Sacroiliac Joint Injections & Radiofrequency Ablation

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NASS Coverage Policy Recommendations

NASS Coverage Committee

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Coverage Policy Recommendations
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Introduction
North American Spine Society (NASS) coverage recommendations are intended to assist payers and members by proactively defining appropriate coverage positions. Historically, NASS has provided comment on payer coverage policy upon request. However, in considering coverage policies received by the organization, NASS believes proactively examining medical evidence and recommending credible and reasonable positions may be to the benefit of both payers and members in helping achieve consensus on coverage before it becomes a matter of controversy. This coverage recommendation reflects the best available data as of 6/5/2019; information and data available after 6/5/2019 is thus not reflected in this recommendation and may warrant deviations from this recommendation, if appropriate.

Methodology
The coverage recommendations put forth by NASS use an evidence-based approach to spinal care when possible. In the absence of strict evidence-based criteria, coverage recommendations reflect the multidisciplinary experience and expertise of the authors in order to reflect reasonable standard practice indications in the United States.

NASS Coverage Policy Methodology

Scope and Clinical Indications
Low back pain (LBP) is the leading cause of global disability. The sacroiliac joint (SIJ) represents a specific and identifiable cause of LBP. The SIJ is the cause of chronic LBP in 15-30% of patients, with a higher prevalence in older patients, those with a history of lumbosacral fusion, trauma, spondylarthropathy, and/or maximal pain below the L5 vertebrae. Although no single physical exam maneuver has a high predictive value for diagnosing SIJ pain,  the following criteria predict a positive response to a diagnostic intra-articular anesthetic block in 70-80% of patients: maximal pain below L5 and positive findings on at least 3 of 6 provocation tests (1. Patrick’s or FABER, 2. Gaenslen, 3. Thigh thrust, 4. Sacral thrust, 5. Distraction, 6. Compression). With the exception of acute inflammatory sacroiliitis, imaging is of limited use in diagnosing presumed SIJ pain. The reference standard for the diagnosis of SIJ pain remains a positive response to a fluoroscopically-guided intra-articular injection of local anesthetic. Several critical variables need to be accounted for when utilizing an SIJ injection, including the need for image-guidance and recording, an established false positive rate of around 20%, potential for extravasation of the anesthetic outside of the SIJ capsule, and the potential contribution of the SIJ dorsal ligaments to the LBP in question.

The innervation of the SIJ and dorsal ligaments are important to understand when considering SIJ interventions. Just as the SIJ itself is a well innervated structure and a known cause of pain, the dorsal ligaments surrounding the SIJ are also well innervated by at least the L5 primary dorsal ramus, as well as the lateral branches of the 1st-3rd sacral dorsal rami. Noxious stimulation of the dorsal SIJ ligaments do cause pain in healthy volunteers and anesthetic blockade of these nerves inhibit this pain. Because the SIJ itself receives innervation from these dorsal nerves, as well as branches ventral to the sacrum, anesthetizing the dorsal nerve branches does not relieve pain from all aspects of the SIJ joint. Specifically, the more ventral joint surfaces and capsule may be unaffected by anesthetic blockade of the L5 dorsal ramus and sacral lateral branches. Thus, while a precisely placed intra-articular injection of anesthetic can eliminate pain from the SIJ intra-articular surfaces and capsule, it may fail to identify patients with pain from the dorsal ligaments. Similarly, while L5 dorsal ramus and sacral dorsal rami lateral branch anesthetic injections can eliminate pain from the dorsal and interosseous ligaments, they may fail to identify patients with pain from more ventral portions of the SIJ. In summary, a SIJ intra-articular injection should not be considered interchangeable with sacral lateral branch blocks.

Taking all of these variables into account, the following sections provide utilization recommendations for diagnostic and therapeutic SIJ interventions, including SIJ intra-articular injections and SIJ dorsal nerve (L5 primary dorsal ramus and 1st-3rd sacral dorsal rami lateral branches) anesthetic blocks and radiofrequency ablation (RFA).

