Diagnosis and Treatment of Sacroiliac Joint Pain

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Last Review: 2/2018  
Next Review: 7/2018  

Policy

Blue Cross and Blue Shield of Kansas City (Blue KC) will provide coverage for diagnosis and treatment of sacroiliac joint when it is determined to be medically necessary because the criteria shown below are met.

When Policy Topic is covered

Injection of anesthetic for diagnosing sacroiliac joint pain may be considered medically necessary when the following criteria have been met:

- Pain has failed to respond to 3 months of conservative management, which may consist of therapies such as nonsteroidal anti-inflammatory medications, acetaminophen, manipulation, physical therapy, and a home exercise program; AND
- Dual (controlled) diagnostic blocks with 2 anesthetic agents with differing duration of action are used; AND
- The injections are performed under imaging guidance

Injection of corticosteroid may be considered medically necessary for the treatment of sacroiliac joint pain when the following criteria have been met:

- Pain has failed to respond to 3 months of conservative management, which may consist of therapies such as nonsteroidal anti-inflammatory medications, acetaminophen, manipulation, physical therapy, and a home exercise program; AND
- The injection is performed under imaging guidance; AND
- No more than 3 injections are given in one year

Minimally invasive fusion/stabilization of the sacroiliac joint using a titanium triangular implant may be considered medically necessary when ALL of the following criteria have been met:

- Pain is at least 5 on a 0 to 10 rating scale that impacts quality of life or limits activities of daily living; AND
- There is an absence of generalized pain behavior (eg, somatoform disorder) or generalized pain disorders (eg, fibromyalgia); AND
▪ Patients have undergone and failed a minimum 6 months of intensive nonoperative treatment that must include medication optimization, activity modification, bracing, and active therapeutic exercise targeted at the lumbar spine, pelvis, sacroiliac joint, and hip, including a home exercise program; AND
▪ Pain is caudal to the lumbar spine (L5 vertebra), localized over the posterior sacroiliac joint, and consistent with sacroiliac joint pain; AND
▪ A thorough physical examination demonstrates localized tenderness with palpation over the sacral sulcus (Fortin’s point) in the absence of tenderness of similar severity elsewhere; AND
▪ There is a positive response to a cluster of 3 provocative tests (eg, thigh thrust test, compression test, Gaenslen sign, distraction test, Patrick test, posterior provocation test); AND
▪ Diagnostic imaging studies include ALL of the following:
  o Imaging (plain radiographs and computed tomography or magnetic resonance imaging) of the sacroiliac joint excludes the presence of destructive lesions (eg, tumor, infection) or inflammatory arthropathy of the sacroiliac joint; AND
  o Imaging of the pelvis (anteroposterior plain radiograph) rules out concomitant hip pathology; AND
  o Imaging of the lumbar spine (computed tomography or magnetic resonance imaging) is performed to rule out neural compression or other degenerative condition that can be causing low back or buttock pain; AND
  o Imaging of the sacroiliac joint indicates evidence of injury and/or degeneration; AND
▪ There is at least a 75% reduction in pain for the expected duration of the anesthetic used following an image-guided, contrast-enhanced intra-articular sacroiliac joint injection on 2 separate occasions; AND
▪ A trial of a therapeutic sacroiliac joint injection (ie, corticosteroid injection) has been performed on at least once.

When Policy Topic is not covered
Fusion/stabilization of the sacroiliac joint for the treatment of back pain presumed to originate from the SI joint is considered investigational, under all other conditions and with any other devices not listed above.

Radiofrequency denervation of the sacroiliac joint is considered investigational.

Arthrography of the sacroiliac joint is considered investigational.

Considerations
This policy does not address treatment of pain in the sacroiliac joint due to infection, trauma, or neoplasm.

Conservative nonsurgical therapy for the duration specified should include the following:
▪ Use of prescription strength analgesics for several weeks at a dose sufficient to induce a therapeutic response
Analgesics should include anti-inflammatory medications with or without adjunctive medications such as nerve membrane stabilizers or muscle relaxants AND

- Participation in at least 6 weeks of physical therapy (including active exercise) or documentation of why the patient could not tolerate physical therapy, AND
- Evaluation and appropriate management of associated cognitive, behavioral, or addiction issues
- Documentation of patient compliance with the preceding criteria.

A successful trial of controlled diagnostic lateral branch blocks consists of 2 separate positive blocks on different days with local anesthetic only (no steroids or other drugs), or a placebo-controlled series of blocks, under fluoroscopic guidance, that has resulted in a reduction in pain for the duration of the local anesthetic used (eg, 3 hours longer with bupivacaine than lidocaine). There is not a consensus on whether a minimum of 50% or 75% reduction in pain would be required to be considered a successful diagnostic block, although evidence supports a criterion standard of 75% to 100% reduction in pain with dual blocks. No therapeutic intra-articular injections (ie, steroids, saline, other substances) should be administered for a period of at least 4 weeks before the diagnostic lateral branch block. The diagnostic blocks should not be conducted under intravenous sedation unless specifically indicated (eg, the patient is unable to cooperate with the procedure).

