

Sacroiliac Joint Interventions

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[➔ Instructions for Use](#)

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Related Policies
<ul style="list-style-type: none"> • Ablative Treatment for Spinal Pain • Epidural Steroid Injections for Spinal Pain • Facet Joint and Medial Branch Block Injections for Spinal Pain

Coverage Rationale

Note: This policy addresses intraarticular Sacroiliac Joint injections and fusion. This policy does not address radiofrequency ablation of the Sacroiliac Joint. For coverage criteria regarding radiofrequency ablation of the Sacroiliac Joint, refer to the Clinical Policy titled [Ablative Treatment for Spinal Pain](#).

Sacroiliac Joint (SI) injections are proven and medically necessary in certain circumstances. For medical necessity clinical coverage criteria, refer to the InterQual® CP: Procedures, Sacroiliac (SI) Joint Injection.

[Click here to view the InterQual® criteria.](#)

Sacral Lateral Branch Nerve Blocks as a diagnostic tool prior to radiofrequency ablation are unproven and not medically necessary due to insufficient evidence of efficacy and/or safety.

Open Sacroiliac Joint Fusion is proven and medically necessary for treating the following indications:

- Stabilization of a traumatic, severe disruption, or fracture of the pelvic ring
- Management of sacral tumor (e.g., sacrectomy or partial sacrectomy related to tumors involving the sacrum)
- As an adjunctive to medical treatment for Sacroiliac Joint infection or sepsis
- When performed as part of multisegmental spinal constructs for the correction of spinal deformity (e.g., idiopathic scoliosis, neuromuscular scoliosis)

Minimally invasive joint fusion for degenerative sacroiliac disease using a Titanium Triangular Implant System is proven and medically necessary when all the following criteria are met.

- Have undergone and failed a minimum 6 months of intensive nonoperative treatment that includes all of the following:
 - Medication optimization (unless contraindicated)
 - Activity modification
 - Active therapeutic exercise targeted at the lumbar spine, pelvis, Sacroiliac Joint (SIJ), and hip
- Individual reports nonradicular, typically, unilateral pain that is maximal below the L5 vertebrae, localized over the posterior SIJ, and consistent with SIJ pain
- A physical examination demonstrating localized tenderness with palpation over the sacral sulcus (Fortin's point, i.e., at the insertion of the long dorsal ligament inferior to the posterior superior iliac spine or PSIS) or the absence of tenderness elsewhere (e.g., greater trochanter, lumbar spine, coccyx) that would explain the patient's symptoms
- Positive response to a cluster of at least 3 Provocative Tests
 - Patrick's (Fabere)

- Gaenslen
- Thigh thrust
- Sacral thrust
- Distraction
- Compression
- Absence of generalized pain behavior (e.g., somatoform disorder) or generalized pain disorders (e.g., fibromyalgia)
- Diagnostic imaging studies that include all of the following:
 - Imaging (plain radiographs and a CT or MRI) that
 - Demonstrates degenerative disease of the SI joint; and
 - Excludes the presence of destructive lesions (e.g., tumor, infection), or autoimmune arthropathy that would not be properly addressed by percutaneous SIJ fusion
 - Imaging of the pelvis (anteriorposterior plain radiograph) to rule out concomitant hip pathology that would better explain the patient's symptoms
 - Imaging of the lumbar spine (CT or MRI) to rule out neural compression or other degenerative condition that, in combination with the patient's history, physical, and other testing would more likely be the source of their low back or buttock pain
- At least 75% reduction of pain, documented by pain diary, for the expected duration of the anesthetic used following an image-guided, contrast-enhanced intra-articular SIJ injection on 2 separate occasions
- A trial of at least one therapeutic intra-articular SIJ injection (i.e., corticosteroid injection)

Fusion of the Sacroiliac Joint for the treatment of back pain presumed to originate from the Sacroiliac Joint is unproven and not medically necessary for all other indications and with any other devices not listed above due to insufficient evidence of efficacy.

Medical Records Documentation Used for Reviews

Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. Medical records documentation may be required to assess whether the member meets the clinical criteria for coverage but does not guarantee coverage of the service requested; refer to the protocol titled [Medical Records Documentation Used for Reviews](#).

Definitions

Provocative Tests: Tests performed to reproduce the patient's typical pain in the SI region, and can include:

- Thigh thrust test: Involves applying downward pressure along the femur while the individual is supine. Pain at the ilium or SI joint suggests SI joint dysfunction.
- Compression test (approximation test): Applies stress to the SI joint structures in an attempt to replicate the patient's symptoms.
- Gaenslen's test: Performed in the supine position. One hip is flexed by pushing the individual's knee to the chest, and the other knee is extended toward the opposite hip joint. This maneuver stresses both Sacroiliac Joints.
- Distraction test (gaping test): The application of downward pressure to the iliac crest while in the supine position.
- Patrick's sign (Fabere test): The affected leg is flexed, abducted, externally rotated, and extended so that the ankle of that leg is on top of the opposite knee. The affected leg is then slowly lowered toward the examining table. (NASS, 2021)

Sacrectomy/Partial Sacrectomy: Removal or partial removal of the sacrum. Reconstruction of the union between the lumbar spine and the ilium following the procedure is done with spinal instrumentation to achieve stabilization. (Newman, 2022)

Sacroiliac Joint Fusion (Arthrodesis): Intended to join the sacrum and the iliac bones together to stabilize the joint, with the goal of alleviating or reducing low back pain. There are two kinds of fusion surgery: minimally invasive and open.