Clinical Criteria for the Procedures:
Item 1: Diagnostic intra-articular SIJ injections
Intra-articular SIJ joint injections are indicated to aid in the diagnostic work-up of low back pain when ALL of the listed criteria are met. Of note, any and all SIJ injections should be performed with some form of radiographic image guidance (eg, fluoroscopic, CT). Further, volume of injectate should be limited to 2 mL, the inclusion of steroid with local anesthetic is not inappropriate. A diagnosis of SI joint
pain is confirmed with at least 75% reduction of pain for the expected duration of the anesthetic used on 2 separate occasions.

a) 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
b) A physical examination typically demonstrating localized tenderness with palpation over the sacral sulcus (Fortin’s point, ie, at the insertion of the long dorsal ligament inferior to the posterior superior iliac spine or PSIS) or the absence of tenderness elsewhere (eg, greater trochanter, lumbar spine, coccyx) that would explain the patient’s symptoms.
c) Positive response to a cluster of at least 3 provocative tests (1. Patrick’s or FABER, 2. Gaenslen, 3. Thigh thrust, 4. Sacral thrust, 5. Distraction, 6. Compression). Note that the thrust tests may not be recommended in pregnant patients or those with connective tissue disorders.

Item 2: Diagnostic anesthetic blocks of the L5 primary dorsal ramus and sacral dorsal rami lateral branches (S1-S3)
Small volume (<0.5 mL per nerve) image-guided anesthetic blockade of the L5 primary dorsal ramus and 1st-3rd sacral dorsal rami lateral branches are indicated to aid in the diagnostic work-up of LBP and must be considered prior to radiofrequency lesioning of these nerves. A positive response is at least 75% reduction of pain for the expected duration of the anesthetic used on 2 separate occasions.

These blocks are appropriate when ALL of the listed criteria are met:

a) 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.
b) A physical examination typically demonstrating localized tenderness with palpation over the sacral sulcus (Fortin’s point, ie, at the insertion of the long dorsal ligament inferior to the posterior superior iliac spine or PSIS) or the absence of tenderness elsewhere (eg, greater trochanter, lumbar spine, coccyx) that would explain the patient’s symptoms.
c) Positive response to a cluster of at least 3 provocative tests (1. Patrick’s or FABER, 2. Gaenslen, 3. Thigh thrust, 4. Sacral thrust, 5. Distraction, 6. Compression). Note that the thrust tests may not be recommended in pregnant patients or those with connective tissue disorders.

d) Advanced imaging (bone scan or MRI) demonstrate uptake or inflammation in the SIJ.
e) Patients with spondyloarthopathies such as ankylosing spondylitis.

Item 3: Therapeutic intra-articular SI joint injections
Image-guided intra-articular SIJ injections of corticosteroid with or without local anesthetic are indicated for the treatment of sacroiliac pain when ≥ 1 of the listed criteria are met:

a) Clinical criteria for diagnostic SIJ injection are met (as above in item 1) AND pain has been present for at least 1 month AND pain is > 4/10 with functional limitation OR any pain level with functional limitation despite other conservative treatment.
b) SIJ joint pain has been confirmed with diagnostic intra-articular SIJ injections.
c) SIJ pain has recurred following a previous therapeutic SIJ injection which resulted in >50% pain relief for ≥ 3 months.
d) Advanced imaging (bone scan or MRI) demonstrate uptake or inflammation in the SIJ.
e) Patients with spondyloarthopathies such as ankylosing spondylitis.

Item 4: Radiofrequency neurotomy of the L5 primary dorsal ramus and sacral dorsal rami lateral branches (S1-S3)
Image-guided thermal radiofrequency neurotomy of the L5 primary dorsal ramus and sacral dorsal rami lateral branches at S1, S2 and S3 are indicated for the treatment of sacroiliac pain when either of the listed criteria are met:

a) Clinical criteria for positive diagnostic anesthetic blocks of the L5 primary dorsal ramus and sacral dorsal rami lateral branches (as above in item 2) are met AND pain has been present for at least 2 months AND pain is severe enough to cause some degree of functional deficit despite other conservative treatment.
b) Posterior sacroiliac ligament complex pain has recurred after ≥ 50% improvement for ≥ 6 months from prior radiofrequency neurotomy of the L5 primary dorsal ramus and sacral dorsal rami lateral branches.