### Description of Procedure or Service

<table>
<thead>
<tr>
<th>Populations</th>
<th>Interventions</th>
<th>Comparators</th>
<th>Outcomes</th>
</tr>
</thead>
</table>
| Individuals:  
- With sacroiliac joint pain | Interventions of interest are:  
- Therapeutic corticosteroid injections | Comparators of interest are:  
- Physical therapy | Relevant outcomes include:  
- Symptoms  
- Functional outcomes  
- Quality of life  
- Medication use  
- Treatment-related morbidity |
| Individuals:  
- With sacroiliac joint pain | Interventions of interest are:  
- Radiofrequency ablation | Comparators of interest are:  
- Conservative therapy | Relevant outcomes include:  
- Symptoms  
- Functional outcomes  
- Quality of life  
- Medication use  
- Treatment-related morbidity |
| Individuals:  
- With sacroiliac joint pain | Interventions of interest are:  
- Sacroiliac joint fusion/fixation with a triangular implant | Comparators of interest are:  
- Conservative therapy | Relevant outcomes include:  
- Symptoms  
- Functional outcomes  
- Quality of life  
- Medication use  
- Treatment-related morbidity |
| Individuals:  
- With sacroiliac joint pain | Interventions of interest are:  
- Sacroiliac joint fusion/fixation with | Comparators of interest are:  
- Conservative therapy | Relevant outcomes include:  
- Symptoms  
- Functional outcomes |

Diagnosis and Treatment of Sacroiliac Joint Pain 6.01.23
Summary
Sacroiliac joint (SIJ) arthrography using fluoroscopic guidance with injection of an anesthetic has been explored as a diagnostic test for SIJ pain. Duplication of the patient’s pain pattern with the injection of contrast medium suggests a sacroiliac etiology, as does relief of chronic back pain with injection of local anesthetic. Treatment of SIJ pain with corticosteroids, radiofrequency ablation (RFA), stabilization, or minimally invasive SIJ fusion has also been explored.

For individuals who have SIJ pain who receive therapeutic corticosteroid injections, the evidence includes small randomized controlled trials (RCTs) and case series. Relevant outcomes are symptoms, functional outcomes, quality of life, medication use, and treatment-related morbidity. In general, the literature on injection therapy of joints in the back is of poor quality. Results from 2 small RCTs showed that therapeutic SIJ steroid injections were not as effective as other active treatments. Larger trials, preferably using sham injections, are needed to determine the degree of benefit of corticosteroid injections over placebo. The evidence is insufficient to determine the effects of the technology on health outcomes.

For individuals who have SIJ pain who receive RFA, the evidence includes 4 small RCTs using different radiofrequency applications and case series. Relevant outcomes are symptoms, functional outcomes, quality of life, medication use, and treatment-related morbidity. For RFA with a cooled probe, the 2 small RCTs reported short-term benefits, but these are insufficient to determine the overall effect on health outcomes. The RCT on palisade RFA of the SIJ did not include a sham control. Another sham-controlled randomized trial showed no benefit of RFA. Further high-quality controlled trials are needed that compare this procedure in defined populations with sham control and with alternative treatments. The evidence is insufficient to determine the effects of the technology on health outcomes.

For individuals who have SIJ pain who receive SIJ fusion/fixation with a triangular implant, the evidence includes 2 nonblinded RCTs of minimally invasive fusion and 2 case series with more than 85% follow-up at 2 to 3 years. Relevant outcomes are symptoms, functional outcomes, quality of life, medication use, and treatment-related morbidity. Both RCTs reported superior short-term results for fusion, however, a preferable design for assessing pain outcomes would be independent, blinded assessment of outcomes or, when feasible, a sham-controlled trial. Longer term follow-up from these RCTs has indicated that the results obtained at 6 months persist to 2 years. An additional cohort study and case series, with sample sizes ranging from 45 to 149 patients and low dropout rates (<15%), have also shown reductions in pain and disability at 2 years. One small case series showed outcomes that persisted to 5 years. The cohort studies and case series are consistent with the durability of treatment benefit. Analysis of an insurance
database reported an overall incidence of complications to be 16.4% at 6 months and cumulative revision rate at 4 years of 3.54%. The evidence is sufficient to determine that the technology results in a meaningful improvement in the net health outcome.

For individuals who have SIJ pain who receive SIJ fusion/fixation with a cylindrical threaded implant, the evidence includes a prospective cohort. Relevant outcomes are symptoms, functional outcomes, quality of life, medication use, and treatment-related morbidity. The prospective cohort study will follow patients for 2 years following implantation of slotted screws filled with autologous bone. Results at 1 year are consistent with findings from the studies using a triangular implant. However, longer follow-up and controlled trials are needed to evaluate this type of implant. The evidence is insufficient to determine the effects of the technology on health outcomes.

Clinical input (2014) also has supported the use of controlled diagnostic blocks with at least 75% pain reduction for diagnosis of sacroiliac pain. Clinical input supported the use of corticosteroids for the treatment of SIJ pain. Based on clinical input (2014) and the established use of injections to diagnose and treat pain in other joints, controlled diagnostic (2 blocks with anesthetics of different duration) and therapeutic (corticosteroid) injections may be considered medically necessary for the diagnosis and treatment of SIJ pain.

Clinical input (2017) supports that fusion/stabilization of the sacroiliac joint using percutaneous and minimally invasive techniques for carefully selected patients as outlined in statements from the North American Spine Society provides a clinically meaningful improvement in the net health outcome and is consistent with generally accepted medical practice. Thus, this use may be considered medically necessary.

**Background**

Similar to other structures in the spine, it is assumed that the sacroiliac joint may be a source of low back pain. In fact, prior to 1928, the sacroiliac joint was thought to be the most common cause of sciatica. In 1928, the role of the intervertebral disc was elucidated, and from that point forward, the sacroiliac joint received less research attention.

Research into sacroiliac joint pain has been thwarted by any criterion standard to measure its prevalence and against which various clinical examinations can be validated. For example, sacroiliac joint pain is typically without any consistent, demonstrable radiographic or laboratory features and most commonly exists in the setting of morphologically normal joints. Clinical tests for sacroiliac joint pain may include various movement tests, palpation to detect tenderness, and pain descriptions by the patient. Further confounding study of the sacroiliac joint is that multiple structures, such as posterior facet joints and lumbar discs, may refer pain to the area surrounding the sacroiliac joint.
Because of inconsistent information obtained from history and physical examination, some have proposed the use of image-guided anesthetic injection into the sacroiliac joint for the diagnosis of sacroiliac joint pain. Treatments being investigated for sacroiliac joint pain include prolotherapy, corticosteroid injection, radiofrequency ablation, stabilization, and arthrodesis. Some procedures have been referred to as SIJ fusion but may be more appropriately called fixation (this is because there is little to no bridging bone on radiographs). Devices for SIJ fixation/fusion that promote bone ingrowth to fixate the implants include a triangular implant (iFuse Implant System) and cylindrical threaded devices (Rialto, Simmetry, Silex, SambaScrew, SI-LOK). Some devices also have a slot in the middle where autologous or allogeneic bone can be inserted. This added bone is intended to promote fusion of the SIJ.