- During minimally invasive (percutaneous) surgery, small cuts are made through the buttocks and scans are employed to guide placement of the instrumentation. Holes are drilled in the sacrum and ilium and implants are inserted across the two joints. Several devices have received U.S. Food and Drug Administration (FDA) marketing clearance. One device system, the iFuse SI Fusion System® (SI-Bone, Inc.), uses Titanium Triangular Implants to stabilize the SI joint.
- During open surgery, a seven-to-eight-inch incision is made, and muscles and tissue are separated to expose the SI joint. Cartilage is then removed between the sacrum and ilium, and a bone graft taken from the pelvis is used to

connect and stabilize the joint. Screws are then inserted to keep the graft in place and stable during healing. (Newman, 2022)

Sacroiliac Joint: The joint or articulation between the sacrum and ilium. (Merriam-Webster)

Sacral Lateral Nerve Block: Injection of corticosteroid and/or local anesthetic adjacent to the sacral lateral nerve resulting in the temporary interruption of conduction of impulses for analgesia. Sacral Lateral Nerve Blocks attempt to block pain signals and theoretically provide relief from pain. The duration of the block depends on the dose, concentration, and type of pharmacological agent injected. (Newman, 2022)

Titanium Triangular Implant: A Sacroiliac Joint (SIJ) implant intended for Sacroiliac Joint Fusion for conditions including Sacroiliac Joint disruptions and degenerative sacroiliitis. (Darr, 2018)

Applicable Codes

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

CPT Code	Description
27096	Injection procedure for sacroiliac joint, anesthetic/steroid, with image guidance (fluoroscopy or CT) including arthrography when performed
27278	Arthrodesis, sacroiliac joint, percutaneous, with image guidance, including placement of intra-articular implant(s) (e.g., bone allograft[s], synthetic device[s]), without placement of transfixation device
27279	Arthrodesis, sacroiliac joint, percutaneous or minimally invasive (indirect visualization), with image guidance, includes obtaining bone graft when performed, and placement of transfixing device
27280	Arthrodesis, sacroiliac joint, open, includes obtaining bone graft, including instrumentation, when performed
64451	Injection(s), anesthetic agent(s) and/or steroid; nerves innervating the sacroiliac joint, with image guidance (i.e., fluoroscopy or computed tomography)

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HCPCS Code	Description
G0260	Injection procedure for sacroiliac joint; provision of anesthetic, steroid and/or other therapeutic agent, with or without arthrography

Description of Services

Sacroiliac Joint Fusion (SIJF) is a surgical procedure, which fuses the iliac bone (pelvis) to the spine (sacrum) for stabilization. It is performed for a variety of conditions including trauma, infection, cancer, and spinal instability. SIJF may be performed as a minimally invasive procedure or as an open surgical procedure requiring a larger incision and subsequent increased recovery time.

Minimally invasive SI Fusion is a procedure that attempts to stabilize the sacroiliac (SI) joints by fusing the sacrum to the ilium with allograft material, limiting movement of the joint. (Hayes, 2023)

There are two surgical approaches that are commonly used for minimally invasive SIJF:

- A lateral transarticular approach, in which devices are placed across the SI joint from lateral to medial. In the lateral approach, the SI joint is accessed laterally through a small incision made in the buttock to access the ilium. A pin is passed through the ilium across the SI joint into the center of the sacrum, avoiding the neural foramen. A drill is used to create a pathway through the ilium to the sacrum. An implant is inserted (with the lateral portion of the implant sitting in the ilium and the medial end in the sacrum), spanning the SI joint. Typically three implants are used per side.

- A posterior approach, in which devices are placed into the ligamentous portion of the joint via dissection of the multifidus muscle and removal of ligaments covering the outer posterior surface of the joint. In the posterior approach, a portion of the interosseous SIJ ligament is sometimes removed.

Open surgical techniques involve direct visualization of the Sacroiliac Joint and may include anterior and posterior approaches that can be performed with and without screws or plates, and a posterior midline fascial splitting approach.

Diagnosis of SIJ dysfunction is based on a combination of tests or provocative maneuvers during physical examination to help localize the pain to the SIJ. Imaging studies do not generally help to localize pain but can be used to exclude other diagnoses that may mimic SIJ pain (e.g., hip osteoarthritis, spine degeneration at the L5/S1 level, spinal stenosis). The physical examination may include Provocative Tests (e.g., Gaenslen's maneuver, Patrick's test, thigh thrust, and compression and distraction tests) to stress the SIJ and reproduce the patient's pain. (Hayes, 2020, Foley and Buschbacher, 2006; Hooten and Cohen, 2015, Lorio, 2016)

Clinical Evidence

Sacroiliac Joint (SI) Injections

Cohen et al. (2022) evaluated patients in a multicenter study which looked at factors associated with treatment outcomes for low back pain injections. 346 participants were enrolled; 112 underwent lumbar facet blocks, 67 received SIJ injections and 167 underwent lumbar ESI. The participants were over 18 years of age, had more than six weeks of pain in the lumbosacral area or SI joint and had an average leg or low back pain score of greater than 4 out of 10 over a week. SI joint injections included 3 mL solution containing 1 mL of 40 mg/mL of methylprednisolone and 2 mL of 0.5% bupivacaine. It was considered a positive outcome if the patient received $\geq 50\%$ pain reduction that lasted at least 3 hours; this was based on patient documentation from a pain diary with activity log. Follow-up occurred at one month and if the patient had a positive outcome from the procedure, they did not need to return until 3 months later. Participants with negative outcomes were allowed to exit from study and pursue other options. The authors found there was a significant decrease in pain overall and no significant differences amongst the groups. With the 139 successful patients, the mean reductions in the numerical rating scale (NRS) scores for facet interventions, SIJ injections and ESI were 4.0 ± 1.5 , 3.6 ± 2.0 , 3.6 ± 1.9 , respectively. Limitations included the combination of three different low back pain treatments which addressed different etiologies, the variability in radiologic and physical exam findings and less stringent inclusion criteria due to practice setting versus clinical trial setting.

