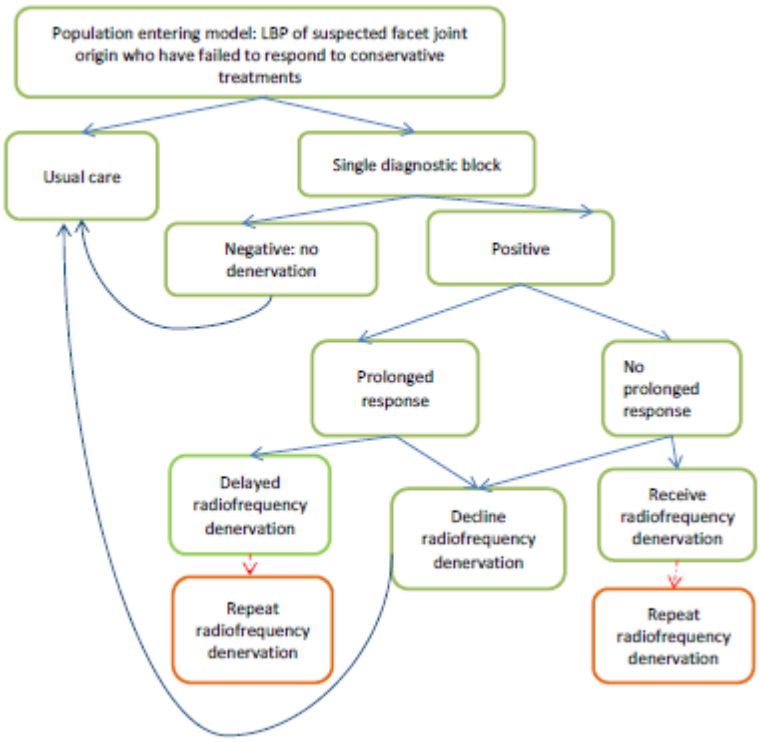
Placename CCG

Policies for the Commissioning of Healthcare

Policy for Managing Back Pain- Spinal Injections and Radiofrequency Denervation

1	**Introduction**
1.1	This document is part of a suite of policies that the CCG 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 polices in that suite.
1.2	This policy is based on the CCGs Statement of Principles for Commissioning of Healthcare (version in force on the date on which this policy is adopted).
2	**Policy**
2.1	**Spinal injections** Invasive, non-surgical interventions and treatments for low back pain and sciatica must be considered in line with NICE NG59 published 30.11.2016.
2.1.1	**Radicular pain** An initial assessment should be undertaken in line with NICE guidance, including the consideration of red flags and a validated tool and the use of non-pharmacological & pharmacological interventions, including self-management, should be **optimised prior to injection therapy.** **Eligibility criteria:** When all the following criteria are satisfied the CCG will commission a maximum of two spinal facet joint and caudal injections prior to Consultant referral for further management. A maximum of two further therapeutic injections will be funded within any individual treatment cycle prior to patient discharge or surgical referral: **a)** Selective nerve root blocks or DRG block can be used for diagnostic purposes in people with **acute and severe sciatica**. **b)** Epidural injections (nerve root block, dorsal root ganglion block, DRG) with local anaesthetics and steroids for radicular pain (neck & back) will only be funded in people with **acute and severe sciatica.** **c)** Injections must be part of a multimodal, multidisciplinary management plan (injection + medications + physiotherapy +/- CBT)
2.1.2	**Non-specific low back pain (NSLBP)**

