Effective for dates of service on or after March 19, 2023, refer to LCD L39402 and Article A59192.

BlueCross BlueShield of Alabama

Name of Blue Advantage Policy:

Diagnosis and Treatment of Sacroiliac Joint Pain

Policy #: 558
Latest Review Date: January 2023
Category: Surgery

BACKGROUND:

Blue Advantage *medical policy does not conflict with Local Coverage Determinations (LCDs), Local Medical Review Policies (LMRPs) or National Coverage Determinations (NCDs) or with coverage provisions in Medicare manuals, instructions or operational policy letters. In order to be covered by Blue Advantage the service shall be reasonable and necessary under Title XVIII of the Social Security Act, Section 1862(a)(1)(A). The service is considered reasonable and necessary if it is determined that the service is:*

1. *Safe and effective;*
2. *Not experimental or investigational*;*
3. *Appropriate, including duration and frequency that is considered appropriate for the service, in terms of whether it is:*
   - *Furnished in accordance with accepted standards of medical practice for the diagnosis or treatment of the patient's condition or to improve the function of a malformed body member;*
   - *Furnished in a setting appropriate to the patient's medical needs and condition;*
   - *Ordered and furnished by qualified personnel;*
   - *One that meets, but does not exceed, the patient's medical need; and*
   - *At least as beneficial as an existing and available medically appropriate alternative.*

Routine costs of qualifying clinical trial services with dates of service on or after September 19, 2000 which meet the requirements of the Clinical Trials NCD are considered reasonable and necessary by Medicare. Providers should bill* ***Original Medicare* *for covered services that are related to* ***clinical trials*** *that meet Medicare requirements (Refer to Medicare National Coverage Determinations Manual, Chapter 1, Section 310 and Medicare Claims Processing Manual Chapter 32, Sections 69.0-69.11).*

POLICY:

Blue Advantage will treat an **injection of anesthetic for diagnosing sacroiliac joint pain** as a **covered benefit** when **ALL** the following criteria have been met:

- Pain has failed to respond to 3 months of conservative management*; AND
- Dual (controlled) diagnostic blocks** with 2 anesthetic agents with differing duration of action are used; AND
- The injections are performed under imaging guidance.

Blue Advantage will treat **injection of corticosteroid for the treatment of sacroiliac joint pain** as a **covered benefit** when **all** of the following criteria have been met:

- Pain has failed to respond to 3 months of conservative therapy*; **AND**
- The injection is performed under imaging guidance; **AND**
- No more than 3 injections are given in one year.

Blue Advantage will treat **arthrography of the sacroiliac joint** as a **non-covered benefit** and as **investigational.**

Blue Advantage will treat **radiofrequency denervation of the sacroiliac joint** as a **non-covered benefit** and as **investigational.**

Blue Advantage will treat **cryoablation (cryodenervation, cryoneurolysis, cryosurgery, or cryoanesthesia) of the sacroiliac joint** as a **non-covered benefit** and as **investigational**.

*Conservative therapy is the use of structured physician-directed modalities which may include: prescription strength analgesics/anti-inflammatory medications if not contraindicated; participation in therapeutic physical medicine modality(ies) and/or manipulations when rendered by an eligible provider (including active exercise).

** 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., three hours longer with bupivacaine than lidocaine). There is not a consensus on whether a minimum of 50% or 75% reduction in pain would be required to be considered a successful diagnostic block, although evidence supports a criterion standard of 75% to 100% reduction in pain with dual blocks. No therapeutic intra-articular injections (i.e., steroids, saline, and other substances) should be administered for a period of at least four weeks before the diagnostic lateral branch 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).

Blue Advantage does not approve or deny procedures, services, testing, or equipment for our members. Our decisions concern coverage only. The decision of whether or not to have a certain test, treatment or procedure is one made between the physician and his/her patient. Blue Advantage administers benefits based on the members' contract and medical policies. Physicians

should always exercise their best medical judgment in providing the care they feel is most appropriate for their patients. Needed care should not be delayed or refused because of a coverage determination.