In 2022 the Department of Veterans Affairs (VA)/ Department of Defense (DoD) published a guideline for the diagnosis and treatment of low back pain makes the following recommendations for patients with nonsurgical invasive therapy: For patients with low back pain, there is insufficient evidence to recommend for or against sacroiliac joint injections (Neither for nor against).

Young et al. (2022) studied a cohort of 373 adults with a diagnosis of SIJ pain. In this retrospective study 354 patients received an intraarticular steroid (IAS) injection and 19 patients received lateral branch radiofrequency neurotomy (LBRFN). The main outcome was the self-report pain score, which was measured by the numeric rating scale (NRS). The secondary outcome was the functional score which was measured by the Eastern Cooperative Oncology Group (ECOG) performance scale. The mean score for the IAS injection was reduced from 6.77 to 2.72; the LBRFN mean score was reduced from 5.96 to 3.54 post procedure. The ECOG functional scores trended towards improvement for the cohort, however they were not statistically significant. The participants that received the IAS injections obtained 38 days of pain relief which was shorter in duration when compared to those that received the LBRFN which experienced 82 days of pain relief. The authors concluded that SIJ pain can be effectively treated with either injections or LBRFN, however SIJ injections may give a shorter tenure of pain relief. Limitations included the disproportion of participants that received SIJ injections versus LBRFN, missing data, and sampling bias.

Chen et al. (2021) compared injections of intraarticular SI joint platelet rich plasma to that of intraarticular steroids on patients with SI joint pain. The 26 participants were randomized to either the group that underwent a fluoroscopically-guided intra-articular injection of steroid or a platelet rich plasma injection. Primary outcome was level of pain as scored by the 0- to 100-mm Numeric Pain Rating Scale and functional disability score using the Oswestry Disability Index (ODI). Patients were evaluated at 1-month, 3-months, and 6-months. The authors found while both groups had improvements with pain, the steroid group had a greater response.

Clinical Practice Guidelines

American Society of Pain and Neuroscience (ASPN)

In a comprehensive evidence-based guideline on interventional treatments for low back pain, the evidence for sacroiliac joint injections has been associated with positive predictive value in diagnosis as well as short term relief of SIJ dysfunction as Sayed et al. (2023)

Sacral Lateral Branch Nerve Blocks

In 2022, The American Society of Pain and Neuroscience (ASPN) published guidance on the treatment of lower back pain.

No specific mention of lateral branch blocks. (Sayed, 2022)

King et al. (2015) evaluated the literature on sacral lateral branch interventions and found it to be sparse. The searches yielded two primary publications on sacral lateral branch blocks and 15 studies of the effectiveness of sacral lateral branch thermal radiofrequency neurotomy. One study demonstrated the face validity of multisite, multidepth sacral lateral branch blocks for diagnosis of posterior sacroiliac complex pain. Some evidence of moderate quality exists on therapeutic procedures, but it is insufficient to determine the indications and effectiveness of sacral lateral branch thermal radiofrequency neurotomy, and more research is required.

Clinical Practice Guidelines

In the Evidence-Based Clinical Guidelines for Multidisciplinary Spine Care, NASS (2020) lists the following recommendation for the diagnosis and treatment of low back pain:

- Lateral branch nerve blocks can be utilized diagnostically, especially for dorsal ligament pain of the sacroiliac (SI) joint; however, evidence supporting this is limited.

Open Sacroiliac Joint Fusion

Surgical management of primary sacral tumors is challenging because of their size and location. Reconstruction is often required in individuals who require a radical resection with total sacrectomy for tumors such as chordoma, chondrosarcoma, Ewing sarcoma, and giant cell tumor of the sacrum. Sacroiliac joint fusion has been performed as an adjunct to en bloc sacrectomy or partial sacrectomy in the setting of sacral tumors. The evidence in the peer-reviewed literature to support the use of lumbar pedicle screws in combination with other surgical techniques involving the ilia in spinal pelvic reconstruction surgery (for example, Galveston rods, transiliac bar placement) consists of articles that review surgical techniques (Zhang, 2003) and small case series. (Gallia, 2005; Newman, 2009; Salehi, 2002)

Sacroiliac joint infection is an uncommon condition that generally responds to long-term antibiotics and occasionally requires drainage for abscess. Additional surgical treatment may involve debridement, decompression, and internal screw fixation when symptoms do not resolve with initial intravenous antibiotic therapy. The evidence in the peer-reviewed literature to support the use of sacroiliac joint fusion as an adjunct to the medical treatment of sacroiliac joint infection consists of single and small case series. (Davidson, 2003; Giannoudis, 2007; Sar, 2003)

Minimally Invasive Fusion of the Sacroiliac Joint

Chang et al. (2022) conducted a systematic review on the existing literature to assess the safety and efficacy of minimally invasive SI joint fusion. A search was conducted from 1987 through 2021 using PubMed, Embase, Cochrane and a clinical trial registry. A total of 40 studies were included for evaluation of SI joint pain; five studies [two RCTs and three controlled cohort studies (CCSs)] provided evidence about effectiveness, and all 40 studies provided evidence about safety. Two RCTs and one CCS compared minimally invasive SI joint fusion with the iFuse Implant System to that of conservative management; two CCSs compared the effectiveness of alternative minimally invasive fusion procedures. The authors found the minimally invasive SI joint fusion appeared to improve pain, physical function, and QOL when compared to conservative treatment. Two of the CCSs evaluated alternative minimally invasive fusion procedures and one CCS compared the iFuse implant system to that of the Rialto SI Fusion System (a cylindrical threaded implant system). Pain was measured by visual analog scale (VAS) in both groups and the authors found improvements in pain for both groups but no significant difference between the two. However it was noted that the group receiving the Rialto system had an increase in revision rates when compared with those in the iFuse group. Limitations included small sample sizes and heterogeneity when reporting adverse effects, inconsistencies in the reported findings for the two RCTs, and only two studies that compared the iFuse implant system with that of another limiting the generalizability of findings to other devices.