**Regulatory Status**
A number of radiofrequency generators and probes have been cleared for marketing by the U.S. Food and Drug Administration (FDA) through the 510(k) process. In 2005, the SInergy® (Halyard; formerly Kimberly-Clark), a water-cooled single-use probe, was cleared by the FDA, listing the Baylis Pain Management Probe as a predicate device. The intended use is in conjunction with a radiofrequency generator to create radiofrequency lesions in nervous tissue. FDA product code: GXD.

A number of percutaneous or minimally invasive fixation/fusion devices have been cleared for marketing by the FDA through the 510(k) process. They include the iFuse® Implant System (SI Bone), the Rialto™ SI Joint Fusion System (Medtronic), SIJ-Fuse (Spine Frontier), the Simmetry® Sacroiliac Joint Fusion System (Zyga Technologies), Silex™ Sacroiliac Joint Fusion System (XTANT Medical), SambaScrew® (Orthofix), and the SI-LOK® Sacroiliac Joint Fixation System (Globus Medical). FDA product code: OUR.

**Rationale**
This evidence review was created in February 2000 and has been updated regularly with searches of the MEDLINE database. The most recent literature update was performed through September 11, 2017. The following is a summary of key references to date.

**Diagnosis of sacroiliac joint Pain**
The use of diagnostic blocks to evaluate sacroiliac joint (SIJ) pain builds on the use of diagnostic blocks to evaluate pain in other joints. Blinded studies with placebo controls (although difficult to conduct when dealing with invasive procedures) are ideally required for scientific validation of SIJ blocks, particularly when dealing with pain relief well-known to respond to placebo controls. In the typical evaluation of a diagnostic test, the results of sacroiliac diagnostic block would then be compared with a criterion standard. However, no current criterion standard for SIJ disease exists. In fact, some have positioned SIJ injection as the criterion standard against which other diagnostic tests and physical exam may be measured. Ultimately, the point of diagnosis is to select patients appropriately for
treatment that improves outcomes. Diagnostic tests that differentiate patients who do or do not benefit from a particular treatment are clinically useful.

Two 2009 practice guidelines from the American Pain Society were based on a systematic review commissioned by the Society and conducted at the Oregon Evidence-based Practice Center.\textsuperscript{2,3} The systematic reviews concluded that no reliable evidence existed to evaluate the validity or utility of diagnostic SIJ block as a diagnostic procedure for low back pain with or without radiculopathy, with a resulting guideline recommendation of insufficient evidence. Data on SIJ steroid injection were limited to a small controlled trial, resulting in a recommendation of insufficient evidence for therapeutic injection of this joint. In 2010, Manchikanti et al published systematic reviews for interventional techniques for treatment and diagnosis of low back pain.\textsuperscript{4,5} Evidence for diagnostic sacroiliac injections was considered to be fair to poor, and no additional literature was identified since a 2009 systematic review by Rupert et al.\textsuperscript{6}

In 2013, the American Society of Interventional Pain Physicians published an updated evidence review with guidelines on diagnosis of SIJ pain.\textsuperscript{7} Various studies evaluating diagnostic blocks were reviewed in which the criteria for a positive test varied from 50\% to 100\% relief from either single or dual blocks. The most stringent criterion, 75\% to 100\% relief with dual blocks, was evaluated in 7 studies. The prevalence of a positive test in the 7 studies ranged from 10\% to 44.4\% in patients with suspected sacroiliac disease. The evidence for diagnostic sacroiliac intra-articular injections was considered to be good using 75\% to 100\% pain relief with single or dual blocks as the criterion standard.

**Section Summary: Diagnosis**

Although there is no independent reference standard for the diagnosis of SIJ pain, SIJ blocks are considered the reference standard for the condition. The utility of this test ultimately depends on its ability to identify patients who benefit from treatment.

**Treatment of SIJ Pain**

Evidence reviews assess the clinical evidence to determine whether the use of a technology improves the net health outcome. Broadly defined, health outcomes are length of life, quality of life, and ability to function—including benefits and harms. Every clinical condition has specific outcomes that are important to patients and to managing the course of that condition. Validated outcome measures are necessary to ascertain whether a condition improves or worsens; and whether the magnitude of that change is clinically significant. The net health outcome is balance of benefits and harms.

To assess whether the evidence is sufficient to draw conclusions about the net health outcome of a technology, 2 domains are examined: the relevance and the quality and credibility. To be relevant, studies must represent one or more intended clinical use of the technology in the intended population and compare an effective and appropriate alternative at a comparable intensity. For some conditions the alternative will be supportive care or surveillance. The quality and
credibility of the evidence depend on study design and conduct, minimizing bias and confounding that can generate incorrect findings. The randomized controlled trial (RCT) is preferred to assess efficacy; however, in some circumstances, nonrandomized studies may be adequate. RCTs are rarely large enough or long enough to capture less common adverse events and long-term effects. Other types of studies can be used for these purposes and to assess generalizability to broader clinical populations and settings of clinical practice.

**Systematic Reviews**

Hansen et al published a systematic review of SIJ interventions in 2012. The primary outcome was short-term (≤6 months) or long-term (>6 months) pain relief. Evidence was classified as good, fair, or limited/poor based on the quality of evidence. Eleven studies (6 randomized, 5 nonrandomized trials) met inclusion criteria. Reviewers found that evidence for intra-articular steroid injections is limited or poor, as was the evidence for periarticular injections (local anesthetic and steroid or botulinum toxin). For radiofrequency neurotomy, the evidence for cooled radiofrequency was found to be fair (2 randomized controlled trials [RCTs]), while evidence for conventional radiofrequency or pulsed radiofrequency was limited or poor. The 2013 American Society of Interventional Pain Physicians evidence review found no additional studies on intra-articular or periarticular injections besides those identified by Hansen.

