

Subject: Sacroiliac Injections and Radiofrequency Ablation (RFA) for Sacroiliac Joint Pain		Original Effective Date: 7/5/07
Policy Number: MCR-033	Revision Date(s): 12/3/09, 8/23/12, 12/11/13, 6/25/14, 12/5/16, 2/9/17, 7/25/17, 4/23/20	
Review Date: 6/25/14, 12/16/15, 6/15/16, 3/8/18, 6/19/19, 4/23/20, 4/5/21		
MCPC Approval Date: 7/25/17, 3/8/18, 6/19/19, 4/23/20, 4/5/21		

Contents

DISCLAIMER	1
Description of Procedure/Service/Pharmaceutical.....	1
Criteria Recommendation	2
Limitations	4
Summary of Medical Evidence.....	4
PROFESSIONAL SOCIETY GUIDELINES	5
Coding Information.....	6
Resource References.....	6
REVISION/REVIEW HISTORY	9

DISCLAIMER

This Molina Clinical Review (MCR) is intended to facilitate the Utilization Management process. It expresses Molina's determination as to whether certain services or supplies are medically necessary, experimental, investigational, or cosmetic for purposes of determining appropriateness of payment. The conclusion that a particular service or supply is medically necessary does not constitute a representation or warranty that this service or supply is covered (i.e., will be paid for by Molina) for a particular member. The member's benefit plan determines coverage. Each benefit plan defines which services are covered, which are excluded, and which are subject to dollar caps or other limits. Members and their providers will need to consult the member's benefit plan to determine if there are any exclusion(s) or other benefit limitations applicable to this service or supply. If there is a discrepancy between this policy and a member's plan of benefits, the benefits plan will govern. In addition, coverage may be mandated by applicable legal requirements of a State, the Federal government or CMS for Medicare and Medicaid members. CMS's Coverage Database can be found on the CMS website. The coverage directive(s) and criteria from an existing National Coverage Determination (NCD) or Local Coverage Determination (LCD) will supersede the contents of this Molina Clinical Review (MCR) and provide the directive for all Medicare members.¹

DESCRIPTION OF PROCEDURE/SERVICE/PHARMACEUTICAL ⁴⁵⁻⁴⁶

Sacroiliac Joint Injections:

Intraarticular sacroiliac joint injections are performed for both diagnostic and therapeutic purposes. Diagnostic injections are performed to confirm the location of pain originating in the sacroiliac joint region. The procedure is performed most commonly using fluoroscopy guidance for accurate needle placement. The needle is placed in the sacroiliac joint region and contrast media is injected for arthrogram viewing to confirm correct needle placement. An injection of a small

amount of anesthetic is injected to determine the patient's pain relief response. If pain is reduced by 50% or removed, a therapeutic injection of anesthetic with or without corticosteroid would be provided to achieve long term pain relief.

Radiofrequency Ablation:

Radiofrequency ablation (RFA) for sacroiliac (SI) joint pain involves the use of radiofrequency (RF) current to generate heat and destroy sensory nerves to the SI joint. The goal of this therapy is to interrupt transmission of pain signals from the SI joint nerves to the brain in patients with refractory SI joint pain.

Pulsed Radiofrequency:

Pulsed RFA (PRFA) has been introduced as a nonablative alternative to RFA. PRFA delivers short bursts of radiofrequency (RF) current, instead of the continuous flow of RF current produced by continuous RF generators. This allows the tissue to cool between bursts, resulting in considerably lower maximum temperatures as compared with the continuous mode, and reduces the risk of neighboring tissue destruction. It does not destroy targeted nerves and surrounding tissue and therefore requires less precise electrodes placement. During PRFA, intermittent low temperature electric currents of 2 Hz at temperatures not exceeding 42°C are transmitted to the nerve.

Cooled Radiofrequency

Similar to pulsed RFA, cooled RFA enables larger lesions to be created as adjacent tissue is cooled during the procedure. Cooling is regulated by an attached computer. Internally cooled electrodes can create lesions 8 to 10 millimeters (mm) in diameter, with the depth extending distal to the electrode tip.

