NHS
Cheshire and Merseyside

Clinical Commissioning Policy

CMICB_Clin088
Spinal decompression for low back pain and sciatica policy (adults aged 16 years or older)

(Based on Evidence Based Intervention (EBI) Programme Best Practice Guidance)

Category 2 Intervention - Only routinely commissioned when specific criteria are met

Contents

Last Reviewed: May 2025

This policy statement will be reviewed 5 years from the date of the last review unless new evidence or technology is available sooner.

1. Policy statement

1.1 Lumbar spinal decompression (laminectomy, facetectomy, foraminotomy or discectomy) for people with sciatica is routinely commissioned when ALL the following criteria are satisfied:

1.1.1 Radiological findings are concordant with sciatic symptoms.

AND

1.1.2 Nonsurgical treatment for at least 3 months has not improved pain or function, except in severe cases for which the 3-month minimum period does not apply. [1]

1.2 Experimental lumbar spinal decompression procedures are not routinely commissioned.

1.3 This policy applies to adults aged 16 years or older.

2. Exclusions

2.1 Patients presenting with neurological symptoms (e.g. objective weakness; cauda equina syndrome).

3. Core Eligibility Criteria

3.1 There are several circumstances where a patient may meet a 'core eligibility criterion' which means they are eligible to be referred for this procedure or treatment, regardless of whether they meet the policy statement criteria, or the procedure or treatment is not routinely commissioned.

3.2 These core clinical eligibility criteria are as follows:

- Any patient who needs 'urgent' treatment will always be treated.
- All NICE Technology Appraisals Guidance (TAG), for patients that meet all the eligible criteria listed in a NICE TAG will receive treatment.
- In cancer care (including but not limited to skin, head and neck, breast and sarcoma) any lesion that has features suspicious of malignancy, must be referred to an appropriate specialist for urgent assessment under the 2-week rule.
  NOTE: Funding for all solid and haematological cancers are now the responsibility of NHS England.
- Reconstructive surgery post cancer or trauma including burns.
- Congenital deformities: Operations on congenital anomalies of the face and skull are usually routinely commissioned by the NHS. Some conditions are considered highly specialised and are commissioned in the UK through the National Specialised Commissioning Advisory Group (NSCAG). As the incidence of some cranio-facial congenital anomalies is small and the treatment complex, specialised teams, working in designated centres and subject to national audit, should carry out such procedures.
- Tissue degenerative conditions requiring reconstruction and/or restoring function e.g. leg ulcers, dehisced surgical wounds, necrotising fasciitis.
- For patients expressing gender incongruence, further information can be also be found in the current ICB gender incongruence policy and within the NHS England gender services programme - https://www.england.nhs.uk/commissioning/spec-services/npc-crg/gender-dysphoria-clinical-programme/

[1] In Cheshire and Merseyside, there is currently a spinal specialist centre at the Walton Centre.

4. Rationale behind the policy statement

4.1 See NICE NG 59 : Low back pain and sciatica in over 16s and also Evidence-Based Interventions Programme - see Evidence Based Interventions (EBI) programme https://ebi.aomrc.org.uk/resources/.

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5. Summary of evidence review and references

5.1 NICE NG59 states that spinal decompression surgery should be considered for people with sciatica 'when non-surgical treatment has not improved pain or function and their radiological findings are consistent with sciatic symptoms'. It is important that radiological findings are concordant with the clinical presentation, to avoid exposing patients to the harms of ineffective surgery[1].

5.2 NHS England's Evidence Based Interventions (EBI) guidance advises that patients with radiculopathy who are objectively improving within 6 weeks of the onset of pain are likely to continue to improve with conservative management, which includes activity modification, weight loss, analgesia and physiotherapy. Surgery should be considered in carefully selected patients, who have not responded to conservative measures. The need for careful consideration of surgery is because for some patients, irreversible degenerative disease means that surgery is not likely to be effective in relieving pain. On the other hand, spinal decompression may be effective in relieving pain in the long-term in patients with sciatic pain and concordant MRI changes. In these patients an excessive period of conservative management can result in negative outcomes, such as neurological dysfunction, chronic pain, repeated emergency department attendances and time off work[2].The evidence reviewing underpinning NICE NG59 refers to the following decompression procedures: laminectomy, discectomy, foraminotomy and facetectomy[1].

