NEW YORK STATE OF OPPORTUNITY.

Workers' Compensation Board

Medical Treatment Guidelines

Mid and Low Back Injury

Effective May 2, 2022

Contributors

The NYS Workers' Compensation Board would like to thank the members of the New York Workers' Compensation Board Medical Advisory Committee (MAC). The MAC served as the Board's advisory body to adapt the American College of Occupational and Environmental Medicine (ACOEM) Practice Guidelines to a New York version of the Medical Treatment Guidelines (MTG). In this capacity, the MAC provided valuable input and made recommendations to help guide the final version of these Guidelines. With full consensus reached on many topics, and a careful review of any dissenting opinions on others, the Board established the final product.

New York State Workers' Compensation Board Medical Advisory Committee

Joseph Canovas, Esq.
Special Counsel
New York State AFL-CIO

Kenneth B. Chapman, MD
Director Pain Medicine, SIUH Northwell Health Systems
Assistant Clinical Professor, NYU Langone Medical Center
Adjunct Assistant Professor, Hofstra Medical School

Robert Goldberg, DO
Attending Physician, Department of Rehabilitation, Beth Israel Hospital and Medical Center of NYC
Professor of Physical Medicine and Rehabilitation and Health Policy
Clinical Associate Professor of Rehabilitation Medicine, New York Medical College
Clinical Professor of Rehabilitation Medicine, Philadelphia College of Osteopathic Medicine
Member Council on Medical Education of the American Medical Association

Brian M. Gordon, MD
Former Medical Director,
New York State Workers' Compensation Board

Frank Kerbein, SPHR
Director, Center for Human Resources
The Business Council of New York State, Inc.

Joseph Pachman, MD, PhD, MBA, MPH
Licensed Psychologist and Physician
Board Certified in Occupational Medicine
Fellow in ACOEM
Vice President and National Medical Director, Liberty Mutual

James A. Tacci, MD, JD, MPH
Medical Director and Executive Medical Policy Director,
New York State Workers' Compensation Board

Edward C. Tanner, MD
Chair, Department of Orthopaedics at Rochester General Hospital
Past President, New York State Society of Orthopaedic Surgeons (NYSSOS)
Member, American Academy of Orthopaedic Surgeons (AAOS)
Member, American Association of Hip and Knee Surgeons (AAHKS)

Revised July 2021

Table of Contents

A. General Guideline Principles

The principles summarized in this section are key to the intended application of the New York State Medical Treatment Guidelines (MTG) and are applicable to all Workers' Compensation Medical Treatment Guidelines.

A.1 Medical Care

Medical care and treatment required as a result of a work-related injury should be focused on restoring functional ability required to meet the patient's daily and work activities with a focus on a return to work, while striving to restore the patient's health to its pre-injury status in so far as is feasible.

A.2 Rendering Of Medical Services

Any medical provider rendering services to a workers' compensation patient must utilize the Treatment Guidelines as provided for with respect to all work-related injuries and/or illnesses.

A.3 Positive Patient Response

Positive results are defined primarily as functional gains which can be objectively measured. Objective functional gains include, but are not limited to, positional tolerances, range of motion, strength, endurance, activities of daily living (ADL), cognition, psychological behavior, and efficiency/velocity measures which can be quantified. Subjective reports of pain and function may be considered and given relative weight when the pain has anatomic and physiologic correlation in proportion to the injury.

A.4 Re-Evaluate Treatment

If a given treatment or modality is not producing positive results within a well-defined timeframe, the provider should either modify or discontinue the treatment regime. The provider should evaluate the efficacy of the treatment or modality 2 to 3 weeks after the initial visit and 3 to 4 weeks thereafter. These timeframes may be slightly longer in the context of conditions that are inherently mental health issues, and shorter for other non-musculoskeletal medical conditions (e.g. pulmonary, dermatologic etc.). Recognition that treatment failure is at times attributable to an incorrect diagnosis a failure to respond should prompt the clinician to reconsider the diagnosis in the event of an unexpected poor response to an otherwise rational intervention.

A.5 Education

Education of the patient and family, as well as the employer, insurer, policy makers and the community should be a primary emphasis in the treatment of work-related injury or illness. Practitioners should develop and implement effective educational strategies and skills. An education-based paradigm should always start with communication providing reassuring information to the patient. No treatment plan is complete without addressing issues of individual and/or group patient education as a means of facilitating self-management of symptoms and prevention of future injury.

Time Frames

A.6 Acuity

Acute, Subacute and Chronic are generally defined as timeframes for disease stages:

- Acute – Less than one month
- Subacute - One to three month, and
- Chronic - greater than three months.
-

A.7 Initial Evaluation

Initial evaluation refers to the acute timeframe following an injury and is not used to define when a given physician first evaluates an injured worker (initial encounter) in an office or clinical setting.

A.8 Diagnostic Time Frames

Diagnostic time frames for conducting diagnostic testing commence on the date of injury. Clinical judgment may substantiate the need to accelerate or decelerate the time frames discussed in this document.

A.9 Treatment Time Frames

Treatment time frames for specific interventions commence once treatments have been initiated, not on the date of injury. It is recognized that treatment duration may be impacted by disease process and severity, patient compliance, as well as availability of services. Clinical judgment may substantiate the need to accelerate or decelerate the time frames discussed in this document.

A.10 Delayed Recovery

For those patients who fail to make expected progress 6-12 weeks after an injury and whose subjective symptoms do not correlate with objective signs and tests, reexamination in order to confirm the accuracy of the diagnosis and re-evaluation of the treatment program should be performed. When addressing a clinical issue that is not inherently a mental health issue, assessment for potential barriers to recovery (yellow flags/psychological issues) should be ongoing throughout the care of the patient. At 6-12 weeks, alternate treatment programs, including formal psychological or psychosocial evaluation should be considered. Clinicians must be vigilant for any pre-existing mental health issues or subsequent, consequential mental health issues that may be impacting recovery. For issues that are clearly and inherently mental health issues from the outset (i.e. when it is evident that there is an underlying, work-related, mental health disorder as part of the claim at issue), referral to a mental health provider can and should occur much sooner. Referrals to mental health providers for the evaluation and management of delayed recovery do not indicate or require the establishment of a psychiatric or psychological condition. The evaluation and management of delayed recovery does not require the establishment of a psychiatric or psychological claim.

Treatment Approaches

A.11 Active Interventions

Active interventions emphasizing patient responsibility, such as therapeutic exercise and/or functional treatment, are generally emphasized over passive modalities, especially as treatment progresses. Generally, passive and palliative interventions are viewed as a means to facilitate progress in an active rehabilitation program with concomitant attainment of objective functional gains.

A.12 Active Therapeutic Exercise Program

Active therapeutic exercise program goals should incorporate patient strength, endurance, flexibility, range of motion, sensory integration, coordination, cognition and behavior (when at issue) and education as clinically indicated. This includes functional application in vocational or community settings.

A.13 Diagnostic Imaging And Testing Procedures

Clinical information obtained by history taking and physical examination should be the basis for selection of imaging procedures and interpretation of results. All diagnostic procedures have characteristic specificities and sensitivities for various diagnoses. Usually, selection of one procedure over others depends upon various factors, which may include: relative diagnostic value; risk/benefit profile of the procedure; availability of technology; a patient's tolerance; and/or the treating practitioner's familiarity with the procedure.

When a diagnostic procedure, in conjunction with clinical information, provides sufficient information to establish an accurate diagnosis, a second diagnostic procedure is not required. However, a subsequent diagnostic procedure including a repeat of the original (same) procedure can be performed, when the specialty physician (e.g. physiatrist, sports medicine physician or other appropriate specialist) radiologist or surgeon documents that the initial study was of inadequate quality to make a diagnosis. Therefore, in such circumstances, a repeat or complementary diagnostic procedure is permissible under the MTG.

It is recognized that repeat imaging studies and other tests may be warranted by the clinical course and/or to follow the progress of treatment in some cases. It may be of value to repeat diagnostic procedures (e.g., imaging studies) during the course of care to reassess or stage the pathology when there is progression of symptoms or findings, prior to surgical interventions and/or therapeutic injections when clinically indicated, and post-operatively to follow the healing process. Regarding serial imaging, (including x-rays, but particularly CT scans), it must be recognized that repeat procedures result in an increase in cumulative radiation dose and associated risks.

A given diagnostic imaging procedure may provide the same or distinctive information as obtained by other procedures. Therefore, prudent choice of procedures(s) for a single diagnostic procedure, a complementary procedure in combination with other procedures(s), or a proper sequential order in multiple procedures will ensure maximum diagnostic accuracy, minimize the likelihood of adverse effect on patients, and promote efficiency by avoiding duplication or

redundancy.

A.14 Surgical Interventions

Consideration of surgery should be within the context of expected functional outcome. The concept of "cure" with respect to surgical treatment by itself is generally a misnomer. All operative interventions must be based upon positive correlation of clinical findings, clinical course and imaging and other diagnostic tests. A comprehensive assimilation of these factors must lead to a specific diagnosis with positive identification of pathologic condition(s). For surgery to be performed to treat pain, there must be clear correlation between the pain symptoms and objective evidence of its cause. In all cases, shared decision making with the patient is advised. The patient should be given the opportunity to understand the pros and cons of surgery, potential for rehabilitation as an alternative where applicable, evidence-based outcomes, and specific surgical experience.

A.15 Pre-Authorization

All diagnostic imaging, testing procedures, non-surgical and surgical therapeutic procedures, and other therapeutics within the criteria of the Medical Treatment Guidelines and based on a correct application of the Medical Treatment Guidelines are considered authorized, with the exception of the procedures listed in section 324.3(1)(a) of Title 12 NYCRR. These are not included on the list of pre-authorized procedures. Providers who want to perform one of these procedures must request pre-authorization from the carrier before performing the procedure.

Second or subsequent procedures (the repeat performance of a surgical procedure due to failure of, or incomplete success from the same surgical procedure performed earlier, if the Medical Treatment Guidelines do not specifically address multiple procedures) also require pre-authorization.

A.16 Psychological/Psychiatric Evaluations

In select patients, mental health evaluations are essential to make, secure or confirm a diagnosis. Of course, the extent and duration of evaluations and/or interventions by mental health professionals may vary, particularly based on whether: the underlying clinical issue in the claim is inherently a mental health issue; or there is a mental health issue that is secondary or consequential to the medical injury or illness that is at issue in the claim in question; or there is a pre-existing, unrelated mental health issue that has been made worse by, or is impeding the recovery from (or both) the medical injury or illness that is at issue in the claim in question.

Tests of psychological function or psychometric testing, when indicated, can be a valuable component of the psychological evaluation in identifying associated psychological, personality and psychosocial issues. Although these instruments may suggest a diagnosis, neither screening nor psychometric tests are capable of making a diagnosis. The diagnosis should only be made after careful analysis of all available data, including from a thorough history and clinical interview.

A professional fluent in the primary language of the patient is strongly preferred. When such a provider is not available, services of a professional language interpreter must be provided.

Frequency: When assessing for a pre-existing, unrelated mental health issue that has been made worse by, or is impeding the recovery from (or both) a work-related, medical injury or illness, then a one-time visit for initial psychiatric/psychological encounter should be sufficient, as care would normally be continued by the prior treating provider. If psychometric testing is indicated by findings in the initial encounter, time for such testing should not exceed an additional three hours of professional time. For conditions in which a mental health issue is a central part of the initial claim, or in which there is a mental health issue that is secondary or consequential to the work-related, medical injury or illness, that is part of the claim in question, then more extensive diagnostic and therapeutic interventions may be clinically indicated, and are discussed in detail in the Medical Treatment Guidelines for such mental health conditions.

A.17 Personality/Psychological/Psychosocial Intervention

Following psychosocial evaluation, when intervention is recommended, such intervention should be implemented as soon as possible. This can be used alone or in conjunction with other treatment modalities. For all psychological/psychiatric interventions, there must be an assessment and treatment plan with measurable behavioral goals, time frames and specific interventions planned**.**

- Time to produce effect: two to eight weeks.
- Optimum duration: six weeks to three months.
- Maximum duration: three to six months.
- Counseling is not intended to delay but rather to enhance functional recovery.

For PTSD Psychological Intervention:

- Optimum duration three to six months.
- Maximum duration: nine to twelve months.

For select patients, longer supervision and treatment may be required, and if further treatment is indicated, documentation of the nature of the psychological factors, as well as projecting a realistic functional prognosis, should be provided by the authorized treating practitioner every four weeks during the first six months of treatment. For treatment expected to last six to twelve months, such documentation should be provided every four to eight weeks. For long-term treatment beyond twelve months, such documentation should be provided every eight to twelve weeks. All parties should strive for ongoing and continuous communications, in order to facilitate seamless, continuous and uninterrupted treatment.

