Sacroiliac Joint Interventions for Pain Relief

Spine, Pain, and Joint (SPJ) Utilization Management Policy

Effective Date: 06/13/2024

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Policy Statement

Intraarticular SIJ injections would be considered medically necessary when the following criteria are met:

- At least three months of moderate to severe pain with functional impairment inadequately responsive to conservative care such as NSAIDS, a prescribed home exercise program, activity modification and physical/chiropractic therapy. (Qaseem, 2017; Al-Subahi, 2017)
- Predominant lower axial spine pain primarily over the location of the SIJ(s) between the upper level of the iliac crests and gluteal fold that is not associated with radiculopathy or neurogenic claudication. (Treede, 2018)
- Clinical assessment, including positive provocative testing, implicates the sacroiliac joint as the potential source of pain. (MacVicar, 2017)

Diagnostic intraarticular SIJ injections:

- Two diagnostic SIJ sessions (unilateral or bilateral) are allowed and may be performed at a minimum of two weeks apart. (Manchikanti, 2013) The patient should experience at least 75% pain relief after the first intraarticular SIJ injection. Imaging guidance with fluoroscopy or CT should be utilized. (Buchanan, 2021; MacVicar, 2017; Manchikanti, 2013)

Therapeutic intraarticular SIJ injections:

- Two diagnostic sacroiliac joint injections have provided ≥ 75% relief of the primary axial pain consistent with the expected physiological effects of the agents and the ability of the patient to perform previously painful movements. (Buchanan, 2021)
- The therapeutic injections should provide greater than 50% improvement in pain and function for at least 10 weeks. Imaging guidance with fluoroscopy or CT should be utilized. (MacVicar, 2017; Buchanan, 2021)
- No more than four therapeutic SIJ sessions per 12 month period (unilateral or bilateral) are allowed. (Manchikanti, 2013)
- Repeat therapeutic SIJ injections to treat recurrent SIJ pain in a patient who has failed other conservative measures may be covered without repeating the diagnostic injections if the patient has experienced expected or prolonged pain relief with improvement in function for at least 10 weeks in the past following therapeutic SIJ injections. No more than four therapeutic SIJ injection sessions should be performed per 12-month period.

Radiofrequency neurotomy/denervation of the SIJ would be considered unproven and not medically necessary for the treatment of SIJ pain as its effectiveness has not been established. Additional well-designed studies are necessary to support the effectiveness of cooled radiofrequency neurotomy. High-quality well-designed studies are also necessary to support the effectiveness of conventional and pulsed radiofrequency neurotomy. Therefore, diagnostic branch nerve blocks for subsequent ablative procedures and pain relief would also be considered unproven and not medically necessary.

Scope

All in and out of network programs where utilization review determinations are rendered. This policy also serves as a resource for peer-to-peer interactions in describing the position of Optum on the reporting of interventions for the treatment of SIJ pain.

Background

In patients with chronic low back pain, the SIJ has been identified as the cause in 15-30% of the cases. (Buchanan, 2021) However, in the diagnosis of low back pain, there is no universally accepted gold standard treatment even if the suspected source is SIJ(s). (Manchikanti, 2013) SIJ dysfunction and pain can result from degenerative conditions such as arthritis or age, trauma, pregnancy, or prior spine surgery. Radiological imaging is essential to eliminate diagnoses such as infection, malignancy, or fracture. (Buchanan, 2021) Intraarticular SIJ injections may be used both diagnostically and therapeutically for SIJ pain. These injections may include a local anesthetic (diagnostic) or a combination of local anesthetic and corticosteroids (therapeutic) which are introduced into the joint. (Wu, 2023; Buchanan, 2021)

Fluoroscopic or CT guidance should be utilized for SIJ injections. When used in the diagnosis of SIJ pain, the initial SIJ block is determined as successful if the patient experiences >75% pain relief. Therapeutic injections may provide prolonged SIJ pain relief for six weeks or more. Repeat injections may be required. (Wu, 2023)

Provocative tests that may be utilized to identify SIJ pain and dysfunction may include (Buchanan, 2021):

- Compression test
- Distraction test
- Thigh thrust or Posterior Shear test
- Gaenslen test
- Patrick's sign or FABER test
- Yeoman test

