

LOW BACK PAIN WITH OR WITHOUT SCIATICA CRITERIA BASED ACCESS (CBA)

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Application Form	EBI Generic application form if appropriate to apply

**LOW BACK PAIN WITH OR WITHOUT SCIATICA
CRITERIA BASED ACCESS (CBA) POLICY**

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VERSION CONTROL

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DOCUMENT CHANGE HISTORY		
Version	Date	Comments
1718.v2 July	August 2017	Correction of spelling Update with NICE cg173 on page 6
1718.v2b	February 2019	House styling updated, Background data removed, wording from NHSE EBI statutory policy, inclusion of wording 'with and without sciatica'
1920.v3	January 2020	Inclusion of guidance documents & Radiofrequency Denervation commissioned, OASIS review
1920.v3b	September 2020	Amend RFD wording to include' is commissioned for LBP +/- without sciatica with a positive response to MBB

Equality Impact Assessment (EIA) Form OR EIA Screening Form completed. Date:	January 2019
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1 GENERAL PRINCIPLES

- 1.1 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 CCG's Evidence Based Interventions Panel (EBIP) by submission of an EBI application
- 1.2 Clinicians should assess their patients against the criteria within this policy prior to a referral and/or treatment
- 1.3 Treatment should only be undertaken where the criteria have been met and 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
- 1.4 Referring patients to secondary care without them meeting the criteria or funding approval having been secured 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
- 1.5 On limited occasions, the CCG may approve funding for an assessment 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
- 1.6 Patients should be advised being referred does not confirm that they will receive treatment or surgery for a condition as a consent discussion will need to be undertaken with a clinician prior to treatment
- 1.7 Where funding approval is given by the Evidence Based Interventions Panel, it will be available for a specified period of time, normally one year
- 1.8 Funding approval will only be given where there is evidence that the treatment requested is effective and the patient has the potential to benefit from the proposed treatment. Where it is demonstrated that patients have previously been provided with the treatment with limited or diminishing benefit, funding approval is unlikely to be agreed
- 1.9 Funding approval must be secured by primary care/secondary care prior to referring/treating patients seeking surgery
- 1.10 The CCG does not commission surgery for cosmetic purposes alone
- 1.11 The policy does not apply to patients with suspected malignancy who should continue to be referred under 2 week wait pathway rules for assessment and testing as appropriate

1.12 Patients with an elevated BMI of 30 or more are likely to receive fewer benefits from surgery and should be encouraged to lose weight further prior to seeking surgery. In addition, the risks of surgery are significantly increased (Thelwall, 2015)

1.13 Patients who are smokers should be referred to smoking cessation services in order to reduce the risk of surgery and improve healing

2 **BACK FACTS**

Appendix 1- Page 8

3 **CRITERIA - LOW BACK PAIN with SCIATICA**

3.1 **Repeat** injections for low back pain 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

3.2 **A single Epidural Injection and Nerve Root Block** will be commissioned for patients with acute and severe sciatica who met the criteria below;

- a patient is unable to participate effectively in conservative pain management **OR**
- a Specialist Pain or Trauma & Orthopaedic clinician judges that **a single** injection is necessary and appropriate to enable participation by the patient in a Conservative Pain Management Programme

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

3.4 **Radio Frequency Denervation – refer to item 5**

3.5 For recommendations on pharmacological management of sciatica, see NICE's guideline on neuropathic pain in adults

<https://www.nice.org.uk/guidance/cg173>

- Offer a choice of amitriptyline, duloxetine, gabapentin or pregabalin as initial treatment for neuropathic pain (except trigeminal neuralgia)
- If the initial treatment is not effective or is not tolerated, offer one of the remaining 3 drugs, and consider switching again if the second and third drugs tried are also not effective or not tolerated
- Consider tramadol only if acute rescue therapy is needed (see [treatments that should not be started in non-specialist settings](#) about long-term use)

- Consider capsaicin cream for people with localised neuropathic pain who wish to avoid, or who cannot tolerate, oral

