

## HEALTH EVIDENCE REVIEW COMMISSION (HERC)

### COVERAGE GUIDANCE: LOW BACK PAIN: NON-PHARMACOLOGIC/NON-INVASIVE INTERVENTIONS\*

DATE: 06/14/2012

#### HERC COVERAGE GUIDANCE

For pain  $\leq$  4 weeks, self-care is recommended, and for those who do not improve with self-care, spinal manipulation should be covered.

For pain > 4 weeks duration, the following treatments may be covered:

- Acupuncture
- Cognitive-behavioral therapy
- Exercise therapy
- Intensive interdisciplinary rehabilitation
- Massage therapy
- Progressive relaxation
- Spinal manipulation
- Yoga (viniyoga)

The following should not be covered for low back pain:

- Continuous or intermittent traction
- Transcutaneous electrical nerve stimulation

\*Coverage guidance for pharmacologic interventions, imaging, percutaneous interventions and surgery for low back pain will be addressed in subsequent documents.

#### RATIONALE FOR GUIDANCE DEVELOPMENT

The HERC selects topics for guideline development or technology assessment based on the following principles:

- Represents a significant burden of disease
- Represents important uncertainty with regard to efficacy or harms
- Represents important variation or controversy in clinical care
- Represents high costs, significant economic impact
- Topic is of high public interest

Coverage guidance development follows to translate the evidence review to a policy decision. Coverage guidance may be based on an evidence-based guideline developed by the Evidence-based Guideline Subcommittee or a health technology assessment developed by the Health Technology Assessment Subcommittee. In addition, coverage guidance may utilize an existing evidence report produced by one of HERC's trusted sources, generally within the last three years.

## EVIDENCE SOURCES

Livingston, C., King, V., Little, A., Pettinari, C., Thielke, A., & Gordon, C. (2011). *State of Oregon Evidence-based Clinical Guidelines Project. Evaluation and management of low back pain: A clinical practice guideline based on the joint practice guideline of the American College of Physicians and the American Pain Society (Diagnosis and treatment of low back pain)*. Salem: Office for Oregon Health Policy and Research. Available at: <http://www.oregon.gov/OHA/OHPR/HERC/Evidence-Based-Guidelines.shtml>

Chou, R., Huffman, L. *Nonpharmacologic Therapies for Acute and Chronic Low Back Pain: A Review of the Evidence for an American Pain Society/American College of Physicians Clinical Practice Guideline*. *Ann Intern Med.* 2007; 147; 492-504. Available at: <http://www.annals.org/content/147/7/492.full.pdf+html>

Chou R., Qaseem, A., Snow, V., Casey, D., Cross, J.T., Jr., Shekelle, P., Owens, D.K.; Clinical Efficacy Assessment Subcommittee of the American College of Physicians; American College of Physicians; American Pain Society Low Back Pain Guidelines Panel. *Diagnosis and treatment of low back pain: a joint clinical practice guideline from the American College of Physicians and the American Pain Society*. *Annals of Internal Med.* 2007; 147(7); 478-491. Available at: <http://www.annals.org/content/147/7/478.long>

The summary of evidence in this document is derived directly from these evidence sources, and portions are extracted verbatim.

## SUMMARY OF EVIDENCE

### **Clinical Background**

Low back pain is the fifth most common reason for all physician visits in the United States. Approximately one quarter of U.S. adults reported having low back pain lasting at least 1 whole day in the past 3 months, and 7.6% reported at least 1 episode of severe acute low back pain within a 1-year period. Low back pain is also very costly: Total incremental direct health care costs attributable to low back pain in the U.S. were estimated at \$26.3 billion in 1998. In addition, indirect costs related to days lost from work are substantial, with approximately 2% of the U.S. work force compensated for back injuries each year.

Many patients have self-limited episodes of acute low back pain and do not seek medical care. Among those who do seek medical care, pain, disability, and return to work typically improve rapidly in the first month. However, up to one third of patients report persistent back pain of at least moderate intensity 1 year after an acute episode, and 1 in 5 report substantial limitations in activity. Approximately 5% of the people with back pain disability account for 75% of the costs associated with low back pain.

Many options are available for evaluation and management of low back pain. However, there has been little consensus, either within or between specialties, on appropriate clinical evaluation and management of low back pain. Numerous studies show unexplained, large variations in use of diagnostic tests and treatments. Despite wide variations in practice, patients seem to experience broadly similar outcomes, although costs of care can differ substantially among and within specialties.

### **Evidence Review**

**Recommendation 1:** *Clinicians should provide patients with evidence-based information on low back pain with regard to their expected course, advise patients to remain active, and provide information about effective self-care options (strong recommendation, moderate-quality evidence).*

Clinicians should inform all patients of the generally favorable prognosis of acute low back pain with or without sciatica, including a high likelihood for substantial improvement in the first month. General advice on self-management for nonspecific low back pain should include recommendations to remain active, which is more effective than resting in bed for patients with acute or subacute low back pain. Self-care education books based on evidence-based guidelines, such as *The Back Book* are recommended because they are an inexpensive and efficient method for supplementing clinician-provided back information and advice and are similar or only slightly inferior in effectiveness to such costlier interventions as supervised exercise therapy, acupuncture, massage, and spinal manipulation.

