NHS
Somerset
Clinical Commissioning Group

LOW BACK PAIN AND SCIATICA INTERVENTIONS POLICY IN OVER 16S
CRITERIA BASED ACCESS

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Application Form	Generic IFR application form

LOW BACK PAIN AND SCIATICA INTERVENTIONS IN OVER 16S POLICY
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MANAGEMENT OF LOW BACK PAIN AND SCIATICA POLICY IN OVER 16S - CRITERIA BASED ACCESS AND INDIVIDUAL FUNDING

General Principles for CBA

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 Individual Funding Request (IFR) Panel by submission of an IFR application.

1. Clinicians should assess their patients against the criteria within this policy prior to treatment.

2. 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.

3. 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.

4. 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)

5. Patients who are smokers should be referred to smoking cessation services in order to reduce the risk of surgery and improve healing. (Loof S., 2014)

General Principles for IFR

Funding approval will 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 will not be given.

1. The CCG does not commission surgery for cosmetic purposes alone.

2. Funding approval must be secured by primary care prior to referring patients seeking corrective surgery.

3. Referring patients to secondary care without 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.

4. 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.

5. 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.

6. Patients should be advised that receiving funding approval 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.

7. 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)

8. Patients who are smokers should be referred to smoking cessation services in order to reduce the risk of surgery and improve healing. (Loof S., 2014)

9. Where funding approval is given by the Individual Funding Panel, it will be available for a specified period of time, normally one year.

Background

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. This includes:

- 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 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 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 behavioral 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 gastro-protective 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 behavioral 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 (e.g. 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 TO ACCESS TREATMENT - CBA

Funding Approval for surgical treatment will only be provided by the NHS for patients meeting criteria set out below;

1. **Epidural Injections and Nerve Root Blocks**

   a) A **single** epidural injection of local anesthetic and steroid is commissioned for patients with acute and severe sciatica where:

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

   OR

   c) A specialist pain or T&O clinician judges that a single injection is necessary and appropriate to enable participation in a conservative Pain Management Programme

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

   e) 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. These are not routinely commissioned.

Policy – CRITERIA TO ACCESS TREATMENT - IFR

The treatments, interventions and devices listed below are not routinely funded:

2. **Facet Joint Injections or sacroiliac injections**
   a. Facet joint injections or sacroiliac injections, either for diagnostic or therapeutic purposes are not routinely commissioned

3. **Therapeutic, Multiple or Repeat Medial Branch Blocks**
   a. Medial Branch Blocks are not commissioned for therapeutic purposes

4. **Radiofrequency Denervation**

5. **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**

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

   a) **Intradiscal therapy** is aimed at treating internal disc disruption (IDD), which some therapists believe can be a cause of low back pain. Both steroids and non-steroidal anti-inflammatory drugs have been injected into the disc in an attempt to suppress inflammation and reduce pain

   b) **Prolotherapy** (also known as proliferation therapy or regenerative injection therapy) involves injecting tissue with an irritant solution. This may be a joint, ligament or tendon insertion, or injected into connective tissue or muscle

   c) **Trigger Point Injections**
      a. use various mixtures of local anesthetics and a steroid, or botulinum toxin. A trigger point is argued to be a painful or irritable knot in a muscle. Injections are usually carried out in an outpatient setting, and repeated at intervals

   d) Belts Or Corsets,
   e) Rocker Sole Shoes,
   f) Traction,
   g) Acupuncture,
   h) Ultrasound,
   i) Percutaneous Electrical Nerve Simulation (PENS),
   j) Transcutaneous Electrical Nerve Simulation (TENS)
   k) Interferential Therapy
   l) Opioids,
   m) Selective Serotonin Reuptake Inhibitors, Serotonin–Norepinephrine Reuptake Inhibitors Or Tricyclic Antidepressants,
   n) Anticonvulsants
   o) Spinal Injections
   p) Epidural Injections For Neurogenic Claudication In People Who Have Central Spinal Canal Stenosis,
   q) Spinal Fusion,
   r) Disc Replacement

For recommendations on pharmacological management of sciatica, see NICE's guideline on neuropathic pain in adults https://www.nice.org.uk/guidance/cg173

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. Applications cannot be considered from patients personally.

Provided these patients receive the full support of their general practitioner, or clinician, in pursuing their funding request an application may be made to the Individual Funding Request Panel for consideration.

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 IFRP. This will reassure the Panel that the patient has a reasonable expectation of the outcome of the application and its context.

An application put forward for consideration must demonstrated 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

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.

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

REFERENCES

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