A.18 Functional Capacity Evaluation (FCE)

Functional capacity evaluation is a comprehensive or more restricted evaluation of the various aspects of function as they relate to the patient's ability to return to work. Areas such as endurance, lifting (dynamic and static), postural tolerance, specific range-of-motion, coordination and strength, worker habits, employability, as well as psychosocial, cognitive, and sensory perceptual aspects of competitive employment may be evaluated. Components of this evaluation may include: (a) musculoskeletal screen; (b) cardiovascular profile/aerobic capacity; (c)

coordination; (d) lift/carrying analysis; (e) job-specific activity tolerance; (f) maximum voluntary effort; (g) pain assessment/psychological screening; (h) non-material and material handling activities; (i) cognitive and behavioral; (j) visual; and (k) sensory perceptual factors.

In most cases, the question of whether a patient can return to work can be answered without an FCE.

An FCE may be considered at time of MMI, following reasonable prior attempts to return to full duty throughout course of treatment, when the treating physician is unable to make a clear determination on work status on case closure. An FCE is not indicated early during a treatment regime for any reason including one to support a therapeutic plan.

When an FCE is being used to determine return to a specific job site, the treating physician is responsible for understanding and considering the job duties. FCEs cannot be used in isolation to determine work restrictions. The authorized treating physician must interpret the FCE in light of the individual patient's presentation and medical and personal perceptions. FCEs should not be used as the sole criteria to diagnose malingering.

A.19 Return To Work

For purposes of these guidelines, return to work is defined as any work or duty that the patient is able to perform safely. It may not be the patient's regular work. Ascertaining a return to work status is part of medical care, and should be included in the treatment and rehabilitation plan. It is normally addressed at every outpatient visit. A description of the patient's status and task limitations is part of any treatment plan and should provide the basis for restriction of work activities when warranted. Early return to work should be a prime goal in treating occupational injuries. The emphasis within these guidelines is to move patients along a continuum of care and return to work, since the prognosis of returning an injured worker to work drops progressively the longer the worker has been out of work.

A.20 Job Site Evaluation

The treating physician may communicate with the employer or employer's designee, either in person, by video conference, or by telephone, to obtain information regarding the individual or specific demands of the patient's pre-injury job. This may include a description of the exertional demands of the job, the need for repetitive activities, load lifting, static or awkward postures, environmental exposures, psychological stressors and other factors that would pose a barrier to re-entry, risk of re-injury or disrupt convalescence. When returning to work at the patient's previous job tasks or setting is not feasible, given the clinically determined restrictions on the patient's activities, inquiry should be made about modified duty work settings that align with, the patient's condition in view of proposed work activities/demands in modified duty jobs. It should be noted, that under certain circumstances, more than one job site evaluation may be indicated.

Ideally, the physician would gain the most information from an on-site inspection of the job settings and activities; but it is recognized that this may not be feasible in most cases. If job videos/CDs/DVDs are available from the employer, these can

contribute valuable information, as can video conferences, conducted from the worksite and ideally workstation or work area.

Frequency: one or two contacts

- 1st contact: Patient is in a functional state where the patient can perform some work.
- 2nd contact: Patient has advanced to state where the patient is capable of enhanced functional demands in a work environment.

The physician shall document the conversation.

Other

A.21 Guideline Recommendations And Medical Evidence

The Workers' Compensation Board and its Medical Advisory Committee have not independently evaluated or vetted the scientific medical literature used in support of the guidelines but have relied on the methodology used by the developers of various guidelines utilized and referenced in these Guidelines.

A.22 Experimental/Investigational Treatment

Medical treatment that is experimental/investigational and not approved for any purpose, application or indication by the FDA is not permitted under these Guidelines.

A.23 Injured Workers As Patients

In these Guidelines, injured workers are referred to as patients recognizing that in certain circumstances there is no doctor-patient relationship.

A.24 Scope of Practice

These Guidelines do not address scope of practice or change the scope of practice.

Mid and Low Back Injury

Effective date will coincide with the launch of OnBoard: Limited Release

B. Introduction to Mid and Lower Back Injury

B.1 History Taking and Physical Examination

History taking and physical examination establish the foundation/basis for and dictate subsequent stages of diagnostic and therapeutic procedures.

When findings of clinical evaluations and those of other diagnostic procedures are not consistent with each other, the objective clinical findings have greater weight. The medical records should reasonably document the following:

B.1.a. History of Present Illness

A detailed history, taken in temporal proximity to the time of injury, should primarily guide evaluation and treatment. The history should include:

B.1.a.i Mechanism of Injury: This includes details of symptom onset and progression. The mechanism of injury should include a detailed description of the incident and the position of the body before, during, and at the end of the incident. Inclusion of work body postures, frequency during the workday and lifting/push/pull requirements should be included in the absence of a known specific incident.

B.1.a.ii Location of pain, nature of symptoms, and alleviating/ exacerbating factors (e.g. sitting tolerance). The history should include both the primary and secondary complaints (e.g., primary back pain, secondary hip, groin pain).

B.1.a.iii The use of an accepted pain assessment tool, (e.g. the Visual Analog Scale [VAS]) is highly recommended, especially during the first two weeks following injury, to assure that all work-related symptoms, including pain, are being addressed.

B.1.a.iv Presence and distribution of lower extremity numbness, paresthesias, or weakness, especially if precipitated or worsened by coughing or sneezing.

B.1.a.v Alteration in bowel, bladder or sexual function.

B.1.a.vi Prior occupational and non-occupational injuries to the same area including specific prior treatment, history of specific prior motor vehicle accidents, chronic or recurrent symptoms, and any functional limitations. Review of any prior spinal imaging studies.

B.1.a.vii History of emotional and/or psychological reactions to the current injury/illness.

B.1.a.viii Ability to perform job duties and activities of daily living.

B.1.b Past History

B.1.b.i Comprehensive past medical history.

B.1.b.ii A review of systems should be conducted, the elements of which may include signs or symptoms related to the following systems: constitutional symptoms; eyes; ear, nose, mouth, and throat; cardiovascular; respiratory; gastrointestinal; genitourinary; musculoskeletal; integumentary/breast; neurological; psychiatric; endocrine; hematologic/lymphatic; allergic/immunologic. Based on the underlying condition being addressed, and clinical judgement, the breadth and focus of the review of systems can be tailored on a case by case basis.

B.1.b.iii Smoking history.

B.1.b.iv Vocational and recreational pursuits.

B.1.b.v History of depression, anxiety, or other psychiatric illness.

B.1.c Physical Examination

Guided by the medical history, should include accepted tests and exam techniques applicable to the area being examined, including:

B.1.c.i Vital signs;

B.1.c.ii General inspection, including posture, stance and gait;

B.1.c.iii Visual inspection;

B.1.c.iv Palpation;

B.1.c.v Lumbar range of motion, quality of motion, and presence of muscle spasm. Motion evaluation of specific joints may be indicated.

B.1.c.vi Examination of thoracic spine and pelvis;

B.1.c.vii Nerve tension testing. When the Lassegue Test (Straight Leg Raise test) is performed, a result is generally not considered to be positive at an elevation less than 25 or greater than 60 degrees (and degrees should always be reported).

B.1.c.viii Sensory and motor examination of the lower extremities with specific nerve root focus.

B.1.c.ix Deep tendon reflexes.

B.1.c.x If applicable, abdominal examination, , circumferential lower extremity measurements, or evaluation other lower extremity abnormalities.

B.1.c.xi Hip exam to include ROM, pain, deformity etc.

B.1.c.xii Lower extremity vascular exam to include palpation of distal pulses.

B.1.d Spinal Cord Evaluation

In cases where the mechanism of injury, history, or clinical presentation suggests a possible severe injury, additional evaluation is indicated. A full neurological examination for possible spinal cord injury may include:

B.1.d.i Sharp and light touch, deep pressure, temperature and proprioceptive sensory function;

B.1.d.ii Strength testing;

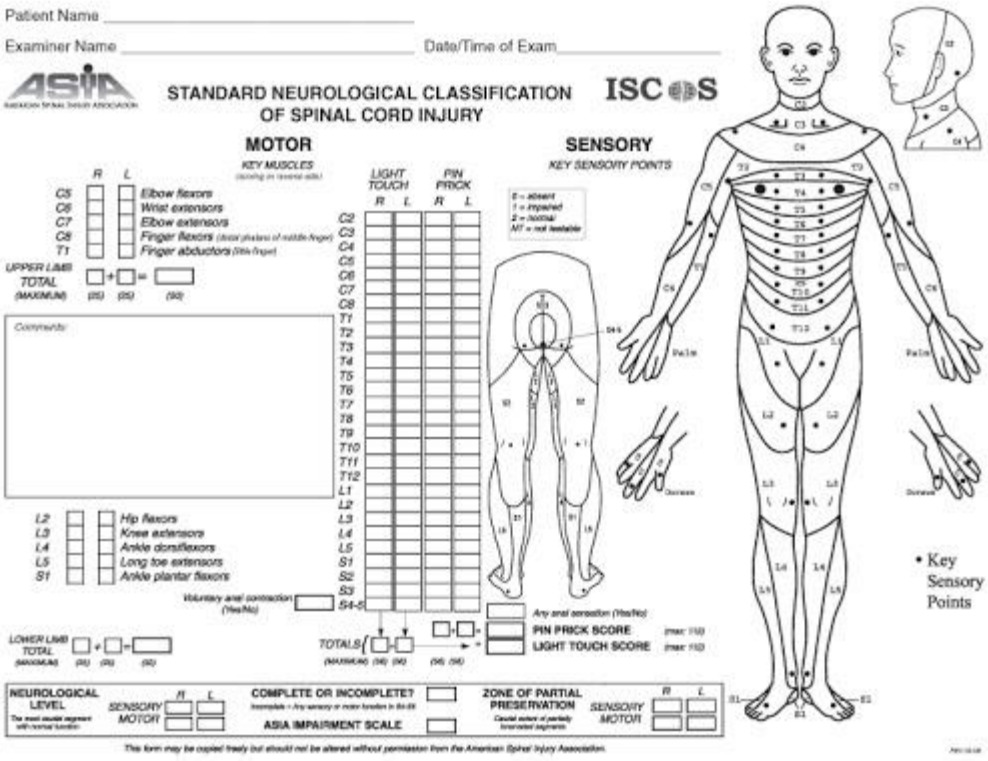
B.1.d.iii Anal sphincter tone and/or perianal sensation;

B.1.d.iv Presence of pathological reflexes.

B.1.d.v Spinal cord lesions should be classified according to the American Spine Injury Association (ASIA) impairment scale.

ASA Impairment Scale		
A	Complete	No motor or sensory function is preserved in the sacral segments S4 – S5
B	Incomplete	Sensory but not motor function is preserved below the neurological level and includes the sacral segments S4 – S5.
C	Incomplete	Motor function is preserved below the neurological level, and more than half of key muscles below the neurological level have a muscle grade less than three.
D	Incomplete	Motor function is preserved below the neurological level, and at least half of key muscles below the neurological level have a grade three or more.
E	Normal	Motor and sensory function are normal.

A worksheet which details dermatomes and muscle testing required is available from ASIA.



B.1.e Red Flags

Certain findings, "red flags," raise suspicion of potentially serious and urgent medical conditions. Assessment (history and physical examination) should include evaluation for red flags. In the mid and low back, these findings or indicators may include: acute fractures, dislocations, infection, tumor, progressive neurologic deficit or cauda equina syndrome, and extraspinal disorders. Further evaluation/consultation or urgent/emergent intervention may be indicated, and the *New York Mid and Low Back Injury Guidelines* incorporate changes in clinical management triggered by the presence of "red flags."

B.2 Imaging / Anatomical Tests

Imaging studies should not be routinely performed without indications.

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 attributing a patient's complaints to the finding on imaging. The focus of treatment should be improving symptoms and function, and not the correction of abnormalities on imaging studies.

B.3 Laboratory Testing

Laboratory tests are rarely indicated at the time of initial evaluation, unless there is a suspicion of systemic illness, infection, neoplasia or underlying rheumatologic disorder, connective tissue disorder, or other findings based on history and/or physical examination. Laboratory tests can provide useful diagnostic information. Tests include, but are not limited to:

B.3.i Complete blood count (CBC) with differential

Recommended - for patients with suspicion of infection, blood dyscrasias, and medication side effects.

B.3.ii Erythrocyte sedimentation rate (ESR), rheumatoid factor (RF), anti-nuclear antigen (ANA), human leukocyte antigen (HLA), and C-reactive protein (CRP)

Recommended - to detect evidence of a rheumatologic, infection, or connective tissue disorder.

B.3.iii Serum calcium, phosphorous, uric acid, alkaline phosphatase, and acid phosphatase

Recommended - in select patients with suspicion of metabolic bone disease.

B.3.iv Liver and kidney function

Recommended - in select patients with prolonged anti-inflammatory use or other medications requiring monitoring.

B.3.v Serum Protein Electrophoresis

Recommended - to evaluate for multiple myeloma.