[\[Evidence source\]](#)

**Recommendation 2:** *For patients who do not improve with self-care options, clinicians should consider the addition of nonpharmacologic therapy with proven benefits—for acute low back pain, spinal manipulation; for chronic or subacute low back pain, intensive interdisciplinary rehabilitation, exercise therapy, acupuncture, massage therapy, spinal manipulation, yoga, cognitive-behavioral therapy, or progressive relaxation (weak recommendation, moderate-quality evidence).*

For acute low back pain (duration <4 weeks), spinal manipulation administered by providers with appropriate training is associated with small to moderate short-term benefits. Supervised exercise therapy and home exercise regimens are not effective for acute low back pain, and the optimal time to start exercise therapy after the onset of symptoms is unclear. For subacute (duration >4 to 8 weeks) low back pain, intensive interdisciplinary rehabilitation (defined as an intervention that includes a physician consultation coordinated with a psychological, physical therapy, social, or vocational intervention) is moderately effective, and functional restoration with a cognitive-behavioral component reduces work absenteeism due to low back pain in occupational settings. For chronic low back pain, moderately effective nonpharmacologic therapies include acupuncture, exercise therapy, massage therapy, Viniyoga-style yoga, cognitive-behavioral therapy or progressive relaxation, spinal manipulation, and intensive interdisciplinary rehabilitation. Transcutaneous electrical nerve stimulation and intermittent or continuous traction (in patients with or without sciatica) have not been proven effective for chronic low back pain.

[\[Evidence source\]](#)

### **Overall Summary**

Non-pharmacologic treatments that have been shown to be effective for LBP include spinal manipulation, intensive interdisciplinary rehabilitation, exercise therapy, acupuncture, massage therapy, yoga, cognitive-behavioral therapy and progressive relaxation. Transcutaneous electrical nerve stimulation and intermittent or continuous traction have not been proven effective in the treatment of chronic LBP.

### **PROCEDURES**

Acupuncture  
Cognitive-behavioral therapy  
Continuous or intermittent traction  
Exercise therapy  
Intensive interdisciplinary rehabilitation  
Massage therapy  
Progressive relaxation  
Spinal manipulation  
Transcutaneous electrical nerve stimulation  
Viniyoga-style yoga

### **DIAGNOSES**

Low back pain

## APPLICABLE CODES

CODES	DESCRIPTION
<b>ICD-9 Diagnosis Codes</b>	
170.2	Tumor lumbosacral region primary
198.5	Tumor lumbosacral region secondary
344.60	Cauda equine syndrome
720.1	Spinal enthesopathy
720.2	Sacroiliitis, not elsewhere classified
721.3	Lumbosacral spondylosis without myelopathy
721.42	Spondylosis with myelopathy, lumbar region
721.5	Kissing spine
721.6	Ankylosing vertebral hyperostosis
721.7	Traumatic spondylopathy
721.8	Other allied disorders of spine
721.9	Spondylosis of unspecified site
722.1	Displacement of thoracic or lumbar intervertebral disc without myelopathy
722.2	Displacement of intervertebral disc, site unspecified, without myelopathy
722.32	Schmorl's nodes, lumbar region
722.39	Schmorl's nodes, other region
722.5	Degeneration of thoracic or lumbar intervertebral disc
722.6	Degeneration of intervertebral disc, site unspecified
722.70	Intervertebral disc disorder with myelopathy, unspecified region
722.72	Intervertebral disc disorder with myelopathy, thoracic region
722.73	Intervertebral disc disorder with myelopathy, lumbar region
722.80	Postlaminectomy syndrome, unspecified region
722.82	Postlaminectomy syndrome, thoracic region
722.83	Postlaminectomy syndrome, lumbar region
722.90	Other and unspecified disc disorder, unspecified region
722.92	Other and unspecified disc disorder, thoracic region
722.93	Other and unspecified disc disorder, lumbar region
724	Other and unspecified disorders of back
724.0	Spinal stenosis other than cervical
724.00	Spinal stenosis, unspecified region
724.01	Spinal stenosis, thoracic region
724.02	Spinal stenosis, lumbar region, without neurogenic claudication
724.03	Spinal stenosis, lumbar region, with neurogenic claudication
724.09	Spinal stenosis, other region
724.1	Pain in thoracic spine
724.2	Lumbago
724.3	Sciatica
724.4	Thoracic or lumbosacral neuritis or radiculitis, unspecified
724.5	Backache, unspecified
724.6	Disorders of sacrum
724.7	Disorders of coccyx
724.70	Unspecified disorder of coccyx
724.71	Hypermobility of coccyx
724.79	Other disorders of coccyx
724.8	Other symptoms referable to back