SIJ pain

The sacroiliac joint (SI) joint, the largest axial joint in humans, connects the sacrum to the ilium in the spine. The SI joint has been identified as a primary source of chronic low back pain (LBP). Pain in the SI joint may be caused by a wide variety of events, including infection; benign or malignant tumors; inflammatory arthritis; injuries caused by sudden impact during motor vehicle accidents; athletic injury; protracted lifting and bending; torsional strain; altered gait mechanics; and spine misalignment.

CRITERIA RECOMMENDATION 42.44 47 48

1. Radiofrequency ablation (including water cooled RFA) and pulsed radiofrequency for treating acute, subacute, or chronic SI joint pain are considered experimental, investigational, or unproven and may NOT be authorized due to insufficient evidence in the peer reviewed literature.
2. Sacroiliac injections (local anesthetics with or without corticosteroids) with fluoroscopy are considered medically necessary for chronic severely debilitating low back pain in adults who are age 18 years or older as part of a comprehensive pain management treatment program when all of the following criteria are met: [ALL]
 - Physical examination documentation reveals *all* of the following clinical characteristics of sacroiliac joint disease:
 - Somatic or nonradicular low back pain and lower extremity pain (greater than 6 on scale 0-10) below the level of L5 vertebra for minimally three months; *and*
 - Intermittent or continuous pain causing functional disability; *and*

- ❑ Has tried and failed conservative therapy that includes: [ALL]
 - Physical therapy (PT) a minimum of 4 weeks (3-4x per week for a total of 12 sessions); or
 - There must be documentation submitted that explains why physical therapy is contraindicated:
 - **Note:* PT may be contraindicated if any of the following are present:
 - pain worsened with PT;
 - PT tried but was not able to be tolerated
- AND
- Activity modification a minimum of 6 weeks; and
- Drug therapy (i.e. NSAIDS, muscle relaxants, corticosteroids, antidepressants, anticonvulsants, or opiates)

Initiation of Treatment and Injection Frequency following Criteria Approval

- ❑ In the ***diagnostic phase:***
 - A total of two injections for diagnosis may be given no less than one week apart, preferably two weeks apart.
 - If the patient does not experience significant functional pain relief of 50% measured by a decrease in pain medications and increase in physical function for a minimum of 2 months, no further injections should be given
- ❑ In the therapeutic phase ***all*** of the following criteria must be met:
 - the previous diagnostic or therapeutic injection provided symptom or significant functional pain relief of 50% measured by a decrease in pain medications and increase in physical function for a minimum of 2 months before subsequent injections within the same region are authorized
 - The frequency should be 2 months or longer between each injection in the same joint not to exceed a total of 4 injections in one region per year. The injections should only be repeated as necessary if the medical necessity criteria above are achieved.
 - Injections at different joints can be given 2 weeks apart but no sooner than 1 week following an injection in a different region.
 - A maximum of 4 injections total per rolling calendar year may be given for local anesthetic and corticosteroid injections.
 - A patient must be experiencing a return of pain or deterioration in function to receive a therapeutic injection.

Notes:

- ❑ *A rolling calendar year is twelve months after the event, beginning and ending in the same month the initial event took place; (e.g., first diagnostic injection is given in June 2020, the rolling calendar year would end in June 2021)

- ❑ When sacroiliac joint dysfunction is present in conjunction with other primary pain generators (such as lumbar radiculitis secondary to degenerative disc disease or lumbar facet arthropathy secondary to lumbar facet arthritis, treatment should first address the non-sacroiliac joint pain generators, as SI joint dysfunction may resolve once these pain generators have been successfully treated. If there is residual sacroiliac pain, it may be appropriate to perform SI joint injections to address the remaining pain.
 - only one type of a block or injection (e.g., sacroiliac, epidural) should be performed in a given session so that the effectiveness of its treatment can be assessed prior to attempting another type of spinal block or injection.

