VA/DoD Clinical Practice Guidelines

Diagnosis and Treatment of Low Back Pain

Provider Summary

Version 3.0 | 2022

VA/DoD CLINICAL PRACTICE GUIDELINE FOR THE DIAGNOSIS AND TREATMENT OF LOW BACK PAIN

Department of Veterans Affairs

Department of Defense

Provider Summary

QUALIFYING STATEMENTS

The Department of Veterans Affairs and the Department of Defense guidelines are based upon the best information available at the time of publication. They are designed to provide information and assist decision making. They are not intended to define a standard of care and should not be construed as one. Neither should they be interpreted as prescribing an exclusive course of management.

This Clinical Practice Guideline is based on a systematic review of both clinical and epidemiological evidence. Developed by a panel of multidisciplinary experts, it provides a clear explanation of the logical relationships between various care options and health outcomes while rating both the quality of the evidence and the strength of the recommendation.

Variations in practice will inevitably and appropriately occur when clinicians take into account the needs of individual patients, available resources, and limitations unique to an institution or type of practice. Every healthcare professional making use of these guidelines is responsible for evaluating the appropriateness of applying them in the setting of any particular clinical situation with a patient-centered approach.

These guidelines are not intended to represent Department of Veterans Affairs or TRICARE policy. Further, inclusion of recommendations for specific testing and/or therapeutic interventions within these guidelines does not guarantee coverage of civilian sector care. Additional information on current TRICARE benefits may be found at www.tricare.mil by contacting your regional TRICARE Managed Care Support Contractor.

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Introduction

The Department of Veterans Affairs (VA) and Department of Defense (DoD) Evidence-Based Practice Work Group (EBPWG) was established and first chartered in 2004, with a mission to advise the Health Executive Committee (HEC) "… on the use of clinical and epidemiological evidence to improve the health of the population …" across the Veterans Health Administration (VHA) and Military Health System (MHS), by facilitating the development of clinical practice guidelines (CPGs) for the VA and DoD populations. (1) Development and update of VA/DoD CPGs is funded by VA Evidence Based Practice, Office of Quality and Patient Safety. The system-wide goal of evidence-based CPGs is to improve patient health and well-being.

In 2017, the VA and DoD published a CPG for the Diagnosis and Treatment of Low Back Pain (2017 VA/DoD LBP CPG), which was based on evidence reviewed on or after December 2006 to October 2016. Since the release of that CPG, a growing body of research has expanded the evidence base and understanding of low back pain (LBP). Consequently, the VA/DoD EBPWG initiated the update of the 2017 VA/DoD LBP CPG in 2020. This updated CPG's use of GRADE reflects a more rigorous application of the methodology than previous iterations. Consequently, the strength of some recommendations may have been modified due to the confidence in the quality of the supporting evidence (see Methods).

This CPG provides an evidence-based framework for the diagnosis and treatment of patients with acute, subacute, or chronic LBP with or without neurological symptoms with the aim of improving clinical outcomes. Successful implementation of this CPG will:

- Assist providers in assessing the patient's condition and collaborating with the patient, family, and caregivers to determine optimal management of patient care
- Emphasize the use of patient-centered care and shared decision making
- Minimize preventable complications and morbidity
- Optimize individual health outcomes and quality of life

The full VA/DoD LBP CPG, as well as additional toolkit materials including a pocket card and provider summary, can be found at: https://www.healthquality.va.gov/.

Recommendations

The following evidence-based clinical practice recommendations were made using a systematic approach considering four domains as per the GRADE approach (see Methods). These domains include: confidence in the quality of the evidence, balance of desirable and undesirable outcomes (i.e., benefits and harms), patient values and preferences, and other implications (e.g., resource use, equity, acceptability).

Recommendations for "patients with low back pain" encompass patient populations with acute, subacute, or chronic LBP with or without neurological symptoms. Recommendations specific to one or more LBP types include additional detail regarding the patient population.