ECRI (2022) published a literature search on Rialto Sacroiliac Fusion System (Medtronic plc.) for Minimally Invasive Spinal Fusion through October 2022 and stated the following. Whether Rialto improves pain, functional status, or quality of life (QOL) in patients with SI dysfunction is unclear because two nonrandomized comparative studies and one before-and-after study are at too high a risk of bias to be conclusive. Additional studies that provide long-term comparative-effectiveness data are needed to determine whether any Rialto improvements in patient outcomes are sustained long-term and how Rialto compares with other MIS systems and open surgery.

For use of cylindrical threaded implants (CTIs) for SIJ fusion in adult patients, an updated 2021 Hayes health technology report reflects a very-low-quality body of evidence and is insufficient for drawing any conclusions regarding the efficacy and safety of this technology. There continues to be substantial uncertainty for this technology due to a small body of evidence and lack of comparative studies.

A Hayes technology assessment (2020) stated that there is moderate-quality evidence suggesting that minimally invasive sacroiliac joint (SIJ) fusion with the iFuse Implant System is efficacious for adult patients with SIJ dysfunction that is unresponsive to non-surgical management (NSM). iFuse implants are consistently associated with improved pain and disability from baseline without substantial safety concerns. Consistent evidence suggests that the use of the iFuse for the treatment of SIJ dysfunction may lead to clinically significant reductions in pain and disability. Comparative results suggest that SIJ fusion with iFuse is associated with better patient-reported outcomes.

Claus et al. (2020, included Chang et al., 2022 above) conducted a clinical outcome comparison of minimally invasive SI joint fusion between the iFuse [triangular dowel implant (TDI)] Implant system and the Rialto [cylindrical threaded implant (CTI)] system. A total of 156 patients were evaluated; 82 received the iFuse system and 74 patients received the Rialto system. The primary outcomes were postoperative visual analog scale (VAS), Oswestry Disability Index (ODI), and Short Form-12 evaluation at 6 months and 1 year; secondary outcomes included rate of surgery revision and time to revision. Both sets of cohorts experienced significant improvement in patient reported outcomes at six months when compared to their preoperative assessments. However, the authors found a significant difference in the length of the procedure between the two groups. The CTI procedure averaged 60 minutes in length, while the TDI averaged only 41.2 minutes. In addition, it should be noted that there was a 6.1% revision rate for the CTI cohort and only a 2.4% revision rate for the TDI patient group. While the authors found both the iFuse and Rialto SI joint fusion devices appear to suggest a significant improvement in pain, disability, and QoL, further attention should be allocated to the evaluation of the complication rates as they were found to be as high as 52% in the CTI system. Study limitations included the retrospective study design, small number of participants for each group, lack of randomization of participants and lack of long-term outcomes.

ECRI performed a literature review of the iFuse implant system for minimally invasive sacroiliac Joint fusion. The report stated that iFuse reduces SIJ pain and improves pain and quality of life (QOL) compared with nonsurgical conservative management (NCM) and screw-type implants. At four-year follow-up, revision surgery rates were 3.6%. How well iFuse works compared with MIS (e.g., Rialto) or open surgery cannot be determined from nonrandomized comparison and single-arm studies that provide very-low-quality evidence. Additionally, studies in the SR are at risk of bias because of small size, retrospective design, and lack of control groups and randomization. The RCTs are at risk of bias from use of subjective measures, (e.g., pain, QOL) and lack of blinding. (ECRI, 2016; updated 2022)

In 2019, Whang et al., reported long-term (5-year) results from two prospective clinical trials (INSITE and SIFI; previously described) investigating the use of minimally invasive lateral transiliac SIJF using TTI (iFuse implant System, SI-BONE, Inc.) as a treatment for sacroiliac joint dysfunction. As previously described, a total of 103 participants were enrolled in the LOIS study with clinic visits at 3, 4, and 5 years and comparison of CT scans performed at 5 years to prior CT scans at 1 or 2 years. At the 5-year follow-up, the mean reported SIJ pain score had significantly reduced by 54.1 points, from 81.5 points at baseline to 27.1 points. A total of 77 (82.8%) study participants reported improvements of at least 20 points in SIJ pain scores. The study's primary outcome (VAS improvement of at least 20 points in the absence of severe device-related adverse event, neurologic adverse event, and revision surgery) was achieved in 76 participants at 5 years (81.7%, 95% CI, 72.4-89.0%). ODI was reduced from 56.3 points preoperatively to 29.9 points; a statistically significant improvement of 26.2 (21.6) points. Furthermore, an independent radiographic analysis exhibited a high rate of successful bone apposition to implants on both the sacral and iliac sides of the SI joint, a high rate of bony bridging, and a low rate of radiolucency's (98%, 87%, and 5%, respectively). Authors concluded that the 5-year data from the LOIS study establish the long-term safety and effectiveness of minimally invasive SIJF with TTI for SIJ dysfunction, demonstrated by improvement in pain, disability and QOL in conjunction with a low risk of complications and high rate of long-term durability.