5.3 Although traditionally a 6-week trial of conservative treatment has been recommended for patients with sciatica, the guideline development group behind the NICE guideline declined to specify a minimum time for nonsurgical treatment, due to a lack of evidence for the optimum time to trial conservative management[1]. They agreed however that some trial of nonsurgical treatment should be attempted and that in practice it would therefore be 3-6 months before surgery would be offered. The EBI guidance states that conservative management should be tried for at least 3 months, except in severe cases[2]. The National Back Pain Pathway states that in some very severe cases early surgery may be required at the 1–3-week stage. For other non-tolerable radicular pain surgery should be offered in 8-12 weeks, but surgery may be later for people with neurogenic claudication (around 6 months) or symptoms of fluctuating severity[3].

5.4 There is evidently a consensus that in most cases a trial of conservative management is necessary prior to offering surgery but that clinical judgement is required in determining the optimum timing of surgery, which will vary by presentation. This policy therefore follows the EBI guidance in mandating a 3-month trial of conservative management except in severe cases, in which case clinical judgement should be used.

5.5 NICE NG59 applies to people aged 16 years and older[1]. The EBI guidance applies to adults aged 19 years and over[2]. It is not clear why there is a discrepancy, but this policy follows NICE NG59 as the underpinning evidence review relates to those aged 16 years and over.

References
1. NICE NG59 Low back pain and sciatica in over 16s: assessment and management (November 2016): https://www.nice.org.uk/guidance/ng59.
2. Evidence Based Interventions. List 2. Academy of Medical Royal Colleges. November 2020 - https://ebi.aomrc.org.uk/resources/
3. National Low Back Pain and Radicular Pain Pathway 2017: National Back Pain Pathway.

6. Advice and Guidance

6.1 Aim and Objectives

6.1.1 This policy aims to ensure a common set of criteria for treatments and procedures across the region. This is intended to reduce variation of access to NHS services in different areas and allow fair and equitable treatment for all patients.

6.1.2 This policy relates to the commissioning of interventions which optimise clinical effectiveness and represent value for money.

6.1.3 This document is part of a suite of policies which the Integrated Care Board (ICB) uses to drive its commissioning of healthcare. Each policy is a separate public document in its own right but should be considered alongside all the other policies in the suite as well as the core principles outlined.

6.1.4 At the time of publication, the evidence presented per procedure/treatment was the most current available.

6.1.5 The main objective for having healthcare commissioning policies is to ensure that:
- Patients receive appropriate health treatments
- Treatments with no or a very limited evidence base are not used; and
- Treatments with minimal health gain are restricted.

6.1.6 Owing to the nature of clinical commissioning policies, it is necessary to refer to the biological sex of patients on occasion. When the terms ‘men’ and ‘women’ are used in this document (unless otherwise specified), this refers to biological sex. It is acknowledged that this may not necessarily be the gender to which individual patients identify.

6.2 Core Principles

6.2.1 Commissioning decisions by ICB Commissioners are made in accordance with the commissioning principles set out as follows:

- Commissioners require clear evidence of clinical effectiveness before NHS resources are invested in the treatment.
- Commissioners require clear evidence of cost effectiveness before NHS resources are invested in the treatment.
- Commissioners will consider the extent to which the individual or patient group will gain a benefit from the treatment.
- Commissioners will balance the needs of an individual patient against the benefit which could be gained by alternative investment possibilities to meet the needs of the community.
- Commissioners will consider all relevant national standards and consider all proper and authoritative guidance.
- Where a treatment is approved Commissioners will respect patient choice as to where a treatment is delivered, in accordance with the ‘NHS Choice’ framework.

- Commissioning decisions will give 'due regard' to promote equality and uphold human rights. Decision making will follow robust procedures to ensure that decisions are fair and are made within legislative frameworks.

6.3 Individual Funding Requests (Clinical Exceptionality Funding)

6.3.1 If any patients are excluded from this policy, for whatever reason, the clinician has the option to make an application for clinical exceptionality. However, the clinician must make a robust case to the Panel to confirm their patient is distinct from all the other patients who might be excluded from the designated policy.

6.3.2 The ICB will consider clinical exceptions to this policy in accordance with the Individual Funding Request (IFR) Governance Framework consisting of: IFR Decision Making Policy; and IFR Management Policy available on the C&M ICB website: https://www.cheshireandmerseyside.nhs.uk/your-health/individual-funding-requests-ifr/

6.4 Cosmetic Surgery

6.4.1 Cosmetic surgery is often carried out to change a person's appearance to achieve what a person perceives to be a more desirable look.