Table 1. Recommendations

Topic	#	Recommendation	Strength[a]	Category[b]
Evaluation and Diagnostic Approach	1.	For patients with low back pain, we recommend the history and physical examination include evaluation for progressive or otherwise serious neurologic deficits and other red flags (e.g., signs, symptoms, history) associated with serious underlying pathology (e.g., malignancy, fracture, infection).	Strong for	Reviewed, Amended
	2.	For patients with low back pain, we recommend diagnostic imaging and appropriate laboratory testing when neurologic deficits are progressive or otherwise serious or when other red flags (e.g., signs, symptoms, history) are present.	Strong for	Reviewed, Amended
	3.	For patients with acute low back pain, without focal neurologic deficits or other red flags (e.g., signs, symptoms, history), we recommend against routinely obtaining imaging studies or performing invasive diagnostic tests.	Strong against	Reviewed, New-replaced
	4.	For patients with low back pain, we suggest assessing psychosocial factors and using predictive screening instruments (e.g., STarT Back and The Orebro Musculoskeletal Pain Screening Questionnaire) to inform treatment planning.	Weak for	Reviewed, New-replaced
	5.	For patients with low back pain, with or without radicular symptoms, there is insufficient evidence to recommend for or against specific physical exam maneuvers to assist in the diagnosis of facet or sacroiliac joint pain, or a lumbar/lumbo-sacral radiculopathy.	Neither for nor against	Reviewed, New-added
Patient Education and Self-care	6.	For patients with low back pain, there is insufficient evidence to recommend for or against pain neuroscience education, clinician-directed education with patient-led goal setting, or back school.	Neither for nor against	Reviewed, New-replaced
	7.	For the self-management of low back pain, there is insufficient evidence to recommend for or against technology-based modalities.	Neither for nor against	Reviewed, New-added
Non-pharmacologic and Non-invasive Therapy	8.	For patients with chronic low back pain, we suggest cognitive behavioral therapy.	Weak for	Reviewed, New-replaced
	9.	For patients with low back pain, we suggest a structured clinician-directed exercise program (e.g., aerobic, aquatic, mechanical diagnosis and therapy, mobility, motor control, Pilates, strengthening exercises, structured walking program, tai chi).	Weak for	Reviewed, New-replaced
	10.	For patients with chronic low back pain, we suggest spinal mobilization/manipulation.	Weak for	Reviewed, New-replaced
	11.	For patients with acute low back pain, there is insufficient evidence to recommend for or against spinal mobilization/manipulation.	Neither for nor against	Reviewed, New-replaced
	12.	For patients with chronic low back pain, there is insufficient evidence to recommend for or against mindfulness-based stress reduction.	Neither for nor against	Reviewed, New-replaced
	13.	For patients with low back pain, there is insufficient evidence to recommend for or against lumbar supports.	Neither for nor against	Reviewed, Amended

