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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 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 surgical (MIS) fusion of the sacroiliac (SI) joint is considered medically necessary when ALL of the following criteria are met:

- Have moderate to severe pain with functional impairment and pain persists despite a minimum six months of intensive non-operative 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
- Patient's report of typically unilateral pain that is caudal to the lumbar spine (L5 vertebrae), localized over the posterior SIJ, and consistent with SIJ pain
- A thorough physical examination 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) in the absence of tenderness of similar severity elsewhere (e.g. greater trochanter, lumbar spine, coccyx) and that other obvious sources for their pain do not exist
- Positive response to a cluster of 3 provocative tests (e.g. thigh thrust test, compression test, Gaenslen's test, distraction test, Patrick's sign, posterior provocation test).
- Absence of generalized pain behavior (e.g. somatoform disorder) or generalized pain disorders (e.g. fibromyalgia)
- Diagnostic imaging studies that include ALL the following:
  - Imaging (plain radiographs and a CT or MRI) of the SI joint that excludes the presence of destructive lesions (e.g. tumor, infection), fracture, traumatic SIJ instability, or inflammatory arthropathy that would not be properly addressed by percutaneous SIJ fusion
  - Imaging of the pelvis (AP plain radiograph) to rule out concomitant hip pathology
  - Imaging of the lumbar spine (CT or MRI) to rule out neural compression or other degenerative condition that can be causing low back or buttock pain
- At least 75 percent reduction of pain for the expected duration of two anesthetics (on separate visits each with a different duration of action), and the ability to perform previously painful maneuvers, following an image-guided, contrast-enhanced intra-articular SIJ injection.
- A trial of at least one therapeutic intra-articular SIJ injection (i.e. corticosteroid injection).

## **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.

## **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 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 (1-3 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

## **CODING**

### **Commercial Products**

The following CPT code 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, please refer to the Related Policies section.

### **Medicare Advantage Plans and Commercial Products**

The following CPT codes 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 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)

## **RELATED POLICIES**

Prior Authorization of Spinal Procedures

## **PUBLISHED**

Provider Update, May 2022, December 2022

Provider Update, June 2021

Provider Update, June 2020

Provider Update, September 2019

## **REFERENCES**

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