

Policy for Spinal Injections and Radiofrequency Denervation for Low Back Pain*

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Purpose	This document is part of a suite of policies that the Integrated Care Board (ICB) uses to drive its commissioning of healthcare. Each policy in that suite is a separate public document in its own right but will be applied with reference to other policies in that suite.
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Document control:		
Date:	Version Number:	Section and Description of Change
May 2021	V1.0	Ratified by Strategic Commissioning Committee
June 2021	V1.1	OPCS Codes finalised
July 2022	V1.2	Policy adopted by Lancashire and South Cumbria ICB – references to CCG replaced by ICB where relevant
September 2026	V2	Policy revised to align with NICE guidance, GIRFT recommendations, and the National Back and Radicular Pain Pathway. Clinical criteria for spinal injections and radiofrequency denervation have been clarified and expanded, exclusions have been added, and guidance on multidisciplinary care, rehabilitation, and repeat procedures has been incorporated.

1. Policy

- 1.1 This policy applies to those aged 16 years and over.
- 1.2 Spinal injections for non-specific low back pain are not routinely commissioned (this includes all injections such as facet joint injections, therapeutic medial branch blocks and intradiscal therapy together with prolotherapy and trigger point injections e.g. botulinum toxin – this list is not exclusive).
- 1.3 Epidural injections for neurogenic claudication in people with central spinal canal stenosis are not routinely commissioned.
- 1.4 Epidural injections of local anaesthetic and steroid or selective nerve root blocks are routinely commissioned for people with acute and severe sciatica.
- 1.5 Radiofrequency denervation of the facet joint for a person with chronic low back pain is routinely commissioned in the following circumstances: -
 - 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, as confirmed by a positive response to a diagnostic medial branch block within the last 6 months
 - AND**
 - they have moderate or severe levels of localised back pain (rated as 5 or more on a visual analogue scale, or equivalent).
- 1.6 Ensure all patients undergoing radiofrequency denervation have received a rehabilitation programme tailored to their needs and continue to commit to long term self-management of their rehabilitation.
- 1.7 A repeat denervation procedure is allowed at a frequency of not less than two years.

Notes for clinicians:

Please also refer to NHS England BestMSK guidance toolkit for primary and community care – Spinal pain/sciatica. This guidance can be found on the BestMSK Health Collaborative workspace on the NHS England NHS Futures website FutureNHS Home - FutureNHS Collaboration Platform

1.8 Exclusions

The following indications are considered outside the scope of this policy and are therefore excluded:-

- Conditions with a select and uniform pathology of a mechanical nature (for example, spondylolisthesis, scoliosis, vertebral fracture or congenital diseases) **OR**
- Conditions of a non-mechanical nature (for example, ankylosing spondylitis or diseases of the viscera) **OR**

- Sacroiliac joint dysfunction.

1.8.1 This policy applies to the therapeutic use of spinal injections. When these are being used diagnostically, this is considered to be outside the scope of the policy and are therefore excluded.

1.8.2 In line with the Getting It Right First Time (GIRFT) pathway (October 2023), it is recommended that:-

- emergency (i.e. same day) referral is made for patients with back pain and symptoms of Cauda Equina Syndrome **OR**
- urgent (i.e. within 2 weeks) referral with sudden onset of back pain without Cauda Equina Syndrome symptoms.

Otherwise, cauda equina syndrome is considered to be outside the scope of this policy.

** Nominally the title of the policy is “low back pain” but NICE recognises that this term is synonymous with non-specific, mechanical, musculoskeletal or simple low back pain*

*¹ **Symptoms of CES:** difficulty in micturition, altered perianal, perineal or genital sensation S2-S5 dermatomes, neurological deficit of both legs, loss of sensation of rectal fullness, sexual dysfunction. (NB this list is not exhaustive). Please see full pathway.*

2. Scope and definitions

2.1 This policy is based on the ICB’s Statement of Principles for Commissioning of Healthcare (version in force on the date on which this policy is adopted).

2.2 This policy applies to people aged 16 years and over for whom spinal injections or radiofrequency denervation are being considered for the management of low back pain or sciatica.

2.3 For the purposes of this policy:

- Low back pain means pain or stiffness between the lower rib margin and the buttock creases that is not attributable to a specific underlying pathology. It may also be described as non-specific, mechanical, musculoskeletal or simple low back pain.
- Sciatica or radicular pain means pain arising from irritation or compression of a lumbosacral nerve root, typically experienced predominantly in the leg.
- Spinal injections include facet joint injections, therapeutic medial branch blocks, intradiscal therapy, prolotherapy, trigger point injections and other injections into spinal joints or tissues. This list is not exhaustive.
- Epidural injection means the administration of local anaesthetic and steroid into the epidural space.
- Radiofrequency denervation means a percutaneous procedure using radiofrequency energy to disrupt the medial branch nerves supplying a painful facet joint.