**Therapeutic Corticosteroid Injections**

**Randomized Controlled Trials**

The available literature on therapeutic corticosteroid injections is limited, consisting of small RCTs and case series. Case series studies evaluating corticosteroid injections, described in systematic reviews, have shown variable findings at generally short-term follow-up.

A 2013 trial randomized 51 patients with SIJ and leg pain to physical therapy, manual therapy, or intra-articular injection of corticosteroid. Diagnosis of SIJ pain was based on provocation tests and not SIJ injections. In a blinded assessment, 25 (56%) patients were considered to be successfully treated at the 12-week follow-up visit based on complete relief of pain and improvement in the visual analog scale (VAS) score for pain. Physical therapy was successful in 20%, manual therapy in 72%, and intra-articular injection in 50%.

Kim et al reported a randomized, double-blind, controlled trial of intra-articular prolotherapy (see evidence review 2.01.26) compared with steroid injection for SIJ pain in 2010. The trial included 48 patients with SIJ pain, confirmed by 50% or greater improvement in response to a single local anesthetic block, who had failed medical treatment. Intra-articular dextrose water prolotherapy or steroid injections were administered under fluoroscopic guidance on a biweekly schedule, with a maximum of 3 injections. Injections were stopped when pain relief was 90% or greater, which required a mean of 2.7 prolotherapy injections and 1.5 steroid injections. Pain (numeric rating scale) and disability scores (Oswestry Disability Index [ODI]) were assessed at baseline, 2 weeks, and then monthly on completing
treatment. At the 2-week follow-up, pain and disability scores were significantly improved in both groups, with no significant difference between groups. The numeric rating scale pain score improved from 6.3 to 1.4 in the prolotherapy group and from 6.7 to 1.9 in the steroid group. At 6 months after treatment, 63.6% of patients in the prolotherapy group remained improved from baseline (≥50%), compared with 27.2% in the steroid group. At 15-month follow-up, the cumulative incidence of sustained pain relief was 58.7% in the prolotherapy group compared with 10.2% in the steroid group. The median duration of recurrence of severe SIJ pain was three months for the steroid group.

**Section Summary: Therapeutic Corticosteroid Injections**
Results from these 2 small trials are insufficient to permit conclusions on the effect of this procedure on health outcomes. Steroid injections were not the most effective treatment in either trial, and the degree of pain relief was limited. Larger trials with rigorous designs, preferably using sham injections, are needed to determine whether the treatment is effective.

**Radiofrequency Ablation**
Evidence comparing radiofrequency ablation (RFA) of the SIJ with other treatments is limited. Two small RCTs using a cooled radiofrequency probe were identified. A third RCT used palisade SIJ radiofrequency neurotomy. Another RCT used a multi-electrode radiofrequency probe to perform the procedure.

**Systematic Reviews**
Aydin et al published a meta-analysis of RFA for sacroiliac pain in 2010. Nine studies included reported the primary outcome measure of a reduction of pain of 50% or greater, including a randomized placebo-controlled study, 3 prospective observational studies, and 5 retrospective studies. All studies used injection of local anesthetic to determine if RFA was indicated for the patient. Seven studies reported follow-up to 3 months; 6 studies reported follow-up to 6 months. The meta-analysis indicated that at least 50% of patients who received RFA to the SIJ showed a reduction in their pain of 50% or more at 3 and 6 months. Analysis found no evidence of publication bias, but heterogeneity in studies was observed for the 6-month follow-up. This meta-analysis included low-quality studies and lacked RCTs. In addition, as noted by reviewers, no standards have been established for the specific nerves to ablate or type of technique.

No additional studies were identified in the 2013 American Society of Interventional Pain Physicians evidence review, which concluded that evidence was limited for conventional radiofrequency neurotomy, limited for pulsed radiofrequency neurotomy, and fair for cooled radiofrequency neurotomy.

**Randomized Controlled Trials**
The single RCT included in the Aydin meta-analysis was published in 2008. This trial by Cohen et al examined the effect of lateral branch radiofrequency denervation with a cooled probe in 28 patients with injection-diagnosed SIJ pain. Two (14%) of 14 patients in the placebo-control group reported pain relief at 1-month follow-up. None reported benefit at 3-month follow-up. Of 14 patients
treated with radiofrequency denervation, 11 (79%) reported pain relief at 1 month, 9 (64%) at 3 months, and 8 (57%) at 6 months.

In 2012, Patel et al reported a randomized, double-blind, placebo-controlled trial of lateral branch neurotomy with a cooled radiofrequency probe. \(^{14}\) Twelve-month follow-up was reported in 2016. \(^{15}\) Fifty-one patients who had a positive response to 2 lateral branch blocks were randomized 2:1 to lateral branch radiofrequency or to sham. At 3-month follow-up, significant improvements were observed in pain levels (-2.4 vs -0.8), physical function (14 vs 3), disability (-11 vs 2), and quality of life (0.09 vs 0.02) for radiofrequency treatment compared with controls (all respectively). With treatment success defined as a 50% or greater reduction in numeric rating scale score, 47% of radiofrequency-treated patients and 12% of sham-treated patients achieved treatment success. The treatment response was durable to 12 months in the 25 of 34 patients who completed all follow-up visits. \(^{15}\) Of the 9 patients who terminated study participation, 4 (12%) of 34 were considered treatment failures.