Note: Criteria recommendations are mainly obtained from the Official Disability Guidelines, AMR peer review and other professional society guidelines.^{42 44 47 48}

LIMITATIONS^{42 44 47 48}

1. **Lateral Nerve blocks and Radiofrequency ablation (including water cooled RFA) and pulsed radiofrequency** for diagnosing or treating acute, subacute, or chronic SI joint pain procedures are considered experimental, investigational, or unproven and may NOT be authorized due to insufficient evidence in the peer reviewed literature.
2. Sacroiliac injections are *excluded* for the following:
 - ❑ Members that do not meet the outlined criteria listed above
 - ❑ Use of agents other than local anesthetic agents with or without corticosteroids
 - ❑ Requests for sacroiliac injections exceeding the limits outlined above
 - ❑ Treatment of patients with acute low back and acute pain syndromes

Contraindications to receiving sacroiliac joint injections include, but are not limited to, the following:

- ❑ Allergy to the medication to be administered
- ❑ Anticoagulation therapy
- ❑ Bleeding disorder
- ❑ Localized infection in the region to be injected
- ❑ Systemic infection
- ❑ Other comorbidities that could exacerbate the procedure/steroid use (e.g., diabetes, congestive heart failure, poorly controlled hypertension)
- ❑ Fluoroscopy use is contraindicated for members that are pregnant

SUMMARY OF MEDICAL EVIDENCE⁴⁻³⁸

Radiofrequency Ablation

The peer reviewed published literature for RFA as a treatment for SIJ pain is limited to case series or uncontrolled studies, and small randomized and placebo-controlled studies. Overall the quality of the evidence regarding RFA was low, limited by the small number of studies, small size of the study populations, lack of placebo control in all except two of the studies, variation in technique and patient characteristics, and short duration of follow-up. Efficacy of conventional, pulsed, and cooled RFA is limited and suggests that conventional RFA can provide short-term (3 to 6 months) pain relief in patients with SI joint pain. The percentage of patients who achieved at least 50% reduction in pain ranged from 47% to 89% at 3 months after RFA, with a mean of 68% across studies. This effect decreased over time, with 38% to 80% of patients still reporting \geq 50% pain relief at 6 months. Results were similar for cooled and pulsed RFA, although there was only one

small study on pulsed RFA. One study provided a direct comparison of conventional and cooled RFA, reporting comparable findings with both techniques. One of the two randomized placebo-controlled studies reported that 93% of patients had a positive GPE at 1 month after RFA, compared with 21% of control patients; by 3 months follow up, 71% of patients still had a positive GPE. The other placebo-controlled study did not report the proportion of patients with pain relief at follow-up. Instead, the authors compared outcome measures for patients treated with RFA and patients who underwent a placebo procedure. Three months after treatment, RFA was considered to be successful in a larger proportion of patients in the treatment group compared with those in the placebo control group (47% versus 12%). Similarly, a larger percentage of patients in the treatment group (47% versus 8%) reported a positive GPE during the same follow-up time frame.^{4 6 7-10 15 16 22 26 27 29 30-36 46}

SIJ Injections^{5 11-14 17-21 23-25 28 37 38}

The current peer reviewed published literature for SIJ injections with corticosteroids and local anesthetic for treatment of chronic low back pain consists of randomized controlled trials (RCT) prospective cohort studies and retrospective reviews. One RCT compared the long-term efficacy of SIJ injection of triamcinolone and levobupivacaine with intra-articular prolotherapy in 48 patients with chronic SIJ pain confirmed by diagnostic injections. At 2 weeks, pain ($\geq 50\%$ reduction) and disability scores were significantly improved in both groups ($P < 0.001$ for each) with no difference between the groups. However, the proportion of patients whose improvement was $\geq 50\%$ at 6 months was lower in the SIJ injection group than in the prolotherapy group (27.2% versus 63.6%; $P < 0.01$) and at 15 months (10.2% versus 58.7%; $P < 0.005$). Another RCT compared the short-term efficacy of 3 treatments in 51 patients with chronic SIJ-related leg pain: fluoroscopically guided SIJ injection with lidocaine plus triamcinolone, PT, and manual therapy. SIJ-related pain was not confirmed by diagnostic injection. Rates of treatment success, defined as complete relief of symptoms at 6- or 12-week follow-up or reduced VAS scores for pain at the final visit compared with baseline, were 50% in the SIJ injection group, 20% in the PT group, and 72% in the manual therapy group; the difference between the groups was significant ($P = 0.011$). Manual therapy was significantly more efficacious than PT ($P = 0.003$) although no differences were found between SIJ injection and manual therapy ($P = 0.17$) or between SIJ injection and PT ($P = 0.07$). Only patients in the manual therapy group had a significant improvement in pain between baseline and either follow-up visit ($P = 0.014$). Another small RCT compared the short-term efficacy of US-guided SIJ injections versus fluoroscopic guidance in 120 patients with noninflammatory sacroiliac arthritis. Patients were not blinded, but pain, disability, and satisfaction scores were evaluated by a blinded investigator. Pain and disability scores improved at 2 and 12 weeks in both groups ($P < 0.025$ for each), and patient satisfaction at 12 weeks was similar between the groups.^{14 17 28}