B.4 Follow-Up Diagnostic Imaging and Testing Procedures

As outlined in detail in General Principles section A-13, the selection of diagnostic imaging studies depends on the case-specific clinical presentation, as well as clinical judgment. In addition, there may be instances where repeat or alternate diagnostic imaging may be clinically indicated. Such instances include, but are not necessarily limited to when: a prior test is of poor quality and/or nondiagnostic; the clinical situation changes (e.g. new or worsening symptoms, preparing for surgery or therapeutic injections, etc.); it is necessary to monitor clinical progress (e.g. post-operatively) or deterioration over time.

Prudent choice of procedure(s) or a proper sequential order in multiple procedures will ensure maximum diagnostic accuracy, minimize adverse effect to patients and promote clinical efficiency. Repeat procedures result in an increase in cumulative radiation dose and associated risks.

Diagnostic imaging procedures have varying degrees of sensitivity and specificity for any diagnosis. Clinical history, physical examination and clinical judgment should be the basis for selection and interpretation of imaging studies.

Generally, plain X-rays are a useful starting point, but they are not always sufficient. Magnetic resonance imaging (MRI), myelography, or computed axial tomography (CT) scanning following myelography may provide useful information for many spinal disorders. Regarding CT examinations, it must be recognized that repeat procedures result in an increase in cumulative radiation dose and associated risks. In certain circumstances as stated above, repeat or alternate imaging may be warranted. Usually, selection of one procedure over others depends upon multiple factors.

After initial imaging is performed, as may be indicated by clinical presentation, history of significant trauma or other clinical "red flags" that raise suspicions for serious underlying conditions, in the absence of a significant neurologic deficit/abnormality, myelopathy or progressive neurological changes, imaging usually is not clinically indicated until conservative therapy has been tried and failed. A minimum of four weeks, but as long as six to eight weeks of treatment are usually an adequate period of time before an imaging procedure is in order, but the clinician should use judgment in this regard. When the findings of the diagnostic imaging and testing procedures are not consistent with the clinical examination, objective clinical findings should be given greater weight. There is good evidence that in the over-40, asymptomatic population, the prevalence of disc degeneration is greater than 50%. Disc degeneration, seen as loss of signal intensity on MRI, may be due to age-related changes causing biochemical changes and structural changes separate and distinct from traumatic injury and may not have pathological significance. Disc bulging and posterior disc protrusion, while not rare, is less commonly symptomatic in the lumbar spine than in the cervical spine due to the smaller cervical spinal canal. Mild reduction in the cross-sectional area of the spinal cord may be seen without myelopathy in patients older than 40; therefore, clinical correlation is required.

When indicated, the following studies can be utilized for further evaluation of mid and low back injuries, based upon the mechanism of injury, symptoms, and patient history. The studies below are not listed in order of preference, clinical indication, or clinical utility, as that may vary based on the clinical details of any given case.

C. Diagnostic Studies

C.1 Imaging Studies

C.1.a Roentgenograms (X-Rays)

C.1.a.i Routine x-rays for acute non-specific back pain.

Recommended - for acute back pain with red flags for fracture or serious systemic illness, back pain that is not improving, or non-

acute back pain, as an option to rule out other possible conditions.

Frequency/Duration: Obtaining x-rays once is generally sufficient except in patients with fractures where more frequent monitoring may be required. For patients with non-acute back pain, it may be reasonable to obtain a second set months or years subsequently to re-evaluate the patient's condition, particularly if symptoms change.

Not Recommended - in the absence of red flags (indicators of potentially serious disease, such as fever, weight loss, nocturnal pain, night sweats, bowel or bladder incontinence or major trauma), imaging tests are not recommended in the first four to six weeks of back pain symptoms.

C.1.a.ii Flexion and Extension Views

Recommended - for evaluating symptomatic spondylolisthesis in which there is consideration for surgery or other invasive treatment or occasionally in the setting of trauma.

Frequency/Duration: Obtaining flexion and extension and lateral flexion and extension views are generally needed no more frequently than every few years, in the absence of a rapidly changing clinical course.

C.1.b Magnetic Resonance Imaging (MRI)

MRI is considered the gold standard in diagnostic imaging for defining anatomy because it offers excellent resolution without radiation exposure. While CT remains an important analytical tool especially for evaluating bony or calcified structures of the spine, due to the greater resolution of MRI, particularly with respect to soft tissue of the spine (nerve root compression, spinal cord and nerve root abnormality), there is less need for using CT at the current time. Ferrous material/metallic objects in tissue may be a contraindication for the performance of an MRI. There are many instances in which a metallic object may be dislodged by the MRI's magnetic field, causing significant harm, or even death.

Patients who have had prior thoracic or lumbar surgery, concerns for malignancy or infection may require the use of Gadolinium enhancement for the MRI study. This should be performed in consultation of the requesting physician taking into account any underlying medical conditions that would be a contraindication to an enhanced MRI.

Inadequate resolution on the first scan may require a second MRI using a different technique. A subsequent diagnostic MRI may be a repeat of the same procedure when the rehabilitation physician (e.g., physiatrist, sports medicine physician etc.) radiologist or surgeon documents that the study

was of inadequate quality to make a diagnosis. All questions in this regard should be discussed with the MRI center and/or radiologist.

C.1.b.i **Recommended** - for patients with acute back pain during the first 6 weeks if they have demonstrated a significant neurological deficit, progressive neurologic deficit, cauda equina syndrome, significant trauma, a history of neoplasia (cancer), or atypical presentation (e.g., clinical picture suggests multiple nerve root involvement).

C.1.b.ii **Recommended** - for acute radicular pain syndromes in the first six weeks if the symptoms are severe and not trending towards improvement and both the patient and the physician are willing to consider prompt surgical treatment, assuming the MRI confirms ongoing nerve root compression.

Frequency/Duration: Repeat MRI imaging without significant clinical deterioration in symptoms and/or signs is not recommended.

C.1.b.iii **Recommended** - for patients with non-acute radicular pain syndromes lasting at least six weeks, in whom the symptoms are not trending towards improvement, if both the patient and surgeon are considering prompt surgical treatment, assuming the MRI confirms ongoing nerve root compression.

C.1.b.iv In cases where an epidural glucocorticosteroid injection is being considered for temporary relief of acute or subacute radiculopathy, MRI at three to four weeks (before the epidural steroid injection) may be reasonable (see Section D.6, Injections: Therapeutic Spinal).

C.1.b.v **Recommended** - as an option for the evaluation of select non-acute back pain patients in order to rule out concurrent pathology unrelated to injury. This should rarely be considered before three months and failure of several treatment modalities (including NSAIDs, aerobic exercise, other exercise, and considerations for manipulation, and/or acupuncture).

C.1.b.vi **Not Recommended** - for acute back pain or acute radicular pain syndromes in the first six weeks, in the absence of red flags.

C.1.b.vii **Not Recommended** - standing or weight-bearing MRI is not indicated for any back or radicular pain syndrome or condition. In the absence of studies demonstrating improved patient outcomes, this technology is currently considered experimental/investigational.

C.1.c Computerized Tomography (CT)

Due to the far greater resolution of MRIs, particularly with respect to the soft tissue structures of the spine, there is much less need for CT. However, CT remains a good test to evaluate bony or calcified structures of the spine. CT is most useful to evaluate the spine in patients with contraindications for MRI (most typically an implanted metallic-ferrous device). CT is not invasive (minimally invasive when contrast is needed), has low potential adverse effects, but entails radiation exposure. In patients with radicular symptoms, CT myelography should be considered given the greater sensitivity for identification of nerve root compression. In select patients for whom the benefits of the procedure outweigh the risks and for whom MRI is non-diagnostic, not indicated or clinically contraindicated.

C.1.c.i **Recommended** - CT is recommended in select patients (MRI preferred) for those with radicular pain syndrome that has failed to improve within four to six weeks and there is consideration for an epidural glucocorticoid injection or surgical discectomy (see Section D.6, Injections: Therapeutic Spinal).

C.1.c.ii **Recommended** - in patients with an indication for MRI who cannot undergo MRI examination due to contraindications such as implanted metallic-ferrous device or significant claustrophobia.

Frequency/Duration: Obtaining serial CT exams is not recommended, although if there has been a significant worsening in the patient's history of examination, repeat imaging may be warranted.

C.1.c.iii **Not Recommended** - routine CT for acute or non-acute non-specific back pain or for radicular pain syndromes.

C.1.d Myelography (Including CT Myelography and MRI Myelography)

May be useful only when MRI or other tests are contraindicated, are not considered diagnostic or not available. This testing may be indicated in select patients for whom the clinical benefits outweigh the risks, and for whom MRI is either non-diagnostic, or not clinically indicated or clinically contraindicated.

Note: Potential complications of this more invasive technique include pain, infection, and allergic reactions.

C.1.d.i **Recommended** - Myelography, including CT myelography, is recommended in select patients in uncommon specific situations (e.g., implanted metal that precludes MRI, equivocal findings of disc herniation on MRI suspected of being falsely positive, spinal stenosis, and/or a post-surgical situation that requires myelography).

C.1.d.ii **Not Recommended** - Myelography (as well as CT myelography and MRI myelography) as the first diagnostic study for the diagnosis of lumbar root compromise.

Indications: This testing may be indicated in select patients for whom the clinical benefits outweigh the risks, and for whom MRI is either non-diagnostic, or not clinically indicated or clinically contraindicated.

Note: Potential complications of this more invasive technique include pain, infection, and allergic reactions.

C.1.e Bone Scans

C.1.e.i **Recommended** - in select patients as clinically indicated.

Indications: Bone scanning is a good diagnostic test for specific situations which involve a minority of patients and may be useful in diagnosing neoplasia, suspected metastases, infection (e.g. osteomyelitis), inflammatory arthropathies and occult fractures.

C.1.e.ii **Not Recommended** - for routine use in back pain patients.

Note: This technology is generally not used for evaluation of most occupational back pain situations.

C.1.f Fluoroscopy

C.1.f.i **Not Recommended** - for the evaluation of acute or non-acute back pain.

C.1.g Single Proton Emission Computed Tomography (SPECT)

C.1.g.i **Recommended** - in select patients as clinically indicated.

Indications: SPECT is not generally recommended, aside from cases of suspected inflammatory arthropathies not diagnosed by more common tests or to rule out possible acute spondylolysis; SPECT has a very limited role in the evaluation of patients with back pain

C.1.h Ultrasound (Diagnostic)

C.1.h.i **Not Recommended** - for patients with back pain.

C.1.i Videofluoroscopy

C.1.i.i **Not Recommended** - for the assessment of acute or non-acute back pain.

C.2 Other Tests / Procedures

C.2.a Electrodiagnostic Studies (EDX)

EDX include needle EMG, peripheral nerve conduction velocity studies (NCV) and motor and sensory evoked potentials. Needle EMG is usually what substantiates the diagnosis of radiculopathy or spinal stenosis in patients with back pain and/or radiculopathy problems.

Needle EMG can help determine if radiculopathy is acute or chronic. NCV are done in addition to needle EMG to rule out other potential causes for the symptoms (co-morbidity or alternate diagnosis involving peripheral nerves) and to confirm radiculopathy. It is recommended and preferred that EDX in the out-patient setting be performed and interpreted by physicians board-certified in Neurology or Physical Medicine and Rehabilitation.

C.2.a.i EDX (must include needle EMG and NCV)

Recommended - in select patients as clinically indicated.

Indications: Where a CT or MRI is equivocal and there are ongoing complaints of pain, weakness, and/or numbness/parasthesias that raise questions about whether there may be a neurological compromise that may be identifiable. This means leg symptoms consistent with radiculopathy, spinal stenosis, peripheral neuropathy, etc.

Nerve conduction studies are done in addition to the needle EMG both to rule out other potential causes for the symptoms (co-morbidity or alternate diagnosis involving peripheral nerves, e.g., compression neuropathies) and to confirm radiculopathy, but the testing must include needle EMG.

Where there is failure of suspected radicular pain to resolve or plateau after waiting four to six weeks (to provide for sufficient time to develop EMG abnormalities as well as time for conservative treatment to resolve the problems), equivocal imaging findings, e.g., on CT or MRI studies, and suspicion by history and physical examination that a neurologic condition other than radiculopathy may be present instead of or in addition to radiculopathy.

Not Recommended - for patients with acute or non- acute back pain who do not have significant leg pain or numbness.

C.2.b Surface Electromyography (Surface EMG)

Not Recommended

C.2.c Diagnostic Facet Blocks

See Section D.6.f.

C.2.d Lumbar Discography

Not Recommended - whether performed as a solitary test or when paired with imaging (e.g., MRI), is not recommended for acute or non-acute back pain or radicular pain syndromes.

Note: Improvement in surgical outcomes has not been shown to follow the use of discography, and there is evidence that performing discography on normal discs is associated with an enhanced risk of degenerative changes in those discs in later years. Lumbar discography also carries a risk of complications that include, but are not necessarily limited to: infection, discitis, and post-discogram herniation.

