Medical Coverage Policy | Diagnosis and Treatment of Sacroiliac Joint Pain

EFFECTIVE DATE: 02|01|2024
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OVERVIEW

Sacroiliac joint (SIJ) arthrography using fluoroscopic guidance with an injection of an anesthetic has been explored as a diagnostic test for SIJ 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 an injection of local anesthetic. Treatment of SIJ pain with corticosteroids, radiofrequency ablation (RFA), stabilization, or minimally invasive SIJ fusion has also been explored.

This policy addresses the following services:

- Minimally invasive surgical fusion
- Injection of anesthetic for diagnosing pain
- Injection of corticosteroid for the treatment of pain
- Radiofrequency denervation

MEDICAL CRITERIA

Commercial Products

Minimally invasive fixation/fusion of the SIJ using transiliac placement of a titanium triangular implant (eg, iFuse) may be considered **medically necessary** when ALL of the following criteria have been met:

- Pain is at least 5 on a 0 to 10 rating scale that impacts quality of life or limits activities of daily living; and
- There is an absence of generalized pain behavior (eg, somatoform disorder) or generalized pain disorders (eg, fibromyalgia); and
- Individuals have undergone and failed a minimum 6 months of intensive nonoperative treatment that must include medication optimization, activity modification, bracing, and active therapeutic exercise targeted at the lumbar spine, pelvis, SIJ, and hip, including a home exercise program; and
- Pain is caudal to the lumbar spine (L5 vertebra), localized over the posterior SIJ, and consistent with SIJ pain; and
- A thorough physical examination demonstrates localized tenderness with palpation over the sacral sulcus (Fortin's point) in the absence of tenderness of similar severity elsewhere; and
- There is a positive response to a cluster of 3 provocative tests (eg, thigh thrust test, compression test, Gaenslen sign, distraction test, Patrick test, posterior provocation test); and
- Diagnostic imaging studies include ALL of the following:
    - Imaging (plain radiographs and computed tomography or magnetic resonance imaging) of the SIJ excludes the presence of destructive lesions (eg, tumor, infection) or inflammatory arthropathy of the SIJ; and
    - Imaging of the pelvis (anteroposterior plain radiograph) rules out concomitant hip pathology; and
    - Imaging of the lumbar spine (computed tomography or magnetic resonance imaging) is performed to rule out neural compression or other degenerative conditions that can be causing low back or buttock pain; and
    - Imaging of the SIJ indicates evidence of injury and/or degeneration; and
- There is at least a 75% reduction in pain for the expected duration of the anesthetic used following an image-guided, contrast-enhanced intra-articular SIJ injection on 2 separate occasions; and
- A trial of a therapeutic SIJ injection (ie, corticosteroid injection) has been performed at least once.

PRIOR AUTHORIZATION

Prior authorization is recommended for Commercial Products for minimally invasive surgical fusion of the sacroiliac joint. For Medicare Advantage Plans, please refer to the Related Policies section.

POLICY STATEMENT

Medicare Advantage Plans

Please refer to the Related Policies section for minimally-invasive surgical (MIS) fusion of the sacroiliac (SI) joint.

Injection of anesthetic for diagnosing sacroiliac joint pain and injection of corticosteroid for the treatment of sacroiliac joint pain is covered.

Radiofrequency denervation of the sacroiliac joint is not covered as the evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

Commercial Products

Minimally-invasive surgical (MIS) fusion of the sacroiliac (SI) joint is considered medically necessary when the medical criteria above has been met.

Injection of anesthetic for diagnosing sacroiliac joint pain and injection of corticosteroid for the treatment of sacroiliac joint pain is covered.

Radiofrequency denervation of the sacroiliac joint is not medically necessary as the evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

Fixation/fusion of the sacroiliac (SI) joint for the treatment of back pain presumed to originate from the sacroiliac (SI) joint is considered not medically necessary under all other conditions and with any other devices not listed above.

COVERAGE

Benefits may vary between groups and contracts. Please refer to the appropriate section of the Benefit Booklet, Evidence of Coverage, or Subscriber Agreement for applicable surgery and not medically necessary/not covered benefits/coverage.

BACKGROUND

Sacroiliac Joint Pain

Similar to other structures in the spine, it is assumed 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 study of the SIJ is that multiple structures, (eg, 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, 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 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.