Rationale

Items 1 and 2
Patient Selection: The challenges associated with identifying patients with SIJ pain by history and physical exam alone has been well-studied. No single historical finding is diagnostic of SIJ pain, but the following are common: unilateral pain, maximal pain below the L5 vertebrae, pain aggravated with sitting and transitions from sitting to standing, history of trauma, referred pain to the buttock, groin,
thigh and occasionally below the knee. The utility of physical exam findings has been more extensively evaluated in multiple studies, reviews and meta-analyses. Studies agree that no single physical exam maneuver is reliable for diagnosis of SIJ pain, but a combination of provocative maneuvers can achieve a PPV of 70-80% for predicting at least a 50% improvement on a diagnostic intra-articular SIJ injection. No combination of tests can predict an 80% or greater response. History and physical exam cannot effectively differentiate between pain from the SIJ itself versus pain from the dorsal ligaments or both. Based on the available evidence, it is reasonable to select patients for all types of diagnostic SIJ procedures on the basis of having maximal pain below the L5 vertebrae and at least 3 positive provocation maneuvers (1. Patrick’s or FABE, 2. Gaenslen, 3. Thigh thrust, 4. Sacral thrust, 5. Distraction, 6. Compression) and lack of a better explanation for symptoms (eg, discogenic and/or radicular pain).

Value of Radiographic Findings: While various imaging modalities can identify structural abnormalities of the SIJ, imaging abnormalities are not needed for a diagnosis of SIJ pain or for responsiveness to SIJ injections. Plain radiographs and CT can identify late stage sacroiliitis or SIJ arthropathy. A positive bone scan can increase the likelihood that the SIJ is the source of pain, but a negative bone scan does not reduce the probability. An MRI is more sensitive than bone scan or plain radiographs for early detection of sacroilitis and may be useful for monitoring treatment response in patients with inflammatory spondyloarthropathy. However, in the nonspondyloarthropathy population that makes up the vast majority of patients with LBP, neither MRI, nor any other imaging modality, has proven better than clinical selection to predict responsiveness to diagnostic SI joint injections. Furthermore, imaging findings have not been shown to be better than diagnostic injections for predicting responsiveness to therapeutic SIJ procedures. Thus, imaging is considered to be helpful in identifying patients who might benefit from further evaluations such as a diagnostic injection, though the absence of abnormalities on imaging does not negate the appropriateness of performing the procedure.

Image-guidance: Fluoroscopy remains the gold standard for diagnostic SIJ injections. Nonimage guided "blind" injections successfully enter the SIJ capsule 12-22% of the time. CT scan can be used for image-guidance, but is less effective than fluoroscopy at capturing the escape of injectate from the joint to adjacent structures and cannot rule out concurrent intravascular flow. In systematic reviews of SI joint interventions, fluoroscopic or CT guidance has been considered an inclusion criteria. However, in the nonspondyloarthropathy population that makes up the vast majority of patients with LBP, neither MRI, nor any other imaging modality, has proven better than clinical selection to predict responsiveness to diagnostic SIJ injections. Furthermore, imaging findings have not been shown to be better than diagnostic injections for predicting responsiveness to therapeutic SIJ procedures. Thus, imaging is considered to be helpful in identifying patients who might benefit from further evaluations such as a diagnostic injection, though the absence of abnormalities on imaging does not negate the appropriateness of performing the procedure.

Utility of Diagnostic Injections: History, physical exam and imaging studies are inadequate for confirmation of SIJ pain, at least in patients without spondyloarthropathy. Multiple studies and reviews have evaluated the utility of single and dual anesthetic blocks for the diagnosis of SIJ pain. A single SIJ injection of anesthetic, with or without steroid, carries with it a false positive rate of around 20%. This is true if either 50% or 75% improvement in pain is used as the threshold for a “positive” response. Due to the high false positive rates from a single injection, true confirmation of SIJ pain requires at least 75% improvement on 2 separate anesthetic blocks. Relaxing positive block criteria from 75% down to 50% will significantly increase the observed prevalence of SIJ pain. While studies are more limited regarding the diagnostic utility of anesthetic blocks of the L5 primary dorsal ramus and 1st-3rd sacral dorsal rami lateral branches for the diagnosis of SIJ dorsal ligament pain, the available evidence suggests similar criteria should be applied. Furthermore, multi-site and multi-depth anesthetic blocks may be needed to completely anesthetize the dorsal and interosseous ligaments.

