

**MANAGEMENT OF NON-SPECIFIC LOW BACK PAIN AND SCIATICA IN OVER 16s**

|  |  |
| --- | --- |
| **Commissioning decision** | The Clinical Commissioning Group will provide funding for people who meet the criteria within this policy. |

# Policy Statement:

Patients with non-specific low back pain should be managed conservatively where possible. Patients should be referred to physiotherapy services or pain management services in the first instance. Referral to secondary care should be via the MSK triage services where cases will be initially triaged by physiotherapy.

In addition to our local pathway, NICE make a number of recommendations on how patients with non-specific low back pain are managed, including the following:

Consider using risk stratification (for example, the STarT Back risk assessment tool) at first point of contact with a healthcare professional for each new episode of non-specific low back pain (with or without sciatica) to inform shared decision-making about stratified management

**Policy – Criteria to Access Treatment – CRITERIA BASED ACCESS**

Funding Approval for Interventional Treatment will only be provided by the NHS for patients meeting the criteria set out below:

**1. Medial Branch Block to Assess for Radiofrequency Denervation**

**OPCS code: V544, V485, V486, V487, V488, V489**

A single **diagnostic** medial branch block is commissioned for patients in order to assess whether they would benefit from Radiofrequency Denervation where:

1. Conservative management including non-surgical treatment has failed;

**AND**

b) The main source of pain is thought to come from structures supplied by the medial branch nerve;

**AND**

c) The patient has moderate to severe levels of localised back pain (rated as 5 or more out of 10, on a Visual Analogue Scale, or equivalent) at the time of referral/assessment.

Radiofrequency Denervation is only commissioned for patients with chronic non-specific low back pain after a positive response (50% or more reduction in pain) to a diagnostic lumbar medial branch block with 1ml or less of local anaesthetic at each level (no steroids).

Lumbar radiofrequency facet joint denervation (RFD) should only be offered in accordance with NICE Guideline NG59 which recommends it as an adjunct in the management of chronic low back pain only when non-operative treatment has failed, and the main source of pain is thought to arise from one or more degenerate facet joints

**2. Epidural Injections and Nerve Root Blocks**

**OPCS-4.7 Code: A521 A522**

A single epidural injection or nerve root block of local anaesthetic and steroid is commissioned for patients with acute and severe sciatica where:

* A specialist Pain or Trauma & Orthopaedic clinician judges that a single injection is necessary and appropriate to enable participation in a conservative pain management programme.

Repeat injections are not routinely commissioned as there is a lack of high quality supporting evidence for long term pain relief and clinical advice suggests diminishing returns with increased risk of adverse events.

**Policy – Criteria to Access Treatment – INDIVIDUAL FUNDING PANEL APPROVAL REQUIRED (INNF)**

The treatments and devices listed below are **not** routinely funded:

**3. Facet Joint Injections**

**OPCS- 4.7 Code: V544**

Facet joint injections either for diagnostic or therapeutic purposes are not routinely commissioned.

**Exceptions from criteria:**

The following patients will be exempt from the policy:

* When a patient fulfils the criteria for MBB but are not suitable for RFD due to co-morbidities
* Post traumatic facet joint arthritis
* Spondylolysis/spondylolisthesis
* Adult scoliosis

For patients who are exempt from the criteria, a single injection is funded. **Prior approval** is required for further injections where there has been a 50% or more reduction in pain, lasting for at least 6 months, with proven improved function during the period of benefit- e.g. improved mobility, ability to work, reduced medications, or ability to care for themselves or others

**Therapeutic, Multiple or Repeat Medial Branch Blocks/Repeat Radiofrequency Denervation**

a) a) Medial Branch Blocks are not commissioned for therapeutic purposes i.e. repeat MBB are not commissioned.

b) b) Medial Branch Blocks ahead of a repeat Radiofrequency Denervation within the 16 month period following the previous RFD are not commissioned.

**NICE Recommendations**

The treatments set out below **will not** be routinely funded for people with non-specific low back pain (with or without sciatica), as recommended by NICE:

* **Intradiscal Therapy** is aimed at treating internal disc disruption (IDD), which some therapists believe can be a cause of non-specific low back pain. Both steroids and non-steroidal anti-inflammatory drugs have been injected into the disc in an attempt to suppress inflammation and reduce pain.
* **Prolotherap**y (also known as proliferation therapy or regenerative injection therapy) involves injecting tissue with an irritant solution. This may be a joint, ligament or tendon insertion, or injected into connective tissue or muscle.
* **Trigger Point Injections** use various mixtures of local anaesthetics and a steroid, or botulinum toxin. A trigger point is argued to be a painful or irritable knot in a muscle. Injections are usually carried out in an outpatient setting and repeated at intervals.
* Imaging in a Non-Specialist Setting
* Belts or Corsets
* Foot Orthotics
* Rocker Sole Shoes
* Traction
* Acupuncture
* Ultrasound
* Percutaneous Electrical Nerve Simulation (PENS)
* Transcutaneous Electrical Nerve Simulation (TENS)
* Interferential Therapy
* Paracetamol **alone**
* Anti-epileptic medication where there is no neuropathic pain component and in accordance with the Gloucestershire Joint Formulary advice
* Epidural Injections for Neurogenic Claudication in People who have Central Spinal Canal Stenosis
* Spinal Fusion
* Disc Replacement

Patients who are not eligible for treatment under this policy may be considered on an individual basis where their GP or consultant believes exceptional circumstances exist that warrant deviation from the rule of this policy.

