

*Treatment Options for Low Back Disorders*

*Clinical Subcommittee Call Summary  
December 6, 2010*

***Present:***

**ICER:** Steve Pearson, Dan Ollendorf, Marc Silverstein, Analisa Andry, Sarah Emond, Aurelie Cordier

**Clinical Subcommittee:** Don Casey, Anthony Delitto, Rick Deyo, Mary Ann Farrell, Christina Farup, Carolyn Langer, John Loeser, Bill Meeker, Rick Rosenquist, Steve Stanos

***Absent:*** Steve Atlas, Chris Bono

**Meeting Summary**

- ***Literature Search & Review***
  - Caution was urged in decisions to rely on prior systematic reviews for certain interventions and focus on individual RCTs for others. For example, judgments made in the spinal injections review for the Washington state HTA program (ICER initially intended to use this review as a basis for its own assessment) have been criticized by multiple clinical societies.
  - While ICER's stated approach is to focus on interventions offered to patients who have failed simple conservative treatment, there was interest in ensuring that a comprehensive overview of conservative care is provided as background material in the report.
  - In addition, it is expected that emerging techniques such as robot-assisted surgery will soon gain a foothold in this area; ICER will summarize introduction of these technologies as part of its background material.

- ***Outcome Measures***

- Questions were raised regarding the ability to make summary judgments on return-to-work measures, due to (a) variability in measurement; (b) the proportion of patients for whom return to work is a reasonable goal; and (c) the proportion of patients covered under worker's compensation vs. other insurance
- It was noted that measures of meaningful clinical change for pain and functional indices have focused on within-group changes for individual patients. This is an issue because (a) these changes do not translate to between-group differences when comparing interventions; and (b) RCT findings typically report only summary group statistics on changes from baseline. *ICER will develop an approach for estimating the proportion of patients with a sufficient clinical response from these studies and will propose thresholds for comparing interventions. This draft approach will be shared with the ERG.*

- ***Patient Categories***

- A suggestion was made to replace the stratification of "radicular" vs. "non-radicular" pain, as radiating pain may not be due to any nerve impingement and the categorization will not be usable by patients. The suggested replacement categories of "back pain" vs. "back and leg pain" were felt to be more illustrative. *ICER will make this change.*
- There was some discussion about the "imaged, nonspecific or incidental" findings category, as the suggestion that findings on imaging are not the source of back and/or leg pain reflects a level of detail not provided in most RCTs or observational studies.
- Many in the group felt that the graphic depiction of the patient categories was too similar to a treatment pathway or guideline. *ICER will modify the graphic so that it is clear that the list of interventions is present only to depict the focus of our evidence review.*

- *Interventions*

- The point was made that the term “multidisciplinary rehabilitation” might be misleading, as multiple disciplines might be involved in the care of a patient without any overarching coordination. The term “interdisciplinary rehabilitation” was suggested instead.
- In general, the presentation of the major components of identified interdisciplinary rehabilitation programs was well-received. Several suggestions were made to improve this classification, however, including (a) identification of physical therapy as passive PT alone vs. PT to achieve specific goals; (b) use of a “minimum threshold” to define interdisciplinary rehabilitation; (c) more specificity on what was contained in the “usual care” control arms of the RCTs; and (d) whether sub-categories of programs were specified, such as work conditioning and fear avoidance.