Injections into the sacral lateral branch nerves are used exclusively to predict a positive response to radiofrequency neurotomy and not as a diagnostic assessment for SIJ dysfunction. There is a paucity of literature for their use as a prognostic test when considering surgical procedures such as SIJ fusion. (Buchanan, 2021)

Pain and soreness are the most common complaints following SIJ intraarticular injections. Rare complications may include nerve trauma, hematoma, sciatic palsy, abscess, meningitis, and systemic infection. (Wu, 2023)

Absolute contraindications of SIJ injections include:

- History of allergy to steroid agents
- Local malignancy

Relative contraindications include:

- Current or recent use of blood-thinners or history of coagulopathy
- Pregnancy
- Systemic infection, septic joint, osteomyelitis
- Diabetes mellitus II with poor glycemic control (Wu, 2023)

Clinical Evidence

SIJ intraarticular injections

A Health Technology Assessment by Hayes (2023) on SIJ injection with corticosteroids for SIJ and low back pain indicates the body of evidence is of overall low-quality. There are uncertainties for both diagnostic and therapeutic injections due to lack of standardized patient selection and treatment protocols, assessment intervals, and effectiveness assessment methodology. Chronic low back pain is defined by the NIH as a back problem that persists for ≥3 months with pain on ≥50% of days in the previous six months. Of the six studies included in this technology assessment, only two identified corticosteroid injection as significantly improving pain from baseline while the other four studies identified no significant improvement. A Hayes rating of "C" indicates there is low-quality evidence that SIJ corticosteroid injections are safe but with inconsistent outcomes for pain relief in short to intermediate duration compared to baseline.

Buchanan et al (2021) note studies on the effectiveness of SIJ injections are sparse. There is also lack of standardization in patient selection, steroid dosing, use of imaging and injection procedures. SIJ dysfunction is typically validated when at least three provocative tests are positive with an 85% probability that an intraarticular SIJ injection would be successful. Imaging with X-rays and MRIs can rule out red flags that may be the etiology of the SIJ pain. Intraarticular SIJ blocks utilizing anesthetics and/or steroids are used diagnostically to confirm SIJ dysfunction. Fluoroscopic or CT guidance should be utilized for accurate needle placement. Some guidelines on this topic recommend a single diagnostic injection while others recommend two diagnostic blocks using different anesthetic agents. Recent recommendations for diagnostic SIJ injections include a reduction of pain >75% using dual injections prior to therapeutic SIJ injections.

A multicenter study by Cohen et al (2022) assessed three treatment options for low back pain (LBP) which included epidural steroid injections, sacroiliac joint injections and facet interventions (n=346). All procedures were performed by a pain medicine physician (or a trainee with direct supervision) utilizing fluoroscopic guidance. The SIJ intraarticular injections (n=67) were considered as diagnostically positive when ≥50% pain reduction lasting at least three hours was achieved. Fifty percent of the SIJ injection cohort experienced a positive response as measured by ≥50%-79% pain reduction. All three cohorts were found to have significantly reduced NRS pain scores from baseline with no significant differences noted between the groups. The limitations of this study included assessment of three different LBP etiologies and treatments, lenient inclusion criteria, and inter-rater reliability variability.

A retrospective analysis by Young et al (2022) evaluated the use of intraarticular steroid injections and lateral branch radiofrequency neurotomy for the treatment of SIJ pain. Data from electronic medical records identified 354 patients who had received 930 SIJ intraarticular injections and 19 patients who had received 41 SIJ lateral branch

radiofrequency neurotomies. In the SIJ steroid injection group, 196 patients had received one injection and 154 had received serial injections averaging 4.76 injections each patient. Both cohorts demonstrated significant self-reported pain reduction with the radiofrequency patients experiencing 82 days of pain relief and the steroid injection patients experiencing 38 days of pain relief. Secondary outcome assessing ECOG functional scores demonstrated some improvement in the SIJ injection cohort but were not statistically significant.

Chen et al (2022) performed a double-blinded, randomized study comparing intraarticular injections of corticosteroids to intraarticular injections of platelet rich plasma (PRP) for SIJ pain. Out of the 64 subjects eligible for study participation, only 26 achieved a positive response to a diagnostic block. These 26 subjects were randomized to either fluoroscopically guided intraarticular SIJ injection of either steroid (n=11) or PRP (n=15). At follow-up periods of 1, 3, and 6 months, both cohorts experienced improvement in pain level. However, the steroid cohort reported lower pain scores than did the cohort that received PRP injections. The steroid cohort also had more responders (NPRS scores improving ≥50% from baseline) at 1 and 3 months than the PRP cohort experienced.

