NHS
Lancashire and South Cumbria
Integrated Care Board

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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Author (inc Job Title):	
Ratified by: (Name of responsible Committee)	ICB Board (adopted 1 July 2022)
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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

1. Policy

1.1 Invasive, non-surgical interventions and treatments for low back pain and sciatica must be considered in line with NICE NG59, the National Low Back and Radicular Pain Pathway, and Evidence Based Interventions, 2019 wave and 2021 wave. Clinical review or triage should establish whether the pain is non-specific or specific low back pain or back pain with radicular pain (sciatica).

1.2 Spinal Injections for low back pain

1.2.1 The ICB considers that, in line with NICE Guidance NG59, spinal injections for managing low back pain do not accord with the Principle of Effectiveness, therefore the ICB will **not routinely commission** this intervention.

1.3 Spinal Injections - Low back pain with Radicular pain (sciatica)

1.3.1 An early clinical review should be undertaken in line with the National Back and Radicular Pain Pathway to ensure emergency symptoms such as impending cord compression or cauda equina are treated rapidly.

1.3.2 The use of non-pharmacological (physiotherapy, psychological therapies, exercise) and pharmacological interventions, including self-management, should be optimised prior to injection therapy. The injection should only be given as part of package of multi-disciplinary care with a current service provider.

1.3.3 The ICB will commission one therapeutic epidural steroid injection of the lumbar spine for the management of radicular pain when the following criteria are satisfied:

1.3.3.1 The patient has acute and severe sciatica and

AND

1.3.3.2 The injection is part of a comprehensive multi-disciplinary package of care

1.3.4 The ICB will commission medial branch blocks for diagnostic purposes, as a prerequisite for radiofrequency denervation.

1.4 Radiofrequency denervation

1.3.5 The ICB will commission one radiofrequency denervation procedure for a person with chronic low back pain with radicular pain in the following circumstances:

1.3.5.1 non-surgical treatment has not worked for them

AND

1.3.5.2 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

1.3.5.3 they have moderate or severe levels of localised back pain (rated as 5 or more on a visual analogue scale, or equivalent)

AND

1.3.5.4 the treatment is part of package of multi-disciplinary care with a current service provider

2. Scope and definitions

2.1 The scope of this policy includes the use of spinal injections, including facet joint injections and epidural injections of steroid and anaesthetic and radiofrequency denervation for the management of low back pain in patients over the age of 16 years.

2.2 The scope of this policy does not include the specific management of back pain related to related to the following conditions:

- Infection
- Trauma (e.g. fractured spine which may need vertebroplasty or kyphoplasty as approved by NICE)
- Inflammatory disease such as spondyloarthritis
- The evaluation of people with sciatica with progressive neurological deficit or cauda equina
- Scoliosis
- Spinal injury
- Metastatic spinal cord compression
- Suspected cancer
- Sacroiliac joint pain

If serious underlying pathology is suspected refer to the relevant NICE guidance.

2.3 The ICB recognises that a patient may have certain features, such as

- having back pain,
- wishing to have a service provided for back pain,
- being advised that they are clinically suitable for spinal injections, and
- being distressed by their back pain, and by the fact that that they may not meet the criteria specified in this commissioning policy.

Such features place the patient within the group to whom this policy applies and do not make them exceptions to it.

2.4 There are two groups of pathologies that commonly affect the lumbar spine and cause back pain for which injections have been considered. These groups respond differently to injection therapy. Before treatment, patients need adequate assessment by a multi-disciplinary team and management approach to make a diagnosis or diagnoses. Injections may be part of the diagnosis process (diagnostic blocks).

2.5 For the purpose of this policy the ICB follows the definitions used in NICE guidance NG59. The groups are as follows:

a. **Radicular pain** - Patients with nerve root compression irritation and/or inflammation. Patients typically present with predominantly leg pain or sciatica. The two most common causes of radicular pain are prolapsed (herniated) intervertebral disc and spinal canal stenosis. Patients should be managed on an explicit care pathway with explicit review and decision points.