Topic	#	Recommendation	Strength[a]	Category[b]
Non-pharmacologic and Non-invasive Therapy (cont.)	14.	For patients with low back pain, with or without radicular symptoms, there is insufficient evidence to recommend for or against mechanical lumbar traction.	Neither for nor against	Reviewed, New-replaced
	15.	For patients with chronic low back pain, there is insufficient evidence to recommend for or against auricular acupressure.	Neither for nor against	Reviewed, New-added
	16.	For patients with low back pain, there is insufficient evidence to recommend for or against yoga or qi gong.	Neither for nor against	Reviewed, New-replaced
	17.	For patients with low back pain, there is insufficient evidence to recommend for or against cupping, laser therapy, transcutaneous electrical nerve stimulation, and ultrasound.	Neither for nor against	Reviewed, New-replaced
Pharmacotherapy	18.	For patients with chronic low back pain, we suggest duloxetine.	Weak for	Reviewed, New-replaced
	19.	For patients with low back pain, we suggest nonsteroidal anti-inflammatory drugs.	Weak for	Reviewed, New-replaced
	20.	For patients with low back pain, with or without radicular symptoms, there is insufficient evidence to recommend for or against gabapentin or pregabalin.	Neither for nor against	Reviewed, Amended
	21.	For patients with low back pain, there is insufficient evidence to recommend for or against tricyclic antidepressants.	Neither for nor against	Reviewed, New-added
	22.	For patients with low back pain, there is insufficient evidence to recommend for or against topical preparations.	Neither for nor against	Reviewed, Amended
	23.	For patients with acute low back pain, there is insufficient evidence to recommend for or against a non-benzodiazepine muscle relaxant for short-term use.	Neither for nor against	Reviewed, New-replaced
	24.	For patients with chronic low back pain, we suggest against offering a non-benzodiazepine muscle relaxant.	Weak against	Reviewed, Not changed
	25.	For patients with low back pain, we suggest against acetaminophen.	Weak against	Reviewed, New-replaced
	26.	For patients with low back pain, we suggest against monoclonal antibodies.	Weak against	Reviewed, New-added
	27.	For patients with chronic low back pain, we suggest against opioids. For patients who are already using long-term opioids, see the VA/DoD CPG for the Use of Opioids in the Management of Chronic Pain.	Weak against	Reviewed, New-replaced
	28.	For patients with low back pain, with or without radicular symptoms, we suggest against systemic corticosteroids (oral or intramuscular injection).	Weak against	Not reviewed, Amended
	29.	For patients with low back pain, we recommend against benzodiazepines.	Strong against	Reviewed, Not changed
Dietary Supplements	30.	For patients with low back pain, there is insufficient evidence to recommend for or against any specific diet or nutritional, herbal, or homeopathic supplements (e.g., anti-inflammatory diet, turmeric, vitamin D), cannabis, or cannabinoids.	Neither for nor against	Reviewed, New-replaced

Topic	#	Recommendation	Strength[a]	Category[b]
Non-surgical Invasive Therapy	31.	For patients with chronic low back pain, we suggest lumbar medial branch and/or sacral lateral branch radiofrequency ablation.	Weak for	Reviewed, New-replaced
	32.	For patients with low back pain, there is insufficient evidence to recommend for or against sacroiliac joint injections.	Neither for nor against	Reviewed, New-added
	33.	For patients with low back pain, we suggest against the injection of corticosteroids for intra-articular facet joint injections and therapeutic medial branch blocks with steroid.	Weak against	Reviewed, New-replaced
	34.	For patients with chronic low back pain, we suggest acupuncture.	Weak for	Reviewed, Amended
	35.	For patients with acute low back pain, there is insufficient evidence to recommend for or against acupuncture.	Neither for nor against	Reviewed, Amended
	36.	For patients with low back pain, there is insufficient evidence to recommend for or against ortho-biologics (e.g., platelet-rich plasma, stem cells).	Neither for nor against	Reviewed, New-added
	37.	For patients with low back pain, with radicular symptoms, there is insufficient evidence to recommend for or against epidural steroid injections.	Neither for nor against	Reviewed, New-replaced
	38.	For patients with low back pain, we suggest against spinal cord stimulation.	Weak against	Reviewed, New-added
Team Approach	39.	For patients with chronic low back pain, we suggest a multidisciplinary or interdisciplinary program. These programs should include at least one physical component and at least one other component of the biopsychosocial model (psychological, social, and/or occupational) used in an explicitly coordinated manner.	Weak for	Reviewed, Amended

[a] For additional information, see Determining Recommendation Strength and Direction in the full VA/DoD LBP CPG.

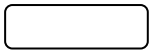
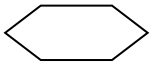
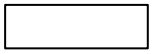
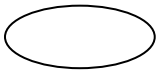
[b] For additional information, see Recommendation Categorization and Appendix D in the full VA/DoD LBP CPG.

