

Low Back Pain and Lumbar Spine Conditions - Referral Management

MCG Health
Ambulatory Care
30th Edition

RMG: R-0056 (AC)

[Link to Codes](#)

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Clinical Indications

- Referral for low back pain may be indicated for **1 or more** of the following(1)(2)(3)(4)(5):
 - ☐ Emergent evaluation or management of **1 or more** of the following(6)(7):
 - Bladder disturbance (eg, acute urinary retention or incontinence)(8)
 - Bowel disturbance or flaccid anal sphincter(8)
 - Cauda equina syndrome, known or suspected[A](11)(12)(13)
 - Epidural abscess
 - Lytic bone lesion on spine imaging(14)
 - Motor deficits in both lower extremities (ie, bilateral involvement)(15)(16)
 - Recent significant trauma, and concern for lumbar spine injury (eg, fall from height, motor vehicle accident)(15)(16)(17)
 - Saddle anesthesia (ie, in perineal region)(16)
 - Spinal cord compression (eg, myelopathy)(15)
 - Spinal fracture(13)
 - Spinal infection (eg, vertebral osteomyelitis)(12)(15)
 - Spinal tumor(8)(18)
 - Transverse myelitis
 - ☐ Behavioral health referral for evaluation or management of **1 or more** of the following(7)(19)(20)(21)(22):
 - Cognitive behavioral therapy needed (eg, to address misperceptions, poor coping skills)(23)(24)(25)(26)(27)
 - Depression(28)
 - Psychosocial issues (eg, job dissatisfaction)(29)
 - Somatization(28)

- Endocrinology referral for evaluation or management of metabolic bone disease (eg, osteoporosis, Paget disease)(30)(31)
- ☐ Infectious disease referral for evaluation or management of **1 or more** of the following:
 - Abnormal finding on spinal imaging (eg, evidence of osteomyelitis)(32)
 - Immunosuppression
 - Recent genitourinary infection(6)
 - Spinal infection (eg, diskitis, vertebral osteomyelitis)(15)(33)(34)
 - Substance abuse (ie, intravenous drug use with risk of osteomyelitis)(15)
- ☐ Neurology referral for evaluation or management of **1 or more** of the following:
 - Abnormal finding on spinal imaging (eg, demyelination within spinal cord)[B](35)(36)(37)(38)
 - Demyelinating disease (eg, multiple sclerosis)(35)(37)
 - Focal neurologic deficit (eg, foot drop)(15)
 - Neurologic examination equivocal
- ☐ Neurosurgery referral for evaluation or management of **1 or more** of the following:
 - Interpretation or management of imaging or other diagnostic testing result (eg, electromyographic studies, nerve conduction study, spine CT scan, spine MRI)(39)(40)
 - Lumbar herniated disk and **ALL** of the following(28)(41)(42):
 - Failure of trial of conservative care, including **1 or more** of the following(19):
 - Activity modification
 - Analgesic or anti-inflammatory medication
 - Exercise or physical therapy, as clinically indicated(43)
 - Nerve root compression consistent with clinical findings evident on imaging (eg, MRI)(8)
 - Lumbosacral spinal stenosis (with or without spondylolisthesis) and **ALL** of the following(28)(42)(44):
 - Failure of trial of conservative care, including **1 or more** of the following(19):
 - Activity modification
 - Analgesic or anti-inflammatory medication
 - Exercise or physical therapy, as clinically indicated(45)(46)
 - Lumbar stenosis on imaging (eg, CT myelogram, MRI), if patient is surgical candidate
 - Neurogenic claudication[C]
 - Neurogenic claudication (ie, lumbar stenosis)[C](28)(42)
 - Persistent low back pain despite trial of conservative care, including **1 or more** of the following(19)(47):
 - Activity modification
 - Analgesic or anti-inflammatory medication
 - Exercise or physical therapy, as clinically indicated(48)
 - Significant pathology on imaging tests, including **1 or more** of the following:
 - Bone scan positive(30)(32)
 - Lytic bone lesion in spine(14)
 - Pars defect (spondylolysis) in patient age 20 years or younger(49)
 - Vertebral compression fracture, with 50% or greater loss of height(50)
 - Skin stigmata overlying spine associated with spinal defects (eg, cafe au lait spot, tuft of hair, midline hemangioma)(51)(52)(53)
- Occupational medicine referral for evaluation or management of low back pain (eg, need for work restrictions)(22)(26)(54)
- ☐ Oncology referral for evaluation or management of **1 or more** of the following(18):
 - Abnormal finding on spinal imaging (eg, lytic lesion, positive bone scan)(14)(32)