In 2014, Zheng et al reported an RCT of palisade sacroiliac RFA in 155 patients with ankylosing spondylitis. \(^{16}\) Palisade RFA uses a row of radiofrequency cannulae perpendicular to the dorsal sacrum. Inclusion criteria were ages 18 to 75 years; diagnosis of ankylosing spondylitis; chronic low back pain for at least 3 months; axial pain below L5; no peripheral involvement; pain aggravation on manual pressing of the SIJ area; and at least 50% pain relief following fluoroscopically guided anesthetic injection into the joint. Patients who met the inclusion criteria were randomized to palisade RFA or celecoxib. Blinded evaluation to 24 weeks found that RFA (2.8) resulted in lower global VAS scores than celecoxib (5.0; \(p<0.001\)) as well improved scores for secondary outcome measures. This study lacked a sham control.

In 2016, van Tilburg et al reported a sham-controlled randomized trial of percutaneous RFA in 60 patients with SIJ pain. \(^{17}\) Patients selected had clinically suspected SIJ pain and a decrease of 2 or more points on a 10-point pain scale with a diagnostic sacroiliac block. At 3-month follow-up, there was no statistically significant difference in pain level over time between groups (group by period interaction, \(p=0.56\)). Both groups improved over time (\(\approx2\) points out of 10; \(p \text{ value for time, } p<0.001\)). In their discussion, authors mentioned that the criteria and method used for diagnosing SIJ pain may have resulted in selection some patients without SIJ pain.

In 2017, Kuch et al reported a nonblinded multicenter RCT of radiofrequency denervation in 228 of 2498 patients with suspected sacroiliac pain who were asked to participate in the trial. \(^{18}\) Patient selection criteria included BMI (<35 kg/m\(^2\)), age (<70 years old), and pain reduction of at least 50% within 30 to 90 minutes of receiving a diagnostic sacroiliac block (\(n=228\)). An additional 202 patients who had negative diagnostic sacroiliac block; 1666 patients declined to participate in the trial. Patients meeting criteria were randomized to exercise plus radiofrequency denervation (\(n=116\)) or an exercise program alone (\(n=112\)), and were followed for a year. The RFA group had a modest improvement for the
primary outcome at 3 months (-0.71; 95% confidence interval [CI], -1.35 to -0.06), but the control group improved over time and there were no statistically significant differences between the groups for pain intensity score (p=0.09) or in the number of patients who had more than 30% reduction in pain intensity (p=0.48) at 12 months. Limitations included the use of several techniques to achieve radiofrequency denervation, self-selection, lack of blinding, and high dropout rate (31%) in the control group.

Section Summary: Radiofrequency Ablation
The randomized trials of RFA have methodologic limitations; moreover, there is limited data on duration of treatment effect. Heterogeneity of RFA treatment techniques precludes generalizing results across different studies.

SIJ Fusion/Fixation With a Triangular Implant System

Randomized Controlled Trials

INSITE
In 2015, Whang et al reported an industry-sponsored nonblinded RCT (INSITE) of the iFuse Implant System in 148 patients. Twelve-month follow-up to this RCT was reported by Polly et al in 2015, and 2-year follow-up was reported by Polly et al in 2016. However, by 12 months, almost all patients in the control group had crossed over to SIJ fusion, precluding comparison between groups. Trial inclusion was based on a determination of the SIJ as a pain generator from a combination of a history of SIJ-localized pain, positive provocative testing on at least 3 of 5 established physical tests, and at least a 50% decrease in SIJ pain after image-guided local anesthetic injection into the SIJ. The duration of pain before enrollment averaged 6.4 years (range, 0.47-40.7 years). A large proportion of subjects (37%) had previously undergone lumbar fusion, SIJ steroid injections (86%), and RFA (16%).

Patients were randomized 2:1 to minimally invasive SIJ fusion (n=102) or to nonsurgical management (n=46). Nonsurgical management included a stepwise progression of nonsurgical treatments, depending on individual patient choice. During follow-up, control patients received physical therapy (97.8%), intra-articular steroid injections (73.9%), and RFA of sacral nerve roots (45.7%). The primary outcome measure was 6-month success rate, defined as the proportion of treated subjects with a 20-mm improvement in SIJ 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 6 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).

Results from the INSITE trial are shown in Table 1. At 6 months, success rates were 23.9% in the control group vs 81.4% in the surgical group (posterior probability of superiority >0.999). 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 quality of life (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 6 months, 35 (79.5%) crossed over to fusion. Compared with baseline, opioid use at 6 months decreased from 67.6% to 58% in the surgery group, and increased from 63% to 70.5% in the control group (p=0.082). At 12 months, opioid use was similar between groups (55% vs 52%, p=0.61).

Table 1. Summary of 6-Month iFuse Results From INSITE and iMIA

<table>
<thead>
<tr>
<th>Results</th>
<th>VAS Score</th>
<th>Success End Point</th>
<th>ODI Score</th>
<th>SF-36 PCS Score</th>
<th>EQ-5D TTO Index</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Ctl</td>
<td>iFuse</td>
<td>Ctl</td>
<td>iFuse</td>
<td>Ctl</td>
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<td>INSITE</td>
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<tr>
<td>Baseline</td>
<td>82.2</td>
<td>82.3</td>
<td>61.1</td>
<td>62.2</td>
<td>0.47</td>
</tr>
<tr>
<td>Follow-up</td>
<td>70.4</td>
<td>29.8</td>
<td>56.4</td>
<td>31.9</td>
<td>0.52</td>
</tr>
<tr>
<td>Change</td>
<td>-12.1</td>
<td>-52.6</td>
<td>-4.9</td>
<td>-30.3</td>
<td>1.2</td>
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<td></td>
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<td>0.29</td>
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iMIA

| Baseline| 73.0 | 77.7 |
| Follow-up| 67.8 | 34.4 |
| Change  | -5.7 | -43.3 |

Adapted from Whang et al (2015) and Sturesson et al (2015). The success end point was defined as a reduction in VAS pain score of ≥20, absence of device-related events, absence of neurologic worsening, and absence of surgical intervention. Ctl: control; EQ-5D TTO Index: EuroQoL Time Tradeoff Index; ODI: Oswestry Disability Index; SF-36 PCS: 36-Item Short-Form Health Survey Physical Component Summary; VAS: visual analog scale.