C.2.e CT/MRI Discography

Recommendations - See Lumbar Discography above.

C.2.f Myeloscopy

Not Recommended - for acute or non-acute back pain, spinal stenosis, radicular pain syndromes or post-surgical back pain problems.

C.2.g Thermography

Not Recommended - for the assessment of acute or non-acute back pain, or radicular pain patients.

D. Therapeutic Procedures: Non-Operative

Before initiation of any therapeutic procedure, the authorized treating provider, employer, and insurer must consider these important issues in the care of the patient.

First, patients undergoing therapeutic procedure(s) should be released or returned to modified or restricted duty during their rehabilitation at the earliest appropriate time.

Second, cessation and/or review of treatment modalities should be undertaken when no further significant subjective or objective improvement in the patient's condition is noted. If patients are not responding within the recommended duration periods, alternative treatment interventions, further diagnostic studies or consultations should be pursued.

Third, providers should provide and document education to the patient. No treatment plan is complete without addressing issues of individual and/or group patient education as a means of facilitating self-management of symptoms.

Lastly, for those patients who fail to make expected progress six to 12 weeks after an injury and whose subjective symptoms do not correlate with objective signs and tests,

reexamination in order to confirm the accuracy of the diagnosis should be made. Formal psychological or psychosocial evaluation may be considered.

Home therapy is an important component of therapy and may include active and passive therapeutic procedures as well as other modalities to assist in alleviating pain, swelling, and abnormal muscle tone.

The following are listed in alphabetical order.

D.1 Acupuncture

Recommended - in select patients as clinically indicated.

Indications: For select use in non-acute back pain as an adjunct to more efficacious treatments. Acupuncture may be recommended as treatment of non- acute back pain as a limited course during which time there are clear objective and functional goals that are to be achieved.

Not Recommended - routine use of acupuncture is not recommended for acute back pain or radicular pain.

Not Recommended - for treatment of acute, subacute, radicular, or post-operative low back pain.

Indications: Consideration for time-limited use in non-acute back pain patients without underlying serious pathology is an adjunct to a conditioning program that has both graded aerobic exercise and strengthening exercises. Acupuncture is only recommended to assist in increasing functional activity levels more rapidly and the primary attention should remain on the conditioning program.

This intervention is not recommended for patients not involved in a conditioning program, or who are non- compliant with graded increases in activity levels.

Frequency/Duration:

a) There are different patterns which are used in quality studies. These range from weekly for a month to 20 appointments over 6 months; however the norm is generally no more than eight to 12 sessions.

b) An initial trial of five to six appointments would appear reasonable in combination with a conditioning program of aerobic and strengthening exercises.

c) Future appointments should be tied to improvements in objective measures and would justify an additional 6 sessions, for a total of 12 sessions.

Discontinuation: Resolution, intolerance, or non- compliance, including non-compliance with aerobic and strengthening exercises.

D.2 Appliances

D.2.a Shoe Insoles and Shoe Lifts

Recommended - for the treatment of acute or non-acute back pain or radicular pain syndrome in the presence of significant leg length discrepancy.

Not Recommended - in the absence of significant leg length discrepancy

D.2.b Kinesiotaping, Taping or Strapping

Not Recommended

D.2.c Lumbar Supports

Recommended - for select patients as clinically indicated.

Indications: Lumbar supports may be useful for specific treatment of spondylolisthesis, documented instability, or post- operative treatment.

Not Recommended - for the prevention or treatment of other back pain conditions.

D.2.d Magnets

Not Recommended

D.2.e Mattresses, Water Beds, and Sleeping Surfaces

Recommendations

D.2.e.i It is recommended that patients select mattresses, pillows, bedding, or other sleeping options that are most comfortable for them.

D.2.e.ii There is no recommendation regarding mattresses other than that providers should be aware that ordering patients to sleep on firm mattresses or on the floor may be incorrect.

D.2.e.iii There is no quality evidence to guide recommendations regarding other optimal sleeping surfaces (e.g., bedding, water beds, and hammocks).

D.3 Bed Rest

D.3.a **Recommended** - in the management of unstable spinal fractures or cauda equina.

Indications: Although there are no quality studies evaluating the role of bed rest in the management of unstable spinal fractures or cauda equina

syndrome, there is consensus that these require bed rest or other marked activity limitations to prevent adverse events. Although bed rest has no documented benefits, the hazard of mobilization in this setting is theoretically catastrophic, thus this treatment strategy is recommended.

D.3.b **Not Recommended** - for the management of acute or non-acute back pain, radicular pain syndromes including sciatica or other back pain-related problems including spondylolisthesis, spondylolysis, spinal stenosis, facet-related pain, or pain thought to be related to the sacroiliac joint.

Rationale: There is no quality evidence that these conditions are successfully treated with bed rest and there are also likely adverse effects. Although it is non-invasive rest has no documented benefits and is expected to be associated with higher morbidity.

D.4 Biofeedback

D.4.a **Recommended** - for select patients with non- acute back pain, as a component of an interdisciplinary approach. Please consult the *New York Non-Acute Pain Medical Treatment Guidelines* for further recommendations.

D.4.b **Not Recommended** - in patients with acute back pain. It is suggested that other treatments for which there is quality evidence of efficacy are more appropriate.

D.5 Electrical Therapies

D.5.a Interferential Therapy

Not Recommended - for treatment of acute or non-acute back pain, non-acute radicular pain syndromes, or other back-related conditions.

D.5.b Transcutaneous Electrical Neurostimulation (TENS)

Transcutaneous Electrical Nerve Stimulation (TENS) treatment should include at least one instructional session for proper application and use.

Recommended - for select use in treatment of chronic low back pain or chronic radicular pain syndrome as a second line adjunct to other first line treatments**.**

Indications: include muscle spasm, atrophy and control of concomitant pain in the office setting. Minimal TENS unit parameters should include a pulse rate, pulse width and amplitude modulation. Consistent, measurable, functional improvement must be documented, and a determination made of the likelihood of chronicity prior to the provision of a home unit. TENS treatment should be used in conjunction with active physical therapy.

Frequency: Variable, with immediate effect and optimum duration of three sessions.

Maximum Duration: Three sessions. Purchase or provide with home unit if effective.

D.5.c Percutaneous Electrical Nerve Stimulation (PENS)

Not Recommended - for acute or subacute back pain or radicular pain syndromes.

D.5.d Microcurrent Electrical Stimulation

Not Recommended - for acute or non-acute back pain or radicular pain syndrome patients.

D.5.e Electrical Nerve Block

Not Recommended

D.5.f Electrical Stimulation (Physician or Therapist Applied)

Recommended - may be a component of a comprehensive treatment plan.

Frequency: Two to three times per week for a maximum of up to two months.

Not Recommended - Electrical Stimulation (like other passive modalities) as a stand-alone treatment,

D.5.g Transcutaneous Neurostimulator (TCNS)

Not Recommended

D.5.h H-Wave Stimulation

Not Recommended - not recommended for acute or non- acute back pain or radicular pain syndromes.

D.5.i High-Voltage Galvanic

Not Recommended - not for the treatment of acute or non-acute back pain or radicular pain syndromes or other back-related conditions.

D.5.j Iontophoresis

Not Recommended - for the treatment of acute, subacute or chronic low back pain or radicular pain syndromes or other back-related conditions.

D.6 Injections: Therapeutic Spinal

D.6.a Introduction

Therapeutic spinal injections may be used after initial conservative treatments, such as physical and occupational therapy, medication, manual therapy, exercise, acupuncture, have been undertaken.

- Therapeutic injections should be used only after imaging studies and diagnostic injections have established pathology.
- Injections are invasive procedures that can cause catastrophic complications; thus clinical indications and contraindications should be closely adhered to.
- The purpose of spinal injections is to facilitate active therapy by providing short-term relief through reduction of pain and inflammation.
- All patients should continue appropriate exercise with functionally directed rehabilitation.
- Active treatment, which patients should have had prior to injections, will frequently require a repeat of the sessions previously ordered.
- Injections, by themselves, are not likely to provide long-term relief. Rather, active rehabilitation with modified work achieves long-term relief by increasing active range of motion, strength, and stability.
- Injections should not be repeated if the first injection does not provide:
    - Improvement in function
    - Temporary and sustained pain relief as measured by accepted pain scales, i.e., 50% pain reduction on Visual Analog Scale

    and/or
- Reduction in the use of prescribed analgesic medication. Medical management should be continued or adjusted based upon patient assessment and response.

Special Considerations

- For all thoracic, lumbar and sacroiliac injections (excluding trigger point) multi-planar fluoroscopy during procedures is required to document technique and needle placement.

- All injections (excluding trigger point) must be performed by a physician experienced in the procedure. Trigger point injections may be performed by a physician or a Nurse Practitioner/Physician Assistant experienced in the procedure.

- Permanent images are required to document needle placement.

- The subspecialty disciplines of the physicians performing injections may be varied, including, but not limited to: anesthesiology, radiology, surgery, or physiatry.

- The practitioner should have completed fellowship training in an appropriate medical specialty (neurosurgery, orthopedic surgery, physiatry, pain management etc.) with interventional training. The practitioner must also be knowledgeable in radiation safety.

Complications

General complications of spinal injections may include:

- transient neurapraxia

- local pain

- nerve injury

- infection

- headache

- vasovagal effects

- Epidural hematoma, permanent neurologic damage, dural perforation and CSF leakage, and/or spinal meningeal abscess may also occur.

- More serious complications are rare but can include spinal cord damage, quadriplegia, permanent ataxia, and death.

- With steroid injections, there may be a dose-dependent suppression of the hypothalamic-pituitary-adrenal axis lasting between one and three months.

- With steroid injections, there may be a transient rise in glucose levels, especially in diabetics.

Contraindications

Absolute contraindications to therapeutic injections include:

- bacterial infection, systemic or localized to region of injection
- bleeding diatheses
- hematological conditions
- possible pregnancy

Relative contraindications to diagnostic injections may include:

- allergy to contrast
- poorly controlled Diabetes Mellitus
- hypertension

Drugs affecting coagulation, such as aspirin, NSAIDs, anti-platelets or anticoagulants are often restricted prior to injection.

Decisions regarding anticoagulation should be made in consultation between the provider performing the injection and the prescribing physician and other specialists as indicated, in the context of the patient's specific underlying medical history.

D.6.b Lumbar Transforaminal/Interlaminar/Caudal Epidural Injections (ESI)

The purpose of ESI is to reduce pain and inflammation, restoring range of motion and thereby facilitating progress in more active programs.

As with all treatments, it is important to ensure that patients have realistic expectations regarding treatment outcomes.

Diabetics who are candidates for ESI should be counseled that a blood glucose increase may be apparent post-intervention, but the increase is generally transient.

Needle Placement: Lumbar ESI must be fluoroscopically guided to verify needle placement. Permanent images are required to document needle placement.

Contrast epidurograms allow one to verify the flow of medication into the epidural space. One epidurogram per series of ESI is recommended as clinically indicated.

Recommended - ESI is useful in patients with symptoms of lumbar radicular pain syndromes.

Not Recommended - ESI is not effective for lumbar axial pain or non-radicular pain syndromes.

Indications:

- Medications for ESI include anesthetics and/or steroids.
- ESI is an option for acute radicular pain syndromes.
- ESI is an option for radicular pain syndromes lasting at least 3 weeks having been treated with NSAIDs and without evidence of trending toward spontaneous resolution.
- ESI is an option for second-line treatment for acute flare-ups of spinal stenosis.
- ESI is an option for symptoms of spinal stenosis of at least one to two months, with prior treatment that has included NSAIDs and progressive exercise.
- ESI is not recommended for acute or non-acute back pain in the absence of significant radicular symptoms.

Not Recommended – as first- or second-line treatment in individuals with back pain symptoms that predominate over leg pain

Not Recommended – as treatment for any non-acute axial back pain without a radicular component.

- The above referenced time frames for consideration of ESIs may vary based on patient specific clinical considerations.

Maximum Frequency:

- Three injections (per spinal region) may be done in one 12-month period, depending on patient response (improved function and pain reduction). No more than 2 levels per treatment session.
- It is recommended that each injection be scheduled separately, and effects of each injection be evaluated, depending upon patient response (improved function and pain reduction) rather than scheduling a “Series of Three.”
- If the first injection does not provide a response with temporary and sustained pain relief (at least two weeks) substantiated by accepted pain scales (i.e., 50% pain reduction as measured by tools such as VAS) and improvement in function, repeat injections are not recommended.

- A positive result (functional improvement) should include measurable improvement in physical activity goals, and a return to baseline function or to work duties.

Patients should be reassessed after each injection for:

- Improvement in function
- Temporary and sustained pain relief as measured by accepted pain scales, i.e., 50% pain reduction on Visual Analog Scale

  and/or

- Reduction in the use of prescribed analgesic medication**.**

Medical management should be continued or adjusted based upon patient assessment and response.

Discontinuation:

- Resolution of symptoms decrease in symptoms to a tolerable level or absence of response.