The International Society for the Advancement of Spine Surgery (Lorio, 2020) indicated that an acute reduction in pain at the SIJ joint following intraarticular block with local anesthetic is a positive test that suggests the injected joint is a pain generator. However, there is no high-level evidence that supports the short- or long-term efficacy of intraarticular SIJ steroid injections. There have been no studies demonstrating long-term relief in pain or confirming the benefit of multiple repetitive injections. No predictive correlation has been found between a positive response to lateral branch blocks or SIJ anesthesia and a subsequent positive response to radiofrequency ablation.

The American Society of Pain and Neuroscience (ASPN) published an evidence-based guideline on the treatment of low back pain (Sayed, 2022). This guideline included evidence on sacroiliac joint injections and indicated they are the most common and often first-line therapy for SIJ dysfunction. If a patient has a positive response to at least three provocative tests, the likelihood of a positive outcome to a diagnostic SIJ block can be predicted. In a diagnostic SIJ block, an anesthetic is injected into the posterior SIJ under image-guidance and if there is a certain degree of pre-defined pain relief following the injection for the duration of the anesthetic, the diagnosis of SIJ dysfunction is established. In therapeutic SIJ injections, a local anesthetic is combined with a corticosteroid to provide pain relief in the SIJ. Intraarticular therapeutic injections have proven superior to periarticular injections. Ultrasound guidance for injections cannot verify intraarticular placement and is inferior to fluoroscopic guidance. CT guidance can be utilized but has been identified as less effective than fluoroscopy. Based on two RCTs and several observational studies, the committee's strong recommendation was that sacroiliac joint injections are associated with positive predictive value in the diagnosis of SIJ dysfunction and moderate recommendation that sacroiliac joint injections demonstrate short term relief.

In 2020, the North American Spine Society (NASS) listed recommendations for the diagnosis and treatment of low back pain. These recommendations included the use of intra-articular steroid joint injections for patients with suspected SI joint pain. This recommendation was graded as C: poor quality evidence (Level IV or V studies) for or against the recommending intervention.

The Spine Intervention Society (MacVicar, 2017) recommends proceeding with image-guided local anesthetic and steroid injections for those patients who have significant SIJ pain and functional limitation. Therapeutic injections of steroid with local anesthetic, injections of steroid alone, and lateral branch blocks would all be considered appropriate after an initial diagnostic injection that provided >75% pain relief. Additional injections of local anesthetic and steroid would be appropriate if there was at least 50% relief following an initial therapeutic injection of at least 75% relief after a subsequent injection.

A 2010 updated report by the American Society of Anesthesiologists Task Force on Chronic Pain Management and the American Society of Regional Anesthesia and Pain Medicine indicates SIJ injections may be considered for symptomatic relief of sacroiliac joint pain. The literature, however, is insufficient to evaluate the efficacy of sacroiliac joint injections for pain relief (Category D evidence).

The International Association for the Study of Pain (IASP) provides criteria for diagnosing SIJ dysfunction. These criteria include pain around the area of the SIJ which is reproducible with provocative tests and relieved with local anesthetic injection into the SIJ or lateral branch nerves. (Treede, 2018)

SIJ radiofrequency neurotomy/denervation and diagnostic nerve blocks

A Hayes Health Technology Assessment (2022) on cooled and pulsed radiofrequency for chronic SIJ pain indicates the body of evidence is overall of low-quality for evaluating cooled RFA for treatment of SIJ pain. The long-term efficacy of cooled RFA on quality of life is uncertain. The effectiveness of cooled RFA compared with other treatment

for chronic SIJ pain is also uncertain. For pulsed RFA, the body of evidence is noted as overall very low-quality on its efficacy for treating SIJ pain. Again, it is uncertain whether pulsed RFA reduces pain long-term and improves physical function or quality of life. Its effectiveness compared to other treatments for SIJ pain is also uncertain. The authors indicate the prognostic validity of minimum levels of pain relieved by diagnostic blocks remains in question. Cooled radiofrequency for treatment of chronic SIJ pain received a Hayes rating of "C" (potential but unproven benefit) and pulsed radiofrequency received a Hayes rating of "D^2" (insufficient evidence).