<b>CODES</b>	<b>DESCRIPTION</b>
724.9	Other unspecified back disorders
730.2	Unspecified osteomyelitis
732.0	Juvenile osteochondrosis of spine
733.0	Osteoporosis
737.2	Lordosis (acquired)
737.30	Scoliosis [and kyphoscoliosis], idiopathic
737.39	Other kyphoscoliosis and scoliosis
737.4	Curvature of spine associated with other conditions
737.8	Other curvatures of spine
737.9	Unspecified curvature of spine
738.4	Acquired spondylolisthesis
738.5	Other acquired deformity of back or spine
739.2	Nonallopathic lesions, thoracic region
739.3	Nonallopathic lesions, lumbar region
739.4	Nonallopathic lesions, sacral region
754.2	Congenital musculoskeletal deformities of spine
756.1	Congenital anomalies of spine
846	Sprains and strains of sacroiliac region
847.1	Sprain of thoracic
847.2	Sprain of lumbar
847.3	Sprain of sacrum
847.4	Sprain of coccyx
847.9	Sprain of unspecified site of back
<b>ICD-9 Volume 3 (procedure codes)</b>	
None	
<b>CPT</b>	
<b>Spinal Manipulation</b>	
98925	Osteopathic manipulative treatment (OMT); 1-2 body regions involved
98926	3-4 body regions involved
98927	5-6 body regions involved
98928	7-8 body regions involved
98929	9-10 body regions involved
98940	Chiropractic manipulative treatment (CMT); spinal, 1-2 regions
98941	spinal, 3-4 regions
98942	spinal, 5 regions
98943	extraspinal, 1 or more regions
<b>Acupuncture</b>	
97810	Acupuncture, 1 or more needles; without electrical stimulation, initial 15 minutes of personal one-on-one contact with the patient
+97811	without electrical stimulation, each additional 15 minutes of personal one-on-one contact with the patient, with re-insertion of needle(s)
97813	with electrical stimulation, initial 15 minutes of personal one-on-one contact with the patient
+97814	with electrical stimulation, each additional 15 minutes of personal one-on-one contact with the patient, with re-insertion of needle(s)
<b>Cognitive Behavioral Therapy</b>	
90804	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in

<b>CODES</b>	<b>DESCRIPTION</b>
	an office or outpatient facility, approximately 20 to 30 minutes face-to-face with the patient
90805	with medical evaluation and management services
90806	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 45 to 50 minutes face-to-face with the patient
90807	with medical evaluation and management services
90808	Individual psychotherapy, insight oriented, behavior modifying and/or supportive, in an office or outpatient facility, approximately 75 to 80 minutes face-to-face with the patient
90809	with medical evaluation and management services
90810	Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, approximately 20 to 30 minutes face-to-face with the patient
90811	with medical evaluation and management services
90812	Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, approximately 45 to 50 minutes face-to-face with the patient
90813	with medical evaluation and management services
90814	Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication, in an office or outpatient facility, approximately 75 to 80 minutes face-to-face with the patient
90815	with medical evaluation and management services
90875	Individual psychophysiological therapy incorporating biofeedback training by any modality (face-to-face with the patient), with psychotherapy (eg, insight oriented, behavior modifying or supportive psychotherapy)
97001	Physical therapy evaluation
97002	Physical therapy re-evaluation
97012	Traction, mechanical
97014	Electrical stimulation (unattended)
97110	Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility
97112	neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities
97116	gait training (includes stair climbing)
97124	massage, including effleurage, petrissage and/or tapotement (stroking, compression, percussion)
97140	Manual therapy techniques (eg, mobilization/manipulation, manual lymphatic drainage, manual traction), 1 or more regions, each 15 minutes
97150	Therapeutic procedure(s), group (2 or more individuals) (Group therapy procedures involve constant attendance of the physician or therapist, but by definition do not require one-on-one patient contact by the physician or therapist)
97530	Therapeutic activities, direct (one-on-one) patient contact by the provider (use of dynamic activities to improve functional performance), each 15 minutes
<b>HCPCS Level II Codes</b>	
E0830	Ambulatory traction device, all types, each
E0941	Gravity assisted traction device, any type
H0002	Behavioral health screening to determine eligibility for admission to treatment

<b>CODES</b>	<b>DESCRIPTION</b>
	program
H0004	Behavioral health counseling and therapy, per 15 minutes
H0031	Mental health assessment, by nonphysician
H0032	Mental health service plan development by nonphysician
H2000	Comprehensive multidisciplinary evaluation
H2001	Rehabilitation program, per ½ day
S9451	Exercise classes, nonphysician provider, per session

Note: Inclusion on this list does not guarantee coverage

Coverage guidance is prepared by the Health Evidence Review Commission (HERC), HERC staff, and subcommittee members. The evidence summary is prepared by the Center for Evidence-based Policy at Oregon Health & Science University (the Center). This document is intended to guide public and private purchasers in Oregon in making informed decisions about health care services.

The Center is not engaged in rendering any clinical, legal, business or other professional advice. The statements in this document do not represent official policy positions of the Center. Researchers involved in preparing this document have no affiliations or financial involvement that conflict with material presented in this document.

Superseded