Algorithm

This CPG's algorithm is designed to facilitate understanding of the clinical pathway and decision making process used in managing patients with LBP. This algorithm format represents a simplified flow of the management of patients with LBP and helps foster efficient decision making by providers. It includes:

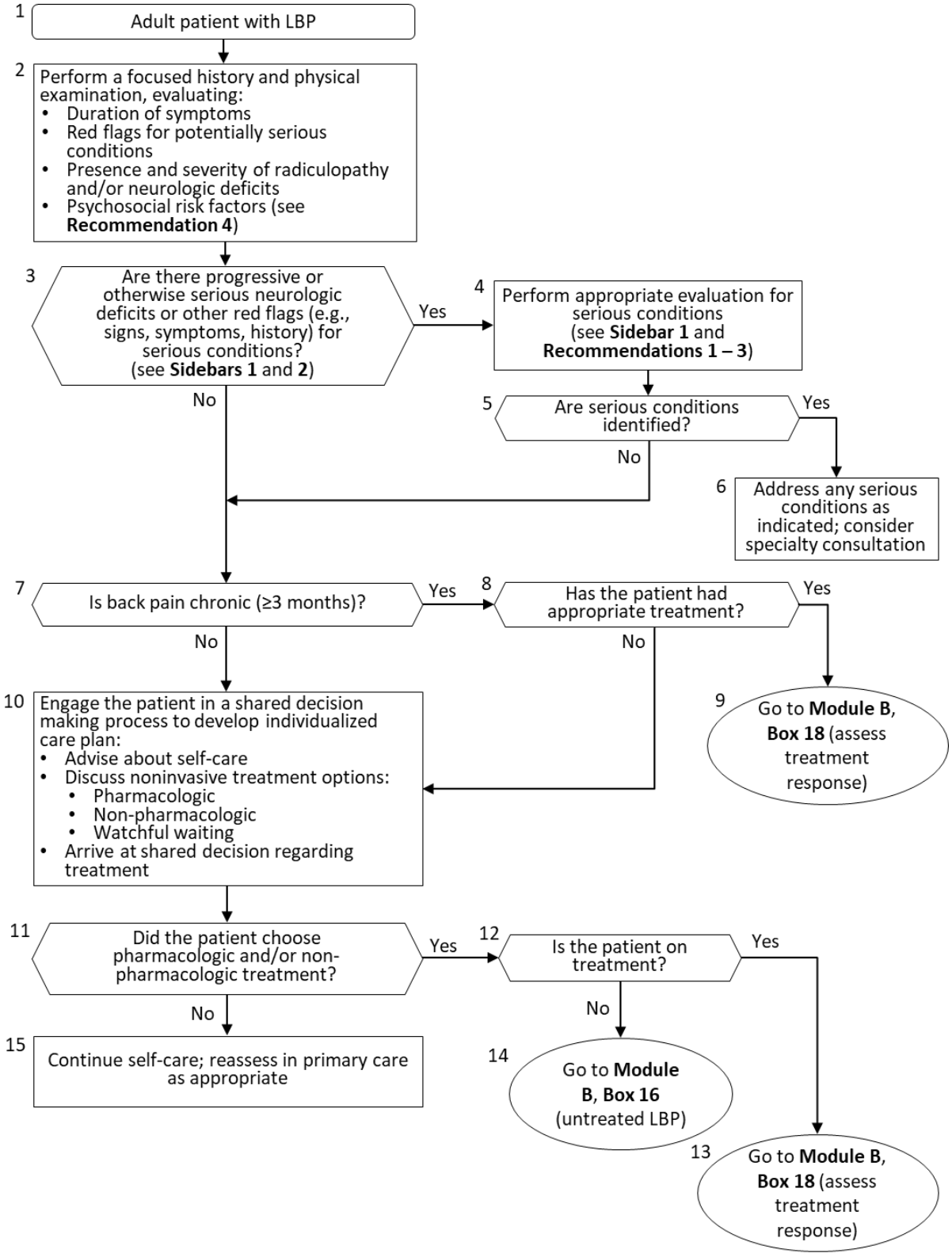
- An ordered sequence of steps of care
- Decisions to be considered
- Recommended decision criteria
- Actions to be taken

The algorithm is a step-by-step decision tree. Standardized symbols are used to display each step, and arrows connect the numbered boxes indicating the order in which the steps should be followed. (2) Sidebars provide more detailed information to assist in defining and interpreting elements in the boxes.

Shape	Description
	Rounded rectangles represent a clinical state or condition
	Hexagons represent a decision point in the process of care, formulated as a question that can be answered "Yes" or "No"
	Rectangles represent an action in the process of care
	Ovals represent a link to another section within the algorithm

For alternative text descriptions of the algorithm, see Appendix I in the full VA/DoD LBP CPG.