Tran et al. (2019) published a systematic review comparing the effectiveness of minimally invasive joint fusion (i.e., utilizing the iFuse device) compared to screw-type surgeries. A total of twenty studies was pooled to calculate a standardized mean difference (SMD) across pain, disability, and global/quality-of-life outcomes, including 14 studies

evaluation the iFuse system and 7 studies evaluated cylindrical, threaded implants. Studies evaluating cylindrical, threaded implants consisted of case series and cohort studies. Patients receiving these implants experienced significantly worse pain outcomes compared to patients receiving iFuse.

Darr et al., [2018b; LOIS (Long Term Outcomes from INSITE and SIFI); NCT02270203] reported 3-year clinical and functional outcomes (including disability and quality of life) following minimally invasive sacroiliac joint fusion with the iFuse Implant System in 103 subjects from the INSITE and SIFI clinical trials. Subjects were evaluated in 12 study clinics at study start and at 3, 4, and 5 years. The primary efficacy endpoint was a composite of 3, 4, and 5 years defined as a reduction from preoperative VAS sacroiliac joint pain score of at least 20 points, absence of device-related serious adverse events, absence of neurological worsening, and absence of surgical revision. Other outcomes included improvements in VAS sacroiliac pain score, ODI, EQ-5D score, proportion of non-working subjects who returned to work, and occurrence of serious adverse events. The mean (standard deviation) preoperative sacroiliac joint pain score was 81.5 and mean preoperative ODI was 56.3. At 3 years, the mean pain sacroiliac joint pain score decreased to 26.2 (a 55-point improvement from baseline; $p < 0.0001$) and the mean ODI was 28.2 (a 28-point improvement from baseline). A total of 82% of subjects were very satisfied with the procedure at 3 years. The proportion of subjects who would have the procedure again was lower at 3 years compared to earlier time points. Limitations of this study include lack of data from a control group that received only non-surgical treatment. Most INSITE study subjects in the non-surgical group who experienced inadequate pain relief crossed over to surgical care at month 6. The authors acknowledged that subjects at participating sites had slightly larger 24-month improvements in sacroiliac joint pain and ODI compared to those at non-participating sites as the calculated impact on 3-year pain scores was small, that is, approximately 4 points for VAS sacroiliac joint pain and 2.4 points for ODI.

Darr et al. (2018a; LOIS trial; NCT02270203) reported 4-year prospective follow-up in participants undergoing minimally invasive SIJF using triangular titanium implants (TTI) (iFuse Implant System, SI-BONE) for sacroiliac joint dysfunction. At 4 years follow-up clinical outcomes were similar to 3-year findings, the mean (standard deviation) preoperative sacroiliac joint pain score in 88.3% ($n = 91$) of participants had decreased by 54 points from baseline, disability ODI scores decreased by 26 points; and QOL rates improved by 0.3 points (0-1 scale). The LOIS study limitations were previously outlined above by Darr and colleagues. (2018b)

In 2022, National Institute for Health and Care Excellence (NICE) published medical technology guidance on using the iFuse implant system for treating chronic sacroiliac joint pain. It provided the following recommendations: iFuse implant system is recommended as an option for treating chronic sacroiliac joint pain. iFuse should be considered for use in people with a confirmed diagnosis of chronic sacroiliac joint pain (based on clinical assessment and a positive response to a diagnostic injection of local anesthetic in the sacroiliac joint) and whose pain is inadequately controlled by non-surgical management.

NICE guidance was published in April 2017 on minimally invasive SIJ fusion surgery for chronic sacroiliac pain. The recommendations include: Current evidence on the safety and efficacy of minimally invasive sacroiliac (SI) joint fusion surgery for chronic SI pain is adequate to support the use of this procedure. Patients having this procedure should have a confirmed diagnosis of unilateral or bilateral SI joint dysfunction due to degenerative sacroiliitis or SI joint disruption. This technically challenging procedure should only be done by surgeons who regularly use image-guided surgery for implant placement. The surgeons should also have had specific training and expertise in minimally invasive SI joint fusion surgery for chronic SI pain.

Rappoport et al. (2017) reported on an industry-sponsored prospective study of SIJ fusion with a cylindrical threaded implant (SI-LOK).³⁵ The study included 32 patients with a diagnosis of SIJ dysfunction who had failed nonoperative treatment, including medication, physical therapy, and therapeutic injections. A diagnostic injection was performed to confirm the source of pain to the SIJ. The procedure included drilling to prepare for screw insertion and implantation of 3 screws, at least one of which was slotted. The slotted screws were packed with autogenous bone graft from the drill reamings. Pain and disability scores were reduced following device implantation, and revisions within the first 12 months of the study were low. Follow-up will continue through 2 years. There is limited evidence on fusion of the SIJ with devices other than the triangular implant. One-year results from a prospective cohort of 32 patients who received a cylindrical slotted implant showed reductions in pain and disability similar to results obtained for the triangular implant. However, there is uncertainty in the health benefit of SIJ fusion/fixation with this implant design. Therefore, controlled studies with a larger number of patients and longer follow-up are needed to evaluate this device.

Two retrospective nonrandomized comparative studies were published in 2017. Vanaclocha et al. found greater pain relief with SIJ fusion than with conservative management or SIJ denervation. Spain and Holt reported a retrospective review of surgical revision rates following SIJ fixation with either surgical screws or the iFuse triangular implant.¹³ Revision rates were lower with the iFuse device than observed with surgical screws.

