



Comments on Oregon Health Authority's Draft Scope Statement on Minimally Invasive and Non-Corticosteroid Percutaneous Interventions (7/20/2016)

Comments Submitted to Oregon Health Authority on July 27, 2016 by:

John MacVicar, MB ChB
President, Spine Intervention Society
c/o Belinda Duszynski
120 East Ogden Avenue, Suite 202
Hinsdale, IL 60521
630.203.2252 phone
bduszynski@spinalinjection.org

The Spine Intervention Society, a multi-specialty association of over 2600 physicians dedicated to the development and promotion of high quality interventional spine care, extends to Oregon Health Authority (OHA) an offer to provide expert input. We are fully cognizant of inappropriate utilization, and therefore wish to identify effective interventions. Without appropriate questions and evidence inclusion/exclusion criteria, the report will not facilitate such determinations, leading to egregious denial of access to procedures for many patients. The methodology employed and questions addressed must ensure that the **highest quality evidence** is addressed scientifically, providing an accurate assessment of these procedures.

We urge OHA to establish a reasonable comment period to allow for adequate consideration and rigorous comments intended to ensure the resulting coverage guidance is accurate and useful. A seven-day comment period is grossly inadequate to enable careful review. The comments below represent a quick assembly of some key issues identified over the past few days. If OHA is interested in obtaining additional assistance and guidance, we invite you to reach out to discuss further.

TOPIC: LOW BACK PAIN - MINIMALLY INVASIVE AND NON-CORTICOSTEROID PERCUTANEOUS INTERVENTIONS

PICO Methodology

- Interventions:
 - OHA is proposing to review within this coverage guidance a diverse assortment of procedures, each of them performed to treat pain of different etiology. Some of these procedures are well-established with good evidence, while others are not. It is imperative that the evidence of effectiveness for each intervention is considered and reported separately.

- It will be important to clarify that these are diagnostic sacroiliac injections of local anesthetic only.
- Diagnostic procedures (i.e. medial branch blocks, diagnostic sacroiliac joint injections) should be assessed for diagnostic/prognostic utility, not therapeutic effectiveness as corticosteroid is not included. May wish to add sacral lateral branch blocks to the list of diagnostic injection procedures.
- Outcomes: Short-term and long-term pain relief are critical primary outcomes to assess when considering the effectiveness of the treatments being reviewed. Further, given the National Institute of Health recommendations for the study of chronic low back pain (1), we would suggest assessing categorical definitions of clinically significant improvement in pain and function, such as $\geq 50\%$ reduction in pain on a numerical rating scale and $\geq 30\%$ improvement in function as measured by validated scales like the Oswestry Disability Index or Roland Morris Disability Questionnaire.

Questions

Key question #1 is unnecessary. It is covered better by question #2.

Key question #2:

- It is critical to assess the effectiveness of each procedure for each diagnosis/etiology (with imaging-confirmed pathology), with subgroup analysis by use of image guidance and different approach/access technique. (2)
- Much of the existing literature, specifically relating to radiofrequency neurotomy (RFN), is based on *inappropriate* patient selection/diagnostic block protocol or *inappropriate* RFN technique and, thus, provides misleading data regarding the effectiveness of this procedure. Alternatively, a subset of studies that utilize *appropriate* technique do address the questions posed in this scope statement. (3-10)
- For assessment of ablative interventions, it is important to include: “response to previous **diagnostic injections**”.

Word Count: 498

References:

1. Deyo RA, Dworkin SF, Amtmann D et al. Report of the NIH task force on research standards for chronic low back pain. *Pain Med* 2014;15:1249-67.
2. Bogduk N (ed). Practice guidelines for spinal diagnostic and treatment procedures. International Spine Intervention Society. San Francisco, 2013.
3. Dreyfuss P, Halbrook B, Pauza K, Joshi A, McLarty J, Bogduk N. Efficacy and validity of radiofrequency neurotomy for chronic lumbar zygapophysial joint pain. *Spine*. 2000 May 15;25(10):1270-7.
4. MacVicar J, Borowczyk JM, MacVicar AM, Loughnan BM, Bogduk N. Lumbar medial branch radiofrequency neurotomy in New Zealand. *Pain Med Malden Mass*. 2013 May;14(5):639-45.

5. Gofeld M, Jitendra J, Faclier G. Radiofrequency denervation of the lumbar zygapophysial joints: 10-year prospective clinical audit. *Pain Physician*. 2007 Mar;10(2):291-300.
6. Burnham RS, Holitski S, Dinu I. A prospective outcome study on the effects of facet joint radiofrequency denervation on pain, analgesic intake, disability, satisfaction, cost, and employment. *Arch Phys Med Rehabil*. 2009 Feb;90(2):201-5.
7. Speldewinde GC. Outcomes of percutaneous zygapophysial and sacroiliac joint neurotomy in a community setting. *Pain Med* 2011; 12:209-218.
8. Dreyfuss P, Snyder BD, Park K, et al. The ability of single site, single depth sacral lateral branch blocks to anesthetize the sacroiliac joint complex. *Pain Med* 2008;9:844-50.
9. Patel N, Gross A, Brown L, Gekht G. A randomized, placebo controlled study to assess the efficacy of lateral branch denervation for chronic sacroiliac joint pain. *Pain Med* 2012;13:383-98.
10. King W, Ahmed SU, Baisden J, Patel N, Kennedy DJ, Duszynski B, MacVicar J. Diagnosis and treatment of posterior sacroiliac complex pain: a systematic review with comprehensive analysis of the published data. *Pain Med*. 2015 Feb;16(2):257-65. doi: 10.1111/pme.12630.