Module A: Initial Evaluation of Low Back Pain



Abbreviation: LBP: low back pain

Sidebar 1: Evaluation for Possible Serious Conditions		
Possible Serious Conditions	**Red Flags (e.g., signs, symptoms, history)**	**Suggested Evaluation[a]**
Cauda equina syndrome or conus medullaris syndrome	• Urinary retention • Urinary or fecal incontinence • Saddle anesthesia • Changes in rectal tone • Severe/progressive lower extremity neurologic deficits	• Emergent MRI[b] (preferred)
Infection	• Fever • Immunosuppression • IV drug use • Recent infection, indwelling catheters (e.g., central line, Foley)	• MRI[c] • ESR and/or CRP
Fracture	• History of osteoporosis • Chronic use of corticosteroids • Older age (≥75 years old) • Recent trauma • Younger patients at risk for stress fracture (e.g., overuse)	• Lumbosacral plain radiography • For inconclusive results, advanced imaging as indicated
Cancer	• History of cancer with new onset of LBP • Unexplained weight loss • Failure of LBP to improve after 1 month • Age >50 years • Multiple risk factors present	• MRI[c] • Lumbosacral plain radiography

[a] Consider specialty consultation

[b] MRI, except where contraindicated (e.g., patients with pacemakers), otherwise CT or CT myelogram

[c] MRI without and with contrast, except where contraindicated (e.g., renal insufficiency)

Abbreviations: CRP: C-reactive protein; CT: computed tomography; ESR: erythrocyte sedimentation rate; IV: intravenous; LBP: low back pain; MRI: magnetic resonance imaging

Sidebar 2: Evaluation for Possible Other Conditions[a]		
Possible Other Conditions	**Red Flags (e.g., signs, symptoms, history)**	**Suggested Evaluation[b]**
Herniated disc	• Radicular back pain (e.g., sciatica) • Lower extremity dysesthesia and/or paresthesia	None
	• Severe/progressive lower extremity neurologic deficits • Symptoms present >1 month	MRI[c]
Spinal stenosis	• Radicular back pain (e.g., sciatica) • Lower extremity dysesthesia and/or paresthesia • Neurogenic claudication • Older age	None
	• Severe/progressive lower extremity neurologic deficits • Symptoms present >1 month	MRI[c]
Inflammatory LBP	• Morning stiffness • Improvement with exercise • Alternating buttock pain • Awakening due to LBP during the second part of the night (early morning awakening) • Younger age	Radiography of pelvis, SI joint, and spine area of interest