4 CRITERIA - LOW BACK PAIN without SCIATICA

4.1 Spinal injections for nonspecific low back pain **is not commissioned** by the CCG

4.2 For other medication treatment options see the Somerset CCG Formulary <https://somersetccg.nhs.uk/about-us/how-we-do-things/prescribing-and-medicines-management/prescribing/>

4.3 **Radio Frequency Denervation – refer to item 5**

5 Radio Frequency Denervation

Is routinely commissioned and can be offered according to NICE guideline (NG59)

- Radiofrequency denervation can be offered to both those with LBP +/- sciatica where there is a positive response to Medial Branch Block (MBB)
- where non-surgical and alternative treatments have been tried and has not worked **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 (MBB)

6 FLOW CHART

Appendix 2 – Page 9

7 Treatments, interventions and devices listed below **are not routinely funded** for the treatment of Low Back Pain with or without sciatica

- | | |
|--|--|
| • Facet joint injections | • Traction |
| • Trigger Point Injections with any agent, including botulinum toxin | • Acupuncture |
| • Intradiscal therapy | • Ultrasound |
| • Prolotherapy | • Spinal Fusion |
| • Interferential Therapy | • Disc Replacement |
| • Percutaneous Electrical Nerve Simulation (PENS) | • Belts or Corsets |
| • Transcutaneous Electrical Nerve Simulation (TENS) | • Epidural injections for neurogenic claudication in people who have central spinal canal stenosis |
| • Anticonvulsants | • Rocker Sole Shoes |

7.1 IMAGING

Explain to people with low back pain with or without sciatica that if they are being referred to specialist opinion, they may not need imaging. The musculoskeletal service will decide on the clinical need or not for imaging

Consider imaging in specialist settings of care (for example, a musculoskeletal interface clinic or hospital) for people with low back pain with or without sciatica **only if the result is likely to change management**

8 EVIDENCE BASED INTERVENTIONS APPLICATION PROCESS

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

8.2 Completion of a **Generic EBI Application Form** by a GP or Consultant may be put forward

8.3 Applications cannot be considered from patients personally

It is expected that clinicians will have ensured that the patient, on behalf of who they are forwarding the application for, is appropriately informed about the existing policies prior to an application to the EBI Panel. This will reassure the Panel that the patient has a reasonable expectation of the outcome of the application and its context

8.4 EBI applications are reviewed and considered for clinical exceptionality

8.5 For further information on 'clinical exceptionality' please refer to the NHS England IFR policy <https://www.england.nhs.uk/wp-content/uploads/2017/11/comm-policy-individual-funding-requests.pdf>

8.6 An application put forward for consideration must demonstrate some unusual or unique clinical factor about the patient that suggests they are exceptional as defined below:

- Significantly different to the general population of patients with the condition in question
- Likely to gain significantly more benefit from the intervention than might be expected from the average patient with the condition

9 ACCESS TO POLICY

9.1 If you would like further copies of this policy or need it in another format, such as Braille or another language, please contact the Patient Advice and Liaison Service on Telephone number: 08000 851067

9.2 **Or write to us:** NHS Somerset Clinical Commissioning Group, Freepost RRKL-XKSC-ACSG, Yeovil, Somerset, BA22 8HR or **Email us:** somccg.pals@nhs.net

10 REFERENCES

- The following sources have been considered when drafting this policy:
- 10.1 <https://www.nice.org.uk/guidance/ng59>
- 10.2 <https://www.ouh.nhs.uk/patient-guide/leaflets/files/12421Plumbar.pdf>
- 10.3 Thelwall, S. P. (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
- 10.4 <https://www.nice.org.uk/guidance/cg173>
- 10.5 United Kingdom Spine Societies Board: <https://www.ukssb.com/improving-spinal-care-project>
- 10.6 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
- 10.7 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
- 10.8 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
- 10.9 [Neuropathic pain in adults: pharmacological management in non-specialist settings](#) (2013 updated 2017) NICE guideline CG173

