MEDICAL POLICY STATEMENT
GEORGIA MEDICAID

Policy Name		Policy Number	Date Effective
Sacroiliac Joint Procedures		MM-0215	10/01/2021-07/31/2022
Policy Type			
MEDICAL	Administrative	Pharmacy	Reimbursement

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.

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A. Subject

Sacroiliac Joint Procedures

B. Background

Interventional procedures for management of acute and chronic pain are part of a comprehensive pain management care plan that incorporates conservative treatment in a multimodality approach. 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. Interventional procedures for the management of pain unresponsive to conservative treatment should be provided only by physicians qualified to deliver these health services.

Up to 10% to 25% of patients with persistent low back pain may have a component of pain related to sacroiliac joints. However, no clear conservative, interventional or surgical management alternatives definitively manage sacroiliac joint pain. Clinicians apply various techniques with wide variation. Available evidence for the diagnostic accuracy of sacroiliac joint injections is good, the evidence for provocation maneuvers is fair, but evidence for imaging of the SI joint is inadequate. In a recent review, pain researchers reported that evidence is poor for short and long-term pain relief from both intra-articular and peri-articular injections of these joints with steroids.

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 SI joint dysfunction.

Professional Society Recommendations:
The following professional society's recommendations are derived from the latest guidelines and scientific based literature available.

American College of Physicians (ACP) (April 2017)
The ACP's recommendations for Noninvasive Treatments for Acute, Subacute and Chronic Low Back Pain: A Clinical Practice Guideline are as follows:

- Clinicians and patients should select nonpharmacological treatment with superficial heat (moderate-quality evidence), massage, acupuncture, or spinal manipulation (low-quality evidence). If pharmacologic treatment is desire, clinicians and patients should select nonsteroidal anti-inflammatory drugs or skeletal muscle relaxants (moderate-quality evidence);
- Clinicians and patients should initially select nonpharmacological treatment with exercise, multidisciplinary rehabilitation, acupuncture, mindfulness-based stress reduction, tai chi, yoga, motor control exercise, progressive relation, electromyography biofeedback, low –level laser therapy, operant therapy, cognitive behavioral therapy or spinal manipulation;
- In patients with chronic low back pain who have had an inadequate response to nonpharmacological therapy, clinicians and patients should consider pharmacologic treatment with nonsteroidal anti-inflammatory drugs as first line therapy, or tramadol or duloxetine as second-line therapy. Clinicians should only consider opioids as an option; and

in patients who have failed the aforementioned treatments and only if the potential benefits outweigh the risks for individual patients and after a discussion of known risks and realistic benefits with patients.

C. Definitions

- **Sacroiliac Joint Procedures** - Corticosteroid and local anesthetic therapeutic injections into the sacroiliac joint to treat pain that hasn't responded to conservative therapies.
- **Radiofrequency Facet Ablation (RFA) -** RFA is performed using percutaneous introduction of an electrode under fluoroscopic guidance to thermocoagulate medial branches of the dorsal spinal nerves.
- **Conservative Therapy -** Conservative Therapy is a multimodality plan of care. Multimodality care plans include ALL of the following:
  - **Active Conservative Therapies** - Such as physical therapy, occupational therapy or a physician supervised home exercise program (HEP)
  - **Inactive Conservative Therapies** - Such as rest, ice, heat, medical devices or TENS unit or prescription medications.
- **Transcutaneous Electrical Nerve Stimulator (TENS Unit) -** TENS Unit is a durable medical equipment device dispensed by prescription.

D. Policy

I. Sacroiliac Joint Procedures
   A. CareSource considers sacroiliac joint procedures for pain management medically necessary when the clinical criteria in this policy is met..
   A. Sacroiliac Joint Injection Codes
      1. Codes 64451 and 27096 are considered the same procedure and may not be billed together.
   B. Sacroiliac Joint Injections
      1. Two (2) diagnostic injections per joint to evaluate pain and attain therapeutic effect, repeating no more than once every seven (7) days and with at least a 75% or > reduction in pain after the first injection.
      2. Once the diagnostic injections are performed and the diagnosis is established, two (2) therapeutic injections per joint may be performed over a rolling 12 month period.
      3. Injections should not be repeated more frequently than every two (2) months with no more than a total of four (4) injections (including both diagnostic and therapeutic) per joint in a rolling 12 months.
   D. Image guidance and/or injection of contrast is included in sacroiliac injection procedures and may not be billed separately.
   E. If neural blockade is applied for different regions, or different sides, injections are performed at least one week apart.
   F. Sacroiliac joint injection for chronic back pain is medically necessary when pain has persisted despite appropriate medical management and ALL of the following criteria are met:
      1. Pain and tenderness are located in sacroiliac joint region.

