Medical Policy

Diagnosis and Treatment of Sacroiliac Joint Pain

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Policy Number: 320
BCBSA Reference Number: 6.01.23 (For Plan internal use only)

Related Policies
- Epidural Steroid Injections for Neck and Back Pain, #690
- Facet Joint Denervation, #140
- Percutaneous Vertebroplasty and Sacroplasty, #484
- Prolotherapy, Joint Sclerotherapy and Ligamentous Injections with Sclerosing Agents, #183

Policy

Commercial Members: Managed Care (HMO and POS), PPO, and Indemnity

Prior Authorization Request Form: Diagnosis and Treatment of Sacroiliac Joint Pain
This form must be completed and faxed to: Medical and Surgical: 1-888-282-0780; Medicare Advantage: 1-800-447-2994
Click here for Diagnosis and Treatment of Sacroiliac Joint Pain Prior Authorization Request Form, #927

Arthrography of the sacroiliac joint is INVESTIGATIONAL.

Minimally invasive fixation/fusion of the sacroiliac joint 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, sacroiliac joint, and hip, including a home exercise program; AND
- Pain is caudal to the lumbar spine (L5 vertebra), localized over the posterior sacroiliac joint, and consistent with sacroiliac joint 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; \textbf{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); \textbf{AND}

Diagnostic imaging studies include \textbf{ALL} of the following:

- Imaging (plain radiographs and computed tomography or magnetic resonance imaging) of the sacroiliac joint excludes the presence of destructive lesions (eg, tumor, infection) or inflammatory arthropathy of the sacroiliac joint; \textbf{AND}
- Imaging of the pelvis (anteroposterior plain radiograph) rules out concomitant hip pathology; \textbf{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; \textbf{AND}
- Imaging of the sacroiliac joint indicates evidence of injury and/or degeneration; \textbf{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 sacroiliac joint injection on 2 separate occasions; \textbf{AND}

A trial of a therapeutic sacroiliac joint injection (ie, corticosteroid injection) has been performed at least once.

\textbf{Note:} This technically demanding procedure should only be done by surgeons who have specific training and expertise in minimally invasive sacroiliac joint fusion surgery for chronic sacroiliac joint pain and who regularly use image-guidance for implant placement.

Fusion/stabilization of the sacroiliac joint for the treatment of back pain presumed to originate from the sacroiliac joint is considered \textbf{INVESTIGATIONAL} under all other conditions and with any other devices not listed above.

Radiofrequency denervation of the sacroiliac joint is considered \textbf{INVESTIGATIONAL}.

\textbf{Prior Authorization Information}

\textbf{Inpatient}

- For services described in this policy, precertification/preauthorization \textbf{IS REQUIRED} for all products if the procedure is performed \textbf{inpatient}.

\textbf{Outpatient}

- For services described in this policy, see below for products where prior authorization \textbf{might be required} if the procedure is performed \textbf{outpatient}.

\begin{tabular}{|l|l|}
\hline
\textbf{Commercial Managed Care (HMO and POS)} & Prior authorization is \textbf{required} for minimally invasive fixation/fusion of the sacroiliac joint. * \\
\hline
\textbf{Commercial PPO} & Prior authorization is \textbf{required} for minimally invasive fixation/fusion of the sacroiliac joint. * \\
\hline
\end{tabular}

*Prior Authorization Request Form: Diagnosis and Treatment of Sacroiliac Joint Pain
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\textbf{CPT Codes / HCPCS Codes / ICD Codes}
Inclusion or exclusion of a code does not constitute or imply member coverage or provider reimbursement. Please refer to the member’s contract benefits in effect at the time of service to determine coverage or non-coverage as it applies to an individual member.

Providers should report all services using the most up-to-date industry-standard procedure, revenue, and diagnosis codes, including modifiers where applicable.

The following codes are included below for informational purposes only; this is not an all-inclusive list.