6.4.2 Cosmetic surgery/treatments are regarded as procedures of low clinical priority and therefore not routinely commissioned by the ICB Commissioner.

6.4.3 A summary of Cosmetic Surgery is provided by NHS Choices. Weblink: Cosmetic procedures - NHS

6.5 Diagnostic Procedures

6.5.1 Diagnostic procedures to be performed with the sole purpose of determining whether or not a restricted procedure is feasible should not be carried out unless the eligibility criteria are met, or approval has been given by the ICB or GP (as set out in the approval process of the patients responsible ICB) or as agreed by the IFR Panel as a clinically exceptional case.

6.5.2 Where a General Practitioner/Optometrist/Dentist requests only an opinion the patient should not be placed on a waiting list or treated, but the opinion given and the patient returned to the care of the General Practitioner/Optometrist/Dentist, in order for them to make a decision on future treatment.

6.6 Clinical Trials

6.6.1 The ICB will not fund continuation of treatment commenced as part of a clinical trial. This is in line with the Medicines for Human Use (Clinical Trials) Regulations 2004 and the Declaration of Helsinki which stipulates that the responsibility for ensuring a clear exit strategy from a trial, and that those benefiting from treatment will have ongoing access to it, lies with those conducting the trial. This responsibility lies with the trial initiators indefinitely.

7. Monitoring and Review

7.1 This policy remains in force until it is superseded by a revised policy or by mandatory NICE guidance or other national directive relating to this intervention, or to alternative treatments for the same condition.

7.2 This policy can only be considered valid when viewed via the ICB website or ICB staff intranet. If this document is printed into hard copy or saved to another location, you must check that the version number on your copy matches that of the one published.

7.3 This policy may be subject to continued monitoring using a mix of the following approaches:
- Prior approval process
- Post activity monitoring through routine data
- Post activity monitoring through case note audits

7.4 This policy will be kept under regular review, to ensure that it reflects developments in the evidence base regarding effectiveness and value.

8. Quality and Equality Analysis

8.1 Quality and Equality Impact Analyses have been undertaken for this policy at the time of its review.

9. Clinical Coding

1.4 Office of Population Censuses and Surveys (OPCS)

V60 Primary percutaneous decompression using coblation to intervertebral disc
V601 Primary percutaneous decompression using coblation to cervical intervertebral disc
V602 Primary percutaneous decompression using coblation to thoracic intervertebral disc
V603 Primary percutaneous decompression using coblation to lumbar intervertebral disc
V608 Other specified primary percutaneous decompression using coblation to intervertebral disc
V609 Unspecified primary percutaneous decompression using coblation to intervertebral disc
V61 Revisional percutaneous decompression using coblation to intervertebral disc
V611 Revisional percutaneous decompression using coblation to cervical intervertebral disc
V612 Revisional percutaneous decompression using coblation to thoracic intervertebral disc
V613 Revisional percutaneous decompression using coblation to lumbar intervertebral disc
V618 Other specified revisional percutaneous decompression using coblation to intervertebral disc
V619 Unspecified revisional percutaneous decompression using coblation to intervertebral disc
V67 Other primary decompression operations on lumbar spine
V671 Primary posterior lumbar medial facetectomy
V672 Primary hemilaminectomy decompression of lumbar spine
V678 Other specified other primary decompression operations on lumbar spine

1.5 International classification of diseases (ICD-10)

M51.0 Lumbar and other intervertebral disc disorders with Myelopathy
M51.1 Lumbar and other intervertebral disc disorders with radiculopathy
M54.1 Radiculopathy
M54.3 Sciatica
M54.4 Lumbago with sciatica

Document Control

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Version 0.1 – June 2023 Merger of previous policies-16.5 Spinal Decompression; 16.8 Endoscopic Lumbar Decompression **AND** 16.9 Percutaneous Disc Decompression using Coblation for Lower Back Pain
Version 0.2 – November 2023 Added footnote to the Walton Centre following Specialist Clinical review and feedback
Version 0.3 – July 2024 – re-formatted
Version 0.4 – May 2025 – This policy was part of a public engagement exercise, there was no feedback received.