DESCRIPTION OF PROCEDURE OR SERVICE:

Sacroiliac joint arthrography using fluoroscopic guidance with injection of an anesthetic has been explored as a diagnostic test for sacroiliac joint pain. Duplication of the patient's pain pattern with the injection of contrast medium suggests a sacroiliac etiology, as does relief of chronic back pain with injection of local anesthetic. Treatment of sacroiliac joint pain with corticosteroids, radiofrequency ablation (RFA), and stabilization has also been explored.

Similar to other structures in the spine, it is assumed that the sacroiliac joint may be a source of low back pain. In fact, before 1928, the sacroiliac joint 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 sacroiliac joint received less research attention.

Research into sacroiliac joint pain has been thwarted by any criterion standard to measure its prevalence and against which various clinical examinations can be validated. For example, sacroiliac joint 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 sacroiliac joint pain may include various movement tests, palpation to detect tenderness, and pain descriptions by the patient. Further confounding study of the sacroiliac joint is that multiple structures, such as posterior facet joints and lumbar discs, may refer pain to the area surrounding the sacroiliac joint.

Because of inconsistent information obtained from history and physical examination, some have proposed the use of image-guided anesthetic injection into the sacroiliac joint for the diagnosis of sacroiliac joint pain. Cryoablation is a minimally invasive procedure that involves the use of extreme cold to destroy abnormal tissue. Treatments being investigated for sacroiliac joint pain include prolotherapy (refer to policy # 235 *Prolotherapy*), corticosteroid injection, RFA, stabilization, and arthrodesis. For indications and coverage criteria related to sacroiliac arthrodesis and minimally invasive procedures related to the SI joint please refer to policy #*555 Sacroiliac Joint Fusion*. Also, this policy does not address treatment of pain in the sacroiliac joint due to infection, trauma, or neoplasm.

KEY POINTS:

The most recent literature review was performed through October 4, 2022. Following is a summary of key references to date.

Summary of Evidence

For individuals who have SIJ pain who receive therapeutic corticosteroid injections, the evidence includes small RCTs and case series. The relevant outcomes are symptoms, functional outcomes, QOL, 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 that the technology results in an improvement in the net health outcome.

For individuals who have SIJ pain who receive RFA, the evidence includes four small RCTs using different radiofrequency applications and case series. The relevant outcomes are symptoms, functional outcomes, QOL, medication use, and treatment-related morbidity. For RFA with a cooled probe, the two small RCTs reported short-term benefits, but these are insufficient to determine the overall effect on health outcomes. The 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 that the technology results in an improvement in the net health outcome.

Practice Guidelines and Position Statements

North American Spine Society

In 2020, NASS published coverage policy recommendation for SIJ injections and radiofrequency ablation.

1. "Diagnostic intra-articular SIJ injections. Intra-articular SIJ injections are indicated to aid in the diagnostic work-up of low back pain when ALL of the listed criteria are met. All SIJ injections should be performed with some form of radiographic image guidance (e.g., fluoroscopic, CT). The volume of injectate should be limited to 2 mL and the inclusion of steroid with local anesthetic is not inappropriate. A diagnosis of SIJ pain is confirmed with at least a 75% reduction of pain for the expected duration of the anesthetic used on 2 separate occasions.
    - Patient's report of nonradicular, typically unilateral, pain that is maximal below the L5 vertebrae, localized over the posterior SIJ, and consistent with SIJ pain
    - A physical examination typically demonstrating localized tenderness with palpation over the sacral sulcus (Fortin's point, i.e., at the insertion of the long dorsal ligament inferior to the posterior superior iliac spine or PSIS) or the absence of tenderness elsewhere (eg, greater trochanter, lumbar spine, coccyx) that would explain the patient's symptoms.
    - Positive response to a cluster of at least 3 provocative tests (1. Patrick's or FABER, 2. Gaenslen, 3. Thigh thrust, 4. Sacral thrust, 5. Distraction, 6. Compression). Note that the thrust tests may not be recommended in pregnant patients or those with connective tissue disorders.
2. Diagnostic anesthetic blocks of the L5 primary dorsal ramus and sacral dorsal rami lateral branches (S1-S3). Small volume (<0.5 mL per nerve) image-guided anesthetic blockade of the L5 primary dorsal ramus and 1st-3rd sacral dorsal rami lateral branches are indicated to aid in the diagnostic work-up of LBP and must be considered prior to radiofrequency lesioning of these nerves. A positive response is at least 75% reduction of pain for the expected duration of the anesthetic used on 2 separate occasions.