BACK FACTS

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- 1. Persistent back pain can be scary, but it's rarely dangerous**
 Persistent back pain can be distressing and disabling, but it's rarely life-threatening and you are very unlikely to end up in a wheelchair


- 2. Getting older is not a cause of back pain**
 Although it is a widespread belief and concern that getting older causes or worsens back pain, research does not support this, and evidence-based treatments can help at any age.
- 3. Persistent back pain is rarely associated with serious tissue damage**
 Backs are strong. If you have had an injury, tissue healing occurs within three months, so if pain persists past this time, it usually means there are other contributing factors. A lot of back pain begins with no injury or with simple, everyday movement. These occasions may relate to stress, tension, fatigue, inactivity or unaccustomed activity which make the back sensitive to movement and loading.


- 4. Scans rarely show the cause of back pain**
 Scans are only helpful in a minority of people. Lots of scary-sounding things can be reported on scans such as disc bulges, degeneration, protrusions, arthritis, etc. Unfortunately, the reports don't say that these findings are very common in people without back pain and that they don't predict how much pain you feel or how disabled you are. Scans can also change, and most disc prolapses shrink over time.


- 5. Pain with exercise and movement doesn't mean you are doing harm**
 When pain persists, it is common that the spine and surrounding muscles become really sensitive to touch and movement. The pain you feel during movement and activities reflects how sensitive your structures are – not how damaged you are. So it's safe and normal to feel some pain when you start to move and exercise. This usually settles down with time as you get more active. In fact, exercise and movement are one of the most effective ways to help treat back pain.
- 6. Back pain is not caused by poor posture**
 How we sit, stand and bend does not cause back pain even though these activities may be painful. A variety of postures are healthy for the back. It is safe to relax during everyday tasks such as sitting, bending and lifting with a round back – in fact, it's more efficient!


- 7. Back pain is not caused by a 'weak core'**
 Weak 'core' muscles do not cause back pain, in fact people with back pain often tense their 'core' muscles as a protective response. This is like clenching your fist after you've sprained your wrist. Being strong is important when you need the muscles to switch on, but being tense all the time isn't helpful. Learning to relax the 'core' muscles during everyday tasks can be helpful.
- 8. Backs do not wear out with everyday loading and bending**
 The same way lifting weights makes muscles stronger, moving and loading make the back stronger and healthier. So activities, like running, twisting, bending and lifting, are safe if you start gradually and practice regularly.


- 9. Pain flare-ups don't mean you are damaging yourself**
 While pain flare-ups can be very painful and scary, they are not usually related to tissue damage. The common triggers are things like poor sleep, stress, tension, worries, low mood, inactivity or unaccustomed activity. Controlling these factors can help prevent exacerbations, and if you have a pain flare-up, instead of treating it like an injury, try to stay calm, relax and keep moving!
- 10. Injections, surgery and strong drugs usually aren't a cure**
 Spine injections, surgery and strong drugs like opioids aren't very effective for persistent back pain in the long term. They come with risks and can have unhelpful side effects. Finding low-risk ways to put you in control of your pain is the key.