#  Rationale:

NICE guidelines recommend that spinal injections should not be offered for nonspecific low back pain.

Radiofrequency denervation (to destroy the nerves that supply the painful facet joint in the spine) can be considered in some cases as per NICE guidance.

Exclusion criteria for the NICE NG59 include:

Conditions of a non-mechanical nature, including;

Inflammatory causes of back pain (for example, ankylosing spondylitis or diseases of the viscera)

Serious spinal pathology (for example, neoplasms, infections or osteoporotic collapse)

Neurological disorders (including cauda equina syndrome or mononeuritis)

Adolescent scoliosis

Not covered were conditions with a select and uniform pathology of a mechanical nature (e.g. spondylolisthesis, scoliosis, vertebral fracture or congenital disease)

Other agreed exclusions by the GDG are: Pregnancy-related back pain, Sacroiliac joint dysfunction, Adjacent-segment disease, Failed back surgery syndrome, Spondylolisthesis and Osteoarthritis.

NICE recommends the following approach for non-surgical invasive treatments for low back pain and sciatica

**Spinal injections**

Do not offer spinal injections for managing nonspecific low back pain.

**Radiofrequency denervation**

Consider referral for assessment for radiofrequency denervation for people with chronic low back pain when:

non-surgical treatment has not worked for them and the main source of pain is thought to come from structures supplied by the medial branch nerve and they have moderate or severe levels of localised back pain (rated as 5 or more on a visual analogue scale, or equivalent) at the time of referral.

Only perform radiofrequency denervation in people with chronic low back pain after a positive response to a diagnostic medial branch block.

Do not offer imaging for people with low back pain with specific facet join pain as a prerequisite for radiofrequency denervation.

 **Evidence base**:

References:

1. <https://www.nice.org.uk/guidance/ng59>,

2. Benyamin RM, Manchikanti L, Parr AT, Diwan S, Singh V, Falco FJ, et al. The effectiveness of lumbar interlaminar epidural injections in managing chronic low back and lower extremity pain. Pain Physician. 2012 Jul-Aug;15(4):E363-404.

3. Choi HJ, Hahn S, Kim CH, Jang BH, Park S, Lee SM, et al. Epidural steroid injection therapy for low back pain: a meta-analysis. Int J Technol Assess Health Care. 2013 Jul;29(3):244-53.

4. Cohen SP, Bicket MC, Jamison D, Wilkinson I, Rathmell JP. Epidural steroids: a comprehensive, evidence-based review. Reg Anesth Pain Med. 2013 May- Jun;38(3):175-200.

5. <https://www.rcoa.ac.uk/document-store/core-standards-pain-management-services-the-uk>

6 National Low Back and Radicular Pain Pathway 2017(Greenough, 2017).

**Plain English Summary:**

Low back pain is soreness or stiffness in the back, between the bottom of your rib cage and the top of your legs. Most people's low back pain is described as 'non-specific'. That means the pain is unlikely to be caused by an infection, a fracture or a disease like cancer.

Some people also get back symptoms radiating down one or both legs (radicular symptoms/sciatica). Radicular symptoms are caused, when the nerves from the back, are irritated causing pain, numbness or tingling down the leg.

This pain, may vary from mild to severe, may be related to or triggered by a particular movement or action or it may be spontaneous. Most people will tend to suffer from back pain at some point in their lives and indeed it may recur. Most back pain usually improves enough within few days to few weeks, to be able to return to normal activities.

Spinal injections of local anaesthetic and steroid should not be offered for patients with nonspecific low back pain without sciatica, as they are unproven clinically.

Link to application form – PA for exemption group only

For further information please contact GLCCG.IFR@nhs.net

|  |  |
| --- | --- |
| **Date of publication** | 19/10/2018 |
| **Policy review date** | June 2023 |

**Consultation**

|  |  |
| --- | --- |
| **Consultee** | **Date** |
| Living well with pain group | July 2018 |
| GP Membership via MSK CPG | Via MSK CPG  |
|  |  |
| Has the consultation included patient representatives? | Yes (via ECCP membership) |

**Policy sign off**

|  |  |
| --- | --- |
| **Reviewing Body** | **Date of review** |
| Effective Clinical Commissioning Policy Group | 21 June 2018 |
| Integrated Governance and Quality Committee | 18 Oct 2018 |

 **Version Control**

|  |  |  |  |
| --- | --- | --- | --- |
| **Version No** | **Type of Change** | **Date**  | **Description of Change** |
| V0.01 | New policy | 19/10/2018 | Replacement of existing policies for medial branch blocks, radiofrequency denervation, epidural injections and facet joint injections. To align policy with NICE ng59 guidance.  |
| V0.02 | Repeat epidural and nerve root blocks to be included in the policy | Jan 2020 | Amendments not agreed by Executives, Policy not changed. Review date changed to 2 years from the review to Jan 2022. |
| V0.03 | EBI Wording added | March 2021 | Wording added around Lumbar radiofrequency facet joint denervation (RFD) into Policy Statement to bring in line with EBI policy |
| V0.04 | Review date | June 2022 | Review date changed to June 2023 |