SPINAL PAIN: NECK AND LOWER BACK PAIN IN PATIENT'S OVER 18 YEARS OF AGE

This applies to all policy related spinal injections irrespective of the specialty providing the service. Exceptional/Prior Approval funding is required as set out below. Locally agreed tariffs apply. On referral to the pain pathway model patients must be informed that the referral is for assessment and development of a pain management plan. Patients will not necessarily be offered an injection or surgery.

BACKGROUND

Cervical (Neck) Pain

Optimal conservative therapies can be useful for reducing pain and disability and these should be trialed as first line. These include advice and information, pharmacotherapy where clinically appropriate, neck exercise, physiotherapy, and manual therapies. Most people with neck pain with or without radiculopathy will improve regardless of the treatment.

Early referral for MRI investigation and / or surgery is strongly recommended in patients presenting with:

- Myelopathy (compression of the spinal cord in the cervical spine)
- Acute neurological progression, e.g., muscle weakness, reflex and/or sensory changes
- Severe radicular arm pain with or without neurology

AND

Red flag symptoms indicative of a serious spinal pathology – refer urgently.

Lumbar (back) pain

This policy does not apply to patients presenting with "red flag symptoms" such as deterioration in neurological function (e.g., objective weakness, sexual dysfunction, cauda equina syndrome). These patients require an urgent referral to an acute spinal Centre for further evaluation and imaging, as non-surgical treatment may lead to irreversible harm.

- **Sciatica or radicular pain** is low-back pain caused by irritation or compression of the sciatic nerve. The symptoms of sciatica can include pain, tingling, pins and needles, numbness, weakness, and rarely bowel and bladder problems. As often, the symptoms will settle naturally, non-operative treatment is the preferred initial option.
- Patients presenting with radiculopathy who show objective evidence of clinical improvement within 6 weeks (e.g., VAS pain scores, ODI), are more likely than not to continue improving with non-operative treatment as the natural history of most intervertebral disc herniation is favorable.
- **Non-specific low back pain**, also known as mechanical axial pain, is common, often multifactorial and responds well to non-operative treatment e.g., lifestyle modifications, weight loss, analgesia, manual therapy, and exercise.
- **Assessment of back pain** should include the biopsychosocial impact on the individual such as with EQ-5D or STarT back tool for low back pain. Conservative therapies, including a course of structured physiotherapy and exercise with or without psychological therapy, should be offered as first line treatment. Interventions are undertaken using a multi-disciplinary team approach.

IMAGING

- Do not routinely offer imaging in a non-specialist setting for patients with low back pain with or without sciatica, where there are no red flags or suspected serious underlying pathology following evaluation of medical history and examination.
- Imaging in low back pain should be offered if serious underlying pathology is suspected. Serious underlying pathology includes but is not limited to cancer, infection, trauma, spinal cord injury (full or partial loss of sensation and/or movement of part(s) of the body) or inflammatory disease.
- Do not offer imaging for people with low back pain with specific facet joint pain as prerequisite for radiofrequency denervation.

CRITERIA BASED ACCESS

First Epidural/ Nerve Root Injection

A single epidural/ nerve root injection can be considered for patients with acute severe neck or back pain **with radiculopathy** where:

- There have been a persistent or progressive objective neurologic finding, or failure to improve after **6 weeks** of documented conservative treatment, which must include the following:

➢ Physiotherapy, including strengthening and stretching exercises, and manual therapy.

OR

➢ Optimal pharmacological treatment where clinically appropriate, including regular analgesia.

OR

➢ The patient is unable to participate effectively in conservative pain management.

AND

- A specialist pain or trauma & orthopaedic clinician judges that a single injection is necessary and appropriate to enable participation in a conservative pain management programme.

Interventions are only performed in conjunction with a multi-disciplinary team approach.