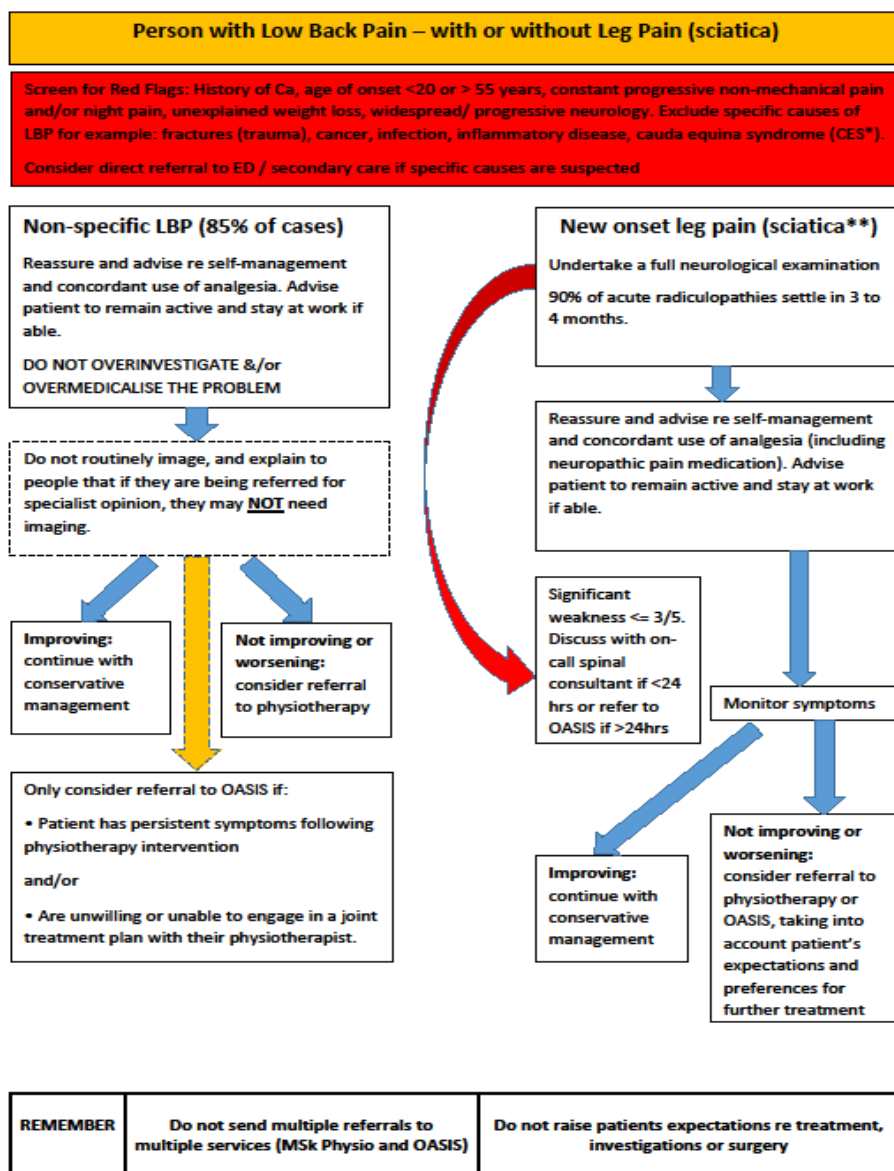






This infographic is a summary only. Please consult the full text for clarification and supporting references.
 O'Sullivan P, Caneiro JP, O'Sullivan K, Lin I, Bunzli S, Wernli K, O'Keaffe M. Back to Basics: 10 facts about low back pain. BJSM. 2019

Appendix 2



*Cauda Equina Syndrome (CES) - British Association of Spinal Surgeons (BASS) have issued a statement regarding the management of suspected CES (December 2018) which states:

“SyndroEquina Syndrome (CES) is a relatively rare but disabling condition which can result in motor and sensory deficits, incontinence of urine and faeces, and loss of sexual function.

Any patient with a possible diagnosis of threatened /partial/complete CES requires urgent investigation.

A patient presenting with back pain and/or sciatic pain with any disturbance of their bladder or bowel function and/or saddle or genital sensory disturbance or bilateral leg pain should be suspected of having a threatened or actual CES.”

Given the above statement any patient presenting with the above pattern of symptoms should be referred to the Emergency Department or discussed with the on-call Spinal Team or Orthopaedic registrar on call (bleep 7005).

**Sciatica (Radiculopathy) - irritation of or injury to a nerve root that typically causes pain, numbness, or weakness in the part of the body which is supplied by the root/roots involved. Symptoms of P&N/numbness in the absence of any radicular pain or abnormal neurological signs, such as weakness, does not require active treatment or further investigation (reassure and monitor patient)