- 2.4 This policy covers the therapeutic use of these interventions. Diagnostic medial branch blocks undertaken to establish suitability for radiofrequency denervation are outside the therapeutic scope of the policy, although a positive response to a diagnostic block is required by the policy criteria.
- 2.5 The policy does not cover back pain associated with infection, trauma or vertebral fracture, inflammatory disease, congenital or structural spinal pathology, scoliosis, spondylolisthesis, suspected cancer, metastatic spinal cord compression, sacroiliac joint dysfunction, progressive neurological deficit or suspected cauda equina syndrome. Where serious underlying pathology or cauda equina syndrome is suspected, the patient should be managed through the relevant urgent or emergency clinical pathway.
- 2.6 A patient's pain, distress, clinical suitability for an intervention or wish to receive NHS-funded treatment places them within the group to whom this policy applies and does not, in itself, demonstrate exceptionality.

3. Appropriate Healthcare

- 3.1 Spinal injections of steroid and anaesthetic are invasive treatments that are used in two ways:
- First (Diagnostic): Selective nerve root block can be used to diagnose the source of radicular back pain. Medial branch block is recognised as a diagnostic tool to identify the source of the pain.
 - Second (Therapeutic): epidural injections and radiofrequency denervation have been used as treatments to relieve radicular pain and specific back pain respectively.
- 3.2 The ICB regards the achievement of this purpose as according with the Principle of Appropriateness. Therefore, this policy does not rely on the principle of appropriateness. Nevertheless, if a patient is considered exceptional in relation to the principles on which the policy does rely, the ICB may consider the principle of appropriateness in the particular circumstances of the patient in question before confirming a decision to provide funding.

4. Effective Healthcare

- 4.1 The ICB has considered the updated evidence review alongside NICE guideline NG59, Evidence-Based Interventions guidance, GIRFT recommendations and the National Back and Radicular Pain Pathway.
- 4.2 The evidence does not support the routine use of spinal injections for non-specific low back pain. Evidence for facet joint injections and other therapeutic spinal injections is limited, inconsistent and generally of low quality, with no clear evidence of sustained clinical benefit. Epidural injections for neurogenic claudication in people with central spinal canal stenosis are therefore not routinely commissioned.

- 4.3 Epidural injections of local anaesthetic and steroid may provide short-term improvement in pain and function for appropriately selected people with acute and severe sciatica. These interventions are therefore commissioned only in the circumstances set out in the policy criteria and when delivered using appropriate image guidance.
- 4.4 The evidence for radiofrequency denervation is more favourable for selected people with chronic localised low back pain where conservative treatment has not worked and a diagnostic medial branch block indicates that the facet joint is the likely source of pain. Evidence regarding the long-term effectiveness and optimal timing of repeat procedures remains limited; consequently, repeat denervation is commissioned no more frequently than once every two years.
- 4.5 The evidence review found limited or no evidence to support routine spinal injections for the conditions excluded from this policy. This policy therefore relies on the Principle of Effectiveness.
- 4.6 Where an application is made on the basis of clinical exceptionality, it should explain why the patient is materially different from the wider group covered by the policy and provide robust evidence that the requested intervention is likely to deliver a clinically meaningful and sustained benefit for that individual.

5. Cost Effectiveness

- 5.1 The ICB has not considered the cost-effectiveness of spinal injections since they do not meet the principle of effectiveness and therefore this policy does not rely on the Principle of Cost-Effectiveness. Nevertheless, if a patient is considered exceptional in relation to the principles on which the policy does rely, the ICB may consider whether the treatment is likely to be cost-effective in this patient before confirming a decision to provide funding.
- 5.2 The ICB has noted NICE guidance (NG59) states that the length of pain relief after radiofrequency denervation is uncertain. Pain relief for more than 2 years would not be an unreasonable clinical expectation.

6. Ethics

- 6.1 The ICB has not called into question the ethics of spinal injections since they do not meet the principle of effectiveness and therefore this policy does not rely on the Principle of Ethics. Nevertheless, if a patient is considered exceptional in relation to the principles on which the policy does rely, the ICB may consider whether the treatment is likely to raise ethical concerns in this patient before confirming a decision to provide funding.

7. Affordability

- 7.1 The ICB has not called into question the affordability of spinal injections since they do not meet the principle of effectiveness and therefore this policy does not rely on the Principle of Affordability. Nevertheless, if a patient is considered exceptional in relation to the principles on which the policy does rely, the ICB may consider whether

the treatment is likely to be affordable in this patient before confirming a decision to provide funding.

