CareSource

MEDICAL POLICY STATEMENT INDIANA MEDICAID			
Policy Name		**Policy Number**	**Date Effective**
Sacroiliac Joint Procedures		MM-0104	08/01/2019
Policy Type			
MEDICAL	Administrative	Pharmacy	Reimbursement

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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.

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) & American Pain Society (APS) (October 2007)

Diagnosis and Treatment of Low Back Pain: A Joint Clinical Practice Guideline from the American College of Physicians and the American Pain Society.

- Clinicians should conduct a focused history and physical examination to help place patients with low back pain into 1 of 3 broad categories: nonspecific low back pain, back pain potentially associated with radiculopathy or spinal stenosis, or back pain potentially associated with another specific spinal cause. The history should include assessment of psychosocial risk factors, which predict risk for chronic disabling back pain.
- Clinicians should not routinely obtain imaging or other diagnostic tests in patients with nonspecific low back pain.
- Clinicians should perform diagnostic imaging and testing for patients with low back pain when severe or progressive neurologic deficits are present or when serious underlying conditions are suspected on the basis of history and physical examination.
- Clinicians should evaluate patients with persistent low back pain and signs or symptoms of radiculopathy or spinal stenosis with magnetic resonance imaging (preferred) or computed tomography only if they are potential candidates for surgery or epidural steroid injection.
- Clinicians should provide patients with evidence-based information on low back pain with regard to their expected course, advise patients to remain active, and provide information about effective self-care options.
- For patients with low back pain, clinicians should consider the use of medications with proven benefits in conjunction with back care information and self-care. Clinicians should assess severity of baseline pain and functional deficits, potential benefits, risks, and relative lack of long-term efficacy and safety data before initiating therapy. For most patients, first-line medication options are acetaminophen or nonsteroidal anti-inflammatory drugs.
- For patients who do not improve with self-care options, clinicians should consider the addition of nonpharmacological therapy with proven benefits—for acute low back pain, spinal manipulation; for chronic or subacute low back pain, intensive interdisciplinary

rehabilitation, exercise therapy, acupuncture, massage therapy, spinal manipulation, yoga, cognitive-behavioral therapy, or progressive relaxation.

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. 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

- **Conservative therapy** is a multimodality plan of care. Start and end dates in the medical record substantiate duration of treatment. Multimodality care plans include **BOTH** of the following:
  - **Active conservative therapies** such as physical therapy, occupational therapy or a physician supervised home exercise program (HEP)
    - **Home Exercise Program (HEP):** includes two components that are both required to meet CareSource policy for completion of conservative therapy:
      - Information provided for an exercise prescription and/or plan documented in the medical record AND follow up documented in the medical record with member with information provided regarding completion of HEP (after suitable six (6) week period), or inability to complete 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").
  - **Passive conservative therapies** such as rest, ice, heat, medical devices, acupuncture, TENS unit, prescription medications.
    - 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.
- **A TENS unit is a Transcutaneous Electrical Nerve Stimulator** is a durable medical equipment device dispensed by prescription.

D. POLICY

Criteria

A prior authorization (PA) is required for each sacroiliac joint injection for pain management.

I. Injection Frequency:
   A. When the medical criteria below is met four (4) sacroiliac injections per joint may be given in a 12 month period.
      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 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 12 months.

II. 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:
   A. Pain and tenderness are located in sacroiliac joint region.
   B. 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:**
      1. The patient has received ACTIVE conservative therapy lasting for six (6) weeks or more within the past six (6) months with start and end dates in the medical record substantiating the duration of treatment including **ONE of the following:**
         1.1 physical therapy
         1.2 occupational therapy
         1.3 a physician supervised home exercise program (HEP) as defined in CareSource policy
      2. Or, the medical record documents at least **ONE of the following** exceptions to the 6 weeks ACTIVE conservative therapy requirement in the past 6 months:
         2.1 at least moderate pain with significant functional loss at work or home
         2.2 severe pain unresponsive to outpatient medical management
         2.3 inability to tolerate non-surgical, non-injection care due to co-existing medical condition(s)
         2.4 prior successful injections for same specific condition with relief of at least 3 months' duration
   C. PASSIVE 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 with start and end dates in the medical record substantiating the duration of treatment that includes at least **ONE of the following:**
      1. rest
      2. ice
      3. heat
      4. medical devices
      5. acupuncture
      6. TENS unit use as defined in CareSource policy
      7. Pain medications (RX or OTC) such as: non-steroidal anti-inflammatory drugs (NSAIDS), acetaminophen. Opioid narcotics are not required for consideration.

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.
Image guidance and/or injection of contrast for sacroiliac joint injections for pain will be denied for coverage as not medically necessary.

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.

If neural blockade is applied for different regions, or different sides, injections are performed at least one week apart.

III. **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.

Thermal or pulsed, cooled **sacroiliac neurotomy** by Radio-Frequency Ablation (RFA) or other techniques for sacroiliac pain are not covered due to insufficient, limited, or inconclusive published data. Also, sacroiliac neurotomy billed as a facet medical branch nerve block are not allowed coverage. Studies provide limited evidence regarding the efficacy and safety of thermal radiofrequency ablation (TRA), for individuals with SI joint pain, and contain insufficient data that allows for definitive conclusions.

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.

Sacroiliac joint fusion procedures are not covered due to limited data, mixed outcomes, and inconclusive evidence. A systematic review in 2015 and evaluated 16 peer reviewed articles with follow up a year or more. Mean duration of follow-up was 60 months for open surgery and 21 months for minimally invasive surgery. Patient satisfaction with surgery ranged from 56% to 100%, and a mean of 84% for 430 patients evaluated. Major complication occurred in 5% to 20%, with 1 study reporting a 56% adverse event rate. The authors concluded that surgical intervention for SIJ pain is beneficial in a subset of patients. However, with the difficulty in accurate diagnosis and evidence for the efficacy of SIJ fusion itself lacking, serious consideration of the cause of pain and treatment options should be given before performing the operation.[10] An industry-sponsored prospective randomized controlled crossover trial in 148 patients evaluated minimally invasive sacroiliac joint fusion using triangular titanium implants vs nonsurgical management evaluated patients at 6- and 12-months follow-up. Surgical titanium implants were more effective than non-surgical management in relieving pain,

improving function and improving quality of life in patients with SI joint dysfunction due to degenerative sacroiliitis or SI joint disruptions. Six month success rates were higher in the surgical group and sustained at 12 months. Adverse events were slightly more common in the surgical group (1.3 vs 1.1 events per subject; P = .31). A narrow group of patients were selected for randomization. The patient candidates included only those with unilateral pain caudal to the lumbar spine, 3 physical exam criteria, and 3 positive provocative tests, including a 75% reduction in SI joint pain on 2 occasions, and a trial of at least one SI joint injection, for example with corticosteroids.

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.

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 POLICIES/RULES

Pain Management PY-0127

G. REVIEW/REVISION HISTORY

DATES		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.
Date Effective	08/01/2019	

H. REFERENCES

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

Independent medical review – 2/2018

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