The following Protocol contains medical necessity criteria that apply for this service. It is applicable to Medicare Advantage products unless separate Medicare Advantage criteria are indicated. If the criteria are not met, reimbursement will be denied and the patient cannot be billed. Preauthorization is required. Please note that payment for covered services is subject to eligibility and the limitations noted in the patient’s contract at the time the services are rendered.

Description

Sacroiliac joint arthrography using fluoroscopic guidance with injection of an anesthetic has been explored as a diagnostic test for sacroiliac joint pain. In 20-30% of these patients, 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 injection of local anesthetic.

Background

Similar to other structures in the spine, it is assumed that the sacroiliac joint may be a source of 15-25% of low back pain. In fact, prior to 1928, the sacroiliac joint 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 sacroiliac joint received less research attention.

Research into sacroiliac joint pain has been thwarted by any criterion standard to measure its prevalence and against which various clinical examinations can be validated. For example, sacroiliac joint pain is typically without any consistent, demonstrable radiographic or laboratory features and most commonly exists in the setting of morphologically normal joints. Clinical tests for sacroiliac joint pain may include various movement tests, palpation to detect tenderness, and pain descriptions by the patient. Further confounding the study of the sacroiliac joint is that multiple structures, such as posterior facet joints and lumbar discs, may refer pain to the area surrounding the sacroiliac joint.

Because of inconsistent information obtained from history and physical examination, some have proposed the use of image-guided anesthetic injection into the sacroiliac joint for the diagnosis of sacroiliac joint pain. Treatments being investigated for sacroiliac joint pain include prolotherapy, corticosteroid injection, and radiofrequency ablation.

Regulatory Status

A number of radiofrequency generators and probes have been cleared for marketing through the U.S. Food and Drug Administration’s (FDA) 510(k) process. One device, the SInergy® by Kimberly Clark/Baylis, is a water-cooled single-use probe that received FDA clearance in 2005, listing the Baylis Pain Management Probe as a predicate device. The intended use is in conjunction with a radiofrequency generator to create radiofrequency lesions in nervous tissue.

Several percutaneous or minimally invasive fixation/fusion devices have received marketing clearance by the FDA. These include the SI-FIX Sacroiliac Joint Fusion System (Medtronic), the IFUSE Implant System (SI Bone), the Symmetry Sacroiliac Joint Fusion System (Zyga Technologies) and the SI-LOK (Globus Medical).
Related Protocols
Prolotherapy
Facet Joint Denervation

Policy (Formerly Corporate Medical Guideline)
Sacroiliac (SI) joint injection using fluoroscopic guidance* may be medically necessary in the absence of significant lumbar spine (LS) disease and/or hip disease which may cause back, buttock or hip pain, if ALL of the following have been done:

- History and physical findings, including three or more positive provocation (see Policy Guideline), AND
- A trial of physical therapy/exercise therapy/chiropractic for four to six weeks with no improvement, AND
- A trial of non steroidal anti-inflammatory medications (NSAIDS) for four to six weeks with no improvement.

SI joint injection using fluoroscopic guidance* may be medically necessary, in the presence of significant lumbar spine disease and/or hip disease which may cause back, buttock or hip pain, if ALL of the following have been done:

- History and physical findings, including three or more positive provocation tests (see Policy Guideline), AND
- A trial of physical therapy/exercise therapy/chiropractic for four to six weeks with no improvement, AND
- A trial of anti-inflammatory medications (NSAIDS) for four to six weeks with no improvement, AND
- Epidural spinal injection (ESI) if significant LS spine findings for which the injection is indicated or lumbar spine surgery if indicated. After therapy, patient must have persistence of pain or a component of pain attributable to possible SI disease rather than LS spine disease, AND/OR
- Intra-articular injection of hip or hip surgery if indicated. After therapy, patient must have persistence of pain or a component of pain attributable to possible SI disease rather than hip disease.

If the above criteria are not met, then sacroiliac (SI) joint injection is considered investigational. Sacroiliac (SI) joint injection performed without fluoroscopic guidance is considered investigational.

Radiofrequency ablation of the sacroiliac joint is considered investigational.

