# MEDICAL POLICY

| POLICY TITLE | DIAGNOSIS AND TREATMENT OF SACROILIAC JOINT PAIN |
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| POLICY NUMBER | MP 5.048 |

| CLINICAL BENEFIT | ☒ MINIMIZE SAFETY RISK OR CONCERN.<br>☒ MINIMIZE HARMFUL OR INEFFECTIVE INTERVENTIONS.<br>☐ ASSURE APPROPRIATE LEVEL OF CARE.<br>☐ ASSURE APPROPRIATE DURATION OF SERVICE FOR INTERVENTIONS.<br>☐ ASSURE THAT RECOMMENDED MEDICAL PREREQUISITES HAVE BEEN MET.<br>☐ ASSURE APPROPRIATE SITE OF TREATMENT OR SERVICE. |
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| **Effective Date:** | **2/1/2024** |


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## I. POLICY

**Sacroiliac Joint Arthrography**
Arthrography of the sacroiliac joint is considered **investigational.** There is insufficient evidence to support a conclusion concerning the general health outcomes or benefits associated with this procedure.

**Sacroiliac Joint Injections**
Sacroiliac joint medication injections may be considered **medically necessary** for pain lasting more than three months despite appropriate conservative treatment. Documentation of fluoroscopy is required with each injection, to ensure correct needle placement. If successful (as documented by the usage of validated patient focused pain intensity assessment scales), it is reasonable to repeat the injection initially in two to four months. It is **not medically necessary** to perform sacroiliac injections more than four per twelve-month period, beginning with the date of the first injection.

Sacroiliac injections are considered **not medically necessary** for indications other than those listed above.

**Radiofrequency Ablation**
Radiofrequency ablation (RFA) of the sacroiliac joint is considered **investigational**. There is insufficient evidence to support a conclusion concerning the general health outcomes or benefits associated with this procedure.

**Policy Guidelines**

This policy does not address the treatment of sacroiliac joint pain due to infection, trauma, or neoplasm.

Conservative nonsurgical therapy for the duration specified should include the following:

- Use of prescription strength analgesics for several weeks at a dose sufficient to induce a therapeutic response

  - Analgesics should include anti-inflammatory medications with or without adjunctive medications such as nerve membrane stabilizers or muscle relaxants AND
- Participation in at least 6 weeks of physical therapy (including active exercise) or documentation of why the patient could not tolerate physical therapy, AND
- Evaluation and appropriate management of associated cognitive, behavioral, or addiction issues
- Documentation of patient compliance with the preceding criteria.

A successful trial of controlled diagnostic lateral branch blocks consists of two separate positive blocks on different days with local anesthetic only (no steroids or other drugs), or a placebo-controlled series of blocks, under fluoroscopic guidance, that has resulted in a reduction in pain for the duration of the local anesthetic used (e.g., 3 hours longer with bupivacaine than lidocaine). There is no consensus on whether a minimum of 50% or 75% reduction in pain would be required to be considered a successful diagnostic block, although evidence that supported a criterion standard of 75% to 100% reduction in pain with dual blocks. No therapeutic intra-articular injections (i.e., steroids, saline, other substances) should be administered for a period of at least 4 weeks before the diagnostic block. The diagnostic blocks should not be conducted under intravenous sedation unless specifically indicated (e.g., the patient is unable to cooperate with the procedure).

***Cross-references:***

**MP 5.049** Facet Joint Denervation
**MP 2.061** Prolotherapy

## II. PRODUCT VARIATIONS

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This policy is only applicable to certain programs and products administered by Capital Blue Cross please see additional information below, and subject to benefit variations as discussed in Section VI below.

**FEP PPO:** Refer to FEP Benefit Brochure for information on Diagnosis and Treatment of SI joint pain *https://www.fepblue.org/benefit-plans/benefit-plans-brochures-and-forms.*

Note* - The Federal Employee Program (FEP) Service Benefit Plan does not have a medical policy related to these services.