D.6.c Intradiscal Steroids

Not Recommended - for the treatment of acute or non- acute back pain.

There is no quality evidence on the value of intradiscal steroid injections in those with acute back pain. There is also no quality evidence that these injections improve on the natural history of acute back pain.

D.6.d Chemonucleolysis (Chymopapain and Collagenase)

Not Recommended – as procedure, while a successful treatment, is not available in the U.S. due to serious adverse effects.

D.6.e Tender and Trigger Point Injections

Myofascial trigger points are localized hyperirritable palpable nodules in extremely sensitive bands of taut skeletal muscle fibers. These nodules are painful on compression and give rise to local pain and pain referred to distant structures.

- Trigger point treatment consists only of dry needling or injection of local anesthetic into myofascial trigger points.
- Trigger point injection is not the equivalent of acupuncture. Please refer to the acupuncture section in each Medical Treatment Guideline.

- There is no evidence that injection of medications improves the results of trigger point injections. Needling alone may account for some of the therapeutic response.

- As with all treatments, it is important to ensure that patients have realistic expectations regarding treatment outcomes.

Recommended - may be a secondary or tertiary option for non-acute pain that is not resolving with more conservative means (e.g., NSAIDs, progressive aerobic exercises, other exercises) within a six-week time frame.

Not Recommended - for treatment of acute back pain.

Indications:

- Trigger point injections should be utilized primarily for facilitating functional progress.

- Trigger point injections may be used to relieve myofascial pain and facilitate active therapy and stretching of the affected areas.

- The use of therapeutic injections without participation in an active therapy program or in the context of maintaining employment is not recommended.

- Patients should be reassessed two weeks after each injection for:

    - Improvement in function

    - Temporary and sustained pain relief as measured by accepted pain scales, i.e., 50% pain reduction on Visual Analog Scale

      and/or

    - Reduction in the use of prescribed analgesic medication.

- Medical management should be continued or adjusted based upon patient assessment and response.

- Functional improvement should last for 3 months.

- A positive result (functional improvement) should include measurable improvement in physical activity goals, and a return to baseline function or to work duties.

- The use of ultrasound or other imaging studies for trigger point injections is not recommended.

Frequency:

- Not more than four injections per session, not to exceed 4 sessions per 12-month period.
- If results are not satisfactory after first set of injections, a second set is reasonable. If there are not documented subjective *and* objective improvements at that point, further injections are not recommended.
- *Indications for Discontinuation* – Resolution, intolerance, or completing two sets of injections without materially affecting the condition.
- If there is a partial demonstrated improvement after the first set of injections, a second set may be reasonable.
- It is recommended to allow at least three to four weeks between these injections.
- If there are no subjective and objective improvements at that point, further injections are not recommended.
- Repeated injections should be linked to subjective and objective improvement.

D.6.f Lumbar Diagnostic and Therapeutic Medial Nerve Branch Blocks or Intra-articular Facet (Zygapophyseal) Joint Injections

Indications:

Medial branch block injections or intra-articular facet joint injections are recommended for:

- Patients with pain suspected to be largely facet in origin based on exam findings (i.e., non-radicular axial pain aggravated by extension-facet loading)

  and/or

- Documented evidence (i.e., imaging study) of facet disease (facet arthropathy/hypertrophy at the targeted level(s)

  and

- Who have completed a documented course of conservative management as defined in the *New York Mid and Low Back Injury Medical Treatment Guidelines*, including but not limited to

medication, modalities, and active exercises.

Description:

These injections must be fluoroscopically guided.

Lumbar medial nerve branch blocks or intra-articular facet joint injections may consist of a diagnostic and/or a therapeutic component.

- The diagnostic component consists of an anesthetic and the therapeutic component, a corticosteroid.
- The diagnostic component (anesthetic only) may be used individually or may be combined with a steroid into a single diagnostic/therapeutic injection.
- A medial nerve branch block is indicated for the diagnosis of pain that is suspected of arising from the facet joint.
- A history and physical examination should document the rationale for the suspected diagnosis.
- A positive response to a therapeutic injection (steroid) is not determinative of the need for radiofrequency ablation.

Recommended - in select patients as clinically indicated.

Indications:

D.6.f.i Acute back pain

Intra-articular facet joint (injection into the intra-articular facet joint space) or medial branch block injections (blocking medial nerve innervation) may be indicated for acute back pain when there is continuing axial back pain after an injury that has not responded to conservative management.

In patients with acute back pain, medial branch block injections may aid in identifying pain generators, therapeutically reduce pain and may be useful in facilitating progress in a rehabilitation program.

For acute pain, these injections involve a combination of an anesthetic and a steroid. Steroid is added to provide longer benefit. The goal of the prolonged therapeutic benefit is to decrease pain and increase function, with the ability to participate in an active rehabilitation program (which the patient was unable to do prior to the injection).

Diagnostic medial branch block injections (anesthetic only without steroids) or diagnostic intra-articular facet joint injections

(anesthetic only without steroids) are not recommended for acute back pain.

Positive Therapeutic Response (either Medial Branch Block Injection or Intra-articular Facet Joint Injection):

- Patients should be reassessed after each therapeutic injection for a documented 50% improvement in pain as measured by accepted pain scales and evidence of functional improvement for at least 4-6 weeks

- A positive result (functional improvement) should include measurable improvement in physical activity goals including progress towards return to baseline function or work activities.

- Pain should be measured by accepted pain scales, pre-procedure, immediately post-procedure and at identified intervals after the procedure.

- If the first therapeutic injection does not provide sustained pain relief substantiated by accepted pain scales (i.e., 50% documented pain reduction as measured by accepted pain tools) and improvement in function for at least 4-to-6 weeks, repeat steroid injections are not recommended.

Time to produce effect: up to 72 hours.

Frequency: Two injections for each applicable joint may be done in one 12-month period, not to exceed three joint levels (four medial branch nerves) per session, depending upon patient's documented response (i.e., improved functional gain and pain reduction). Maximum two sessions/year.

D.6.f.ii Non-acute back pain

Diagnostic medial branch block injections are recommended for a select group of patients with non-acute back pain in order to determine whether specific interventions targeting the facet joint (by blocking medial nerve innervation to the facet joint) should be performed.

The decision to proceed with radiofrequency ablation is based on a positive response to diagnostic injections (anesthetic only or anesthetic with steroid) and not on the response to a therapeutic injection (with steroid only.)

When administering a diagnostic injection, consideration should

be given to combining the anesthetic agent with steroid to allow for the potential of extended pain relief.

Positive Diagnostic Medial Nerve Branch Block Response:

A positive response to the diagnostic component of a medial nerve branch block consists of an initial temporary improvement, which may be as short as one to four hours, and includes a reduction in pain (50% decrease as measured by accepted pain scales), and improvement in function for the duration of the local anesthetic.

The primary goal of a diagnostic medial nerve branch block in the setting of non-acute pain is to determine the need for more definitive treatment (i.e., radiofrequency ablation).

- If a patient has a positive response to a diagnostic medial branch block injection (whether or not steroids are used), a repeat medial branch block injection should be performed to confirm the diagnosis.

- This repeat comparative medial branch block injection should be performed on a different date to confirm the level of involvement.

- If there is a positive response to the repeat diagnostic medial branch block injection, the patient should be evaluated to determine the need for more definitive treatment such as radiofrequency ablation.

- If the first injection does not provide a positive response, the diagnosis should be re-evaluated.

- If the first injection does not provide a positive response, repeat diagnostic injections are not recommended.

Time to produce effect: up to 30 minutes for local anesthetic; corticosteroid up to 72 hours.

Frequency: Two injections for each applicable joint may be done in one 12-month period, not to exceed three joint levels (four medial branch nerves) per session, depending upon patient's documented response (i.e., improved functional gain and pain reduction). Maximum two sessions/year.

D.6.g Facet Joint Hyaluronic Acid Injections

Not Recommended

D.6.h Sacroiliac Joint Injections

D.6.h.i **Recommended** - Sacroiliac joint corticosteroid injections are recommended as a treatment option for patients with a specific cause of sacroiliitis, meaning a work-related aggravation of proven rheumatologic inflammatory arthritis involving the sacroiliac joints.

D.6.h.ii **Recommended -** Sacroiliac joint injections are recommended for the treatment of sacroiliac joint sprain/dysfunction.

Sacroiliac sprain may present with local tenderness corresponding to the anatomical sacroiliac joint. Such presentation is an extra-axial finding, without radiation, and may be the result of inflammation or trauma. The pain may be acute or non-acute.

Frequency/Duration: If the results after the first injection are not satisfactory, fluoroscopic guidance must be used for the second injection. Subsequent injections are not recommended unless significant improvement is noted after the initial injections.

D.6.i Prolotherapy Injections

Not Recommended - for acute or non-acute back pain, or for any radicular pain syndrome.

D.6.j Platelet Rich Plasma (PRP)

Not Recommended

D.7 Medications

For most patients, ibuprofen, naproxen, or other older generation NSAIDs are recommended as first-line medications. Acetaminophen (or the analog paracetamol) may be a reasonable alternative to NSAIDs for patients who are not candidates for NSAIDs, although most evidence suggests acetaminophen is modestly less effective. There is evidence that NSAIDs are as effective for relief of pain as opioids (including tramadol) and less impairing.

D.7.a Non-Steroidal Anti-inflammatory Drugs (NSAIDs) for Treatment of Acute, Subacute, or Chronic Back Pain

Recommended - for treatment of acute, subacute, or chronic backpain

Indications: For acute, subacute, or chronic back pain, NSAIDs are recommended for treatment. Over-the-counter (OTC) agents may suffice and should be tried first.

Frequency/Duration: As needed use may be reasonable for many patients.

Indications for Discontinuation: Resolution of symptoms, lack of efficacy, or development of adverse effects, that necessitate discontinuation.

D.7.b NSAIDs for Patients at High Risk of Gastrointestinal Bleeding

Recommended – for concominent use of cytoprotective classes of drugs: misoprostol, sucralfate, histamine Type 2 receptor blockers, and proton pump inhibitors for patients at high risk of gastrointestinal bleeding.

*Indication*s: For patients with a high-risk factor profile who also have indications for NSAIDs, cytoprotective medications should be considered, particularly if longer term treatment is contemplated. At-risk patients include those with a history of prior gastrointestinal bleeding, elderly, diabetics, and cigarette smokers.

Frequency/Dose/Duration: Proton pump inhibitors, misoprostol, sucralfate, H2 blockers recommended. Dose and frequency per manufacturer. There is not generally believed to be substantial differences in efficacy for prevention of gastrointestinal bleeding.

Indications for Discontinuation: Intolerance, development of adverse effects, or discontinuation of NSAID.

D.7.c NSAIDs for Patients at Risk for Cardiovascular Adverse Effects

Patients with known cardiovascular disease or multiple risk factors for cardiovascular disease should have the risks and benefits of NSAID therapy for pain discussed.

Recommended - Acetaminophen or aspirin as the first-line therapy appear to be the safest regarding cardiovascular adverse effects.

Recommended - If needed, NSAIDs that are non-selective are preferred over COX-2 specific drugs. In patients receiving low-dose aspirin for primary or secondary cardiovascular disease prevention, to minimize the potential for the NSAID to counteract the beneficial effects of aspirin, the NSAID should be taken at least 30 minutes after or eight hours before the daily aspirin.

D.7.d Acetaminophen for Treatment of Back Pain

Recommended - for treatment of back pain, particularly in patients with contraindications for NSAIDs.

Indications: All patients with back pain, including acute, subacute, chronic, and post-operative.

Dose/Frequency: Per manufacturer's recommendations; may be utilized on an as-needed basis. There is evidence of hepatic toxicity when exceeding four gm/day.

Indications for Discontinuation: Resolution of pain, adverse effects or intolerance.

D.7.e Topical Medications

Recommended – In select patients for treatment of pain associated with acute, subacute, or chronic back pain, including topical creams, ointments, and lidocaine patches

Rationale for Recommendation: **TOPICAL DRUG DELIVERY** (e.g., capsaicin, topical lidocaine, topical NSAIDs and topical salicylates and nonsalicylates) may be an acceptable form of treatment in selected patients. A topical agent should be prescribed with strict instructions for application and maximum number of applications per day to obtain the desired benefit and avoid potential toxicity. For most patients, the effects of long-term use are unknown and thus may be better used episodically. These agents may be used in those patients who prefer topical treatments over oral medications. Localized skin reactions may occur, depending on the medication agent used. Prescribers should consider that topical medication can result in toxic blood levels.

Capsaicin offers a safe and effective alternative to systemic NSAIDs, although its use is limited by local stinging or burning sensation that typically disappears with regular use. Patients should be advised to apply the cream on the affected area with a plastic glove or cotton applicator to avoid inadvertent contact with eyes and mucous membranes. Long-term use of capsaicin is not recommended.