Fusion/stabilization of the sacroiliac joint for the treatment of back pain presumed to originate from the SI joint is considered investigational, including but not limited to percutaneous and minimally invasive techniques.

Policy Guideline
Pain provocation tests include:

Compression Test
With the patient in a side-lying position, downward pressure is applied to the uppermost iliac crest, directed toward the opposite iliac crest. It is intended to stretch the posterior sacroiliac ligaments and compress the anterior SI joint. Pain in the SI joint is felt to represent a positive test. But this test has a sensitivity and specificity of only about 60 – 70%.

Thigh Thrust Test
This is more sensitive (~ 90%) but has similar specificity to the compression test. With the patient supine, the hip is flexed to 90° and the knee is bent. The examiner applies posterior shearing stress to the SI joint through the femur. Excessive adduction of the hip is avoided, as combined flexion and adduction is normally painful.
Gaenslen’s Test

With the patient supine, the hip is maximally flexed on one side, and the opposite hip is extended. This maneuver stresses both SI joints simultaneously by counterrotation at the extreme range of motion. This test also stresses the hip joints and stretches the femoral nerve on the side of hip extension, so care is taken to ensure normal hip findings and the absence of neurologic conditions affecting the femoral nerve.

Distraction Test

This test is performed with the patient supine. A posterior and lateral force is applied to both anterior superior iliac spines to stretch the anterior sacroiliac ligaments and synovium.

Patrick’s Sign

Patrick’s sign is elicited by stressing the hip and SI joint by flexion, abduction, and external rotation of the hip. A positive test reproduces back or buttock pain, whereas groin pain is more indicative of hip joint pathology.

*Sacroiliac joint injections must be done with fluoroscopic guidance as not using guidance results in a successful injection only 22% of the time.

Medicare Advantage

Sacroiliac (SI) joint injections would be considered medically necessary for the diagnosis and/or treatment of chronic low back pain that is considered to be secondary to suspected sacroiliac joint dysfunction. Diagnostic and therapeutic injections of the SI joint would not likely be performed unless conservative therapy and noninvasive treatments (i.e., rest, physical therapy, NSAIDs, etc.) have failed.

Diagnostic blocks of a sacroiliac joint can be medically necessary to determine whether it is the source of low back pain. Arthropathy (joint disease) is diagnosed through a double-comparative local anesthetic blockade of the joint by the intra-articular injection of a small volume of local anesthetics (2 to 3 ml) of different durations of actions. A positive response should demonstrate initial pain relief greater than or equal to (> =) 80% - 90% and the ability to perform previously painful maneuvers. Steroids may be injected in addition to the local anesthetic.

Therapeutic sacroiliac (SI) joint injections of an anesthetic and/or steroid to block the joint for immediate, and potentially long lasting, pain relief are considered medically necessary if it is determined that the SI joint is the source of pain in the lower back. No more than four therapeutic injections (interlaminar or caudal epidural, transforaminal epidural, paravertebral facet joint or nerve, and/or sacroiliac joint) per region per patient per year are anticipated for the majority of patients.

SI joint arthrography and/or therapeutic injection of an anesthetic/steroid are only appropriate when imaging confirmation of intra-articular needle positioning with applicable radiological and/or fluoroscopic procedures have been performed.

If previous diagnostic or therapeutic SI injections of an anesthetic and/or steroid to block the joint for immediate, and potentially long lasting, pain relief have not effectively relieved the pain, further injections would not be considered medically necessary. Sacroiliac joint injection would also not be medically necessary for pain associated with “myofascial pain syndrome.”

Services that are the subject of a clinical trial do not meet our Technology Assessment Protocol criteria and are considered investigational. For explanation of experimental and investigational, please refer to the Technology Assessment Protocol.
It is expected that only appropriate and medically necessary services will be rendered. We reserve the right to conduct prepayment and postpayment reviews to assess the medical appropriateness of the above-referenced procedures. Some of this Protocol may not pertain to the patients you provide care to, as it may relate to products that are not available in your geographic area.

References

We are not responsible for the continuing viability of web site addresses that may be listed in any references below.


