CareSource

MEDICAL POLICY STATEMENT
Marketplace

Policy Name & Number	Date Effective
Sacroiliac Joint Procedures-MP-MM-1314	GA, IN, KY, WV: 06/01/20230-04/30/2024 OH: 07/01/2023-04/30/2024
Policy Type	
MEDICAL	

Medical Policy Statement prepared by CareSource and its affiliates are derived from literature based on and supported by clinical guidelines, nationally recognized utilization and technology assessment guidelines, other medical management industry standards, and published MCO clinical policy guidelines. Medically necessary services include, but are not limited to, those health care services or supplies that are proper and necessary for the diagnosis or treatment of disease, illness, or injury and without which the patient can be expected to suffer prolonged, increased or new morbidity, impairment of function, dysfunction of a body organ or part, or significant pain and discomfort. These services meet the standards of good medical practice in the local area, are the lowest cost alternative, and are not provided mainly for the convenience of the member or provider. Medically necessary services also include those services defined in any Evidence of Coverage documents, Medical Policy Statements, Provider Manuals, Member Handbooks, and/or other policies and procedures.

Medical Policy Statements prepared by CareSource and its affiliates do not ensure an authorization or payment of services. Please refer to the plan contract (often referred to as the Evidence of Coverage) for the service(s) referenced in the Medical Policy Statement. If there is a conflict between the Medical Policy Statement and the plan contract (i.e., Evidence of Coverage), then the plan contract (i.e., Evidence of Coverage) will be the controlling document used to make the determination. According to the rules of Mental Health Parity Addiction Equity Act (MHPAEA), coverage for the diagnosis and treatment of a behavioral health disorder will not be subject to any limitations that are less favorable than the limitations that apply to medical conditions as covered under this policy.

☒ **Georgia**	☒ **Indiana**	☒ **Kentucky**	☒ **Ohio**	☒ **West Virginia**

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A. Subject

Sacroiliac Joint Procedures

B. Background

Nearly 84% of adults experience back pain during their lifetime. Long-term outcomes are largely favorable for most patients, but a small percentage of patients' symptoms are persistent. Persistent pain is categorized as subacute when lasting between four and twelve weeks and chronic when persisting for at least three months.

Up to 10% to 25% of patients with persistent low back pain may have a component of pain related to sacroiliac joints (SIJ). Comprehensive pain management care plans are most effective in managing a patient's chronic pain. These plans focus on a person-centered approach and incorporate conservative treatment with other modalities. These multidisciplinary treatments include promoting patient self-management and aim to reduce the impact of pain on a patient's daily life, even if the pain cannot be relieved completely. In addition to conservative therapy, additional treatment options may include nonpharmacologic or pharmacologic treatments, nonsurgical interventions, and surgical interventions. Interventional procedures for the management of pain unresponsive to conservative treatment should be provided only by physicians qualified to deliver these health services.

Sacroiliac joint injections using local anesthetic and/or corticosteroid medication have been shown to be effective for diagnostic purposes but provide limited short-term relief from pain resulting from SIJ dysfunction. Long-term use has not been adequately studied to establish standards of care. Radiofrequency ablation (RFA) is another treatment method, which uses heat to destroy nerves. RFA for the treatment of low back pain has inconsistent results in the peer-reviewed medical literature with limited follow-up. However, clinical experience suggests that some patients obtain more significant relief from these procedures, making it reasonable to offer SIJ injections and/or RFA when conservative management has failed.

C. Definitions

- **Conservative Therapy** - A multimodal plan of care including both active and inactive conservative therapies.
  - **Active Conservative Therapies** - Actions or activities that strengthen supporting muscle groups and target key spinal structures, including physical therapy, occupational therapy, physician supervised home exercise program (HEP), and/or chiropractic care.
    - **HEP** - A six-week program requiring an exercise prescription and/or plan and a follow-up documented in the medical record after completion, or documentation of the inability to complete the HEP due to a stated physical reason (i.e., increased pain, inability to physically perform exercises). Patient inconvenience or noncompliance without explanation does not constitute an inability to complete.
  - **Inactive Conservative Therapies** - Passive activities by the patient that aid in treating symptoms associated with pain, including rest, ice, heat, medical

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devices, TENS use, and/or pharmacotherapy (prescription or over the counter [non-steroidal anti-inflammatory drugs, acetaminophen]).
    - **Transcutaneous Electrical Nerve Stimulator (TENS)** - A device that utilizes electrical current delivered through electrodes placed on the surface of the skin to decrease the patient's perception of pain by inhibiting the transmission of afferent pain nerve impulses and/or stimulating the release of endorphins. Its use, frequency, duration, and start dates must be documented in the medical record to be considered part of conservative therapy during the period of prior authorization request.
- **Radiofrequency Ablation (RFA)** - Minimally invasive treatment modality that percutaneously introduces an electrode under fluoroscopic guidance to thermocoagulate medial branches of the dorsal spinal nerves.
- **Sacroiliac Joint (SIJ) Injections** - Corticosteroid and local anesthetic therapeutic injections into the SIJ to treat pain that has not responded to conservative therapies.