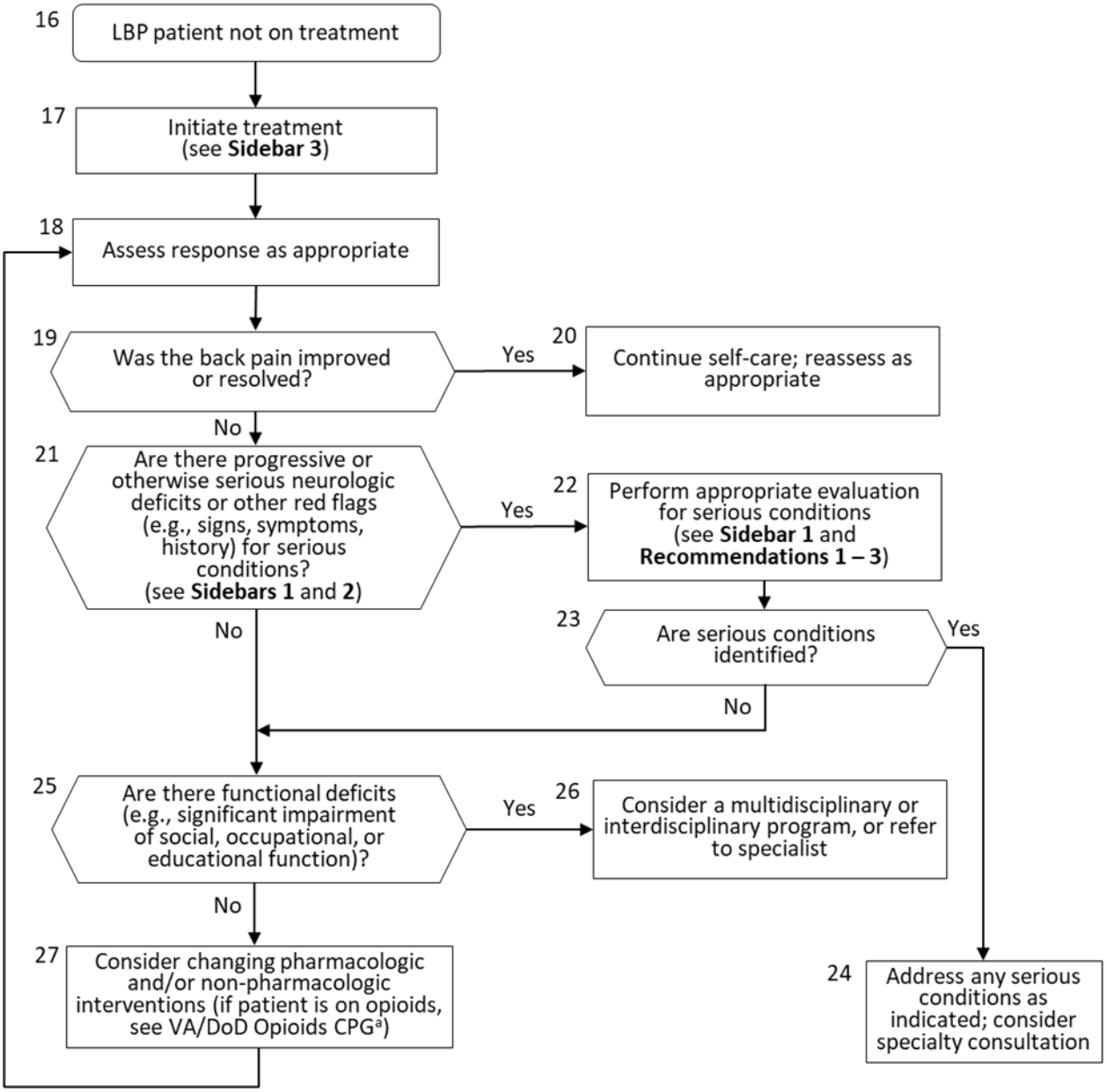
[a] These conditions usually do not require urgent diagnostic evaluation

[b] Consider specialty consultation

[c] Some patients may have contraindications to MRI, contrast usually not required

Abbreviations: LBP: low back pain; MRI: magnetic resonance imaging; SI: sacroiliac

Module B: Management of Low Back Pain



[a] See the VA/DoD Clinical Practice Guideline for the Use of Opioids in the Management of Chronic Pain. Available at: https://www.healthquality.va.gov/.

Abbreviation: CPG: clinical practice guideline; DoD: Department of Defense; LBP: low back pain; VA: Department of Veterans Affairs

Sidebar 3: Management of Low Back Pain			
		Low Back Pain Duration	
Category	**Intervention (listed alphabetically by category)**	**Acute <4 Weeks**	**Subacute or Chronic ≥4 Weeks**
Self-care	Advice to remain active	X	X
Non-pharmacologic treatment	Acupuncture		X Recommendation 34
	CBT and/or MBSR		X Recommendation 8 and Recommendation 12
	Clinician-directed exercise program		X Recommendation 9
	Spinal mobilization/manipulation		X Recommendation 10
Pharmacologic treatment	Duloxetine		X Recommendation 18
	NSAIDs	X Recommendation 19	X Recommendation 19
Other treatment	Multidisciplinary or interdisciplinary program		X Recommendation 39

Abbreviations: CBT: cognitive behavioral therapy; MBSR: mindfulness-based stress reduction; NSAIDs: nonsteroidal anti-inflammatory drugs

Scope of the CPG

This CPG is based on published clinical evidence and related information available through February 1, 2021. It is intended to provide general guidance on best evidence-based practices (see Appendix A in the full VA/DoD LBP CPG for additional information on the evidence review methodology). This CPG is not intended to serve as a standard of care.