2. ACTIVE conservative therapy as part of a multimodality comprehensive approach is addressed in the patient's care plan with documentation in the medical record that includes at least ONE of the following:
   a. The patient has received ACTIVE conservative therapy lasting for six (6) weeks or more within the past six (6) months including ONE of the following:
      01. Physical therapy;
      02. Occupational therapy; or
      03. A physician supervised home exercise program (HEP), including the following two requirements:
         (1). An exercise prescription and/or plan documented in the medical record;
         (2).A follow up documented in the medical record regarding completion of an HEP (after suitable six (6) week period), or inability to complete a 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 "inability to complete").

      OR
   b. The medical record documents at least ONE of the following exceptions to the 6 weeks ACTIVE conservative therapy requirement in the past 6 months:
      01. Moderate pain with significant functional loss at work or home;
      02. Severe pain unresponsive to outpatient medical management;
      03. Inability to tolerate non-surgical, non-injection care due to co-existing medical condition(s); or
      04. Prior successful injections for same specific condition with relief of at least three (3) months' duration.
   c. INACTIVE conservative therapy as part of a multimodality comprehensive approach is addressed in the patient's care plan with documentation in the medical record lasting for six (6) weeks or more within the past six (6) months that includes at least ONE of the following:
      01. Rest;
      02. Ice;
      03. Heat;
      04. Medical devices;
      05. TENS unit use as defined in CareSource policy;
         (1). If a TENS unit is part of the care plan, the frequency of use, and duration of use with dates must be documented in the medical record. General statements in the medical record such as "Patient has a TENS unit" do not document use, and will not suffice to meet this policy criterion.
      06. Pain medications (RX or OTC) such as: non-steroidal anti-inflammatory drugs (NSAIDS), acetaminophen. Opioid narcotics are not required for consideration.

G. Patients 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.

H. Initial Radiofrequency Ablation of the SI Joint
   1. A maximum of one (1) radiofrequency ablation for SI Joint pain per side per rolling twelve (12) months.
   2. Radiofrequency ablation is considered medically necessary when ALL of the following have been met in the last six (6) months.
      a. The clinical criteria above (E. 1. 2. (a.b.c.) has been met; and
      b. One (1) diagnostic injection per joint to evaluate pain and attain therapeutic effect has been performed, with at least a 75% or > reduction in pain after injection.
         01. Codes 64451 and 27096 are considered the same procedure and may not be billed together.

I. Repeat Radiofrequency Ablation of the SI Joint
   1. Conservative therapy and diagnostic injections are not required if there has been a reduction in pain for at least twelve (12) months or more from the initial RFA within the last thirty-six (36) months.
   2. When there has not been a repeat RFA in the last thirty-six (36) months, a diagnostic injection is required.

II. Inconclusive or Non-Supportive Evidence

Pain management literature highlighting controlled studies of SI joint pain management has not demonstrated injections of the SI joint to be effective as a long-term management modality.

Monitored anesthesia and conscious sedation will be denied for coverage for sacroiliac joint injections as not medically necessary.

A randomized placebo-controlled study in 28 patients was performed by Cohen et al for injection-diagnosed sacroiliac joint pain. One, 3, and 6 months after the procedure, 11 (79 %), 9 (64 %), and 8 (57 %) RF-treated patients experienced pain relief of 50 % or greater and significant functional improvement. The authors stated that larger trials with long-term follow-up and comprehensive outcome measures were needed to confirm their results.

Stelzer and colleagues retrospectively evaluated the use of cooled RFA neurotomy for SIJ-mediated low back pain in European subjects. No control group was present. The authors concluded that results showed promising improvements in pain, quality of life, and medication usage some subjects experiencing relief at 20 months after treatment. The study noted missing data for some subjects, and a variable length of time to final follow-up.

Pain management literature does not support the use of sacroiliac joint injections for the treatment of pain as a result of Herpes Zoster.

E. Conditions of Coverage

F. Related Polices/Rules

G. Review/Revision History

	DATE	ACTION
Date Issued	02/22/2018	New Policy
Date Revised	08/01/2019	Annual Update: Addition of PA clarification and documentation requirements. Revision of injection frequency.
	05/13/2020	Annual Update: Added clinical criteria for coverage of radiofrequency ablation of the SI Joint. Added coding information.
	04/28/2021	Annual Update: Removed PA language.
Date Effective	10/01/2021	
Date Archived	07/31/2022	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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8. W. Stelzer, M. Aiglesberger, D. Stelzer, and V. Stelzer, (2013, Jan). "Use of cooled radiofrequency lateral branch neurotomy for the treatment of sacroiliac joint-mediated low back pain: a large case series," Retrieved on April 9, 2021 from www.ncbi.nlm.nih.gov

The Medical Policy Statement detailed above has received due consideration as defined in the Medical Policy Statement Policy and is approved.

Independent medical review – March 2019

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