A prospective study of SIJ injection of steroids in 39 consecutive patients found that 26 patients (66.7%) had significantly reduced pain for > 6 weeks. Mean scores for pain and disability were significantly decreased at a mean of 27.9 months ($P < 0.0001$ for each). In a prospective cohort study evaluating the efficacy of CT-guided SIJ of triamcinolone and bupivacaine in 51 patients with low back pain, VAS scores were significantly lower at all postinjection time points from day 1 to > 6 months ($P < 0.05$ for all time points). The overall initial success rate was 89.2%; however, the success rate at final follow-up at a mean of 26.7 months was lower (69.5%). Five patients (10.8%) had little improvement in pain and were considered treatment failures. The study excluded patients who did not have 2 years of follow-up, possibly biasing results in favor of SIJ injection.^{19 25}

PROFESSIONAL SOCIETY GUIDELINES³⁹⁻⁴³

American Society of Interventional Pain Physicians (ASIPP): Updated 2013 guidelines suggest that for sacroiliac joint interventions, the evidence for cooled radiofrequency neurotomy is fair; limited for intraarticular injections and periarticular injections; and limited for both pulsed radiofrequency and conventional radiofrequency neurotomy.

American Society of Anesthesiologists (ASA): The practice guidelines for chronic pain management indicate that Sacroiliac joint injections may be considered for symptomatic relief of sacroiliac joint pain.

American Society of Anesthesiologists (ASA) / American Society of Regional Anesthesia and Pain Medicine (ASRA): In their Practice Guidelines for Chronic Pain Management, the ASA Task Force on Chronic Pain Management and ASRA in conjunction with consultants state that conventional or thermal RFA of the medial branch nerves should be performed for low back (medial branch) pain only after diagnostic or therapeutic injections of the joint or medial branch nerve have provided temporary relief. The task force recommends the use of water-cooled RFA for chronic SI joint pain, although the members of ASA and ASRA were equivocal on its use for this application. The Task Force recommends that neuroablative procedures should be used as part of a comprehensive pain management regimen, performed only as a last resort when pain is refractory to other therapies.

CODING INFORMATION: THE CODES LISTED IN THIS POLICY ARE FOR REFERENCE PURPOSES ONLY. LISTING OF A SERVICE OR DEVICE CODE IN THIS POLICY DOES NOT IMPLY THAT THE SERVICE DESCRIBED BY THIS CODE IS A COVERED OR NON-COVERED. COVERAGE IS DETERMINED BY THE BENEFIT DOCUMENT. THIS LIST OF CODES MAY NOT BE ALL INCLUSIVE.

CPT	Description
27096	Injection procedure for sacroiliac joint, anesthetic/steroid, with image guidance (fluoroscopy or CT) including arthrography when performed
64451	Injection(s), anesthetic agent(s) and/or steroid; nerves innervating the sacroiliac joint, with image guidance (ie, fluoroscopy or computed tomography)
64625	Radiofrequency ablation, nerves innervating the sacroiliac joint, with imaging guidance (i.e. fluoroscopy or computed tomography)
HCPCS	Description
G0259	Injection procedure for sacroiliac joint; arthrography
G0260	Injection procedure for sacroiliac joint; provision of anesthetic, steroid and/or other therapeutic agent, with or without arthrography

RESOURCE REFERENCES

Government Agency

1. Centers for Medicare & Medicaid Services. Search database. Accessed at: <https://www.cms.gov/medicare-coverage-database/new-search/search.aspx>
2. Centers for Medicare & Medicaid Services. Novitas Solutions, Inc. LCD #L27512 - Paravertebral Facet Joint Nerve Block and Sacroiliac Joint Injection.
3. Centers for Medicare & Medicaid Services. CMS First Coast Service Options. LCD #L29274 for Sacroiliac Joint Injections. Updated Jan 2012.