In 2016, Polly et al reported 2-year outcomes from the SIJ fusion arm of this RCT (see Table 2). Of 102 subjects originally assigned to SIJ fusion and treated, 89 (87%) were evaluated at 2 years. In this report, clinical outcomes were based on the amount of improvement in SIJ pain and in ODI scores. Improvement was defined as a change of 20 points in SIJ pain score and 15 points in ODI score. Substantial improvement was defined as a change in 25 points in SIJ pain score—or an SIJ pain score of 35 or less—and an improvement of 18.8 points in ODI score. At 24 months, 83.1% had improvement in SIJ pain score, and 68.2% had improvement in ODI. By 24 months, the proportion taking opioids was reduced from 68.6% at baseline to 48.3%.

Table 2. Extended Follow-Up From the INSITE and iMIA Trials

<table>
<thead>
<tr>
<th>Outcome Measures</th>
<th>Baseline (SD)</th>
<th>6 Months (SD)</th>
<th>12 Months (SD)</th>
<th>24 Months (SD)</th>
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<tbody>
<tr>
<td>INSITE</td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td>Sacroiliac joint fusion pain score</td>
<td>82.3</td>
<td>29.8</td>
<td>26.7</td>
<td></td>
</tr>
<tr>
<td>Percent ≥20-point improvement pain</td>
<td></td>
<td></td>
<td></td>
<td>83.1%</td>
</tr>
<tr>
<td>Sacroiliac joint fusion ODI score</td>
<td>57.2</td>
<td>31.9</td>
<td>28.7</td>
<td></td>
</tr>
<tr>
<td>% ≥15-point improvement</td>
<td></td>
<td></td>
<td></td>
<td>68.2%</td>
</tr>
</tbody>
</table>
### iMIA

In 2016 and 2017, the iMIA study group (Sturesson et al, Dengler et al) reported another industry-sponsored multicenter RCT of the iFuse Implant System in 103 patients. Selection criteria were similar to those of the Whang trial, including at least 50% pain reduction on SIJ block. The mean pain duration was 4.5 years, and about half of the patients were not working due to lower back pain. Additionally, 33% of patients had undergone prior lumbar fusion. Nonsurgical management included physical therapy and exercises at least twice per week; interventional procedures (eg, steroid injections, RFA) were not allowed. The primary outcome was change in VAS pain score at 6 months.

All patients assigned to iFuse underwent the procedure, and follow-up at 6 months was available for 49 of 51 patients in the control group and for all 52 patients in the iFuse group. Six-month results are shown in Table 1. At 6 months, VAS pain scores improved by 43.3 points in the iFuse group and by 5.7 points in the control group ($p<0.001$). ODI scores improved by 25.5 points in the iFuse group and by 5.8 points in the control group ($p<0.001$, between groups). An improvement in lower back pain by at least 20 VAS points (minimal clinically important difference [MCID]) was achieved in 78.8% of the SIJ fusion group vs 22.4% of controls; $p<0.001$). Quality of life outcomes showed a greater improvement in the iFuse group than in the control group. Changes in pain medication use are not reported. Patients in the conservative management group were allowed to cross over to SIJ fusion at 6 months.

Twelve-month results from the iMIA trial were reported by Dengler et al in 2017 (see Table 2). Twenty-one patients in the conservative management group had little or no improvement in symptoms and crossed over to SIJ fusion after the 6-month visit. Fourteen (56%) of the 25 patients who remained in the conservative management group had at least a 20-point improvement in VAS back pain score (22.4% of patients assigned to conservative management). At 12 months, low back pain had improved by 42 points (SD=27.0) on a 100-point VAS in the SIJ fusion group compared with 14 points (SD=33.4) in the conservative management group ($p<0.001$). Mean ODI scores improved by 25 points in the SIJ fusion group compared with 8.7 points in controls ($p<0.001$).

<table>
<thead>
<tr>
<th>ODI</th>
<th>iMIA</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Low back pain</strong></td>
<td></td>
</tr>
<tr>
<td>Conservative management</td>
<td>73.0 (13.8)</td>
</tr>
<tr>
<td>Sacroiliac joint fusion</td>
<td>77.7 (11.3)</td>
</tr>
<tr>
<td><strong>Leg pain</strong></td>
<td></td>
</tr>
<tr>
<td>Conservative management</td>
<td>47.1 (31.1)</td>
</tr>
<tr>
<td>Sacroiliac joint fusion</td>
<td>52.7 (31.5)</td>
</tr>
<tr>
<td>ODI</td>
<td></td>
</tr>
<tr>
<td>Conservative management</td>
<td>55.6 (13.7)</td>
</tr>
<tr>
<td>Sacroiliac joint fusion</td>
<td>57.5 (14.4)</td>
</tr>
</tbody>
</table>

Subsection Summary: Randomized Controlled Trials

Two RCTs reported outcomes past 6 months, after which crossover was allowed. Both studies reported significantly greater reductions in VAS pain scores and ODI scores in SIJ fusion patients than in control groups. The reductions in pain and disability observed in the SIJ fusion group at 6 months were maintained out to 1 year when compared with controls who had not crossed over. The RCTs were nonblinded without a placebo or active control group. However, pain has a significant subjective and psychologic component. Cognitive behavioral techniques to address pain were specifically excluded from the types of treatment that control subjects could obtain. Thus, as relates to trial design, an independent assessment of pain outcomes would have been preferable.

Nonrandomized Studies

Prospective cohort studies with good follow-up rates are more likely to provide valid estimates of outcomes. Principal results of the studies at 2- to 3-year follow-up are shown in Table 3.