Injection therapy for radicular pain in a carefully selected patient is an appropriate procedure and is therefore funded in certain circumstances. See section 2.4 for eligibility criteria.

b. **Low back pain** – is low back pain not attributable to a specific pathology or cause. It is not associated with potentially serious causes (e.g. infection, tumour, fracture, structural deformity, inflammatory disorder, radicular syndrome, or cauda equina syndrome). The management of non-specific low back pain represents a challenge in health care provision.

Low back pain has been described in the literature as ‘non-specific’, ‘mechanical’, ‘musculoskeletal’ or ‘simple’ low back pain (NG59).

Injection therapy is not an appropriate procedure for low back pain, as advised by NICE NG59, and is therefore not funded.

2.6 Relevant evidence and guidelines have been reviewed including the recommendations of:

- NICE quality standard published 27July 2017 https://www.nice.org.uk/guidance/qs155
- NICE guidance NG59 published 30 November 20161 https://www.nice.org.uk/guidance/ng59
- National Low Back and Radicular Pain Pathway. Third Ed. 3.0 30th June 20172
- Evidence-Based Interventions Guidance3,4

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 NICE guidance (NG59) which states that spinal injections have a role in the treatment of acute sciatica in specified circumstances and similarly that radiofrequency denervation is effective in certain circumstances.

4.2 The ICB has considered the role of spinal injections in the management of low back pain (excluding sciatica) and found that no consistent good quality evidence recommended the use of spinal injections for the management of low back pain; therefore they do not meet the principle of effectiveness.

4.3 This policy relies on the Principle of Effectiveness. Nevertheless, if a patient is considered exceptional in relation to this principle, the ICB may consider whether the treatment is likely to be effective in this patient in deciding whether or not to provide funding.

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. The economic model presented suggested that radiofrequency denervation is likely to be cost effective if pain relief is above 16 months.

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

NICE Guidance NG59 (November 2016) Low back pain and sciatica in over 16s assessment and management
https://www.nice.org.uk/guidance/ng59/resources/low-back-pain-and-sciatica-in-over-16sassessment-and-management-1837521693637

National Low Back and Radicular Pain Pathway. Third Edition 3.0 30th June 2017.
https://ba17bc65-2f2f-4a2f-9427-cd68a3685f52.filesusr.com/ugd/dd7c8a_caf17c305a5f4321a6fca249dea75ebe.pdf

Evidence-Based Interventions: Guidance for Clinical Commissioning Groups ICBs). NHS England and NHS Improvement. 20 November 2018.
https://www.england.nhs.uk/publication/evidence-based-interventions-guidance-for-clinical-commissioning-groups-ICBs/

Evidence-Based Interventions. List 2 Guidance. Academy of Royal Colleges. November 2020
https://www.aomrc.org.uk/wp-content/uploads/2020/12/EBI_list2_guidance_050121.pdf

11. Associated OPCS codes

OPCS Procedure codes	
A521	Therapeutic lumbar epidural injection
A522	Therapeutic sacral epidural injection
A528	Other specified therapeutic epidural injection
A529	Unspecified therapeutic 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
V486	Denervation of spinal facet joint of lumbar vertebra NEC
V487	Radiofrequency controlled thermal denervation of spinal facet joint of vertebra NEC
V488	Other specified denervation of spinal facet joint of vertebra
V489	Unspecified denervation of spinal facet joint of vertebra
V544	Injection around spinal facet of spine
Only with appropriate anatomical codes	
W903	Injection of therapeutic substance into joint
X382	Injection of steroid for local action NEC
Anatomical codes	
Z675	Lumbar intervertebral joint
Z676	Lumbosacral joint
Z677	Sacrococcygeal joint
Z993	Intervertebral disc of lumbar spine
ICD 10 Diagnostic codes	
M431	Spondylolisthesis
M461	Sacroiliitis, not elsewhere classified
M472	Other spondylosis with radiculopathy
M478	Other spondylosis
M479	Spondylosis, unspecified
M480	Spinal stenosis
M511	Lumbar and other intervertebral disc disorders with radiculopathy
M512	Other specified intervertebral disc displacement
M518	Other specified intervertebral disc disorders
M519	Intervertebral disc disorder, unspecified
M533	Sacrococcygeal disorders, not elsewhere classified
M541	Radiculopathy
M543	Sciatica

M544	Lumbago with sciatica
M545	Low back pain
M549	Dorsalgia, unspecified

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.