Peer Reviewed Publications

4. Aydin SM1, Gharibo CG, Mehnert M, Stitik TP. The role of radiofrequency ablation for sacroiliac joint pain: a meta-analysis. PM R. 2010 Sep;2(9):842-51. doi: 10.1016/j.pmrj.2010.03.035.
5. Boswell, M.V., Trescott, A.M., Datta, S., et al. (2007). Interventional techniques: Evidence-based practice guidelines in the management of chronic spinal pain.10:7-111.

6. Buijs EJ, Kamphuis ET, Groen GJ. Radiofrequency treatment of sacroiliac joint-related pain aimed at the first three sacral dorsal rami: a minimal approach. *Pain Clinic*. 2004;16:139-146.
7. Cheng J, Pope JE, Dalton JE, Cheng O, Bensitel A. Comparative outcomes of cooled versus traditional radiofrequency ablation of the lateral branches for sacroiliac joint pain. *Clin J Pain*. 2012. Epub ahead of print. June 7, 2012
8. Cohen SP, Abdi S. Lateral branch blocks as a treatment for sacroiliac joint pain: a pilot study. *Reg Anesth Pain Med*. 2003;28(2):113-119.
9. Cohen SP, Hurley RW, Buckenmaier CC 3rd, Kurihara C, Morlando B, Dragovich A. Randomized placebo-controlled study evaluating lateral branch radiofrequency denervation for sacroiliac joint pain. *Anesthesiology*. 2008;109(2):279-288.
10. Cohen SP, Strassels SA, Kurihara C, et al. Outcome predictors for sacroiliac joint (lateral branch) radiofrequency denervation. *Reg Anesth Pain Med*. 2009;34(3):206-214.
11. Günaydin I, Pereira PL, Fritz J, et al. Magnetic resonance imaging guided corticosteroid injection of sacroiliac joints in patients with spondylarthropathy. Are multiple injections more beneficial? *Rheumatol Int*. 2006;26(5):396-400.
12. Gupta S. Double needle technique: an alternative method for performing difficult sacroiliac joint injections. *Pain Physician*. 2011 May-Jun;14(3):281-4.
13. Hansen, H.C., (2007). Sacroiliac Joint Intervention: A systematic review. *Pain Physician Journal*. 2007;10(1):165-184.
14. Jee H, Lee JH, Park KD, Ahn J, Park Y. Ultrasound-guided versus fluoroscopy-guided sacroiliac joint intra-articular injections in the noninflammatory sacroiliac joint dysfunction: a prospective, randomized, single-blinded study. *Arch Phys Med Rehabil*. 2014;95(2):330-337.
15. Kapural L, Nageeb F, Kapural M, Cata JP, Narouze S, Mekhail N. Cooled radiofrequency system for the treatment of chronic pain from sacroiliitis: the first case-series. *Pain Pract*. 2008;8(5):348-354.
16. Karaman H, Kavak GO, Tüfek A, et al. Cooled radiofrequency application for treatment of sacroiliac joint pain. *Acta Neurochirurgica*. 2011;153(7):1461-1468.
17. Kim WM, Lee HG, Jeong CW, Kim CM, Yoon MH. A randomized controlled trial of intra-articular prolotherapy versus steroid injection for sacroiliac joint pain. *J Altern Complement Med*. 2010;16(12):1285-1290.
18. Levin JH. Prospective-double-blind, randomized placebo-controlled trials in interventional spine: what the highest quality literature tells us. *The Spine Journal* (2009);9:690-703.
19. Liliang PC, Lu K, Weng HC, Liang CL, Tsai YD, Chen HJ. The therapeutic efficacy of sacroiliac joint blocks with triamcinolone acetonide in the treatment of sacroiliac joint dysfunction without spondyloarthropathy. *Spine (Phila Pa 1976)*. 2009;20;34(9):896-900.
20. Manchikanti L, Helm S, Singh V et al. An algorithmic approach for clinical management of chronic spinal pain. *Pain Physician* 2009;12:E225-E264.
21. Manchikanti L, Datta S, Gupta S et al. A Critical Review of the *American Pain Society* Clinical Practice Guidelines For *Interventional Techniques*: Part 2 Therapeutic Interventions. *Pain Physician*. 2010 Jul-Aug;13(4):E215-64.
22. Patel N, Gross A, Brown L, Gekht G. A randomized, placebo-controlled study to assess the efficacy of lateral branch neurotomy for chronic sacroiliac joint pain. *Pain Med*. 2012;13(3):383-398.
23. Rubinstein SM, van Tulder M. A best-evidence review of diagnostic procedures for neck and low-back pain. *Best PractRes Clin Rheumatol* 2008; 22:471-482
24. Rupert MP, Lee M, Manchikanti L et al. Evaluation of sacroiliac joint interventions: a systematic appraisal of the literature. *Pain Physician* 2009; 12(2):399-418.
25. Sahin O, Harman A, Akgun RC, Tuncay IC. An intraarticular sacroiliac steroid injection under the guidance of computed tomography for relieving sacroiliac joint pain: a clinical outcome study with two years of follow-up. *Turk J Rheumatol*. 2012;27(3):165-173.
26. Speldewinde GC. Outcomes of percutaneous zygapophysial and sacroiliac joint neurotomy in a community setting. *Pain Med*. 2011;12(2):209-218.
27. Vallejo R, Benyamin RM, Kramer J, Stanton G, Joseph NJ. Pulsed radiofrequency denervation for the treatment of sacroiliac joint syndrome. *Pain Med*. 2006;7(5):429-434
28. Visser LH, Woudenberg NP, de Bont J, et al. Treatment of the sacroiliac joint in patients with leg pain: a randomized-controlled trial. *Eur Spine J*. 2013;22(10):2310-2317.
29. Yin W, Willard F, Carreiro J, Dreyfuss P. Sensory stimulation-guided sacroiliac joint radiofrequency neurotomy: technique based on neuroanatomy of the dorsal sacral plexus. *Spine (Phila Pa 1976)*. 2003;28(20):2419-2425.