Topical Lidocaine is only indicated when there is documentation of a diagnosis of neuropathic pain. In this instance, a trial for a period of not greater than four weeks can be considered, with the need for documentation of functional gains as criteria for additional use.

Topical NSAIDs (e.g. diclofenac gel) may achieve tissue levels that are potentially therapeutic. Overall the low level of systemic absorption can be advantageous, allowing the topical use of these medications when systemic administration is relatively contraindicated (such as patients with hypertension, cardiac failure, peptic ulcer disease or renal insufficiency).

Topical Salicylates or Nonsalicylates (e.g. methyl salicylate) overall do not appear to be more effective than topical NSAIDs. May be used for a short-term course especially in patients with chronic conditions in whom systemic medication is relatively contraindicated or as an adjuvant to systemic medication

D.7.f Opioids

Not Recommended – for acute, subacute, or chronic back pain.

Recommended – for limited use (not more than seven days) for post-operative pain management as adjunctive therapy to more effective treatments.

Indications: For post-operative pain management, a brief prescription of opioids as adjuncts to more efficacious treatments (especially NSAIDs, acetaminophen) is often required, especially nocturnally.

Frequency/Duration: Prescribed as needed throughout the day, then later only at night, before weaning off completely.

Rationale for Recommendation: Some patients have insufficient pain relief with NSAIDs, thus judicious use of opioids may be helpful, particularly for nocturnal use. Opioids are recommended for brief, select use in post-operative patients with primary use at night to achieve sleep post-operatively.

D.7.g Anti-Depressants

D.7.g.i Tricyclic antidepressants (TCAs)

Recommended - for the treatment of non-acute back pain that is not fully treated with NSAIDs and an exercise program. This intervention may be helpful where there is nocturnal sleep disruption and mild dysthymia.

Frequency/Duration: Generally prescribed at a very low dose at night and gradually increased (e.g., amitriptyline 25 mg at bedtime, increase by 25 mg each week) until a sub-maximal or maximal dose is achieved, sufficient effects are achieved, or adverse effects occur. Most practitioners use lower doses, (e.g., amitriptyline 25 to 75 mg a day to avoid the adverse effects and necessity of blood level monitoring), as there is no evidence of increased pain relief at higher doses. Imipramine is less sedating, thus if there is carryover daytime sedation, this may be a better option.

Discontinuation: Resolution of pain, intolerance, or development of adverse effects.

Recommended - Tricyclic antidepressants (TCAs) are for the treatment of radicular pain.

There is limited evidence that TCAs result in modest reductions in pain ratings in the treatment of radicular pain compared with placebo.

Frequency: Recommendations regarding usage, frequency, duration and discontinuation are as above for non-acute back pain.

D.7.g.ii Selective Serotonin Reuptake Inhibitors, (e.g., paroxetine, as well as bupropion and trazodone)

Not Recommended - for treatment of non-acute pain.

They may be recommended for the treatment of non-acute back pain with concomitant depression, dysthymia and other psychiatric conditions.

Note: There is strong evidence that treatment with these SSRI medications is not of benefit; thus their use is not recommended for the management of non-acute back pain without depression.

Absent other indicators of a need for such treatment, this intervention is not recommended for the management of acute back pain.

D.7.h Anti-Seizure Drugs

D.7.h.i Topiramate

Recommended - in select patients for limited use non- acute back pain patients, where there has been failure of multiple other modalities including trials of different NSAIDs, aerobic exercise, specific stretching exercise, strengthening exercise, tricyclic antidepressants, distractants, and manipulation.

Frequency/Dose: This medication is initiated by gradually increasing the dose. Patients should be carefully monitored for the development of adverse events.

Discontinuation: Resolution, development of adverse effects, or failure to adhere to a functional restoration program. Careful monitoring of employed patients is indicated due in part to elevated risks for central nervous system (CNS) sedating effects.

Not Recommended - not recommended for neuropathic pain, including peripheral neuropathy.

D..7.h.ii Carbamazepine

Recommended - as a potential adjunct for non-acute radicular or neuropathic pain after attempting other treatments (e.g., other medications, aerobic exercise, other exercise, manipulation). While there is not quality evidence for treatment of non- acute

radicular back pain, this may be tried if other medications have failed. Oxcarbazepine and lamotrigine may be useful agents to try if the results from carbamazepine are insufficient for pain relief.

Frequency/Duration: Frequency and dosing are based on the medication prescribed.

Discontinuation: Resolution of back pain, lack of efficacy, or development of side effects that necessitate discontinuation. Careful monitoring of employed patients is indicated due to elevated risks for CNS sedating adverse effects.

D.7.h.iii Gabapentin and Pregabalin

Recommended - for peri-operative management of pain to reduce need for opioids, particularly in those with side effects from opioids.

Discontinuation: Resolution or intolerance. Careful monitoring of employed patients is indicated due in part to elevated risks for CNS-sedating effects.

Recommended - may be considered for the treatment of severe neurogenic claudication from spinal stenosis or non-acute radicular pain syndromes with limited walking distance.

Discontinuation: Resolution or intolerance. Careful monitoring of employed patients is indicated due in part to elevated risks for CNS-sedating effects.

Not Recommended - for non-acute non- neuropathic pain or back pain.

D.7.i Colchicine (Oral and IV Colchicine)

Not Recommended - for acute or non-acute back pain.

D.7.j Compound Medications

Not Recommended - topical, oral and/or systemic compound medications are not recommended.

D.7.k Skeletal Muscle Relaxants

Recommended - Muscle relaxants (not including carisoprodol) are recommended as a second-line treatment in moderate to severe acute low back pain that has not been adequately controlled by NSAIDs.

Not Recommended - for mild to moderate acute back pain due to problems with adverse effects nor are they recommended for chronic use in subacute or non-acute back pain (other than acute exacerbations).

Note: For most cases, these agents are not recommended, since other medications, progressive walking and other exercises will be sufficient to control the symptoms. Generally, it is recommended that these agents be prescribed nocturnally initially and not during workdays or when patients plan to operate motor vehicles. Caution should be used in prescribing skeletal muscle relaxants for those with a history of depression, personality disorder, substance addiction and/or abuse, including alcohol or tobacco. If a muscle relaxant is felt to be necessary in patients with those problems, cyclobenzaprine should be the first drug tried, since its chemical structure resembles a tricyclic antidepressant, and since addiction and abuse of this drug typically do not occur.

Frequency/Duration: This initial dose should be taken in the evening. It is not recommended that the first dose be taken prior to starting a work shift or operating a motor vehicle or machinery. Daytime use is acceptable in circumstances in which the patient has experienced only minimal CNS-sedating effects and little concern about sedation compromising the patient's function or for the patient's or others' safety. There is no evidence of benefit from higher doses of medication (e.g., cyclobenzaprine 10 mg over 5 mg). If significant daytime somnolence results, then the medication may need to be discontinued, particularly if it interferes with performance of the aerobic exercise and other components of the rehabilitation plan. Another option is to decrease a dose of cyclobenzaprine by 50% to as little as 2.5 mg.

Discontinuation: Resolution of the pain, non-tolerance, significant sedating effects that carry over into the daytime, or other adverse effects.

Recommended - as second- or third-line agents for acute radicular pain syndromes or acute post- surgical pain thought to be musculoskeletal in nature.

Other agents may be more efficacious for relieving radicular pain. Generally, muscle relaxants should be prescribed nocturnally initially and not during workdays or when patients plan on operating motor vehicles.

Frequency/Duration: The initial dose should be in the evening. Daytime use is acceptable in circumstances in which the patient has experienced only minimal CNS- sedating effects and there is little concern about sedation compromising the patient's function or for the patient's or others' safety. If significant daytime somnolence results, then the medication may need to be discontinued, particularly if it interferes with the performance of aerobic exercise and other components of the rehabilitation plan.

Frequency/Duration: One week, generally with a maximum duration of two weeks (or longer if used only at night).

Discontinuation: Resolution of the pain, non- tolerance, significant sedating effects that carry over into the daytime, or other adverse effects.

D.7.l Systemic Glucocorticosteroids (aka "Steroids")

Recommended - in select patients for treatment of acute severe radicular pain syndromes for purposes of obtaining a short-term reduction in pain.

Frequency/Duration: one course (five to 14 days) of oral medication (i.e.: tapering dose of methylprednisolone) be prescribed for a given episode of radicular pain. If additional treatment is needed, epidural steroid injections are preferable, since they better target the medication to the affected tissue.

Not Recommended - for axial pain.

Not Recommended - for acute or non-acute back pain without radicular pain or mild to moderate radiculopathy

D.7.l.i Intravenous steroids

Recommended - in select patients in the setting of an acute neurological emergency and should be confined only to the hospital setting. The dose and duration of the intravenous steroids should be determined in consultation with spinal cord experts. The risk of permanent neurological damage from acute spinal cord compression generally outweighs the risk of pharmacologic side effects of steroids in an emergency situation.

D.7.m Tumor Necrosis Factor-α Inhibitors

Not Recommended - for treatment of radicular pain syndromes.

Not Recommended - for treatment of acute or non-acute back pain.

D.8 Rehabilitation

Rehabilitation (supervised formal therapy) required as a result of a work-related injury should be focused on restoring functional ability required to meet the patient's daily and work activities and return to work; striving to restore the injured worker to pre-injury status in so far as is feasible.

Active therapy requires an internal effort by the patient to complete a specific exercise or task. Passive therapy are those interventions not requiring the exertion of effort on the part of the patient, but rather are dependent on modalities delivered by a therapist. Generally passive interventions are viewed as a means to facilitate progress in an active therapy program with concomitant attainment of objective functional gains. Active interventions should be emphasized over passive interventions.

The patient should be instructed to continue both active and passive therapies at home as an extension of the treatment process in order to maintain improvement levels.

Assistive devices may be included as an adjunctive measure incorporated into the rehabilitation plan to facilitate functional gains.

D.8.a Physical / Occupational Therapy

Recommended – to improve function, including range of motion and strength.

Frequency/Dose/Duration: Frequency of visits is usually individualized based on severity of the limitation. Two to three visits per week for two weeks are often used to initiate an exercise program. Total numbers of visits may be as few as two to three for mild patients or up to 12 to 15 with documentation of objective functional improvement.

As part of the rehabilitation plan, patients should be instructed to continue both active and passive therapy, at home as an extension of the treatment process in order to maintain improvement.

Indications: All postoperative and conservatively managed mid and low back pain patients.

Indications for Discontinuation: Resolution of pain, intolerance, lack of efficacy or noncompliance.

D.8.b Therapeutic Exercise

Therapeutic Exercise, with or without mechanical assistance or resistance, may include isoinertial, isotonic, isometric and isokinetic types of exercises.

Recommended - in select patients as clinically indicated.

Indications: Include the need for cardiovascular fitness, reduced edema, improved muscle strength, improved connective tissue strength and integrity, increased bone density, promotion of circulation to enhance soft tissue healing, improvement of muscle recruitment, increased range of motion, and promotion of normal movement patterns. Can also include complementary/ alternative exercise movement therapy.

Frequency: Typically, three to five times per week with two to six treatments needed to produce effect and a maximum of eight weeks as clinically indicated.

D.8.c Aerobic Exercises

Recommended - for treatment of all patients with acute or non-acute back pain, although most available evidence is from studies treating chronic back pain patients.

Consideration should be given, however, to whether an evaluation is required prior to institution of vigorous exercises for those with significant cardiac disease, or significant potential for cardiovascular disease. For most patients, a structured, progressive walking program on level ground or no incline on a treadmill is recommended. There has been some controversy about whether bicycling is helpful or harmful from a biomechanical perspective (lordosis) and the back muscles are less active with bicycling, thus it may be less appropriate. Yet, if bicycling is the preferred exercise for the patient, it is believed to be far superior to performing no aerobic exercise. For those patients who desire other aerobic exercises, there are no specific data, although there are indications that imply that there is a direct correlation between benefit and the amount of aerobic activity that results in higher MET expenditure. Therefore, the activity that the patient will adhere to is believed to be the one most likely to be effective, given that compliance is a recognized problem.

Frequency/Duration: For patients with non-acute back pain, walking at least four times per week at 60% of predicted maximum heart rate (220-age = maximum heart rate) is recommended. One successful study benchmarked 20 minutes during week one, 30 minutes during week two, and 45 minutes after that point. For acute back pain patients, a graded walking program is generally desired, often using distance or time as minimum benchmarks. For example, a patient can start with 10 to 15 minutes twice a day for one week and increase in 10 to 15-minute increments per week until at least 30 minutes per day is achieved.

Discontinuation: Aerobic exercise should be discontinued when there is intolerance (rarely occurs) or development of other disorders. Nearly all patients should be encouraged to maintain aerobic exercises on a long-term basis for both prevention of back pain (see below), and to maintain optimal health.

Recommended – for post-operative patients for treatment of post-operative back pain.

D.8.d Strengthening and Stabilization Exercises

Recommended - for acute or non-acute back pain, or post-operative back pain patients, strengthening exercises are recommended for treatment of back pain. Specific strengthening exercises, such as stabilization exercises, are helpful for the prevention and treatment (including post-operative treatment) of back pain.