Duhon, et al. (2016) reported on a prospective uncontrolled industry sponsored study of subjects with SI joint dysfunction who underwent minimally invasive SI joint fusion with triangular titanium implants. One hundred ninety-four patients were enrolled between August 2012 and December 2013 at 26 sites. Of these, 10 withdrew prior to SI joint fusion and data from 12 subjects at a single site were eliminated due to the site's persistent non-compliance with the study protocol, leaving 172 subjects enrolled and treated. Two additional sites were terminated more than 1 year into the study for protocol non-compliance, resulting in 3 additional subjects not having 24-month study follow-up. Subjects underwent structured assessments preoperatively and at 1, 3, 6, 12, 18 and 24 months postoperatively, including SIJ pain ratings (0-100 visual analog scale), Oswestry Disability Index (ODI), Short Form-36 (SF-36), EuroQOL-5D (EQ-5D), and patient satisfaction. Adverse events were collected throughout follow-up. All participating patients underwent a high-resolution pelvic CT scan at 1 year. The primary study endpoint, evaluated at six months after the most recent SI joint fusion, was a binary success/failure composite endpoint. A subject was considered a success if all of the following were met: reduction from baseline VAS SI joint pain by at least 20 points, absence of device-related serious adverse events, absence of neurological worsening related to the sacral spine, and absence of surgical re-intervention (removal, revision, reoperation, or supplemental fixation) for SI joint pain. Of the 172 participants, 167 (97.1%) had 6-month follow-up, 157 (91.3%) had 12-month follow-up and 149 (86.6%) had 24-month follow-up. At month 6, 138 of 172 subjects met the study's success endpoint definition, for an intent-to-treat success rate of 80.2% (95% posterior credible interval 73.8-85.7%). Using available data only, the 12-month success rate was 127/159 (79.9%) and the 24-month success rate was 119/149 (79.9%). SIJ pain decreased from 79.8 at baseline to 30.4 at 12 months and 26.0 at 24 months. ODI decreased from 55.2 at baseline to 31.5 at 12 months and 30.9 at 24 months. The proportion of subjects taking opioids for SIJ or low back pain decreased from 76.2% at baseline to 55.0% at 24 months. The authors concluded that minimally invasive SI joint fusion resulted in improvement of pain, disability, and quality of life in patients with SI joint dysfunction due to degenerative sacroiliitis and SI joint disruption.

Polly et al. (2016) reported 2-year outcomes from the randomized controlled trial (Polly, 2015; INSITE) of individuals treated with minimally invasive sacroiliac joint fusion for chronic sacroiliac joint dysfunction. Of the 102 participants originally treated with sacroiliac joint fusion, 89 (87%) were evaluated at 2 years. Although the clinical trial used a different composite endpoint, clinical outcomes in this report were based on the amount of improvement in sacroiliac joint pain and ODI scores. Improvement was defined as a change of 20 points in sacroiliac joint pain score and 15 points in ODI score. Substantial improvement was defined as a change of 25 points in sacroiliac joint pain score or a score of 35 or less and an improvement of 18.8 points in ODI score. At 24 months, 83.1% and 82% of participants had improvement and substantial improvement in sacroiliac joint pain score, and 68.2% and 65.9% had improvement and substantial improvement in ODI. In addition, the proportion of participants taking opioids was reduced from 68.6% at baseline to 48.3% (29.6% reduction; $p = 0.0108$ for change). A total of 22 (23%) adverse events related to device or procedure occurred in the sacroiliac joint fusion group ($n = 102$), including ipsilateral or contralateral sacroiliac joint pain and trochanteric bursitis ($n = 9$), surgical wound problems ($n = 5$), postoperative medical problems ($n = 4$, including nausea/vomiting, urinary retention, and atrial fibrillation), iliac fracture ($n = 1$), asymptomatic physical exam or radiographic findings ($n = 2$), and neuropathic symptoms ($n = 1$). Three participants assigned to sacroiliac joint fusion and 1 participant who underwent sacroiliac joint fusion as a crossover treatment underwent revision surgery within the 24-month follow-up period. Limitations of this study include lack of a sham comparator group and the high crossover rate to sacroiliac joint fusion at 6 months.

In 2016, Stureson et al., reported another industry-sponsored nonblinded RCT of the iFuse Implant System in 103 patients. Inclusion was based on similar criteria as the Whang trial, including at least 50% pain reduction on SIJ block. Mean pain duration was 4.5 years. Nonsurgical management included physical therapy and exercises at least twice per week; interventional procedures (e.g., steroid injections, RFA) were not allowed. The primary outcome was change in VAS pain score at 6 months. Of 109 randomized subjects, 6 withdrew before any treatment. All patient assigned to iFuse underwent the procedure, and follow-up at 6 months was in 49 of 51 patients in the control group and in all 52 patients in the iFuse group. At 6 months, VAS pain scores improved by 43.3 points in the iFuse group and by 5.7 in the control group. ODI scores improved by 5.8 points in the control group and by 25.5 points in the iFuse group. Quality of life outcomes showed a greater improvement in the iFuse group than in the control group. Although these results favored fusion, with magnitudes of effect in a range similar to the RCT by Whang, this trial was also not blinded and lacked a sham control. Outcomes were only assessed to 6 months. Patients were assigned 2:1 to minimally invasive SI joint fusion or to nonsurgical management. Nonsurgical management included a stepwise progression of nonsurgical treatments, depending on individual patient choice. The primary outcome measure was 6-month success rate, defined as the proportion of treated subjects with a 20-mm improvement in SI joint pain in the absence of severe device-related or neurologic adverse events or surgical revision. Patients in the control arm could crossover to surgery after six months. Baseline scores indicated that the patients were severely disabled, with VAS pain scores averaging 82.3 out of 100 and ODI scores averaging 61.9 out of 100 (0 = no disability, 100 = maximum disability). At six months, success rates were 23.9% in the control group versus 81.4% in the surgical group. A clinically important (≥ 15 -point) improvement in ODI score was found in 27.3% of controls compared with 75.0% of fusion patients. Measures of QOL (36-Item Short-Form

