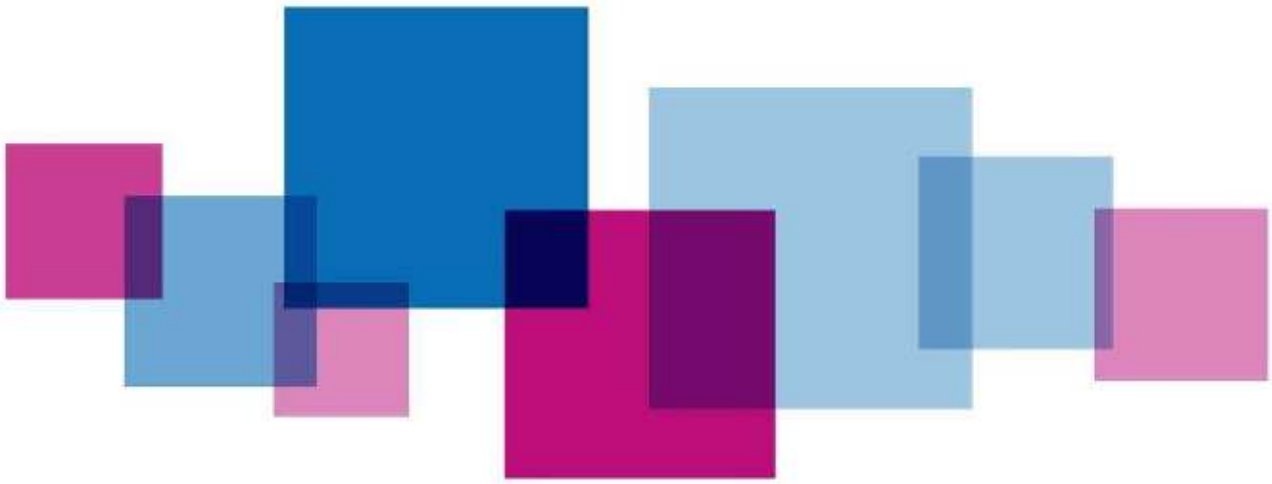
NHS
Bristol, North Somerset and South Gloucestershire
Integrated Care Board

Commissioning Policy

Management of Low Back Pain and Sciatica in over 16's

Criteria Based Access and Individual Funding Request Policy



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Document Control

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Version Control

Version	Date	Reviewer	Comment
1718.1	29/03/2017	IFR Manager	New Policy to CPRG
1718.1.01	04/12/2017	IFR Coordinator	Administration amends to clarify referral route
1718.1.02	21/02/2017	IFR Manager	Clarification with section 3 Facet Joint injections or Sacroiliac injections – in red font.
1718.1.03	28/03/2018	IFR Coordinator	Rebranded to BNSSG CCG
1819.2.00	26/10/2018	Commissioning Policy Development Support Officer	Smoking and BMI references updated, BNSSG branding refreshed, PALS update. Approved on 14th February 2019 by Commissioning Executive.
1920.1.00	24.04.2019	Commissioning Policy Development Support Officer	Statement added in to reflect NHS England Evidence Based Interventions request for due regards.
1920.1.01	23.05.2019	Commissioning Policy Development Support Officer	Admin change.
1920.1.02	03/06/2019	Commissioning Policy Development Manager	Admin Corrections for CPRG and inclusion of OPCS codes
1920.1.03		Commissioning Policy Development Manager	CPRG Feedback admin changes, update referencing link

THIS IS A CRITERIA BASED ACCESS POLICY
TREATMENT MAY BE PROVIDED WHERE PATIENTS MEET THE CRITERIA BELOW

THIS POLICY RELATES TO ALL PATIENTS OVER 16

Management of Low Back Pain and Sciatica in over 16's Policy

General Principles

Treatment should only be given in line with these general principles. Where patients are unable to meet these principles in addition to the specific treatment criteria set out in this policy, funding approval may be sought from the ICB's Exceptional Funding Request Panel.

1. Clinicians should assess the patients against the criteria within this policy prior to referring patients seeking treatment. Referring patients to secondary care that do not meet these criteria not only incurs significant costs in out-patient appointments for patients that may not qualify for surgery, but inappropriately raises the patient's expectation of treatment.
2. Patients should be given advice on self-management and care in order to be managed conservatively.
3. Patients will only meet the criteria within this policy where there is evidence that the treatment requested is effective and the patient has the potential to benefit from the proposed treatment. Where the patient has previously been provided with the treatment with limited or diminishing benefit, it is unlikely that they will qualify for further treatment and the EFR team should be approached for advice.
4. On limited occasions, the ICB may approve funding for a further assessment in secondary care only in order to confirm or obtain evidence demonstrating whether a patient meets the criteria for funding. In such cases, patients should be made aware that the assessment does not mean that they will be provided with surgery and surgery will only be provided where it can be demonstrated that the patients meets the criteria to access treatment in this policy.
5. Where funding approval is given by the Exceptional Funding Request Panel, it will be available for a specified period of time, normally one year.
6. Patients with an elevated BMI of 30 or more may experience more post-surgical complications including post-surgical wound infection so should be encouraged to lose weight further prior to seeking surgery.
https://www.sciencedirect.com/science/article/pii/S1198743X15007193 (Thelwall, 2015).