- History or current diagnosis of cancer(13)(16)(18)
- Immunosuppression

☐ Orthopedic spinal surgery referral for evaluation or management of **1 or more** of the following:

- Interpretation or management of imaging or other diagnostic testing result (eg, electromyographic study, nerve conduction study, spine CT scan, spine MRI)(39)(40)
- Localized bone pain(30)
- Lumbar herniated disk and **ALL** of the following(28)(42):
 - Failure of trial of conservative care, including **1 or more** of the following(19):
 - Activity modification
 - Analgesic or anti-inflammatory medication
 - Exercise or physical therapy, as clinically indicated(43)
 - Nerve root compression consistent with clinical findings evident on imaging (eg, MRI)(8)
- Lumbosacral spinal stenosis (with or without spondylolisthesis) and **ALL** of the following(28)(42)(44):
 - Failure of trial of conservative care, including **1 or more** of the following(19):
 - Activity modification
 - Analgesic or anti-inflammatory medication
 - Exercise or physical therapy, as clinically indicated
 - Lumbar stenosis on imaging (eg, CT myelogram, MRI), if patient is surgical candidate
 - Neurogenic claudication[C]
- Neurogenic claudication (ie, lumbar stenosis)[C](28)(42)
- Persistent low back pain despite trial of conservative care, including **1 or more** of the following(19)(47):
 - Activity modification
 - Analgesic or anti-inflammatory medication
 - Exercise or physical therapy, as clinically indicated(48)
- Recent minor trauma in patient older than 70 years, or in patient with osteoporosis(8)(17)
- Scoliosis(55)(56)
- Significant pathology on imaging tests, including **1 or more** of the following:
 - Bone scan positive(30)(32)
 - Lytic bone lesion in spine(14)
 - Pars defect (spondylolysis) in patient age 20 years or younger(49)
 - Vertebral compression fracture, with 50% or greater loss of height(50)
- Skin stigmata overlying spine associated with spinal defects (eg, cafe au lait spot, tuft of hair, midline hemangioma)(51)(52)(53)
- Spine deformity in child or adolescent (eg, scoliosis, pars defect)(49)(57)
- Pain management referral for evaluation or management of chronic low back pain or prolonged narcotic usage[D](22)(58)(60)(61)

☐ Physical medicine and rehabilitation referral for evaluation or management of **1 or more** of the following(19)(22)(62)(63):

- Education (eg, back school)(47)(64)(65)
- Home exercise program(66)
- Low back pain, with or without radiculopathy[E](41)(66)(67)(68)
- Pain management(61)(69)

☐ Physical therapy referral for evaluation or management of **1 or more** of the following(21)(63)(70)(71):

- Education (eg, back school)(47)(63)(64)(65)
- Home exercise program(66)

- Low back pain, with or without radiculopathy[E](41)(66)(67)(68)
- Pain management(69)(72)(73)
- Rehabilitation needed after lumbar spinal stenosis surgery(74)

☐ Rheumatology referral for evaluation or management of **1 or more** of the following(31)(75):

- Ankylosing spondylitis(76)(77)(78)
- Inflammatory back pain[F](13)(79)
- Limited range of motion
- Metabolic bone disease (eg, osteoporosis, Paget disease)(8)
- Psoriatic spondylitis
- Reactive arthritis
- Spondyloarthropathy on spinal imaging

Evidence Summary

Criteria

The evidence for the clinical indications found in this guideline includes 63 published peer reviewed articles, 4 specialty society or other evidence-based guidelines, 4 Cochrane systematic reviews, and 3 book sections.