For individuals who have SIJ pain who receive therapeutic corticosteroid injections, the evidence includes a systematic review, small randomized controlled trials (RCTs), and case series. 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 2 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 5 RCTs using different radiofrequency applications and case series. Relevant outcomes are symptoms, functional outcomes, QOL, 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 to 3 months) follow-up. However, the RCTs 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, 2 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 RCT 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.

For individuals who have SIJ pain who receive SIJ fixation/fusion with a transiliac triangular implant, the evidence includes 1 meta-analysis, 1 blinded sham controlled trial, 2 nonblinded RCTs of minimally invasive fusion, prospective cohorts with more than 85% follow-up, and case series. Relevant outcomes are symptoms, functional outcomes, QOL, medication use, and treatment-related morbidity. The sham-controlled RCT found no significant difference in the primary outcome of pain reduction or in any secondary outcomes through 6 months of follow-up. Both nonblinded RCTs have reported outcomes past 6 months, after which crossover was allowed. Both studies reported significantly greater reductions in visual analog scale (VAS) pain scores and Oswestry Disability Index (ODI) scores in SIJ fusion patients than in control groups. The reductions in pain and disability observed in the SIJ fusion group at 6 months were maintained out to 1 year compared with controls who had not crossed over. The RCTs were nonblinded without a placebo or an active control group. Prospective cohorts and case series with sample sizes ranging from 45 to 149 patients and low dropout rates (<15%) also showed reductions in pain and disability out to 5 years. The cohort studies and case series are consistent with the durability of treatment benefit. The evidence is sufficient to determine that the technology results in an improvement in the net health outcome. The meta-analysis pooled data from 3 RCTs and found that SIJ fusion with triangular titanium implants resulted in statistically significant improvements in pain, disability, quality of life, and opioid use compared to nonsurgical management for SIJ dysfunction, with similar adverse event rates between groups, though long-term data beyond 12 months was limited to a single trial.

For individuals who have SIJ pain who receive SIJ fusion/fixation with an implant other than a transiliac triangular implant, the evidence includes ~~3~~ 6 prospective cohort studies and retrospective case series. Relevant outcomes are symptoms, functional outcomes, QOL, medication use, and treatment-related morbidity. Three prospective cohort studies were conducted with transiliac screws and the 3 with a device inserted through a posterior approach. One cohort study compared SIJ fusion with the Torpedo device to iFuse (transiliac

triangular implant) and found no differences in pain or function outcomes at 12 months between the two groups. No other controlled studies were identified. Meta-analyses of the available prospective and retrospective studies indicate improvement in subjective outcomes from before surgery to follow-up, but with a possible difference in outcomes between the more well studied triangular transiliac implant and other implant designs and approaches. There is uncertainty in the health benefit of SIJ fusion/fixation with these implant designs. Therefore, controlled studies with a larger number of patients and longer follow-up are needed to evaluate these devices. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

CODING

Medicare Advantage Plans and Commercial Products

The following CPT code(s) are covered and authorization is not required:

27096 Injection procedure for sacroiliac joint, anesthetic/steroid, with image guidance (fluoroscopy or CT) including arthrography when performed

64451 Injection anesthetic agent, nerves innervating the sacroiliac joint with image guidance

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

The following CPT code(s) is not covered for Medicare Advantage Plans and not medically necessary for Commercial Products:

64625 Radiofrequency ablation, nerves innervating the sacroiliac joint, with image guidance (ie, fluoroscopy or computed tomography)

The following CPT code(s) may be medically necessary for Medicare Advantage Plans according to The Prior Authorization of Spinal Procedures Policy and is not medically necessary for Commercial Products:

27278 Arthrodesis, sacroiliac joint, percutaneous, with image guidance, including placement of intra-articular implant(s) (eg, bone allograft[s], synthetic device[s]), without placement of transfixation device (New code effective 1/01/2024)

Commercial Products

The following CPT code(s) is considered medically necessary when the criteria above has been met:

27279 Arthrodesis, sacroiliac joint, percutaneous or minimally invasive (indirect visualization), with image guidance, includes obtaining bone graft when performed, and placement of transfixing device

For Medicare Advantage Plans and CPT code 27279 please refer to the Related Policies section below.

RELATED POLICIES

Prior Authorization of Spinal Procedures

PUBLISHED

Provider Update, June, 2025
Provider Update, February 2024
Provider Update, December 2023
Provider Update, May/December 2022
Provider Update, June 2021

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