In 2016, results from a cohort of 172 patients undergoing SIJ fusion reported to 2 years were published by Duhon et al.\(^{25,26}\) Patients were formally enrolled in a single-arm trial (NCT01640353) with planned follow-up for 24 months. Success was defined as a reduction of pain score of 20 mm on a 100-mm VAS, absence of device-related adverse events, absence of neurologic worsening, and absence of surgical reintervention. Enrolled patients had a mean VAS pain score of 79.8, a mean ODI score of 55.2, and a mean pain duration of 5.1 years. At 6 months, 136 (80.5%) of 169 patients met the success end point, which met the prespecified Bayesian probability of success rate. Mean VAS pain scores were 30.0 at 6 months and 30.4 at 12 months. Mean ODI scores were 32.5 at 6 months and 31.4 at 12 months. At 2 years, 149 (87%) of 172 patients were available for follow-up. The VAS pain score at 2 years was 26.0, and the ODI score was 30.9. Thus, 1-year outcomes were maintained at 2 years. Other outcomes (eg, quality of life scores) showed similar maintenance or slight improvement compared with 1-year outcomes. Use of opioid analgesics decreased from 76.2% at baseline to 55% at 2 years. Over the 2-year follow-up, 8 (4.7%) patients required revision surgery.

### Table 3. Two- to 3-Year Outcomes of the iFuse Implant in Cohorts and Case Series

<table>
<thead>
<tr>
<th>Studies and Outcomes</th>
<th>Mean Baseline Value</th>
<th>Mean 2- to 3-Year Value</th>
<th>Difference or% Achieving Outcome</th>
<th>Follow-Up Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rudolf (2012)(^{27})</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pain score (range, 0-10)</td>
<td>7.59</td>
<td>2.0</td>
<td>5.59</td>
<td>90% (45/50)</td>
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<tr>
<td>&gt;2-point change in pain score</td>
<td>-</td>
<td>-</td>
<td>82%</td>
<td></td>
</tr>
<tr>
<td>Duhon et al (2016)(^{26})</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pain score (range, 0-100)</td>
<td>79.8</td>
<td>26.0</td>
<td>53.3</td>
<td>86.6% (149/172)</td>
</tr>
<tr>
<td>Oswestry Disability Index score</td>
<td>55.2</td>
<td>30.9</td>
<td>24.5</td>
<td></td>
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<tr>
<td>SF-36 score</td>
<td>31.7</td>
<td>40.7</td>
<td>8.9</td>
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<tr>
<td>EQ-5D TTO score</td>
<td>0.43</td>
<td>0.71</td>
<td>0.27</td>
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</table>
### Studies and Outcomes

<table>
<thead>
<tr>
<th>Studies and Outcomes</th>
<th>Mean Baseline Value</th>
<th>Mean 2- to 3-Year Value</th>
<th>Difference or % Achieving Outcome</th>
<th>Follow-Up Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sachs et al (2016)</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Pain score (range 0-10)</td>
<td>7.5</td>
<td>2.5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oswestry Disability Index score</td>
<td></td>
<td>28.2</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

All differences between baseline and 2- to 3-year values were statistically significant.

EQ-5D TTO Index: EuroQoL Time Tradeoff Index; SF-36: 36-Item Short-Form Health Survey.

### Case Series

In 2012, Rudolf retrospectively analyzed his first 50 consecutive patients treated with the iFuse Implant System. There were 10 perioperative complications, including implant penetration into the sacral neural foramen (2 patients) and compression of the L5 nerve (1 patient); these 3 patients required surgical retraction of the implant. At 3 years postsurgery, a single patient required additional implants due to worsening symptoms. At a minimum of 24 months of follow-up (mean, 40 months), the treating surgeon was able to contact 45 patients. The mean pain score was 2 (1 to 10 scale), and 82% of patients had attained the minimal clinically important difference in pain score (defined as ≥2 of 10).

A 2014 report by Rudolph and Capobianco described 5-year follow-up for 17 of 21 consecutive patients treated at their institution between 2007 and 2009. Of the 4 patients lost to follow-up, two had died and one had become quadriplegic due to severe neck trauma. For the remaining patients, mean VAS score (range, 0-10) improved from 8.3 before surgery to 2.4 at 5 years; 88.2% of patients had substantial clinical benefit, which was defined as a 2.5-point decrease in VAS score or a raw score less than 3.5. Mean ODI score at 5 years was 21.5. Imaging by radiograph and computed tomography showed intra-articular bridging in 87% of patients with no evidence of implant loosening or migration.

The 2014 case series (N=144) of Sachs et al, which did not report follow-up rates or study methodologies and did not permit calculation of the complete number of patients treated, will not be further discussed here.

### Nonrandomized Comparative Studies

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. Revision rates were lower with the iFuse device than observed with surgical screws.

### Database Analysis

Database analysis provides insight into treatment-related morbidity. A study by Cher et al (2015) reported rates of implant revision using the Humana insurance database of procedures. Between April 2009 and July 2014, 11,416 cases with the iFuse system took place. After minor adjustments of numbers to account for
nonrecommended uses and inability to match revision cases, the cumulative revision rate at 4 years was 3.54%. Overall, 24% of revision surgeries occurred in the first month and 63% occurred within the first 12 months. One-year revision rates fell over time (9.7% to 1.4% from 2009 to 2014).

In 2016, Schoell et al analyzed postoperative complications tracked in an administrative database of minimally invasive SIJ fusions to determine complications coded in postoperative claims. Using the Humana insurance database, patients with complications were identified using ICD-9 codes corresponding to a surgical complication within 90 days or 6 months if the codes were used for the first time. Of 469 patients, the overall incidence of complications was 13.2% at 90 days and 16.4% at 6 months. For specific complications, the infection rate was 3.6% at 90 days and the rate of complications classified as nervous system complications was 4.3%. Authors noted that the infection rate observed was consistent with the infection rates reported by Polly et al (2015), but much higher than those reported for other types of minimally invasive spine procedures. The incidence of complications in this study may differ from those reported by registries. However, determining the true incidence of adverse events after procedures from either registries or insurance claims data can be difficult due to uncertainty about the completeness of reporting in registries and the accuracy of coded claims in claims databases.