Rationale

Use of this MCG care guideline helps the clinician identify specific complex factors of a patient's condition that may need specialist consultation. It provides evidence-based clinical criteria to help decide when a patient should be referred to a specialist, ensuring timely specialty care. Additionally, this guideline can help limit unnecessary differences in treatment, like variable criteria for emergency or subspecialist referral, thereby promoting equal access and quality of care for similar patients, regardless of location, facility, or clinician.

Related CMS Coverage Guidance

None applicable

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Footnotes

[A] Clinical assessment is limited in its ability to detect cauda equina syndrome; emergent evaluation and imaging are appropriate in suspected cases.(3)(9) The spectrum at presentation may vary from suspected cases (ie, bilateral radiculopathy without associated bladder, bowel, or sexual dysfunction) to incomplete cauda equina syndrome (ie, the addition of urinary symptoms such as loss of sensation of bladder fullness or straining to void yet with ongoing voluntary control of voiding) to cauda equina syndrome with neurogenic urine retention. Ultimately, complete cauda equina syndrome occurs with the loss of all cauda equina function.(3)(9)(10) Timely management reduces the potential for permanent neurologic deficits.(3)(10) [A in Context Link 1]

[B] Spinal cord demyelination may be a clinically isolated syndrome suggestive of multiple sclerosis, or may be associated with autoimmune disorders such as systemic lupus erythematosus, Sjogren syndrome, or Behcet disease.(35)(36) [B in Context Link 1]

[C] Neurogenic claudication (also called neurogenic pseudoclaudication) is buttock or lower extremity pain that occurs with standing or walking and is relieved with spinal flexion (eg, sitting or bending).(28)(44) [C in Context Link 1, 2, 3, 4]

[D] There is some evidence to support the short-term benefit of opioids for mild to moderate pain, but the evidence for improvement in function is inconsistent. Given that chronic opioid therapy for noncancer pain often begins with acute opioid prescriptions, clinicians should provide the lowest effective dose for the shortest duration necessary (eg, 2 to 3 days) to alleviate pain when giving prescriptions for acute pain; limiting the duration of opioid therapy can minimize the need to taper to prevent withdrawal symptoms at the end of the course of opioids and limit unused opioids.(58)(59) [D in Context Link 1]

[E] Therapy for acute low back pain may include spinal manipulation.(1) [E in Context Link 1, 2]

[F] Inflammatory back pain may be the initial presentation of ankylosing spondylitis, psoriatic arthritis, or other inflammatory arthropathies. Characteristic features include dull pain that lasts longer than 3 months. The pain is worse in the second part of the night and early morning. Morning stiffness lasting longer than 30 minutes is noted and relieved with exercise, heat, and/or nonsteroidal anti-inflammatory agents.(79) [F in Context Link 1]

Codes

ICD-10 Diagnosis: A18.01, C41.2, C41.4, G06.1, M00.88, M01.X8, M02.38, M02.88, M08.1, M41.05, M41.06, M41.07, M41.08, M41.115, M41.116, M41.117, M41.125, M41.126, M41.127, M41.25, M41.26, M41.27, M41.35, M41.45, M41.46, M41.47, M41.55, M41.56, M41.57, M41.85, M41.86, M41.87, M42.05, M42.06, M42.07, M42.08, M42.15, M42.16, M42.17, M42.18, M43.05, M43.06, M43.07, M43.08, M43.15, M43.16, M43.17, M43.18, M43.25, M43.26, M43.27, M43.28, M43.5X5, M43.5X6, M43.5X7, M43.5X8, M43.8X5, M43.8X6, M43.8X7, M43.8X8, M45.0, M45.5, M45.6, M45.7, M45.8, M46.05, M46.06, M46.07, M46.08, M46.09, M46.1, M46.25, M46.26, M46.27, M46.28, M46.35, M46.36, M46.37, M46.38, M46.45, M46.46, M46.47, M46.48, M46.55, M46.56, M46.57, M46.58, M46.59, M46.85, M46.86, M46.87, M46.88, M46.89, M46.95, M46.96, M46.97, M46.98, M46.99, M47.015, M47.016, M47.15, M47.16, M47.25, M47.26, M47.27, M47.28, M47.815, M47.816, M47.817, M47.818, M47.895, M47.896, M47.897, M47.898, M48.05, M48.061, M48.062, M48.07, M48.08, M48.15, 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