An additional Hayes Health Technology Assessment (2022) reviewed conventional RFA for chronic SIJ pain unresponsive to conventional treatment. The body of evidence is noted as overall low-quality for the reduction of pain as uncertainty remains for long-term durability. It is also uncertain whether conventional RFA treatment results in decreased pain medication use, improved quality of life and improved function. The patient selection criteria for this treatment has not been defined. Conventional RFA for SIJ denervation to treat chronic low back pain in adults received a Hayes rating of "C" (potential but unproven benefit).

van Tilburg et al (2016) identified no significant difference in pain reduction outcomes between conventional radiofrequency ablation and placebo treatment for SIJ pain relief. Sixty patients with history and exam findings suggestive of sacroiliac joint pain were randomized to a cohort (n=30) receiving percutaneous radiofrequency heat lesion to the lateral branches of S1, S2, S3, and S4 and posterior ramus dorsalis of L5. The second cohort (n=30) comprised the sham group with the same procedure except for the radiofrequency heat lesion. The proportion of patients in the sham cohort reporting significant pain relief was higher than the cohort who received the actual radiofrequency treatment.

Juch et al (2017) published three randomized controlled trials which included 681 patients with chronic low back pain. These patients had a positive diagnostic block at the facet joints (n=251), the sacroiliac joints (n=228) or a combination of fact joints, sacroiliac joints, or intervertebral discs (n=202) and had been unresponsive to conservative care. All patients participated in a 3-month exercise program. The treatment cohort also received radiofrequency denervation. No statistically significant improvement in pain relief was demonstrated between the cohort who underwent a standardized exercise program plus radiofrequency ablation and the cohort treated with a standardized exercise program alone.

A guideline from the American Society of Interventional Pain Physicians (Manchikanti, 2013) rates the evidence for cooled radiofrequency ablation as fair. For conventional and pulsed RFA, the evidence is rated as limited. Patient selection for RFA is not clearly defined and there is no standard approach for denervation of the SIJ. In regards to diagnostic selective nerve root blocks, the evidence is noted as limited.

Chou et al (2021) published an AHRQ comparative effectiveness review on interventional treatments for acute and chronic pain. This systematic review included the use of cooled radiofrequency denervation for treatment of sacroiliac pain. The authors indicate the prior trials evaluating this intervention utilized different techniques with insufficient evidence to determine the optimal method. One previous trial utilized cooled radiofrequency denervation to the S1 to S3 lateral branches and conventional radiofrequency to the L4 and L5 dorsal rami. The other trial utilized cooled radiofrequency to the L5 dorsal ramus and S1 to S3 sites. Both of these trials, however, required patients to have at least 75% pain reduction from a diagnostic block.

A meta-analysis by Sun et al (2018) evaluated the safety and efficacy of cooled RFA for the treatment of chronic SIJ pain. Seven studies (n=240) met the authors' inclusion criteria. The pooled results demonstrated a decrease in pain intensity following the cooled RFA treatment compared to the pain intensity prior to treatment. Mild complications were noted among the seven studies including hip pain, soreness, and numbness. Limitations to this review included the small sample size of the trials and the heterogeneity among the studies. Additional large high-quality randomized controlled trials are necessary in order to substantiate the findings of this meta-analysis.

Coding Information

Code	Description
SIJ intraarticular injections	
27096	Injection procedure for sacroiliac joint, anesthetic/steroid, with image guidance (fluoroscopy or CT) including arthrography when performed

G0260	Injection procedure for sacroiliac joint; provision of anesthetic, steroid and/or other therapeutic agent with or without arthrography
SIJ radiofrequency neurotomy and SIJ nerve blocks	
64625	Radiofrequency ablation, nerves innervating the sacroiliac joint, with image guidance (ie, fluoroscopy or computed tomography)
64451	Injection(s), anesthetic agent(s) and/or steroid; nerves innervating the sacroiliac joint, with image guidance (ie, fluoroscopy or computed tomography)

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Review and Approval History

Date	Description
4/27/2023	Quality Improvement Committee approved activation of the policy.
6/12/2024	Annual review. Document content transitioned to new policy template. Approved by Optum Clinical Guideline Advisory Committee.
6/13/2024	Approved by OrthoNet Quality Improvement Committee (QIC).