MEDICAL POLICY STATEMENT
Georgia Medicaid

Policy Name & Number	Date Effective
Sacroiliac Joint Procedures-GA MCD-MM-0215	08/01/2022-06/30/2023
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.

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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 it lasts between four and twelve weeks and chronic when it persists 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 (SI) joints. Comprehensive pain management care plans are most effective in managing patient's chronic pain. These plans forcus on a person-centered approach and incorporate conservative treatment with other modalities. These 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 SI joint 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 sacroiliac joint injections and/or RFA when conservative management has failed.

C. Definitions

- **Conservative Therapy** - A multimodality plan of care. Multimodality care plans include both active and inactive conservative therapies.
  - **Active Conservative Therapies** - Include physical therapy, occupational Therapy, and/or a physician supervised home exercise program (HEP)
  - **Inactive Conservative Therapies** - Include rest, ice, heat, medical devices or TENS unit, and/or prescription medications.
- **Radiofrequency Facet Ablation (RFA)** – Minimally invasive treatment modalitiy that percutaneously introduces an electrode under fluoroscopic guidance to thermocoagulate medial branches of the dorsal spinal nerves.
- **Sacroiliac Joint Procedures** - Corticosteroid and local anesthetic therapeutic injections into the sacroiliac joint to treat pain that hasn't responded to conservative therapies.
- **Transcutaneous Electrical Nerve Stimulator (TENS Unit)** - A durable medical equipment device dispensed by prescription.

D. Policy
I. Sacroiliac Joint Procedures
A. Initial Injections: CareSource considers sacroiliac joint injection for pain management medically necessary when **ALL** the following criteria are met:
1. Pain and tenderness are located in sacroiliac joint region.
2. Pain has failed to resolve after the patient has completed six consecutive months of conservative management, including **ALL** the following:
a. The patient has documentation, including dates of service, addressing ACTIVE conservative therapy as part of a multimodality comprehensive plan of care in the medical record that includes **ONE** of the following:
01. The patient has received ACTIVE conservative therapy lasting for 6 weeks or more within the past 6 months including **at least ONE** of the following:
(1). Physical therapy;
(2). Occupational therapy;
(3). A physician supervised home exercise program (HEP), including the following two requirements:
i. An exercise prescription and/or plan documented in the medical record; and
ii. A follow up documented in the medical record regarding completion of an HEP (after suitable 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
02. The medical record documents **at least ONE** of the following exceptions to the 6 weeks ACTIVE conservative therapy requirement in the past 6 months:
(1). Moderate pain with significant functional loss at work or home;
(2). Severe pain unresponsive to outpatient medical management;
(3). Inability to tolerate non-surgical, non-injection care due to co-existing medical condition(s);
(4). Prior successful injections for same specific condition with relief of at least 3 months’ duration;
b. Patient has documentation of INACTIVE conservative therapy as part of a multimodality comprehensive approach addressed in the patient’s care plan with documentation in the medical record lasting for 6 weeks or more within the past 6 months that includes **at least ONE** of the following:
01. Rest;
02. Ice;
03. Heat;
04. Medical devices;
05. Acupuncture;
06. TENS unit;
(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;

07. Pain medications (prescription or over the counter) (e.g., non-steroidal anti-inflammatory drugs (NSAIDS), acetaminophen). Opioid narcotics are not required for consideration.

B. Repeat Injections:
   1. Two (2) diagnostic injections per joint to evaluate pain and attain therapeutic effect, repeating no more than once every 7 days.
   2. For repeat therapeutic injections, there must be documentation of at least a 75% or greater reduction in pain with the prior injection.
   3. Once the diagnostic injections are performed and the diagnosis is established, 2 therapeutic injections per joint may be performed over a rolling 12-month period.
   4. Injections should not be repeated more frequently than every 2 months with no more than a total of 4 injections, including both diagnostic and therapeutic, per joint in a rolling 12 months.

C. Exclusions/Limitations
   1. Codes 64451 and 27096 are considered the same procedure and may not be billed together.
   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 SI joint pain management has not demonstrated injections of the SI joint 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 will be denied for coverage for sacroiliac joint injections as not medically necessary.
   6. The use of SI joint 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. Spinal Cord Stimulators/Pain Pumps

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.

III. Radiofrequency Ablation of the SI Joint

A. Initial Radiofrequency Ablation of the SI Joint
   1. Radiofrequency ablation is considered medically necessary when **ALL** the following have been met in the last 6 months:

a. The clinical criteria above for failed conservative therapy (I.A.2.a. and b.) has been met; and
b. 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.

B. 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 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 SI joint pain per side per rolling 12 months is considered medically necessary.

C. Exclusions/Limitations
1. Codes 64451 and 27096 are considered the same procedure and may not be billed together. Only one code will be reimbursed.
2. The use of cooled RFA for SI joint-mediated low back pain is considered not medically necessary due to insufficient evidence demonstrating efficacy in the peer-reviewed published literature.
3. Pain management literature highlighting controlled studies of SI joint 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.

E. Conditions of Coverage
NA

F. Related Polices/Rules
NA

G. Review/Revision History

	DATE	ACTION
Date Issued	02/22/2018	New Policy
Date Revised	08/01/2019 05/13/2020 04/28/2021 04/06/2022	Annual Update: Addition of PA clarification and documentation requirements. Revision of injection frequency. Annual Update: Added clinical criteria for coverage of radiofrequency ablation of the SI Joint. Added coding information. Annual Update: Removed PA language. Annual Review: Updated references and background, re-organized criteria by procedure and initial vs repeat procedure
Date Effective	08/01/2022	
Date Archived	06/30/2023	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.

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

H. References

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