The above medical necessity criteria MUST be met for the following codes to be covered for Commercial Members: Managed Care (HMO and POS), PPO and Indemnity:

**CPT Codes**

<table>
<thead>
<tr>
<th>CPT codes:</th>
<th>Code Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>27279</td>
<td>Arthrodesis, sacroiliac joint, percutaneous or minimally invasive (indirect visualization), with image guidance, includes obtaining bone graft when performed, and placement of transfixing device</td>
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</table>

The following HCPCS and CPT code is considered investigational for Commercial Members: Managed Care (HMO and POS), PPO, and Indemnity:

**HCPCS Codes**

<table>
<thead>
<tr>
<th>HCPCS codes:</th>
<th>Code Description</th>
</tr>
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<tbody>
<tr>
<td>G0259</td>
<td>Injection procedure for sacroiliac joint; arthrography</td>
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</table>

**CPT Codes**

<table>
<thead>
<tr>
<th>CPT codes:</th>
<th>Code Description</th>
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<tbody>
<tr>
<td>64625</td>
<td>Radiofrequency ablation, nerves innervating the sacroiliac joint, with image guidance (ie, fluoroscopy or computed tomography)</td>
</tr>
<tr>
<td>0775T</td>
<td>Arthrodesis, sacroiliac joint, percutaneous, with image guidance, includes placement of intra-articular implant(s) (eg, bone allograft[s], synthetic device[s])</td>
</tr>
<tr>
<td>0809T</td>
<td>Arthrodesis, sacroiliac joint, percutaneous or minimally invasive (indirect visualization), with image guidance, placement of transfixing device(s) and intra-articular implant(s), including allograft or synthetic device(s)</td>
</tr>
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</table>

**DESCRIPTION**

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 a lack of a criterion standard to measure its prevalence and against which various clinical examinations can be validated. For example, SIJ pain typically presents 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, (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 (see evidence review 2.01.26), 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 (eg, Rialto, Symmetry, 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 the 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). 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.

**Summary**

**Description**

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.

**Summary of Evidence**

**Diagnostic**

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 (QOL), medication use, and treatment-related morbidity. Current evidence is conflicting on the diagnostic utility of SIJ blocks. 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 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. Both 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.

For individuals who have SIJ pain who receive SIJ fusion/fixation with an implant other than a transiliac triangular implant, the evidence includes 3 prospective cohort studies and retrospective case series. Relevant outcomes are symptoms, functional outcomes, QOL, medication use, and treatment-related morbidity. Two prospective cohort studies were conducted with transiliac screws and the third with a device inserted through a posterior approach. No 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.

**Policy History**

<table>
<thead>
<tr>
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<th>Action</th>
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<tr>
<td>7/2023</td>
<td>Clarified coding information.</td>
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<tr>
<td>1/2023</td>
<td>Annual policy review. Minor editorial refinements to policy statements; intent unchanged. Clarified coding information.</td>
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<tr>
<td>1/2022</td>
<td>Annual policy review. Policy clarified. &quot;Transiliac placement&quot; and &quot;eg, iFuse&quot; added to the medically necessary statement on sacroiliac joint fusion.</td>
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<tr>
<td>1/2021</td>
<td>Annual policy review. Description, summary, and references updated. Policy statements unchanged.</td>
</tr>
<tr>
<td>1/2021</td>
<td>Medicare information removed. See MP #132 Medicare Advantage Management for local coverage determination and national coverage determination reference.</td>
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<tr>
<td>1/2020</td>
<td>Annual policy review. Description, summary, and references updated. Policy statements unchanged.</td>
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<td>1/2019</td>
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<td>12/2016</td>
<td>Annual policy review. New references added.</td>
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<td>10/2016</td>
<td>Annual policy review. First medically necessary policy statement clarified.</td>
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<tr>
<td>1/2016</td>
<td>Annual policy review. New references added.</td>
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<td>1/2015</td>
<td>Clarified coding information.</td>
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**Information Pertaining to All Blue Cross Blue Shield Medical Policies**
References