7. Patients who are smokers should be referred to smoking cessation services in order to reduce the risk of surgery and improve healing (ASH, 2016)
8. In applying this policy, all clinicians and those involved in making decisions affecting patient care will pay due regard to the need to eliminate unlawful discrimination, harassment, victimisation, etc., and will advance equality of opportunity and foster good relations between people who share a protected characteristic and those who do not. In particular, due regard will be paid in relation to the following characteristics protected by the Equality Act 2010: age, disability, sex, gender reassignment, marriage or civil partnership, pregnancy and maternity, race, religion or belief and sexual orientation.

Background / Purpose and Scope

This policy has been developed using extensively the NICE Guidance NG 59 Low Back Pain and Sciatica in over 16s. (NICE, 2016)

Patients with low back pain should be managed conservatively where possible.

NICE make a number of recommendations on how patients with low back pain are managed, including the following points:

- 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 low back pain (with or without sciatica) to inform shared decision-making about stratified management.

  Based on risk stratification, consider:

  - simpler and less intensive support for people with low back pain (with or without sciatica) are likely to improve quickly and have a good outcome (for example, reassurance, advice to keep active and guidance on self-management).
  - more complex and intensive support for people with low back pain (with or without sciatica) are at higher risk of a poor outcome (for example, exercise programmes with or without manual therapy or using a psychological approach).
- Provide people with advice and information, tailored to their needs and capabilities, to help them self-manage their low back pain (with or without sciatica), at all steps of the treatment pathway. Include:
  - information on the nature of low back pain and sciatica
  - encouragement to continue with normal activities.
- Consider a group exercise programme (biomechanical, aerobic, mind–body or a combination of approaches) within the NHS for people with a specific episode or flare-up of low back pain (with or without sciatica). Take people's specific needs,

preferences and capabilities into account when choosing the type of exercise.

- Consider manual therapy (spinal manipulation, mobilisation or soft tissue techniques such as massage) for managing low back pain (with or without sciatica), but only as part of a treatment package including exercise, with or without psychological therapy.
- Consider psychological therapies using a cognitive behavioural approach for managing low back pain (with or without sciatica) but only as part of a treatment package including exercise, with or without manual therapy (spinal manipulation, mobilisation or soft tissue techniques such as massage).
- Consider oral non-steroidal anti-inflammatory drugs (NSAIDs) for managing low back pain, taking into account potential differences in gastrointestinal, liver and cardio-renal toxicity, and the person's risk factors, including age. When prescribing oral NSAIDs for low back pain, think about appropriate clinical assessment, ongoing monitoring of risk factors, and the use of gastroprotective treatment. Prescribe oral NSAIDs for low back pain at the lowest effective dose for the shortest possible period of time.
- Consider weak opioids (with or without paracetamol) for managing acute low back pain only if an NSAID is contraindicated, not tolerated or has been ineffective.
- Consider a combined physical and psychological programme, incorporating a cognitive behavioural approach (preferably in a group context that takes into account a person's specific needs and capabilities), for people with persistent low back pain or sciatica:
    - when they have significant psychosocial obstacles to recovery (for example, avoiding normal activities based on inappropriate beliefs about their condition)

    OR

    - when previous treatments have not been effective.
- Promote and facilitate return to work or normal activities of daily living for people with low back pain with or without sciatica.

Note: Elements of this conservative management programme recommended by NICE are not commissioned by the Commissioner.

POLICY CRITERIA – COMMISSIONED

CRITERIA BASED ACCESS

Funding Approval for Surgical 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

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

a) 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 or severe levels of localised back pain (rated as 5 or more on a Visual Analogue Scale, or equivalent) at the time of referral/assessment.

Radiofrequency Denervation is only commissioned for patients with chronic low back pain after a positive response to a diagnostic medial branch block.

Continued below

2. Epidural Injections and Nerve Root Blocks

A single Epidural Injection of local anaesthetic or Nerve Root Block (with steroid) is commissioned for patients with acute and severe sciatica where:

a) The patient is unable to participate effectively in conservative pain management.

OR

b) 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.

Patients who have previously exhausted pain management therapies or have been unwilling to follow the recommendations do not qualify for treatment under this policy.

