**, may be considered as a procedure of last resort in patients with chronic LBP.

2. Recommendation: Therapeutic Facet Joint Injection

For patients in whom facet joint injections have been therapeutically successful, the use of radiofrequency neurotomy, neurotomy, and facet rhizotomy may be indicated.

K. SURGICAL CONSIDERATIONS

10. Recommendation: Implantable Spinal Cord Stimulators

~~Spinal cord stimulators are not recommended for treatment of acute, subacute, or chronic LBP. They also are not recommended for treatment of radicular pain syndromes, or failed back surgery syndrome.~~

Strength of Evidence: Not Recommended, Insufficient Evidence (I)

Spinal cord stimulation (SCS) is recommended as a treatment option for severe and chronic pain of the trunk or limbs that is refractory to all other pain therapies. SCS is recommended only for selected patients in cases when less invasive procedures have failed or are contraindicated and following a successful temporary trial.

All of the following conditions must be met for coverage under this guideline:

- The implantation of the stimulator is used only as a late resort (if not a last resort) for patients with chronic intractable pain;
- Other treatment modalities (pharmacological, surgical, physical, or interventional therapies) have been tried and did not prove satisfactory, or are judged to be unsuitable or contraindicated for the given patient;
- Patients have undergone careful screening, evaluation and diagnosis by a multidisciplinary team prior to implantation. (Such screening must include psychological, as well as physical evaluation);
- All the facilities, equipment, and professional and support personnel required for the proper diagnosis, treatment training, and follow-up of the must be available; and
- Demonstration of pain relief with a temporarily implanted electrode precedes permanent implantation.

Strength of Evidence: Recommended, Evidence (B)