NHS
Somerset
Clinical Commissioning Group

Low Back Pain WITH or WITHOUT Sciatica
Criteria Based Access (CBA)
And
Evidence Based Interventions Panel (EBIP) Policy

Version:	1819.v3
Recommendation by:	Somerset CCG Clinical Commissioning Policy Forum (CCPF)
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Name of Originator/Author:	EBI Team
Approved by Responsible Committee/Individual:	Somerset CCG Clinical Executive Group (CEC)
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Target audience:	**SCCG**: • NHS Providers • GP Practices • Contracts Team **Medical Directors:** • Taunton & Somerset NHS FT • Yeovil District Hospital NHS FT • Royal United Hospitals Bath NHS FT • Somerset Partnership NHS FT
Application Form	EBI Generic application form if appropriate to apply

Low Back Pain WITH or WITHOUT Sciatica CBA and EBIP Policy

VERSION CONTROL

Document Status:	Current policy
Version:	1819.v3

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’

Equality Impact Assessment (EIA) Form OR EIA Screening Form completed. Date:	January 2019
Quality Impact Assessment QIA. Date:	January 2019
Sponsoring Director:	Sandra Cory
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1 GENERAL PRINCIPLES (CBA & EBI)

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 LOW BACK PAIN WITH SCIATICA POLICY CRITERIA (CBA)

2.1 **A single Epidural Injection and Nerve Root Block** will be commissioned for patients who met the criteria below;

2.1.2 Patients with acute and severe sciatica, where the patient is unable to participate effectively in conservative pain management **OR**

2.1.2 A specialist pain or Trauma and Orthopaedic clinician judges that a single injection is necessary and appropriate to enable participation in a Conservative / Pain Management Programme

2.2 **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.

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

3 LOW BACK PAIN WITHOUT SCIATICA POLICY CRITERIA (EBIP)

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

3.2 NICE recommends that spinal injections should not be offered for non-specific low back pain. Alternative options like pain management and physiotherapy have been shown to work

3.3 Spinal injections of local anaesthetic and steroid should not be offered for patients with non-specific low back pain

3.4 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.

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

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

- Facet joint injections
- Trigger Point Injections with any agent, including botulinum toxin
- Intradiscal therapy
- Prolotherapy
- Interferential Therapy
- Percutaneous Electrical Nerve Simulation (PENS)
- Transcutaneous Electrical Nerve Simulation (TENS)
- Anticonvulsants
- Traction
- Acupuncture
- Ultrasound
- Spinal Fusion
- Disc Replacement
- Radiofrequency Denervation
- Belts or Corsets
- Rocker Sole Shoes

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 EVIDENCE BASED INTERVENTIONS APPLICATION PROCESS

6.1 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

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

6.3 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

6.4 EBI applications are reviewed and considered for clinical exceptionality

6.5 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-indivdual-funding-requests.pdf

6.6 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

7 ACCESS TO POLICY

7.1 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

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

8 REFERENCES

The following sources have been considered when drafting this policy:

8.1 https://www.nice.org.uk/guidance/ng59

8.2 Loof S., D. B. (2014). Perioperative complications in smokers and the impact of smoking cessation interventions [Dutch]. Tijdschrift voor Geneeskunde, vol./is. 70/4(187-192

8.3 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

8.4 https://www.nice.org.uk/guidance/cg173

8.5 United Kingdom Spine Societies Board: https://www.ukssb.com/improving-spinal-care-project

8.6 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

8.7 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

8.8 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

8.9 Royal College of Anaesthetists: https://www.rcoa.ac.uk/document-store/core-standards-pain-management-services-the-uk

8.10 Neuropathic pain in adults: pharmacological management in non-specialist settings (2013 updated 2017) NICE guideline CG173

9 PROCEDURE AND DIAGNOSTIC CODES

Injections for nonspecific low back pain without sciatica

when left (der.Spell_Dominant_Procedure,4) in ('A521','A522','A528','A529','A577','A735','V363','V368','V369','V382','V383','V384','V385','V386','V388','V389','V544','W903') and leftder.spell_primary_diagnosis,4) in ('G834','G551','M518','M519','M545','M549') and apcs.der_procedure_all like '%Z67[67]%' then 'D_low_back_pain_inj'