## III. DESCRIPTION/BACKGROUND

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### SACROILIAC JOINT PAIN

Similar to other structures in the spine, it is assumed that the sacroiliac joint (SIJ) may be a source of low back pain. In fact, before 1928, the SIJ was thought to be the most common cause of sciatica. In 1928, the role of the intervertebral disc was elucidated, and from that point forward, the SIJ received less research attention.

### Diagnosis

Research into SIJ pain has been plagued by lack of a criterion standard to measure its prevalence and against which various clinical examinations can be validated. For example, SIJ pain is typically without any consistent, demonstrable radiographic or laboratory features and most commonly exists in the setting of morphologically normal joints. Clinical tests for SIJ pain may include various movement tests, palpation to detect tenderness, and pain descriptions by the patient. Further confounding the study of the SIJ is that multiple structures, (e.g., posterior facet joints, lumbar discs) may refer pain to the area surrounding the SIJ.

Because of inconsistent information obtained from history and physical examination, some have proposed the use of image-guided anesthetic injection into the SIJ for the diagnosis of SIJ pain. Treatments being investigated for SIJ pain include prolotherapy (see Medical Policy 2.061), corticosteroid injection, radiofrequency ablation, stabilization, and arthrodesis. Some procedures have been referred to as SIJ fusion but may be more appropriately called fixation due to little to no bridging bone on radiographs. Devices for SIJ fixation/fusion that promote bone ingrowth to fixate the implants include a triangular implant (iFuse Implant System) and cylindrical threaded devices (Rialto, SImmetry, Silex, SambaScrew, SI-LOK). Some devices also have a slot in the middle where autologous or allogeneic bone can be inserted. This added bone is intended to promote fusion of the SIJ.

A 2021 review identified 33 different devices that could be implanted using either a lateral transiliac approach (n=21), posterior allograft approach (n=6), posterolateral approach (n=3), or a combination of the approaches (n=3).1, The iliosacral and posterolateral approaches use up to 3 implants that pass through the ilium, while the posterior approach involves inserting implants directly into the SIJ. Many of the devices are intended to be used with allograft bone. Implants composed entirely of allograft bone are typically inserted through a posterior approach. The authors found no published evidence for 23 of the 33 devices identified.

### REGULATORY STATUS

A number of radiofrequency generators and probes have been cleared for marketing by the U.S. Food and Drug Administration (FDA) through the 510(k) process. In 2005, the SInergy® (Halyard; formerly Kimberly-Clark), a water-cooled single-use probe, was cleared by the FDA, listing the Baylis Pain Management Probe as a predicate device. The intended use is in conjunction with a radiofrequency generator to create radiofrequency lesions in nervous tissue. FDA product code: GXD, GXI.

## IV. Rationale

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### Summary of Evidence

For individuals who have suspected SIJ pain who receive a diagnostic sacroiliac block, the evidence includes systematic reviews. Relevant outcomes are test validity, symptoms, functional outcomes, quality of life, medication use, and treatment-related morbidity. Current

evidence is conflicting on the diagnostic utility of SIJ blocks. The evidence is insufficient to determine the effects of the technology on health outcomes.

For individuals who have SIJ pain who receive therapeutic corticosteroid injections, the evidence includes small RCTs and case series. Relevant outcomes are symptoms, functional outcomes, quality of life, medication use, and treatment-related morbidity. In general, the literature on injection therapy of joints in the back is of poor quality. Results from two small RCTs showed that therapeutic SIJ steroid injections were not as effective as other active treatments. Larger trials, preferably using sham injections, are needed to determine the degree of benefit of corticosteroid injections over placebo. The evidence is insufficient to determine the effects of the technology on health outcomes.

For individuals who have SIJ pain who receive radiofrequency ablation, the evidence includes 5 RCTs using different radiofrequency applications and case series. Relevant outcomes are symptoms, functional outcomes, quality of life, medication use, and treatment-related morbidity. Meta-analysis of available sham controlled RCTs suggests that there may be a small effect of RFA on SIJ pain at short-term (1-3 months) follow-up. However, the randomized trials of RFA have methodologic limitations, and there is limited data on the duration of the treatment effect. The single RCT with 6- and 12-month follow-up showed no significant benefit of RFA compared to an exercise control group at these time points. In addition, heterogeneity of RFA treatment techniques precludes generalizing results across different studies. For RFA with a cooled probe, two small RCTs reported short-term benefits, but these are insufficient to determine the overall effect on health outcomes. An RCT on palisade RFA of the SIJ did not include a sham control. Another sham-controlled randomized trial showed no benefit from RFA. Further high-quality controlled trials are needed to compare this procedure in defined populations with sham control and alternative treatments. The evidence is insufficient to determine the effects of the technology on health outcomes.