Health Survey, EuroQoL-5D) also improved to a greater extent in the surgery group. Of the 44 nonsurgical management patients still participating at six months, 35 (79.5%) crossed over to fusion. Compared to baseline, opioid use at six months decreased from 67.6% to 58% in the surgery group and increased from 63% to 70.5% in the control group. Although these results generally favored fusion, the trial is limited due to the high number of patients that crossed over from the control group to the fusion group. This limits the comparative long-term conclusions that can be drawn.

Clinical Practice Guidelines

American Society of Pain and Neuroscience (ASPN)

In 2022, ASPN published guidance on the treatment of lower back pain. The following recommendations were provided concerning SIJ injections. Minimally invasive sacroiliac fusion (Grade, A; Level, 1-A; Level of certainty, High).

North American Spine Society (NASS)

In the Evidence-Based Clinical Guidelines for Multidisciplinary Spine Care, NASS (2020) lists the following recommendation for the diagnosis and treatment of low back pain:

- Intra-articular steroid joint injections may be considered in patients with suspected SI joint pain [Grade of Recommendation: C (poor quality evidence {Level IV or V studies} for or against the recommending intervention)]

In 2015, NASS published recommendations in a coverage committee document for therapeutic SI joint (SIJ) injections. The document states intraarticular SIJ injections of corticosteroid with or without local anesthetic are indicated for the treatment of low back pain when all of the listed criteria are met:

- Patient's report of nonradicular, typically unilateral pain that is caudal to the lumbar spine (L5 vertebrae), localized over the posterior SIJ, and consistent with SIJ pain.
- A thorough physical examination demonstrating localized tenderness with palpation over the sacral sulcus (Fortin's point, i.e., at the insertion of the long dorsal ligament inferior to the posterior superior iliac spine or PSIS) in the absence of tenderness of similar severity elsewhere (e.g., greater trochanter, lumbar spine, coccyx) and that other obvious sources for their pain do not exist.
- Positive response to a cluster of three provocative tests (e.g., thigh thrust test, compression test, Gaenslen's test, distraction test, Patrick's sign, posterior provocation test). Note that the thrust tests is not recommended in pregnant patients or those with connective tissue disorders.
- SIJ pain has been confirmed with diagnostic SIJ injections.

NASS (2015, updated 2021) published the following coverage policy recommendations on Minimally Invasive Sacroiliac Joint Fusion. The recommendations state "SIJ fusion is indicated for the treatment of SIJ pain for patients with low back/buttock pain who meet all of the following criteria":

- Have undergone and failed a minimum 6 months of intensive nonoperative treatment that must include medication optimization, activity modification, and active therapeutic exercise targeted at the lumbar spine, pelvis, SIJ and hip including a home exercise program.
- Patient's report of nonradicular, typically unilateral pain that is maximal below the L5 vertebrae, localized over the posterior SIJ, and consistent with SIJ pain.
- A physical examination typically demonstrating localized tenderness with palpation over the sacral sulcus (Fortin's point, i.e., at the insertion of the long dorsal ligament inferior to the posterior superior iliac spine or PSIS) or the absence of tenderness elsewhere (e.g., greater trochanter, lumbar spine, coccyx) and that would explain the patient's symptoms.
- Positive response to a cluster of 3 provocative tests (1. Patrick's or FABER, 2. Gaenslen, 3. thigh thrust, 4. sacral thrust, 5. distraction, 6. compression). Note that the thrust test is not recommended in pregnant patients or those with connective tissue disorders.
- Absence of generalized pain behavior (e.g., somatoform disorder) or generalized pain disorders (e.g., fibromyalgia).
- Diagnostic imaging studies that include all of the following:
 - Imaging [plain radiographs and a CT (computed tomography) or MRI (magnetic resonance imaging)] of the SI joint that excludes the presence of destructive lesions (e.g., tumor, infection) or inflammatory arthropathy that would not be properly addressed by percutaneous SIJ fusion.
 - Imaging of the pelvis [AP (anteroposterior) plain radiograph] to rule out concomitant hip pathology that would better explain the patient's symptoms.
 - Imaging of the lumbar spine (CT or MRI) to rule out neural compression or other degenerative condition that, in combination with the patient's history, physical, and other testing would more likely be the source of their low back or buttock pain.
 - Imaging of the SI joint that indicates evidence of injury and/or degeneration.

- At least 75% reduction of pain, documented by pain diary, for the expected duration of the anesthetic used following an image-guided, contrast-enhanced intra-articular SIJ injection on 2 separate occasions.
- A trial of at least one therapeutic intra-articular SIJ injection (i.e., corticosteroid injection).