	Spinal injections for managing NSLBP should not be offered, in line with NICE Guidance, NG59.
2.1.3	**Specific low back pain** An initial assessment should be undertaken in line with NICE guidance, including the consideration of red flags and a validated tool and the use of non-pharmacological & pharmacological interventions, including self-management, should be **optimised prior to injection therapy.** There are multiple possible causes for "Specific low back pain" and consequently the following evidence-based injections could be considered in the following circumstances: ✓ **For Myofascial pain**: o Trigger points injection and if positive Botox injection ✓ **Failed back surgery (epidural scar tissue**) o Release of Epidural adhesions (Adhesiolysis) o Spinal cord stimulation ✓ **Sacroiliac joint (SIJ) stress/ osteoarthritis (after diagnostic block)** o **Radiofrequency Lesion (RFL) denervation** of SIJ (after positive diagnostic block) ✓ **Facet joints pain (after positive medial branch block)** o Facet Joints injection (FJI) o **RFL denervation** of lumbar facets (after positive block) ✓ **Fractured vertebra (osteoporosis or cancer)** o Percutaneous Vertebroplasty or Kyphoplasty ✓ **Discogenic pain (positive discography)** o Percutaneous discectomy (RFL or Mechanical) ✓ **Lumbar sympathetic nerves pathology (after diagnostic sympathetic block)** o Lumbar sympathetic ablation (phenol, alcohol or RFL) **Eligibility criteria:** • Patient assessment & injection must be performed by a clinician trained in back pain assessment, diagnosis and management as part of a full MDT management plan approach. • The CCG will fund a maximum number of two caudal epidurals for specific low back pain before Consultant referral for further management • A maximum of two further therapeutic epidural injections will be funded within any individual treatment cycle prior to patient discharge or surgical referral.
2.2 **2.2.1**	**Radiofrequency denervation** **Consider referral for assessment for radiofrequency denervation for people with chronic low back pain when:** a. Non-surgical treatment has not worked for them **AND**

	b. the main source of pain is thought to come from structures supplied by the medial branch nerve (positive diagnostic medial branch block) **AND** c. 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'
2.2.2	The CCG will commission radiofrequency denervation in the following circumstances: a. In people with chronic low back pain following a positive response to a diagnostic medial branch block b. Current NICE guidance and The National Low Back and Radicular Pain Pathway 2017 have been utilised in the development of this guidance, however clinical experience and best practice has been also been considered. Given nerves generally recover after 6 to 9 months following the denervation procedure meaning the pain could return, the CCG will commission repeat radiofrequency denervation after a period of 6 months, provided the discharge criteria set out in section 8.3.3 below are met.
2.2.3	The following patient discharge criteria must be adhered to by all clinicians following radiofrequency denervation treatment: • Patients must be discharged from the service post denervation if pain relief is >50% for a period of >4 months. • Should a new referral be required this must be accompanied by completion of a new assessment within primary care. Pathway as follows: **Figure 1: Pathway in the model**  https://docs.wixstatic.com/ugd/dd7c8a_caf17c305a5f4321a6fca249dea75ebe.pdf

3	**Scope and definitions**
3.1	The scope of this policy includes the use of spinal injections and radiofrequency denervation for the management of low back pain in patients over the age of 16 years.
3.2	The scope of this policy does not include the specific management of back pain related to red flags or the management of low back pain related to the following conditions: • Infection • Trauma (e.g. fractured spine which may need vertebroplasty or kyphoplasty as approved by NICE) https://www.nice.org.uk/guidance/ta279 • Inflammatory disease such as spondyloarthritis https://www.nice.org.uk/guidance/ng59/chapter/Recommendations#assessment-of-low-back-pain-and-sciatica • The evaluation of people with sciatica with progressive neurological deficit or cauda equina • Scoliosis **Red Flags** Consider specifically if there are features of the conditions below. If serious underlying pathology is suspected refer to the relevant NICE guidance: • Spondyloarthritis http://www.nice.org.uk/guidance/ng65 • Spinal injury http://www.nice.org.uk/guidance/ng41 • Metastatic spinal cord compression http://www.nice.org.uk/guidance/cg75 • Suspected cancer http://www.nice.org.uk/guidance/ng12
3.3	The CCG 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.
3.4	There are three groupings of pathologies that commonly affect the lumbar spine and cause back pain for which injections have been considered. These groups however, are very different in their response to injection therapy. Before treatment, patients need adequate assessment within a multi-disciplinary team and management approach to make a diagnosis or diagnoses. Injections could be part of the diagnosis process (diagnostic block). For the purpose of this policy the CCG defines the groups 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 8.2.1 for eligibility criteria. **B) Non-specific low back pain (NSLBP)** – is low back pain not attributable to a specific pathology/ 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. NSLBP is also known as low back pain, mechanical, musculoskeletal or simple low back pain (NG59) Injection therapy is not an appropriate procedure for NSLBP, as advised by NICE NG59, and is therefore not funded. **(C) Specific low back pain** - is back pain attributed to a specific pathology or cause. Specific back pain can have multiple causes including: Myofascial pain, specific disc bulge, failed back surgery, fracture vertebra, inflammation /stress of Sacroiliac or facet joints (after positive diagnostic block) or lumbar sympathetic nerves pathology. Injection therapy for specific low back pain in carefully selected patients within a multi-disciplinary team management approach is an appropriate procedure and is therefore funded in certain circumstances. See section 8.2.3 for eligibility criteria.
3.5	Relevant evidence and guidelines have been reviewed including taking into account the recommendations of : • NICE quality standard published 27July 2017 https://nice.org.uk/guidance/qs155 • NICE guidance published 30th November 2016 https://www.nice.org.uk/guidance/ng59 • NHSE National Pathway of Care for Low Back Pain & Radicular Pain December 2014 http://rcc-uk.org/wp-content/uploads/2015/01/Pathfinder-Low-back-and-Radicular-Pain.pdf • Royal College of Surgeons Commissioning Guide: Low back pain 2013 and NHSE Guide to Commissioners of Spinal Services January 2013 • NHS RightCare https://www.england.nhs.uk/rightcare/
4	**Appropriate Healthcare**