As evidence of efficacy of aerobic exercises appears greater, these

exercises should be added after either aerobic exercises have already been instituted and additional treatment is needed, or in situations where both are felt to be required. Exercises should be taught and then performed by the patient in a home exercise program. For those patients who do not improve, follow up appointments to verify technique and compliance (by exercise logbooks) are recommended. Some patients, particularly those lacking motivation to be in a home exercise program may benefit from a supervised exercise program, although there are questions about long-term compliance among patients with non-acute back pain. More intensive programs with more intensive exercises and direct supervision with active coaching have been shown to be effective for non-acute back pain.

Frequency/Duration: Home program frequency is one to two times a day for acute back pain, and two to three times a day for non-acute back pain.

Discontinuation: Indications to discontinue strengthening exercises include development of a strain in the course of treatment or failure to improve.

Not Recommended - Abdominal strengthening exercises particularly as either a sole or central goal of a strengthening program are not recommended for treatment or prevention of back pain.

Strengthening of abdominal muscles (e.g., rectus abdominus and obliques with sit-up exercises) is a frequent goal of back pain rehabilitation or prevention programs.

There is no quality evidence that these exercises are effective, there is evidence that suggests they are not effective, and there are other treatment strategies with proven or at least suggested greater efficacy.

D.8.e Aquatic Therapy (Including Swimming)

Recommended - a trial of aquatic therapy is recommended for the treatment of non-acute back pain in a patient who meets criteria for a referral for supervised exercise therapy and has co- morbidities (e.g., extreme obesity, significant degenerative joint disease, etc.) that preclude effective participation in a weight-bearing physical activity. Osteoarthritis of the knee is not a clear contraindication to a walking program, rather walking may be therapeutically indicated based on high quality evidence.

Frequency/Duration: A program should generally begin with three to four visits per week. The patient must have demonstrated evidence of functional improvement within the first two weeks to justify additional visits. The program should include up to four weeks of aquatic therapy with progression towards a land-based, self-directed physical activity or self-directed aquatic therapy program by six weeks.

Discontinuation: Non-tolerance, failure to progress, or reaching a four to six-week time frame.

For all other non-acute back pain patients, and for all acute back pain, aquatic therapy is not recommended as other therapies are believed to be more efficacious.

D.8.f Manipulation

Manipulative treatment (not therapy) is defined as the therapeutic application of manually guided forces by an operator to improve physiologic function and/or support homeostasis that has been altered by the injury or occupational disease and has associated clinical significance.

Contraindications to manipulation may include joint instability, fractures, severe osteoporosis, infection, metastatic cancer, active inflammatory arthritides, and signs of progressive neurologic deficits or myelopathy. Relative contraindications include stenosis, spondylosis, and disc herniation.

Recommended - for treatment of acute back pain when tied to objective measures of improvement and there is no evidence of fracture or significant instability. Care needs to be taken in patients with known spinal stenosis.

Frequency: Up to three times per week for the first four weeks as indicated by the severity of involvement and the desired effect, then up to two treatments per week for the next four weeks with re-evaluation for evidence of functional improvement or need for further workup. Time to produce effect for all types of manipulative treatment: one to six treatments.

Continuance of treatment will depend upon functional improvement

Optimum Duration: Eight to 12 weeks.

Maximum Duration: Three months. Extended durations of care beyond what is considered "maximum" may be necessary in cases of re-injury, interrupted continuity of care, exacerbation of symptoms, and in those patients with comorbidities.

Recommended - a maintenance program of spinal manipulation (by a physician (MD/DO), chiropractor or physical therapist) may be indicated in certain situations, after the determination of MMI, when tied to maintenance of functional status. (See Section D.9, Therapy: Ongoing Maintenance Care.)

Not Recommended - prophylactic treatment is effective, either for primary prevention (before the first episode of pain) or for secondary prevention (after recovery from an episode of back pain) and prophylactic treatment is not recommended.

D.8.g Manipulation under Anesthesia (MUA) and Medication-Assisted Spinal Manipulation (MASM)

Not Recommended

D.8.h Massage (Manual or Mechanical)

Massage (Manual or Mechanical) consists of manipulation of soft tissue with broad-ranging relaxation and circulatory benefits. This may include stimulation of acupuncture points and acupuncture channels (acupressure), application of suction cups and techniques that include pressing, lifting, rubbing, pinching of soft tissues by or with the practitioner's hands. Indications include edema (peripheral or hard and non-pliable edema), muscle spasm, adhesions, the need to improve peripheral circulation and range of motion, or to increase muscle relaxation and flexibility prior to exercise.

As with all passive therapies, massage must be accompanied by exercise and patient education. Objective benefit (functional improvement along with symptom reduction) must be demonstrated in order for further treatment to continue.

Recommended - for select use in non-acute back pain as an adjunct to more efficacious treatments consisting primarily of a graded aerobic and strengthening exercise program.

Frequency: One to two times per week with immediate effect and an optimum duration of six weeks.

D*iscontinuation*: Resolution, intolerance, lack of benefit, or non-compliance with aerobic and strengthening exercises.

Recommended - for acute back pain and non-acute radicular syndromes in which back pain is a substantial symptom component.

Frequency: One to two times per week with immediate effect and an optimum duration of six weeks.

*Discontinuation: R*esolution, intolerance, lack of benefit.

Recommended - for patients with non-acute back pain without underlying serious pathology, such as fracture, tumor, or infection.

Frequency: One to two times per week with immediate effect and an optimum duration of six weeks.

Discontinuation: Resolution, intolerance, lack of benefit.

Not Recommended – the use of mechanical devices for administering massage.

D.8.i Mobilization (Joint)

Mobilization consists of passive movement involving oscillatory motions to the vertebral segment(s). The passive mobility is performed in a graded manner (I, II, III, IV, or V), which depicts the speed and depth of joint motion during the maneuver. It may include skilled manual joint tissue stretching.

Recommended - in select patients as clinically indicated.

Indications: Include the need to improve joint play, segmental alignment, improve intracapsular arthrokinematics, or reduce pain associated with tissue impingement. Mobilization should be accompanied by active therapy. For Level V mobilization, contraindications include joint instability, fractures, severe osteoporosis, infection, metastatic cancer, active inflammatory arthritides, and signs of progressive neurologic deficits, myelopathy, vertebrobasilar insufficiency, or carotid artery disease.

Relative contraindications include stenosis, spondylosis, and disc herniation.

Frequency: Typically up to three times per week with six to nine treatments to produce effect, optimum duration four to six weeks.

Maximum Duration: Six weeks

D.8.j Mobilization (Soft Tissue)

Mobilization of soft tissue is the skilled application of muscle energy, strain/counter strain, manual trigger point release, and other manual therapy techniques designed to improve or normalize movement patterns through the reduction of soft tissue pain and restrictions.

These can be interactive with the patient participating or can be with the patient relaxing and letting the practitioner move the body tissues.

Recommended - in select patients as clinically indicated.

Indications: Include muscle spasm around a joint, trigger points, adhesions, and neural compression. Mobilization should be accompanied by active therapy.

Frequency: Typically up to three per week with four to nine treatments to produce effect, optimum duration four to six weeks.

Maximum Duration: Six weeks

D.8.k Superficial Heat and Cold

Superficial heat and cold are thermal agents applied in various manners that lower or raise the body temperature for the reduction of pain, inflammation, and/or effusion resulting from injury or induced by exercise. It includes application of heat just above the surface of the skin at acupuncture points.

Recommended - for acute pain, edema, and hemorrhage, need to increase the pain threshold, reduce muscle spasm, and promote stretching/flexibility. Cold and heat packs can be used at home as an extension of therapy in the clinic setting.

Frequency: Two to five times per week with immediate effect.

Optimum Duration: Three weeks as primary or intermittently as an adjunct to other therapeutic procedures for up to two months.

D.8.l Diathermy

Not Recommended - in the treatment of any back pain related conditions

D.8.m Low Level Laser Therapy

Not Recommended- for treatment of any back pain-related conditions.

D.8.n Infrared Therapy

Recommended - in select patients as clinically indicated.

Note: For those circumstances where this intervention is used for treatment of acute back pain, it is recommended to only be provider-based treatment and only performed in conjunction with an active exercise program.

*Frequency: N*ot to exceed four visits.

D.8.o Ultrasound

Recommended - in select patients

Indications: In situations where deeper heating is desirable, a limited trial of ultrasound for the treatment of back pain is reasonable, but only if performed as an adjunct with exercise.

Frequency: Typically three times per week with six to 15 treatments to produce effect with an optimum duration of four to eight weeks.

Maximum Duration: Eight weeks.

D.8.p Reflexology

Not Recommended - for the treatment of acute or non-acute back pain, radicular back pain, or other spinal conditions.

D.8.q Neuroflexotherapy

Not Recommended – for the treatment of acute or non-acute back pain, radicular back pain or other spinal conditions.

D.8.r Traction

Not Recommended - for treatment of acute or non-acute back pain or radicular pain syndromes.

D.8.s Vertebral Axial Compression (VAX-D) and Other Decompressive Devices

Not Recommended - VAX-D or other spinal decompressive devices is not recommended for acute or non-acute back pain or radicular pain syndromes.

D.9 Therapy – Ongoing Maintenance Care

A maintenance program of physical therapy, occupational therapy or spinal manipulation (by a physician (MD/DO), chiropractor or physical or occupational therapist) may be indicated in certain situations, after the determination of MMI, when tied to maintenance of functional status.

Although the current body of scientific evidence as reviewed does not support the routine use of this intervention, maintenance therapy modalities may be indicated in certain situations

Recommended - in select patients in order to maintain functional status, without which an objective deterioration of function has been previously observed and documented in the medical record.

Frequency: Maximum up to ten visits/year, after the determination of MMI, according to objectively documented maintenance of functional status. No variance from the maximum frequency is permitted.

Rationale:

- Specific objective goals should be identified and measured in order to support the need for ongoing maintenance care.
- Progressively longer trials of therapeutic withdrawal are to be attempted to ascertain whether therapeutic goals can be maintained in the absence of clinical interventions.
- Within a year and annually thereafter, a trial without

maintenance treatment should be instituted.

- The care of chronic back symptoms should include an ongoing patient self-management plan performed by the patient regularly and a self-directed pain management program initiated as indicated:
    - An ongoing clinically appropriate self-management plan, typically independent, home-based and self-directed, developed jointly by the provider and patient, should be implemented to encourage physical activity and/or work activities despite residual pain, with the goal of preserving function.
    - In addition to the self-management plan, a self-directed pain management plan should be developed which can be initiated by the patient in the event that symptoms worsen and function decreases.
- If deterioration of ability to maintain function is documented, reinstatement of ongoing maintenance may be acceptable.

Note: Ongoing Maintenance Care is a component of the Functional Maintenance Care recommendations detailed in the *New York Non-Acute Pain Medical Treatment Guidelines*. Please consult the *New York Non-Acute Pain Medical Treatment Guidelines* for additional information.

D.10 Radiofrequency Ablation, Neurotomy, Facet Rhizotomy

A procedure designed to denervate the facet joint by ablating the corresponding sensory medial branches. Continuous percutaneous radiofrequency is the method generally used.

Radiofrequency medial branch neurotomy is recommended as the procedure of choice over alcohol, phenol, other injectable agents, or cryoablation.

Fluoroscopic guidance is required for precise positioning of the probe.

Permanent images should be recorded to verify placement of the device.

Recommended - in select patients as clinically indicated.

Indications:

- For patients with proven facet joint pain in whom two diagnostic medial nerve branch blocks have been therapeutically successful, the use of radiofrequency ablation/neurotomy/facet rhizotomy may be indicated.
- This procedure is not recommended for involvement of more than

three facet joints (four medial branch nerves).

- All patients should have a successful response to a diagnostic medial nerve branch block and a separate comparative block.

- To be a positive diagnostic block the patient should report a reduction of pain of 50% or greater from baseline for the length of time appropriate for the local anesthetic used correlated with functional improvement.

- The patient should also identify activities of daily living (which may include measurements of range-of-motion) that are impeded by their pain. The physician should observe and document functional improvement in the identified activities in the clinical setting.

D.10.a Post-Procedure Therapy

Recommended - in select patients as clinically indicated.

- Implementation of a gentle reconditioning program within the first post-procedure week is recommended, barring complications.

- Instruction and participation in a long-term home-based program of range of motion, cervical, scapular, and thoracic strengthening, postural or neuromuscular re-education, endurance, and stability exercises should be accomplished.

Frequency: Four to ten visits post-procedure.

D.10.b Repeat Radiofrequency Neurotomy (or additional level radiofrequency neurotomies)

Recommended – in select patients.

Indications:

- In some cases pain may recur.
- Successful rhizotomy usually provides from six to nine months of relief.
- Before a repeat radiofrequency neurotomy is done, a confirmatory medial branch injection may be performed if the patient's pain pattern presents differently than in the initial evaluation.