This CPG is intended for use by VA and DoD primary care providers (PCPs) and others involved in the healthcare team caring for patients with LBP and associated conditions. Additionally, this CPG is intended for community-based clinicians involved in the care of Service Members, beneficiaries, or Veterans with LBP.

The patient population of interest for this CPG is adults (ages 18 years or older) with acute, subacute, or chronic LBP with or without neurological symptoms, who are eligible for care in the VA or DoD healthcare delivery systems and those who receive care from community-based clinicians. It includes Veterans and Service Members as well as their dependents. Recommended interventions in this CPG are applicable regardless of care setting, unless otherwise indicated, for any patient in the VA and DoD healthcare system.

Management of LBP from visceral disorders, fracture, cancer, infection, inflammatory arthropathy, or other causes is beyond the scope of this CPG. Pregnant women are also excluded from the scope of this CPG.

Methods

The methodology used in developing this CPG follows the *Guideline for Guidelines*, an internal document of the VA/DoD EBPWG updated in January 2019 that outlines procedures for developing and submitting VA/DoD CPGs.(3) The *Guideline for Guidelines* is available at http://www.healthquality.va.gov/policy/index.asp. This CPG also aligns with the National Academy of Medicine's (NAM) principles of trustworthy CPGs (e.g., explanation of evidence quality and strength, the management of potential conflicts of interest [COI], interdisciplinary stakeholder involvement, use of systematic review (SR), and external review).(4) Appendix A in the full VA/DoD LBP CPG provides a detailed description of the CPG development methodology.

The Work Group used the Grading of Recommendations Assessment, Development and Evaluation (GRADE) approach to craft each recommendation and determine its strength. Per GRADE approach, recommendations must be evidence-based and cannot be made based on expert opinion alone. The GRADE approach uses the following four domains to inform the strength of each recommendation: confidence in the quality of the evidence, balance of desirable and undesirable outcomes, patient values and preferences, other considerations as appropriate (e.g., resource use, equity) (see Determining Recommendation Strength and Direction in the full VA/DoD LBP CPG).(5)

Using these four domains, the Work Group determined the relative strength of each recommendation (*Strong* or *Weak*). The strength of a recommendation is defined as the extent to which one can be confident that the desirable effects of an intervention outweigh its undesirable effects and is based on the framework above, which incorporates the four domains.(6) A *Strong* recommendation generally indicates

High or *Moderate* confidence in the quality of the available evidence, a clear difference in magnitude between the benefits and harms of an intervention, similar patient values and preferences, and understood influence of other implications (e.g., resource use, feasibility).

In some instances, there is insufficient evidence on which to base a recommendation for or against a particular therapy, preventive measure, or other intervention. For example, the systematic evidence review may have found little or no relevant evidence, inconclusive evidence, or conflicting evidence for the intervention. The manner in which this is expressed in the CPG may vary. In such instances, the Work Group may include among its set of recommendations a statement of insufficient evidence for an intervention that may be in common practice even though it is not supported by clinical evidence, and particularly if there may be other risks of continuing its use (e.g., high opportunity cost, misallocation of resources). In other cases, the Work Group may decide to not include this type of statement about an intervention. For example, the Work Group may remain silent where there is an absence of evidence for a rarely used intervention. In other cases, an intervention may have a favorable balance of benefits and harms but may be a standard of care for which no recent evidence has been generated.

Using these elements, the Work Group determines the strength and direction of each recommendation and formulates the recommendation with the general corresponding text (see Table 2).

Table 2. Strength and Direction of Recommendations and General Corresponding Text

Recommendation Strength and Direction	General Corresponding Text
Strong for	We recommend …
Weak for	We suggest …
Neither for nor against	There is insufficient evidence to recommend for or against …
Weak against	We suggest against …
Strong against	We recommend against …

It is important to note that a recommendation's strength (i.e., *Strong* versus *Weak*) is distinct from its clinical importance (e.g., a *Weak* recommendation is evidence-based and still important to clinical care). The strength of each recommendation is shown in the Recommendations section.