These block are appropriate when ALL of the listed criteria are met:

- Patient's report of nonradicular, typically unilateral, pain that is maximal below the L5 vertebrae, localized over the posterior SIJ, and consistent with SIJ pain
- A physical examination typically demonstrating localized tenderness with palpation over the sacral sulcus (Fortin's point, i.e., at the insertion of the long dorsal ligament inferior to the posterior superior iliac spine or PSIS) or the absence of tenderness elsewhere (eg, greater trochanter, lumbar spine, coccyx) that would explain the patient's symptoms.
- Positive response to a cluster of at least 3 provocative tests (1. Patrick's or FABER, 2. Gaenslen, 3. Thigh thrust, 4. Sacral thrust, 5. Distraction, 6. Compression). Note that the thrust tests may not be recommended in pregnant patients or those with connective tissue disorders.

3. Therapeutic intra-articular SIJ injections. Image-guided intra-articular SIJ injections of corticosteroid with or without local anesthetic are indicated for the treatment of sacroiliac pain when > 1 of the listed criteria are met:
    - Clinical criteria for diagnostic SIJ injection are met (as above in item 1) AND pain has been present for at least 1 month AND pain is > 4/10 with functional limitation OR any pain level with functional limitation despite other conservative treatment.
    - SIJ pain has been confirmed with diagnostic intra-articular SIJ injections.
    - SIJ pain has recurred following a previous therapeutic SIJ injection which resulted in >50% pain relief for > 3 months.
    - Advanced imaging (bone scan or MRI) demonstrate uptake or inflammation in the SIJ.
4. Patients with spondyloarthopathies such as ankylosing spondylitis. Radiofrequency neurotomy of the L5 primary dorsal ramus and sacral dorsal rami lateral brances (S1-S3). Image-guided radiofrequency neurotomy of the L5 primary dorsal ramus and sacral dorsal rami lateral branches at S1, S2, and S3 are indicated for the treatment of sacroiliac pain when wither of the listed criteria are met:
    - Clinical criteria for positive diagnostic anesthetic blocks of the L5 dorsal ramus and sacral dorsal rami lateral branches (as above in item 2) are met AND pain has been present for at least 3 months AND pain is severe enough to cause some degree of functional deficit despite other conservative treatment.
    - Posterior sacroiliac ligament complex pain has recurred after > 50% improvement for > 6 months from prior radiofrequency neurotomy of the L5 primary dorsal ramus and sacral dorsal rami lateral branches."

American Society of Interventional Pain Physicians Interventional Pain Management
American Society of Interventional Pain Physicians Interventional Pain Management guidelines were updated in 2013. The updated guidelines recommend the use of controlled sacroiliac joint blocks with placebo or controlled comparative local anesthetic block when indications are satisfied with suspicion of sacroiliac joint pain. A positive response to a joint block is considered to be at least a 75% improvement in pain or in the ability to perform previously painful

movements. For therapeutic interventions, the only effective modality with fair evidence was cooled radiofrequency neurotomy, when used after the appropriate diagnosis was confirmed by diagnostic sacroiliac joint injections.

American Society of Anesthesiologists et al
In 2010, the American Society of Anesthesiologists Task Force on Chronic Pain Management and the American Society of Regional Anesthesia and Pain Medicine Practice updated their guidelines for chronic pain management. The guidelines recommend that diagnostic sacroiliac joint injections or lateral branch blocks may be considered for the evaluation of patients with suspected sacroiliac joint pain. Based on opinions of consultants and society members, the guidelines recommend that water-cooled RFA or sacroiliac joint injections may be used for chronic sacroiliac joint pain.