Maximum Frequency: Twice a year as indicated by improvement in pain and function.

D.10.c Dorsal Root Ganglia Radiofrequency Lesioning

Not Recommended - for chronic sciatica because the risks of this invasive procedure have not been shown to outweigh the benefits.

D.10.d Intradiscal Electrothermal Therapy (IDET)

Not Recommended - for treatment of acute or non- acute back pain, or any other back-related disorder.

D.10.e Percutaneous Intradiscal Radiofrequency Thermocoagulation (PIRFT)

Not Recommended - for treatment of acute or non-acute back pain, including discogenic back pain.

E. Therapeutic Procedures: Operative

E.1 Discectomy, Microdiscectomy, Sequestrectomy, Endoscopic Decompression

E.1.a Lumbar Discectomy

Recommended - in select patients as clinically indicated

Indications: Lumbar discectomy is recommended as an effective operation to speed recovery in patients who have radiculopathy due to ongoing nerve root compression, who continue to have significant pain and functional limitation after six to 12 weeks and who have been provided appropriate conservative therapy during which time they experienced no progressive neurological deficits.

All of the following should be present: 1) radicular pain syndrome with current dermatomal pain and/or numbness, or myotomal muscle weakness - consistent with a herniated disc at the corresponding level; 2) imaging findings by MRI or CT with/without myelography that confirm persisting nerve root compression at the level and on the side predicted by the history and clinical examination; 3) continued significant pain and functional limitation after six to 12 weeks and who have been provided appropriate conservative therapy during which time they experienced no progressive neurological deficits.

Patients who are candidates for discectomy should be informed that (other than for cauda equina syndrome and the rare progressive major neurologic deficit), there is evidence that there is no need to rush surgical decisions, since there is no difference in long-term functional recovery whether surgery is performed early or delayed. Open discectomy, microdiscectomy, and endoscopic discectomy are all potentially appropriate ways to perform discectomy. The decision as to which of these procedures to choose should be left to the surgeon and the patient, until quality evidence becomes available to provide evidence-based guidance.

Not Recommended - as treatment of acute or non-acute back pain without radiculopathy.

E.1.b Percutaneous Discectomy

Not Recommended - Percutaneous discectomy (nucleoplasty), laser discectomy, and disc coblation therapy are not recommended as treatment for any back or radicular pain syndrome.

E.2 Adhesiolysis

Not Recommended - for acute or non-acute back pain, spinal stenosis, or radicular pain syndromes.

E.3 Decompressive Surgery (Laminotomy / Facetectomy Laminectomy

Recommended - in select patients as clinically indicated.

Indications: Decompression surgery is recommended as an effective treatment for patients with symptomatic spinal stenosis (neurogenic claudication) that is intractable to conservative management. Decompressive surgery may also be indicated in patients with cauda equina syndrome secondary to disc herniation.

E.4 Spinal Fusion

Lumbar Fusion is not included on the list of pre-authorized procedures. Providers who want to perform one of these procedures must request pre- authorization from the carrier before performing the procedure.

Recommended - in select patients as clinically indicated.

Recommended - as a treatment for spinal stenosis when concomitant spondylolisthesis has been proven. The decision regarding instrumentation should be determined by the surgeon in conjunction with the patient and based on a number of factors including but not limited to the degree of instability, associated deformities/body habitus, the age of the patient, bone quality and medical comorbidities. Lumbar fusion is not recommended for spinal stenosis without spondylolisthesis, instability, or surgical instability and facetectomy of > 50% of the facets.

Indications: All of the following should be present: 1) neurogenic claudication (leg pain and/or numbness with standing or walking); 2) imaging findings, by MRI, or CT/myelogram that confirm the nerve roots compressed are consistent with the neurological symptoms; 3) lack of responsiveness or unsatisfactory response(s) to adequate conservative treatment over a minimum six to eight week period that may or may not include an epidural steroid injection.

Recommended - as an effective treatment for isthmic spondylolisthesis.

Recommended - as an effective treatment for degenerative spondylolisthesis.

E.4.a Spinal Fusion with Third Discectomy

Recommended - in select patients requiring a third lumbar discectomy at the same level, a fusion surgery at the time of the third discectomy may be considered.

Indications: Meeting indications for a third discectomy on the same disc.

Recommended - as a treatment for Degenerative Disc Disease / "Discogenic Back Pain" / "Black Disc Disease" without instability in selected patients for whom non-surgical management has failed to relieve symptoms and improve function. The patient should have full understanding that this type of procedure is not likely to completely alleviate symptoms and may result in no improvement. If available, an intensive Functional Rehabilitation Program should be tried first.

Not Recommended - as a treatment for patients with radiculopathy from herniated nucleus pulposus (disc herniation) or for patients with non-acute back pain after lumbar discectomy.

E.5 Electrical Bone Growth Stimulators

Electrical Bone Growth Stimulators are not included on the list of pre- authorized procedures. Providers who want to perform one of these procedures must request pre-authorization from the carrier before performing the procedure.

Recommended - as an adjunct to spinal fusion surgery for those at high risk for pseudoarthrosis.

Indications: Include one or more of the following fusion failure risk factors:

1. One or more previous failed spinal fusion(s)
2. Grade II or worse spondylolisthesis
3. Fusion to be performed at more than one level
4. Presence of other risk factors that may contribute to non-healing:
    - Current smoking
    - Diabetes
    - Renal disease
    - Other metabolic diseases where bone healing is likely to be compromised (e.g.: significant osteoporosis)
    - Active alcoholism
    - Morbid obesity BMI >40

Recommended - as treatment for individuals with failed spinal fusion. Failed spinal fusion is defined as a spinal fusion that has not healed at a minimum of six months after the original surgery, as evidenced by serial x-rays over a course of three months during the latter portion of the six-month period.

E.6 Disc Replacement

Artificial disc replacement is not included on the list of pre-authorized procedures. Providers who want to perform one of these procedures must request pre-authorization from the carrier before performing the procedure.

Recommended – in select patients as clinically indicated.

Indications: For lumbar degenerative disc disease at one level with radiculopathy that is unresponsive to conservative management.

The following criteria must be met:

1) Skeletally mature patient without renal failure, severe diabetes, osteoporosis, severe spondylosis, severe facet pathology, lumbar instability, localized fracture, or localized or systemic infections.

AND

2) Single-level disc degeneration of L3 to S1 confirmed by imaging studies such as CT or MRI, with **one** of the following diagnoses:

- Herniated disc; **or**
- Osteophyte formation; **or**
- Loss of disc height.

AND

3) The patient must present with **symptoms**, which must correspond with the planned level of disc replacement:

- Intractable radiculopathy (nerve root compression) and/or myelopathy (functional disturbance or pathological change in the spinal cord) causing radicular pain in the lower extremity; **or**
- Functional and/or neurological deficit.

AND

4) Six weeks of non-operative alternative treatments have failed. These treatments may include physical therapy, medications, braces, chiropractic care, bed rest, spinal injections or exercise programs. Documentation of treatments and failure to improve is required.

The disc must be approved by the U.S. Food and Drug Administration (FDA). All other artificial disc systems are considered experimental and investigational.

All other indications, including multilevel degenerative disc disease, are considered experimental and investigational.

Not Recommended - under the following conditions, since safety and effectiveness of the replacement discs has not been established for patients with:

- Previous surgical intervention at the involved level;
- Prior or proposed fusion at an adjacent lumbar level;
- More than one lumbar level requiring artificial disc replacement;
- Clinically compromised vertebral bodies at the affected level due to current or past trauma (including but not limited to the radiographic appearance of fracture callus, malunion or nonunion).
- Active systemic infection or infection at the operating site;
- Allergy to titanium, polyurethane, or ethylene oxide residues;
- Osteoporosis defined as a DEXA bone mineral density T score equal to or worse than -2.5.

E.7 Vertebroplasty and Kyphoplasty

Vertebroplasty and Kyphoplasty are not included on the list of pre-authorized procedures. Providers who want to perform one of these procedures must request pre-authorization from the carrier before performing the procedure.

Recommended - may be considered for treatment of select patients with vertebral body compression fractures with associated with subacute fracture and severe pain not responding to conservative measures. Patients who have had fractures despite bisphosphonate therapy are particularly appropriate candidates.

E.8 Sacroiliac Surgery

Sacroiliac joint fusion is not included on the list of pre-authorized procedures. Providers who want to perform one of these procedures must request pre-authorization from the carrier before performing the procedure.

Recommended – for select patients as clinically indicated

Sacroiliac (SI) joint pain may present with pain that starts in the lower back and buttock, and may radiate to the lower hip, groin or upper thigh. While the pain is usually one sided, it can occur on both sides. Symptoms may worsen with sitting, standing, sleeping, walking or climbing stairs. Often the SI joint is painful sitting or sleeping on the affected side. Some patients have difficulty riding in a car or standing, sitting or walking too long. Pain can be worse with transitional movements (going from sit to stand), standing on one leg or climbing stairs.

Other sources of pain, such as lumbar spine or hip, must be ruled out before considering the SI joint as the pain generator.

SI joint fusion may be considered when **all** of the following criteria are met:

1) The pain is caudal to the lumbar spine (L5 vertebra), localized over the posterior sacroiliac joint, and consistent with sacroiliac joint pain, **and**

2) The pain is at least 5 on a 0 to 10 rating scale that impacts quality of life or limits activities of daily living, **and**
3) There is an absence of generalized pain behavior (eg, somatoform disorder) or generalized pain disorders (eg, fibromyalgia); **and**
4) Patient has undergone and failed a minimum 6 months of intensive nonoperative treatment that must include medication optimization, activity modification, bracing, and active therapeutic exercise targeted at the lumbar spine, pelvis, sacroiliac joint, and hip, including a home exercise program; **and**
5) On physical examination there is localized tenderness with palpation over the sacral sulcus (Fortin's point) in the absence of tenderness of similar severity elsewhere; **and**
6) There is a positive response to **at least 3** of the following provocative tests (eg,
    - thigh thrust test,
    - compression test,
    - Gaenslen sign,
    - distraction test,
    - Patrick test,
    - Posterior provocation test); **and**
7) Diagnostic imaging studies include ALL of the following:
    - plain radiographs and computed tomography or magnetic resonance imaging of the sacroiliac joint excludes the presence of destructive lesions (eg, tumor, infection) or inflammatory arthropathy of the sacroiliac joint; **and**
    - anteroposterior plain radiograph of the pelvis rules out concomitant hip pathology; **and**
    - computed tomography or magnetic resonance imaging of the lumbar spine is performed to rule out neural compression or other degenerative condition that can be causing low back or buttock pain; **and**
    - sacroiliac joint imaging indicates evidence of injury and/or degeneration; **and**
8) Diagnostic injections performed on 2 separate occasions, using an image-guided, contrast-enhanced, intra-articular sacroiliac joint injection, demonstrate at least a 75% reduction in pain for the expected duration of the anesthetic; **and**
9) A trial of a therapeutic sacroiliac joint injection (i.e., corticosteroid injection) has been performed at least once; **and**
10) The procedure is performed by a physician trained in either neurosurgery or orthopedic spine surgery; **and**
11) The physician performing the surgery has either completed procedure-specific training or has been granted hospital privileges to perform the specific type(s) sacroiliac joint surgery(ies) being contemplated. **and**

SI joint fusion may also be considered:

- as an adjunct to the medical treatment of sacroiliac joint infection/sepsis; or
- severe traumatic injuries associated with pelvic ring fracture; or
- when multisegment spinal constructs extend to the sacrum/ilium, as a component of medically necessary lumbar spine fusion procedures.

E.9 Intraoperative Monitoring / Image Guidance / Robotic Surgery

Intraoperative Monitoring has become the standard of care when placing thoracic and lumbar instrumentation, primarily pedicle screws. This type of monitoring may include somatosensory evoked potentials (SSEP) and motor evoked potentials (MEP). The monitoring procedure may be used to evaluate spinal cord and/or nerve root integrity, as well as instrumentation placement during the operative procedure. Image guidance/robotic assistance for the placement of thoracic and lumbar instrumentation has become common to improve the safety of spinal surgical procedures.

Recommended - Intraoperative monitoring/image guidance/robotic surgery as clinically indicated per surgeon discretion.

E.10 Implantable Spinal cord Stimulators (SCS)

Please consult the *New York Non-Acute Pain Medical Treatment Guidelines* for information about Spinal Cord Stimulators. Spinal Cord Stimulators are not included on the list of pre-authorized procedures. Providers who want to perform one of these procedures must request pre-authorization from the carrier before performing the procedure.

Sources:

This Medical Treatment Guideline is adopted, with modification, from ACOEM's·Occupational Medicine Treatment Guidelines for Low Back Disorders with supplementation from the State of Colorado's Low Back Medical Treatment Guidelines.

Third Edition: September 15, 2014
Revised: July 2021