30. Patel N. Twelve-Month Follow-Up of a Randomized Trial Assessing Cooled Radiofrequency Denervation as a Treatment for Sacroiliac Region Pain. *Pain Pract.* 2016 Feb;16(2):154-67. doi: 10.1111/papr.12269. Epub 2015 Jan 7.
31. Stelzer W, Aiglesberger M, Stelzer D, Stelzer V. Use of cooled radiofrequency lateral branch neurotomy for the treatment of sacroiliac joint-mediated low back pain: a large case series. *Pain Med.* 2013 Jan;14(1):29-35. doi: 10.1111/pme.12014. Epub 2012 Dec 28.
32. King W1, Ahmed SU, Baisden J, Patel N, Kennedy DJ, MacVicar J, Duszynski B. Diagnosis and treatment of posterior sacroiliac complex pain: a systematic review with comprehensive analysis of the published data. *Pain Med.* 2015 Feb;16(2):257-65. doi: 10.1111/pme.12630.
33. Romero FR, Vital RB, Zanini MA, Ducati LG, Gabarra RC. Long-term follow-up in sacroiliac joint pain patients treated with radiofrequency ablative therapy. *Arq Neuropsiquiatr.* 2015 Jun;73(6):476-9. doi: 10.1590/0004-282X20150049
34. van Tilburg CW, Schuurmans FA, Stronks DL, Groeneweg JG, Huygen FJ. Randomized Sham-controlled Double-Blind Multicenter Clinical Trial to Ascertain the Effect of Percutaneous Radiofrequency Treatment for Sacroiliac Joint Pain: Three-month Results. *Clin J Pain.* 2016 Apr 1. [Epub ahead of print]
35. Bellini M, Barbieri M. Single strip lesions radiofrequency denervation for treatment of sacroiliac joint pain: two years' results. *Anaesthesiol Intensive Ther.* 2016;48(1):19-22. doi: 10.5603/AIT.2016.0004.
36. Hegarty D. Clinical Outcome Following Radiofrequency Denervation for Refractory Sacroiliac Joint Dysfunction Using the Simplicity III Probe: A 12-Month Retrospective Evaluation. *Pain Physician.* 2016 Jan;19(1):E129-35.
37. Simopoulos TT, Manchikanti L, Gupta S et al. Systematic Review of the Diagnostic Accuracy and Therapeutic Effectiveness of Sacroiliac Joint Interventions. *Pain Physician.* 2015 Sep-Oct;18(5):E713-56.