## V. DEFINITIONS

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**ARTHROGRAPHY** is a diagnostic study that involves the injection of contrast media into a joint.

## VI. BENEFIT VARIATIONS

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The existence of this medical policy does not mean that this service is a covered benefit under the member's health benefit plan. Benefit determinations should be based in all cases on the applicable health benefit plan language. Medical policies do not constitute a description of benefits. A member's health benefit plan governs which services are covered, which are excluded, which are subject to benefit limits, and which require preauthorization. There are different benefit plan designs in each product administered by Capital Blue Cross. Members and providers should consult the member's health benefit plan for information or contact Capital Blue Cross for benefit information.

## VII. DISCLAIMER

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*Capital Blue Cross's medical policies are developed to assist in administering a member's benefits, do not constitute medical advice and are subject to change. Treating providers are*

*solely responsible for medical advice and treatment of members. Members should discuss any medical policy related to their coverage or condition with their provider and consult their benefit information to determine if the service is covered. If there is a discrepancy between this medical policy and a member's benefit information, the benefit information will govern. If a provider or a member has a question concerning the application of this medical policy to a specific member's plan of benefits, please contact Capital Blue Cross' Provider Services or Member Services. Capital Blue Cross considers the information contained in this medical policy to be proprietary and it may only be disseminated as permitted by law.*

## VIII. CODING INFORMATION

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**Note:** This list of codes may not be all-inclusive, and codes are subject to change at any time. The identification of a code in this section does not denote coverage as coverage is determined by the terms of member benefit information. In addition, not all covered services are eligible for separate reimbursement.

**Investigational when used to bill for sacroiliac joint arthrography; therefore, not covered:**

| Procedure Codes | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| 27096 | G0259 | | | | | | | |

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**Investigational when billed for radiofrequency ablation of the sacroiliac joint; therefore, not covered:**

| Procedure Codes | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| 64625 | 64635 | | | | | | | |

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**Covered when medically necessary:**

| Procedure Codes | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| 27096 | G0260 | | | | | | | |

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| ICD-10-CM Diagnosis Codes | Description |
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| M46.1 | Sacroiliitis, not elsewhere classified |
| M53.3 | Sacrococcygeal disorders, not elsewhere classified |
| M54.18 | Radiculopathy, sacral and sacrococcygeal region |
| M54.30 | Sciatica, unspecified side |

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| M54.31 | Sciatica, right side |
| M54.32 | Sciatica, left side |
| M54.40 | Lumbago with sciatic, unspecified side |
| M54.41 | Lumbago with sciatica, right side |
| M54.42 | Lumbago with sciatica, left side |
| M54.5 | Low back pain |
| M54.50 | Low back pain, unspecified |
| M54.51 | Vertebrogenic low back pain |
| M54.59 | Other low back pain |

***Note:** For codes 27279 and 27280 related to arthrodesis, refer to TurningPoint Healthcare policies effective 1/1/2019.*

## VIII. REFERENCES

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## IX. POLICY HISTORY

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| **MP-5.048** | **01/01/20 Coding update.** New code added, 64625. |
| | **6/16/20 Consensus review.** No change to policy statement. References reviewed. Two ICD codes added to include unspecified codes. |
| | **8/9/2021 Consensus review.** Policy statement unchanged. Background, Rationale and References updated. |
| | **9/7/2021: Administrative review.** Added new ICD-10 codes. Effective date 10/1/21. |
| | **12/1/2022- Consensus review.** No change to policy statements. References updated. Background and summary of evidence reviewed. |
| | **11/9/2023 Consensus review.** No change to policy statements. References updated. Coding reviewed and updated. |

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