International Society for the Advancement of Spine Surgery (ISASS)

In 2020, ISASS published a policy update titled: “Minimally Invasive Surgical Sacroiliac Joint Fusion (for Chronic Sacroiliac Joint Pain): Coverage Indications, Limitations, and Medical Necessity” (Lorio, et al, 2020). ISASS recommends coverage for minimally invasive SIJ fusion when all of the following criteria are met:

- Significant SIJ [sacroiliac joint fusion] pain (e.g., pain rating at least 5 on the 0-10 numeric rating scale where 0 represents no pain and 10 represents worst imaginable pain) or significant limitations in activities of daily living.
- SIJ pain confirmed with at least 3 physical examination maneuvers that stress the SIJ and cause the patient’s typical pain.
- Confirmation of the SIJ as a pain generator with $\geq 75\%$ acute decrease in pain upon fluoroscopically guided diagnostic intra-articular SIJ block using local anesthetic.
- Failure to respond to at least 6 months of non-surgical treatment consisting of non-steroidal anti-inflammatory drugs and/or opioids (if not contraindicated) and one or more of the following: rest, physical therapy, SIJ steroid injection. Failure to respond means continued pain that interferes with activities of daily living and/or results in functional disability.
- Additional or alternative diagnoses that could be responsible for the patient’s ongoing pain or disability have been ruled out (e.g., L5/S1 compression, hip osteoarthritis).
- Minimally invasive SIJ fusion is not indicated for patients with the following:
 - Less than 6 months of back pain;
 - Failure to pursue conservative treatment of the SIJ (unless contra-indicated);
 - Pain not confirmed with a diagnostic SIJ block;
 - Existence of other pathology that could explain the patient’s pain.

U.S. Food and Drug Administration (FDA)

This section is to be used for informational purposes only. FDA approval alone is not a basis for coverage.

UnitedHealthcare medical policies are based on clinical evidence and do not represent an endorsement of any specific manufacturer’s product.

Products used for sacroiliac joint fusion are numerous. Refer to the following website for more information and search by product name in device name section: <http://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfPMN/pmnm.cfm>. (Accessed June 24, 2024)

SIJ injection with corticosteroids and/or local anesthetics is a procedure and therefore not subject to FDA regulation. However, any medical devices, drugs, biologics, or tests used as a part of this procedure may be subject to FDA regulation. Refer to the following website for additional information: <http://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfPMN/pmnm.cfm>. (Accessed June 24, 2024)

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The foregoing Oxford policy has been adapted from an existing UnitedHealthcare national policy that was researched, developed and approved by UnitedHealthcare Medical Technology Assessment Committee. [2024T0621K]

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Policy History/Revision Information

Date	Summary of Changes
01/01/2025	<p>Coverage Rationale</p> <p>Sacral Lateral Branch Nerve Blocks</p> <ul style="list-style-type: none"> Added language to indicate Sacral Lateral branch Nerve Blocks as a diagnostic tool prior to radiofrequency ablation are unproven and not medically necessary due to insufficient evidence of efficacy <p>Minimally Invasive Joint Fusion</p> <ul style="list-style-type: none"> Replaced language indicating “minimally invasive joint fusion using a Titanium Triangular Implant is proven and medically necessary when all the [listed] criteria are met” with “minimally invasive joint fusion <i>for degenerative sacroiliac disease</i> using a Titanium Triangular Implant System for is proven and medically necessary when all the [listed] criteria are met” Revised coverage criteria: <ul style="list-style-type: none"> Replaced criterion requiring “diagnostic imaging studies that include imaging (plain radiographs and a CT or MRI) of the Sacroiliac (SI) Joint that excludes the presence of destructive lesions (e.g., tumor, infection), or autoimmune arthropathy that would not be properly addressed by percutaneous SI Joint Fusion” with “diagnostic imaging studies that include imaging (plain radiographs and a CT or MRI) that <i>demonstrates degenerative disease</i> of the Sacroiliac (SI) Joint <i>and</i> that excludes the presence of destructive lesions (e.g., tumor, infection), or autoimmune arthropathy that would not be properly addressed by percutaneous SI Joint Fusion” Revised list of examples of Provocative Tests; replaced “Patrick’s <i>or FABER</i>” with “Patrick’s (<i>Fabere</i>)” Removed notation indicating thrust tests may not be recommended in pregnant patients or those with connective tissue disorders <p>Fusion of the Sacroiliac Joint</p> <ul style="list-style-type: none"> Added language to indicate fusion of the Sacroiliac Joint for the treatment of back pain presumed to originate from the Sacroiliac Joint is unproven and not medically necessary for all other indications and with any other devices not listed [in the policy as proven and medically necessary] due to insufficient evidence of efficacy <p>Medical Records Documentation Used for Reviews (previously titled Documentation Requirements)</p> <ul style="list-style-type: none"> Replaced list of <i>Required Clinical Information</i> with instruction to refer to the protocol titled Medical Records Documentation Used for Reviews <p>Definitions</p>

Date	Summary of Changes
	<ul style="list-style-type: none"> Added definition of “Sacral Lateral Nerve Block” <p>Supporting Information</p> <ul style="list-style-type: none"> Updated <i>Clinical Evidence</i> and <i>References</i> sections to reflect the most current information Archived previous policy version PAIN 027.7

Instructions for Use

This Clinical Policy provides assistance in interpreting UnitedHealthcare Oxford standard benefit plans. When deciding coverage, the member specific benefit plan document must be referenced as the terms of the member specific benefit plan may differ from the standard plan. In the event of a conflict, the member specific benefit plan document governs. Before using this policy, please check the member specific benefit plan document and any applicable federal or state mandates. UnitedHealthcare Oxford reserves the right to modify its Policies as necessary. This Clinical Policy is provided for informational purposes. It does not constitute medical advice.

The term Oxford includes Oxford Health Plans, LLC and all of its subsidiaries as appropriate for these policies. Unless otherwise stated, Oxford policies do not apply to Medicare Advantage members.

UnitedHealthcare may also use tools developed by third parties, such as the InterQual® criteria, to assist us in administering health benefits. UnitedHealthcare Oxford Clinical Policies are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.