Cochrane

38. Maas ET1, Ostelo RW, Niemisto L, Jousimaa J, Hurri H, Malmivaara A, van Tulder MW. Radiofrequency denervation for chronic low back pain. *Cochrane Database Syst Rev.* 2015 Oct 23;(10):CD008572. doi: 10.1002/14651858.CD008572.pub2.

Professional Society Guidelines

39. *American Society of Anesthesiologists (ASA) Practice guidelines for chronic pain management.* An Updated report by the American Society of Anesthesiologists Task Force on Pain Management, Chronic Pain Section. *Anesthesiology.* 2010; 112:1-24.
40. *American Pain Society:*
 - Chou R, Atlas SJ et al. Nonsurgical interventional therapies for low back pain: a review of the evidence for an *American Pain Society* clinical practice guideline. *Spine.* 2009 May 1;34(10):1078-93.
 - Chou R, Huffman LH. *Guideline for the Evaluation and Management of Low Back Pain: Evidence Review.* Glenview, IL: American Pain Society; 2009.
41. *American Society of Interventional Pain Physicians (ASIPP):*
 - Manchikanti L, Abdi S, Atluri S, et al. An update of comprehensive evidence-based guidelines for interventional techniques in chronic spinal pain. Part II: guidance and recommendations. *Pain Physician.* 2013a;16(2 Suppl):S49-S283. Accessed at: <http://www.painphysicianjournal.com/2013/april/2013;16;S49-S283.pdf>
 - Manchikanti L, Falco FJ, Singh V, et al. An update of comprehensive evidence-based guidelines for interventional techniques in chronic spinal pain. Part I: introduction and general considerations. *Pain Physician.* 2013b;16(2 Suppl):S1-S48. Accessed at: <http://www.painphysicianjournal.com/2013/april/2013;16;S1-S48.pdf>
 - Manchikanti L, Boswell MV, Singh V et al. Comprehensive evidence based guidelines for *Interventional Techniques* in the management of chronic spinal pain. *Pain Physician* 2009;12:699-802.
42. *Official Disability Guidelines (ODG). Sacroiliac Joint Blocks.* 2017.
43. Rosenquist R, Benzon H, Connis R, De Leon-Casasola O, Glass D. Practice guidelines for chronic pain management: an updated report by the *American Society of Anesthesiologists* Task Force on Chronic Pain Management and the American Society of Regional Anesthesia and Pain Medicine. *Anesthesiology.* 2010;112(4):810-833.

Other Resources

44. Advanced Medical Review (AMR): Policy reviewed by MD board certified in Physical Medicine & Rehab, Pain Medicine. 8/12, 4/17, & 2/20.
45. Hayes a TractManager Company. Health Technology Assessment:
 - Radiofrequency Ablation for Sacroiliac Joint Denervation for Chronic Low Back Pain. Feb 9, 2017. Updated May, 2020.
 - Sacroiliac Joint Injections with Corticosteroids for Treatment of Low Back Pain. Dec, 2016. Updated Dec, 2018. Archived Jan, 2020.
46. UpToDate. [website]. Waltham, MA: Walters Kluwer Health; 2021.
 - Chou R. Subacute and chronic low back pain: Nonsurgical interventional treatment.
47. AIM's Clinical Appropriateness Guideline. Musculoskeletal Program. Interventional Pain Management. Accessed at: <https://aimspecialtyhealth.com/resources/clinical-guidelines/musculoskeletal/>
48. eviCore Comprehensive Musculoskeletal Management Guidelines. Accessed at: <https://www.evicore.com/provider/clinical-guidelines>

REVISION/REVIEW HISTORY

7/17: Reduced PT requirement from 20 sessions to 10-12 sessions over 8 weeks, changed improvement scales from significant functional improvement of 80% improvement in 6 weeks to significant functional pain relief of 50% measured by a decrease in pain medication and increase in functional ability for a minimum of 2 months. Coding tables updated. Changes are based on 2017 ODG Guidelines per AMR review.

3/8/18 & 6/19/19: Policy reviewed, no changes to criteria.

4/23/20: Policy reviewed, changed PT requirement to a minimum of 4 weeks to be consistent with other guidelines and Molina pain management MCR's. Updated coding table: Added HCPCS code G0259 and removed CPT codes 64635 & 64636.

4/5/21: Policy reviewed, no changes to the criteria. No new good quality studies or guidelines were found. Added two new codes: CPT 64451 & 64625