Volume: The capacity of the SIJ capsule ranges from 0.6 to 2.7 mL. Injection volumes higher than 2.5mL inclusive of contrast medium are unlikely to be retained in the joint and should not be considered target-specific, which is an essential criterion for diagnostic validity. As is the case for lumbar medial branch blocks, the volume of anesthetic used for the L5 dorsal ramus and each sacral dorsal lateral branch should be less than 0.5 mL per nerve, with lower volumes being more target-specific.

Anticoagulation: Reviews and consensus guidelines support that anticoagulant and/or antiplatelet medications should not be withheld for percutaneous SIJ interventions. This is based on a lack of bleeding complications reported in the literature, absence of sensitive neural structures that could be damaged if bleeding did occur, and the known heightened risk of acute cardiovascular events when a prescribed anticoagulant or antiplatelet medication is discontinued.

Item 3
Therapeutic intra-articular SIJ injections: The utility of therapeutic intra-articular SIJ injections has been studied extensively, but with variable selection criteria and outcomes reporting. In the most comprehensive systematic review to date, the evidence is moderate for
the effectiveness of therapeutic SIJ injections. Patients with inflammatory spondyloarthropathy such as ankylosing spondylitis with associated sacroiliitis, may be the most responsive subgroup. Based on the available data, including numerous observational and retrospective studies, along with limited RCTs, it is reasonable to expect that at least 50% of patients selected by the criteria described above will achieve ≥ 50% improvement in pain for at least 4-6 weeks. Proportion of responders increases to 75% if inflammatory spondyloarthropathy present as the cause of SIJ pain. Duration of response is highly variable and can range from 4 weeks to 9 months. Retrospective data indicates that purely intra-articular placement of medicine may not be required for a positive therapeutic response to injection of corticosteroid and incompetent SIJ capsules are common. Recent studies also support that a therapeutic U/S-guided SIJ injection can produce a therapeutic response similar to fluoroscopically-guided injection, but most systematic reviews have included studies based on fluoroscopic or CT-guided injections. A multispecialty collaborative panel of experts published appropriate use criteria for SIJ injections in 2017 and indicated that a SIJ injection with corticosteroid alone (ie, without anesthetic) is not recommended unless the patient has proven responsiveness previously to an image-guided SIJ injection including anesthetic.

While the available data is mixed, it remains reasonable to offer coverage of therapeutic SIJ injections in those cases that fulfill the listed criteria.

Item 4

Radiofrequency neurotomy of the L5 primary dorsal ramus and sacral dorsal rami lateral branches: There is currently limited evidence regarding radiofrequency neurotomy for SIJ posterior ligament complex pain. Based on the available limited data, it is reasonable to estimate a response rate of 35-70% to achieve ≥ 50% improvement in VAS pain scores for at least 3 months, when selected by a positive response (≥ 50%) to diagnostic injection with anesthetic. Positive response is probably both dependent on patient selection and technique. While an optimal diagnostic/selection protocol has not been confirmed, a multi-specialty collaborative panel of experts published appropriate use criteria for SIJ interventions in 2017 recommending more stringent selection criteria of ≥ 75% temporary improvement in pain or function from anesthetic blocks for selection to thermal radiofrequency neurotomy. Similarly, the optimal procedural technique has not been established, but appears to involve multiple lesions per nerve or bipolar lesioning due to variable anatomy of the lateral sacral branches, with single-site, single-depth lesions less likely to be effective.

Acknowledging more limited data, it is reasonable to offer coverage for thermal radiofrequency neurotomy at the L5 dorsal ramus and S1-S3 sacral dorsal rami lateral branches for SIJ posterior ligament complex pain in those cases that fulfill the detailed listed criteria.

References


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