Repeat injections **should not** be routinely provided 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 – CRITERIA BASED ACCESS

These policy restrictions do not apply on the limited occasions where surgery is being planned for the following conditions:

- Facet joint arthritis including Post traumatic FJ arthritis
- Spondylolysis/spondylolisthesis
- Adult scoliosis/adult degenerative changes
- Post fusion adjacent level disease

Policy – Criteria to Access Treatment – INDIVIDUAL FUNDING PANEL APPROVAL REQUIRED

The treatments and devices listed below are not routinely funded:

3. Facet Joint Injections or sacroiliac injections

Facet joint injections or sacroiliac injections, either for diagnostic or therapeutic purposes are not routinely commissioned – *except for those conditions to which these policy restrictions do not apply (as listed in the above CBA section).*

4. Therapeutic, Multiple or Repeat Medial Branch Blocks

a) Medial Branch Blocks are not commissioned for therapeutic purposes.

b) Multiple or repeat Medial Branch Blocks ahead of a repeat Radiofrequency Denervation within an 18 month period are not commissioned. NICE have stated that the evidence supporting this is unclear and no repeat Radio Frequency Denervation should be considered if the benefit is for less than 16 months.

NICE Recommendations

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

https://www.nice.org.uk/guidance/NG59/chapter/Recommendations#assessment-of-low-back-pain-and-sciatica

For guidance please see https://remedy.bnssgccg.nhs.uk/

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.

Individual cases will be reviewed at the 's Exceptional Funding Panel upon receipt of a completed application form from the patient's GP, Consultant or Clinician. Applications cannot be considered from patients personally.

Due Regard

In carrying out their functions, the Bristol North Somerset and South Gloucestershire Commissioning Policy Review Group (CPRG) are committed to having due regard to the Public Sector Equality Duty (PSED). This applies to all the activities for which the ICB is responsible, including policy development and review.

Consideration has been given to this policy and the development process of the above criterion following the recent NHSE Evidence-Based Interventions (EBI) recommendations and local clinicians have confirmed that this criteria supports the recommendations made in regard to the current clinical evidence available.

If you would like further copies of this policy or need it in another format, such as Braille or another language, please contact the Customer Services Team on: **0117 900 2655** or **0800 073 0907** or email them on **BNSSG.customerservice@nhs.net** .

Connected Policies

N/A

This policy has been developed with the aid of the following references:

Anaesthetists, R. C. (2015). *RCOA - Core Standards for Pain Management Services in the UK*. Retrieved May 8, 2019, from RCOA: https://www.rcoa.ac.uk/document-store/core-standards-pain-management-services-the-uk

Ash. (2016). *Ash.org.uk.* Retrieved Sept 24, 2018, from www.ash.org.uk: www.ash.org.uk/briefings

Cohen SP1, B. M. (2013, May). *NCBI - Epidural steroids: a comprehensive, evidence-based review.* Retrieved May 8, 2019, from NCBI: https://www.ncbi.nlm.nih.gov/pubmed/23598728

England, N. (2019, January 11). *NHSE EBI Document.* Retrieved May 8, 2019, from NHS England: https://www.england.nhs.uk/wp-content/uploads/2018/11/ebi-consultation-response-document-v2.pdf

Hyun Jin Choi, S. H.-Y.-J. (2013, july). *International Journal of Technology Assessment in Health Care - EPIDURAL STEROID INJECTION THERAPY FOR LOW BACK PAIN: A META-ANALYSIS*. Retrieved May 8, 2019, from International Journal of Technology Assessment in Health Care: https://www.cambridge.org/core/journals/international-journal-of-technology-assessment-in-health-care/article/epidural-steroid-injection-therapy-for-low-back-pain-a-metaanalysis/1C0D25AF236EB180BA3034FF50D80CCD

NICE. (2016, November). *Low back pain and sciatica in over 16s: assessment and management.* Retrieved from NICE.ORG: https://www.nice.org.uk/guidance/ng59

Ramsin M. Benyamin, M. L. (2012). *Pain Physician - The Effectiveness of Lumbar Interlaminar*. Retrieved May 8, 2019, from Pain Physician : https://www.painphysicianjournal.com/current/pdf?article=MTcyMw%3D%3D&journal=69

Thelwall, S. (2015). Impact of obesity on the risk of wound infection following surgery: results from a nationwide prospective multicentre cohort study in England. *Clinical microbiology and infection : the official publication of the European Society of Clinical Microbiology and Infectious Diseases*, vol. 21, no. 11, p. 1008.e1.

UKSSB. (2018). *Striving to improve Spine Care in the UK*. Retrieved May 8, 2019, from United Kingdom Spine Societies Board: https://www.ukssb.com/

OPCS Procedure codes

OPCS Code: VA521, A522, A528, A529, A577, A735, V363', V368, V369, V382, V383, V384,V3 85, V386, V388, V389, V544, W903
The ICD10 Codes for low back pain are M54.5, M51.2 or (M47.8, 48.5, 48.9, 51.3, 51.8, 51.9, 54.8 or 54.9 with site code 5,6,7 or 8). There are no appropriate Codes for the clinical criteria -

for those provided as an N.b. the ICD10 Codes are: M51.0, 51.1 54.1, 54.4, 47.1 47.2, or (G55.1, 55.2, 55.3 or 99.2 with site codes 5,6,7 or 8); M48.0; M53.2