Second Epidural/ Nerve Root Injection

- A **second injection** at the same site in patients with recurrent and significant neck or back pain with radiculopathy can be offered without prior approval; if there are no red flag symptoms, and the previous injection provided at least a 70% improvement in pain sustained for **at least 6 months.**
- If clinical indication remains, and the first epidural/ nerve root injection has not worked; under the discretion of the clinician a second injection using the alternative method of either epidural or nerve root injection can be offered without prior approval.

Radiofrequency Denervation

Consider referral for assessment for radiofrequency denervation (to destroy the nerves that supply the painful facet joint in the spine) for people with chronic facet joint pain when all the following criteria are met:

- Non-surgical treatment has not worked for them.

AND

- The main source of pain is thought to come from structures supplied by the medial branch nerve.

AND

- For patients with moderate or severe levels of localised back pain (rated as five or more on a visual analogue scale (VAS), or equivalent) at the time of referral.

AND

- For patients with significant functional impairment defined as:
  - Symptoms preventing the patient fulfilling activities of daily living or educational responsibilities.

AND

- Following a positive response to diagnostic medial branch block (MBB) defined as:
  - Significant reduction in pain, measured on a validated pain scale of at least 80% i.e., VAS/Numeric Rating Scale (NRS)

AND

- Patients have actively participated in the decisions in respect of their treatment.

AND

- Patients show commitment to taking responsibility for managing their condition by demonstrating:
  - Relevant lifestyle changes which include weight loss, increased fitness through exercise and physiotherapy; diet control, avoidance of illicit drugs and alcohol, improvement in sleep patterns, managing mood and mental health; and improved engagement in activities of daily living and purposeful occupation where appropriate.

PRIOR APPROVAL REQUIRED

Repeat Epidural/Nerve Root Injections (More than 2)

Repeat epidural/nerve root injections at the same site should be requested via the Prior Approval route only with evidence if **6 months** of pain relief and functional improvement are achieved.

Repeat Radiofrequency Denervation

Repeat radiofrequency denervation after relapse should be requested via the Prior Approval route only with evidence if there is a patient reported outcome measure demonstrating significant improvement in pain relief and function at **16 months** post initial denervation procedure.

Lumbar Discectomy Surgery

Discectomy surgery is only commissioned in adult patients who meet the following criteria:

- The patient has had MRI showing disc herniation (protrusion, extrusion, or sequestered fragment) at a level and side corresponding to the clinical symptoms.

AND

- The patient has radicular pain (below the knee for lower lumbar herniation's, into the anterior thigh for upper lumbar herniation's) consistent with the level of spinal involvement.

OR

- There is evidence of nerve-root irritation with a positive nerve-root tension sign (straight leg raise-positive between 30° and 70° or positive femoral tension sign)

AND

Symptoms persist despite non-operative treatment for at least 3 months (e.g., analgesia, physical therapy, bed rest etc.) except in severe cases and if analgesia is adequate and there is no imminent risk of neurological deficit.

EXCEPTIONAL FUNDING REQUIRED

The following procedures are **not normally funded**

- All local anaesthetic and steroid spinal injections including
  - Diagnostic and therapeutic facet joint intra-articular injections
  - Therapeutic facet joint nerve block/ medial branch block
  - Intradiscal therapy
  - Prolotherapy
  - Trigger point injections with any agent, including botulinum toxin
  - Epidural steroid injections for chronic low back pain or for neurogenic claudication in patients with central spinal canal stenosis
  - Any other spinal injections not specifically covered above.
- Disc replacement
- Spinal fusion* and/or discectomy

*Spinal fusion is usually reserved for,

- Patients with a symptomatic spinal deformity (e.g., scoliosis)
- Instability (e.g., spondylolisthesis; trauma)
- An adjunct during spinal decompression surgery, where a more extensive exposure of the affected neurological structures is required and would otherwise render the spine unstable.

Patients who are not eligible for treatment under this policy may be considered on an individual basis, if their consultant believes there are exceptional circumstances that warrant deviation from the rule of this policy. Applications to be made via the Exceptional funding route including details to show why alternative treatments cannot be sought and what treatment has already been tried.