D. Policy
  I. Sacroiliac Joint Injections
    A. Diagnostic injections: CareSource considers up to 2 diagnostic sacroiliac joint injections for the treatment of chronic low back pain medically necessary when **ALL** the following criteria are met:
      1. Somatic or nonradicular low back and/or lower extremity pain experienced for at least 3 months;
      2. Pain and tenderness located in the sacroiliac joint region;
      3. Positive response to at least one SIJ pain provocation test (e.g., distraction, compression, thigh thrust, Gaenslen's, Patrick's test/FABER test, sacral thrust)
      4. Failure of conservative therapy, as evidenced by **ALL** the following:
        a. Documentation in the medical record of: at least 6 weeks of active conservative therapy (as defined above) within the past 6 months OR inability to complete active conservative therapy due to contraindication, increased pain, or intolerance;
        b. Documentation in the medical record of at least 6 weeks of inactive conservative therapy (as defined above) within the past 6 months;
      5. If a second diagnostic injection is requested, at least 1 week has passed since the initial injection.
    B. Therapeutic injections: CareSource considers therapeutic sacroiliac joint injections medically necessary when **ALL** the following criteria are met:
      1. Most recent SIJ injection led to at least 75% pain relief and functional improvement;
      2. Member experiences return of pain or deterioration in function;
      3. Injection is to be used in conjunction with other conservative therapy (as defined above);
      4. Injection is repeated at a frequency no greater than every 2 months;
      5. No more than 4 injections total (diagnostic and therapeutic) have been administered at the same site in the last 12 months.
    C. Exclusions/Limitations:

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1. Codes 64451 and 27096 are considered the same procedure and may not be billed together. Only one code will be reimbursed.
2. Image guidance and/or injection of contrast is included in sacroiliac injection procedures and may not be billed separately.
3. If neural blockade is applied for different regions or different sides, injections are performed at least one week apart.
4. Pain management literature highlighting controlled studies of SIJ pain management has not demonstrated injections of the SIJ to be effective as a long-term management modality. Long-term continuation may be subject to medical necessity review.
5. Monitored anesthesia and conscious sedation are not medically necessary.
6. The use of SIJ injections for the treatment of pain as a result of Herpes Zoster is considered not medically necessary due to insufficient evidence demonstrating efficacy in the peer-reviewed published literature.

II. Radiofrequency Ablation of the SIJ
   A. Initial radiofrequency ablation of the SIJ
      Radiofrequency ablation is considered medically necessary when **ALL** the following have been met in the last 6 months:
      1. The clinical criteria above for failed conservative therapy (I.A.4.a. and I.A.4.b.) has been met; and
      2. One diagnostic injection per joint to evaluate pain and attain therapeutic effect has been performed, with a 75% or greater reduction in pain after injection was reported.
   B. Repeat radiofrequency ablation of the SIJ
      1. Conservative therapy and diagnostic injections are not required if there has been a reduction in pain for at least 12 months or more from the initial RFA within the last 36 months.
      2. When there has not been a repeat RFA in the last 36 months, a diagnostic injection is required.
      3. A maximum of 1 radiofrequency ablation for SIJ pain per side per 12 months is considered medically necessary.
   C. Exclusions/Limitations
      1. The use of cooled RFA for SIJ-mediated low back pain is considered not medically necessary due to insufficient evidence demonstrating efficacy in the peer-reviewed published literature.
      2. Pain management literature highlighting controlled studies of SIJ pain management has not demonstrated the effectiveness of RFA as a long-term management modality. Long-term continuation may be subject to medical necessity review.

III. Implantable Spinal Cord Stimulators
   Members with indwelling implanted spinal cord stimulators or pain pumps should have a device interrogation report submitted with medical records for a prior authorization request for proposed interventional pain injections. If a device is not functioning properly, an escalation in pain may warrant evaluation and management of the implanted device.

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E. Conditions of Coverage
NA

F. Related Policies/Rules
NA

G. Review/Revision History

	DATE	ACTION
Date Issued	04/13/2022	New policy
Date Revised	03/15/2023	Annual review: restructured conservative management and clinical criteria, added provocation tests. Approved at Committee.
Date Effective	GA, IN, KY, WV: 06/01/2023 OH: 07/01/2023	
Date Archived	GA, IN, KY, WV: 04/30/2024 OH: 04/30/2024	This Policy is no longer active and has been archived. Please note that there could be other Policies that may have some of the same rules incorporated and CareSource reserves the right to follow CMS/State/NCCI guidelines without a formal documented Policy.

H. References

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3. Chou R. (2021, June 11). Subacute and chronic low back pain: nonsurgical interventional treatment. UpToDate. Retrieved February 15, 2023 from www.uptodate.com.
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11. Simopoulos T, et al. A systematic evaluation of prevalence and diagnostic accuracy of sacroiliac joint interventions. Pain Phys. 2012 May-Jun;15(3):E305-E344. Retrieved February 15, 2023 from www.ncbi.nlm.nih.gov.
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I. State-Specific Information
   A. Georgia
      1. Effective: 06/01/2023
   B. Indiana
      1. Effective: 06/01/2023
   C. Kentucky
      1. Effective: 06/01/2023
   D. Ohio
      1. Effective: 07/01/2023
   E. West Virginia
      1. Effective: 06/01/2023

Independent medical review – March 2019

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