4.1	Spinal facet joint and epidural injections 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 diagnose the source of facet joints pain. • Second (**Therapeutic**): spinal facet joint injections and epidural injections are used as a treatment to relieve both radicular and specific pain low back pain.
4.2	The CCG 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 CCG may consider the principle of appropriateness in the particular circumstances of the patient in question before confirming a decision to provide funding.
5	**Effective Healthcare**
5.1	The following policy criteria rely on the principle of effectiveness: • The criterion at section 8.2.2 relating to NSLBP as NICE NG59 states there was no consistent good quality evidence to recommend the use of spinal injections for the management of non-specific low back pain. There was minimal evidence of benefit from injections, and reason to believe that there was a risk of harm, even if rare.
6	**Cost Effectiveness**
6.1	The CCG does not call into question the cost-effectiveness of spinal facet joint and caudal injections 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 CCG may consider whether the treatment is likely to be Cost Effective in this patient before confirming a decision to provide funding.
7	**Ethics**
7.1	The CCG does not call into question the ethics of spinal facet joint and caudal injections 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 CCG may consider whether the treatment is likely to raise ethical concerns in this patient before confirming a decision to provide funding.
8	**Affordability**
8.1	The CCG does not call into question the affordability of spinal facet joint and caudal injections 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 CCG may consider whether

	the treatment is likely to be affordable in this patient before confirming a decision to provide funding.
9	**Exceptions**
9.1	The CCG will consider exceptions to this policy in accordance with the Policy for Considering Applications for Exceptionality to Commissioning Policies.
9.2	In the event of inconsistency, this policy will take precedence over any non-mandatory NICE guidance in driving decisions of this CCG. A circumstance in which a patient satisfies NICE guidance but does not satisfy the criteria in this policy does not amount to exceptionality.
10	**Force**
10.1	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.
10.2	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 CCG will aspire to review and update this policy accordingly. However, until the CCG 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 CCG are concerned.
11	**References**
	NHS England (2013) Guide to the Commissioners of Spinal Services http://www.nationalspinaltaskforce.co.uk/pdfs/NHSSpinalReport_vis7%2030.01.13.pdf Royal College of Surgeons Commissioning Guide: Low back pain 2013 http://www.rcseng.ac.uk/healthcare-bodies/docs/commissioning-guides-boa/lower-back-paincommissioning-guide NHS Guidelines CG 88 (May 2009) Low Back Pain in Adults: Early Management https://www.nice.org.uk/Guidance/CG88 NHS England National Pathfinder Projects (December 2014) National Pathway of Care for Low Back and Radicular Pain *(Report of the Clinical Group)* http://www.rcseng.ac.uk/healthcare-bodies/docs/pathfinder-low-back-and-radicular-pain NHS Wiltshire CCG “Managing Back Pain - Spinal Facet Joint and Epidural Injections Policy” (July 2014)

	http://www.wiltshireccg.nhs.uk/wp-content/uploads/2013/12/Managing-Back-Pain-Spinal-Facet-Joint-and-Epidural-Injections-Policy-AMENDED.pdf NHS Shropshire CCG "PROCEDURES OF LIMITED CLINICAL VALUE POLICY" (September 2015) http://www.shropshireccg.nhs.uk/download.cfm?doc=docm93jijm4n2001.pdf&ver=12190 NHS Guidelines 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

Date of adoption
Date for review