8. Exceptions

- 8.1 The ICB will consider exceptions to this policy in accordance with the Policy for Considering Applications for Exceptionality to Commissioning Policies.
- 8.2 In the event of inconsistency, this policy will take precedence over any non-mandatory NICE guidance in driving decisions of this ICB. A circumstance in which a patient satisfies NICE guidance but does not satisfy the criteria in this policy does not amount to exceptionality.

9. Force

- 9.1 This policy remains in force until it is superseded by a revised policy or by mandatory NICE guidance relating to this intervention, or to alternative treatments for the same condition.
- 9.2 In the event of NICE guidance referenced in this policy being superseded by new NICE guidance, then:
 - If the new NICE guidance has mandatory status, then that NICE guidance will supersede this policy with effect from the date on which it becomes mandatory.
 - If the new NICE guidance does not have mandatory status, then the ICB will aspire to review and update this policy accordingly. However, until the ICB adopts a revised policy, this policy will remain in force and any references in it to NICE guidance will remain valid as far as the decisions of this ICB are concerned.

10. References

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11. OPCS/ICD Codes

OPCS codes
V544 - Injection around spinal facet of spine
A735 - Injection of therapeutic substance around peripheral nerve
O423 - Medial branch of lumbosacral spinal nerve
O428 - Specified medial branch of spinal nerve NEC
V623 - Primary percutaneous intradiscal radiofrequency thermocoagulation to lumbar intervertebral disc
V628 - Other specified primary percutaneous intradiscal radiofrequency thermocoagulation to intervertebral disc
Z998 - Specified intervertebral disc NEC
X305 - Injection of sclerosing substance NEC
X375 - Intramuscular injection for local action
Z675 - Lumbar intervertebral joint
Z676 - Lumbosacral joint
Z677 - Sacrococcygeal joint
A521 - Therapeutic lumbar epidural injection
A522 - Therapeutic sacral epidural injection
A573 - Radiofrequency controlled thermal destruction of spinal nerve root
A574 - Injection of destructive substance into spinal nerve root
A575 - Destruction of spinal nerve root NEC
A577 - Injection of therapeutic substance around spinal nerve root
V485 - Radiofrequency controlled thermal denervation of spinal facet joint of lumbar vertebra
V487 - Radiofrequency controlled thermal denervation of spinal facet joint of vertebra NEC
ICD codes

M545 - Low back pain G951 - Vascular myelopathies M4800 - Spinal stenosis - Multiple sites in spine M4805 - Spinal stenosis - Thoracolumbar region M4806 - Spinal stenosis - Lumbar region M4807 - Spinal stenosis - Lumbosacral region M4808 Spinal stenosis - Sacral and sacrococcygeal region M543 - Sciatica M544 - Lumbago with sciatica
OPCS codes (<i>additional that may be used</i>)
A528 - Other specified therapeutic epidural injection V486 - Denervation of spinal facet joint of lumbar vertebra NEC V488 - Other specified denervation of spinal facet joint of vertebra V489 - Unspecified denervation of spinal facet joint of vertebra
OPCS (Exclusion) codes
Y531 - Approach to organ under radiological control Y532 - Approach to organ under ultrasonic control

Appendix 1: Terms and abbreviations

Term or abbreviation	Definition as used in the policy
Epidural injection	The introduction of a drug (in this case anaesthetic or steroid) into the space around the dura mater of the spinal cord via a needle or canula.
Facet joints	The small joints in between the vertebrae, two connections above each vertebra, one on each side, and two below
Facet joint injections	Injections of local anaesthetic or steroid into the facet joints.
Low back pain	Soreness or stiffness in the back, between the bottom of the rib cage and the top of the legs.
Lumbar	Relating to the major component lower spine. The lower spine also contains the sacrum and coccyx.
Medial branch blocks	Injections of local anaesthetic on to the medial branch nerves that serve the facets joints.
NICE	National Institute for Health and Care Excellence
Low back pain	Low back pain not associated with cancer, fracture, infection or an inflammatory disease process. Also described as mechanical, musculoskeletal or simple low back pain. Includes paraspinal pain. Covers about 90% of low back pain.
Radicular pain/ radicular syndromes/ radiculopathy	Pain felt along the sensory distribution of a nerve due to inflammation or pressure at the nerve root. For example, pressure of the L5 nerve root can cause pain felt down the leg and into the big toe.
Radiofrequency denervation, aka radiofrequency lesioning (RFL)	A minimally invasive and percutaneous procedure, where radiofrequency energy is delivered along a needle in contact with the target nerve to denature it. The nerves may regenerate over time.
Sciatica	Leg pain secondary to lumbosacral nerve root pathology. A form of radiculopathy.
Spinal injections	A broad term encompassing injections into various parts of the spine, including joints and nervous tissue.