American Pain Society
The 2009 practice guidelines from the American Pain Society (APS) were based on a systematic review that was commissioned by the APS and conducted at the Oregon Evidence-based Practice Center. The APS guideline states that there is insufficient evidence to evaluate validity or utility of diagnostic sacroiliac joint block as a diagnostic procedure for low back pain with or without radiculopathy and that there is insufficient evidence to adequately evaluate benefits of sacroiliac joint steroid injection for non-radicular low back pain.

American Society of Pain and Neuroscience
In 2021, the American Society of Pain and Neuroscience published practice a guideline on radiofrequency neurotomy. All of the workgroup members utilized radiofrequency neurotomy in clinical practice. A consensus statement, based on Grade II-1 evidence (well-designed, controlled, nonrandomized clinical trial), was that "lateral branch radiofrequency neurotomy may be used for the treatment of posterior sacral ligament and joint pain following positive response to appropriately placed diagnostic blocks."

U.S. Preventive Services Task Force Recommendations
Not Applicable.

KEY WORDS:
Arthrography, Sacroiliac Joint Arthrography, Sacroiliac Joint Radiofrequency Ablation or Denervation, SI joint Injections, Diagnostic Blocks, Cryodenervation, Cryoneurolysis, Cryosurgery, Cryoanesthesia, Cryoablation

APPROVED BY GOVERNING BODIES:
A number of radiofrequency generators and probes have been cleared for marketing through the U.S. Food and Drug Administration's (FDA) 510(k) process. One device, the SInergy® by Halyard; formerly Kimberly Clark/Baylis, is a water-cooled single-use probe that received FDA clearance in 2005, 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.

BENEFIT APPLICATION:

Coverage is subject to member's specific benefits. Group specific policy will supersede this policy when applicable.

CURRENT CODING:

CPT Codes:

27096	Injection procedure for sacroiliac joint, anesthetic/steroid, with image guidance (fluoroscopy or CT) including arthrography when performed
20552	Injection(s); single or multiple trigger points(s), 1 or 2 muscle(s)
27299	Unlisted procedure, pelvis or hip joint
64451	Injection(s), anesthetic agent(s) and/or steroid; nerves innervating the sacroiliac joint, with image guidance (i.e., fluoroscopy or computed tomography)
64625	Radiofrequency ablation, nerves innervating the sacroiliac joint, with image guidance (i.e., fluoroscopy or computed tomography)
64999	Unlisted procedure, nervous system

HCPCS

G0259	Injection procedure for sacroiliac joint; arthrography
G0260	Injection procedure for sacroiliac joint; provision of anesthetic, steroid and/or other therapeutic agent, with or without arthrography

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POLICY HISTORY:

Adopted for Blue Advantage, January 1, 2012
Medical Policy Group, August 2014
Available for comment September 8 through October 22, 2014
Medical Policy Group, September 2014
Medical Policy Group, May 2015
Medical Policy Group, November 2015
Medical Policy Group, August 2016
Medical Policy Group, October 2016
Medical Policy Group, March 2017
Available for comment March 30 through May 13, 2017
Medical Policy Group, April 2017
Medical Policy Group, December 2017
Medical Policy Group, December 2019: Annual Coding Update
Medical Policy Group, December 2019
Medical Policy Group, December 2020
Medical Policy Group, November 2021
Medical Policy Group, January 2023

services are rendered. All medical policies are based on (i) research of current medical literature and (ii) review of common medical practices in the treatment and diagnosis of disease as of the date hereof. Physicians and other providers are solely responsible for all aspects of medical care and treatment, including the type, quality, and levels of care and treatment.

This policy is intended to be used for adjudication of claims (including pre-admission certification, pre-determinations, and pre-procedure review) in Blue Cross and Blue Shield's administration of plan contracts.