The GRADE of each recommendation made in the 2021 CPG can be found in the section on Recommendations. Additional information regarding the use of the GRADE system can be found in Appendix A in the full VA/DoD LBP CPG.

Recommendation categories were used to track how the previous CPG's recommendations could be reconciled. These categories and their corresponding definitions are similar to those used by the National Institute for Health and Care Excellence (NICE, England).(7, 8) Table 3 lists these categories, which are based on whether the evidence supporting a recommendation was systematically reviewed, the degree to which the previous CPG's recommendation was modified and whether a previous CPG's recommendation is relevant in the updated CPG.

Table 3. Recommendation Categories and Definitions[a]

Evidence Reviewed	Recommendation Category	Definition
Reviewed[b]	New-added	New recommendation
	New-replaced	Recommendation from previous CPG was carried forward and revised
	Not changed	Recommendation from previous CPG was carried forward but not changed
	Amended	Recommendation from previous CPG was carried forward with a nominal change
	Deleted	Recommendation from previous CPG was deleted
Not reviewed[c]	Not changed	Recommendation from previous CPG was carried forward but not changed
	Amended	Recommendation from previous CPG was carried forward with a nominal change
	Deleted	Recommendation from previous CPG was deleted

[a] Adapted from the NICE guideline manual (2012) (8) and Garcia et al. (2014) (7)

[b] The topic of this recommendation was covered in the evidence review carried out as part of the development of the current CPG.

[c] The topic of this recommendation was not covered in the evidence review carried out as part of the development of the current CPG.

Abbreviation: CPG: clinical practice guideline

Guideline Work Group

Table 4. Guideline Work Group and Guideline Development Team

Organization	Names*
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	Evan N. Steil, MD, MBA, MHA, FAAFP (Champion)
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*Additional contributor contact information is available in Appendix G in the full VA/DoD LBP CPG

Patient-centered Care

Guideline recommendations are intended to consider patient needs and preferences. Guideline recommendations represent a whole/holistic health approach to care that is patient-centered, culturally appropriate, and available to people with limited literacy skills and physical, sensory, or learning disabilities. VA/DoD CPGs encourage providers to use a patient-centered, whole/holistic health approach (i.e., individualized treatment based on patient needs, characteristics, and preferences). This approach aims to treat the particular condition while also optimizing the individual's overall health and well-being.

Regardless of the care setting, all patients should have access to individualized evidence-based care. Patient-centered care can decrease patient anxiety, increase trust in clinicians, and improve treatment adherence.(9, 10) A whole/holistic health approach (https://www.va.gov/wholehealth/) empowers and

equips individuals to meet their personal health and well-being goals. Good communication is essential and should be supported by evidence-based information tailored to each patient's needs. An empathetic and non-judgmental approach facilitates discussions sensitive to sex, culture, ethnicity, and other differences.

Shared Decision Making

This CPG encourages providers to practice shared decision making, which is a process in which providers and patients consider clinical evidence of benefits and risks as well as patient values and preferences to make decisions regarding the patient's treatment.(11) Shared decision making was emphasized in *Crossing the Quality Chasm,* an Institute of Medicine (IOM) (now NAM) report, in 2001,(12) and is inherent within the whole/holistic health approach. Providers must be adept at presenting information to their patients regarding individual treatments, expected risks, expected outcomes, and levels and/or settings of care, especially where there may be patient heterogeneity in risks and benefits. The VHA and MHS have embraced shared decision making. Providers are encouraged to use shared decision making to individualize treatment goals and plans based on patient capabilities, needs, and preferences.

References

1. U.S. Department of Veterans Affairs/Department of Defense Health Executive Committee (HEC). Evidence based practice work group charter [updated January 9, 2017]. Available from: www.healthquality.va.gov/documents/EvidenceBasedPracticeWGCharter123020161.pdf.
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3. U.S. Department of Veteran Affairs, Department of Defense. Guideline for guidelines. Veterans Health Administration, Office of Quality & Performance, Evidence Review Subgroup; Revised January 29, 2019.
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