MASSACHUSETTS

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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

- InterQual Musculoskeletal Services Management, #220
- Prolotherapy, Joint Sclerotherapy and Ligamentous Injections with Sclerosing Agents, #183
- Prior Authorization Request Form for Diagnosis and Treatment of Sacroiliac Joint Pain, #927

Policy

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

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; **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 sacroiliac joint excludes the presence of destructive lesions (eg, tumor, infection) or inflammatory arthropathy of the sacroiliac joint; **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 sacroiliac joint 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 sacroiliac joint injection on 2 separate occasions; **AND**
- A trial of a therapeutic sacroiliac joint injection (ie, corticosteroid injection) has been performed at least once.

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 **INVESTIGATIONAL** under all other conditions and with any other devices not listed above.

Radiofrequency denervation of the sacroiliac joint is considered **INVESTIGATIONAL**.

Prior Authorization Information

Inpatient

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

Outpatient

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

	Outpatient
Commercial Managed Care (HMO and POS)	Prior authorization is **required** for minimally invasive fixation/fusion of the sacroiliac joint.
Commercial PPO	Prior authorization is **required** for minimally invasive fixation/fusion of the sacroiliac joint.

Requesting Prior Authorization Using Authorization Manager

Providers will need to use Authorization Manager to submit initial authorization requests for services. Authorization Manager, available 24/7, is the quickest way to review authorization requirements, request authorizations, submit clinical documentation, check existing case status, and view/print the decision letter. For commercial members, the requests must meet medical policy guidelines.

To ensure the request is processed accurately and quickly:

- Enter the facility's NPI or provider ID for where services are being performed.
- Enter the appropriate surgeon's NPI or provider ID as the servicing provider, *not* the billing group.

Authorization Manager Resources

- Refer to our Authorization Manager page for tips, guides, and video demonstrations.

Complete Prior Authorization Request Form for Diagnosis and Treatment of Sacroiliac Joint Pain (927) using Authorization Manager.

For out of network providers: Requests should still be faxed to 888-282-0780.

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

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

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

HCPCS Codes

HCPCS codes:	Code Description
C1737	Joint fusion and fixation device(s), sacroiliac and pelvis, including all system components (implantable)
G0259	Injection procedure for sacroiliac joint; arthrography

CPT Codes

CPT codes:	Code Description
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
64625	Radiofrequency ablation, nerves innervating the sacroiliac joint, with image guidance (ie, fluoroscopy or computed tomography)

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, 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 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).[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.

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 6 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 6 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, 3 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 pain scores and Oswestry Disability Index 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 6 prospective cohort studies and retrospective case series. Relevant outcomes are symptoms, functional outcomes, QOL, medication use, and treatment-related morbidity. Three prospective cohorts 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.

Policy History

Date	Action
1/2025	Clarified coding information. Annual policy review. Description, summary, and references updated. Policy statements unchanged.
1/2024	Annual policy review. Policy updated with literature review through September 13, 2023; references added. Policy statements unchanged. Clarified coding information.
9/2023	Policy clarified to include prior authorization requests using Authorization Manager.
7/2023	Clarified coding information.
5/2023	Policy clarified. Policy reactivated in May 2023 to reinstate policy statements on minimally invasive fixation/fusion of the sacroiliac joint. Effective 5/1/2023. Policy statements on anesthetic injection for diagnosing SIJ pain and corticosteroid injection for treatment of SIJ pain remain retired.
1/2023	Annual policy review. Minor editorial refinements to policy statements; intent unchanged. Clarified coding information.
6/2022	Prior authorization information clarified for PPO plans. Effective 6/1/2022.
1/2022	Annual policy review. Policy clarified. "Transiliac placement" and "eg, iFuse" added to the medically necessary statement on sacroiliac joint fusion.
1/2021	Annual policy review. Description, summary, and references updated. Policy statements unchanged.
1/2021	Medicare information removed. See MP #132 Medicare Advantage Management for local coverage determination and national coverage determination reference.
1/2020	Annual policy review. Description, summary, and references updated. Policy statements unchanged.
1/2020	Clarified coding information.
1/2019	Annual policy review. Description, summary, and references updated. Policy statements unchanged.
6/2018	Annual policy review. New medically necessary indications described for SIJ fusion/stabilization with a titanium triangular implant under the specific conditions. Clarified coding information. Effective 6/1/2018.

12/2016	Annual policy review. New references added.
11/2016	Annual policy review. New references added.
10/2016	Annual policy review. First medically necessary policy statement clarified.
1/2016	Annual policy review. New references added.
6/2015	Annual policy review. New references added.
1/2015	Clarified coding information.
10/2014	Annual policy review. New medically necessary and investigational indications described. Coding information clarified. Effective 10/1/2014.
6/2014	Annual policy review. New medical policy describing investigational indications. Effective 6/1/2014.

Information Pertaining to All Blue Cross Blue Shield Medical Policies

Click on any of the following terms to access the relevant information:
Medical Policy Terms of Use
Managed Care Guidelines
Indemnity/PPO Guidelines
Clinical Exception Process
Medical Technology Assessment Guidelines

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