Subsection Summary: Nonrandomized Studies
In general, cohort studies and case series have shown improvements in VAS pain scores and other outcomes measures consistent in magnitude to the RCTs. The subset of studies with good (>85%) follow-up rates generally showed that short-term outcomes were maintained. Two studies of reasonable sample size with good follow-up showed results maintained to 2 years. One study with a small sample size and a good follow-up showed results maintained to 5 years. Improved health outcomes are also supported by retrospective studies that compare SIJ fusion/fixation using a triangular implant with other treatments for SIJ pain. These results are consistent with medium-term durability of treatment. Analysis of an insurance database reported overall incidence of complications to be 16.4% at 6 months and cumulative revision rate at 4 years of 3.54%.

Section Summary: SIJ Fusion/Fixation With a Triangular Implant
The evidence on SIJ fusion/fixation with a triangular implant includes 2 nonblinded RCTs of minimally invasive fusion and 2 case series with more than 85% follow-up at 2 to 3 years. Both RCTs reported superior short-term results for fusion, however, preferable design for assessing pain outcomes would be independent blinded assessment of outcomes or, when feasible, a sham-controlled trial. Longer term follow-up from these RCTs has indicated that the results obtained at 6 months persist to 2 years. An additional cohort study and case series with sample sizes ranging from 45 to 149 patients and low dropout rates (<15%) also showed reductions in pain and disability at 2 years. One small case series showed outcomes that persisted to 5 years. The cohort studies and case series are consistent with the durability of treatment benefit. Analysis of an insurance
database reported overall incidence of complications to be 16.4% at 6 months and cumulative revision rate at 4 years of 3.54%.

**SIJ Fusion/Fixation With a Cylindrical Threaded Implant**
Rapoport et al (2017) reported on an industry-sponsored prospective study of SIJ fusion with a cylindrical threaded implant (SI-LOK). 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 (see Table 4), and revisions within the first 12 months of the study were low (n=2). Follow-up will continue through 2 years.

**Table 4. Pain and Disability Scores After Implantation With a Cylindrical Threaded Implant**

<table>
<thead>
<tr>
<th>Outcome Measures</th>
<th>Baseline (SD)</th>
<th>3 Months (SD)</th>
<th>6 Months (SD)</th>
<th>12 Months (SD)</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low back pain</td>
<td>55.8 (26.7)</td>
<td>28.5 (21.6)</td>
<td>31.6 (26.9)</td>
<td>32.7 (27.4)</td>
<td>&lt;0.01</td>
</tr>
<tr>
<td>Left leg pain</td>
<td>40.6 (29.5)</td>
<td>19.5 (22.9)</td>
<td>16.4 (25.6)</td>
<td>12.5 (23.3)</td>
<td>&lt;0.01</td>
</tr>
<tr>
<td>Right leg pain</td>
<td>40.0 (34.1)</td>
<td>18.1 (26.3)</td>
<td>20.6 (25.4)</td>
<td>14.4 (21.1)</td>
<td>&lt;0.05</td>
</tr>
<tr>
<td>Oswestry Disability Index</td>
<td>55.6 (16.1)</td>
<td>33.3 (16.8)</td>
<td>33.0 (16.8)</td>
<td>34.6 (19.4)</td>
<td>&lt;0.01</td>
</tr>
</tbody>
</table>

Adapted from Rappoport et al (2017).35

**Section Summary: SIJ Fusion/Fixation With Cylindrical Threaded Implant**
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.

**Summary of Evidence**
For individuals who have SIJ pain who receive therapeutic corticosteroid injections, the evidence includes small RCTs and case series. Relevant outcomes are symptoms, functional outcomes, quality of life, medication use, and treatment-related morbidity. In general, the literature on injection therapy of joints in the back is of poor quality. Results from 2 small RCTs showed that therapeutic SIJ steroid injections were not as effective as other active treatments. Larger trials, preferably using sham injections, are needed to determine the degree of benefit of corticosteroid injections over placebo. The evidence is insufficient to determine the effects of the technology on health outcomes.

For individuals who have SIJ pain who receive RFA, the evidence includes 4 small RCTs using different radiofrequency applications and case series. Relevant outcomes are symptoms, functional outcomes, quality of life, medication use, and
treatment-related morbidity. For RFA with a cooled probe, the 2 small RCTs reported short-term benefits, but these are insufficient to determine the overall effect on health outcomes. The RCT on palisade RFA of the SIJ did not include a sham control. Another sham-controlled randomized trial showed no benefit of RFA. Further high-quality controlled trials are needed that compare this procedure in defined populations with sham control and with alternative treatments. The evidence is insufficient to determine the effects of the technology on health outcomes.

For individuals who SIJ pain who receive SIJ fusion/fixation with a triangular implant, the evidence includes 2 nonblinded RCTs of minimally invasive fusion and 2 case series with more than 85% follow-up at 2 to 3 years. Relevant outcomes are symptoms, functional outcomes, quality of life, medication use, and treatment-related morbidity. Both RCTs reported superior short-term results for fusion, however, a preferable design for assessing pain outcomes would be independent, blinded assessment of outcomes or, when feasible, a sham-controlled trial. Longer term follow-up from these RCTs has indicated that the results obtained at 6 months persist to 2 years. An additional cohort study and case series, with sample sizes ranging from 45 to 149 patients and low dropout rates (<15%), have also shown reductions in pain and disability at 2 years. One small case series showed outcomes that persisted to 5 years. The cohort studies and case series are consistent with the durability of treatment benefit. Analysis of an insurance database reported an overall incidence of complications to be 16.4% at 6 months and cumulative revision rate at 4 years of 3.54%. The evidence is sufficient to determine that the technology results in a meaningful improvement in the net health outcome.

For individuals who have SIJ pain who receive SIJ fusion/fixation with a cylindrical threaded implant, the evidence includes a prospective cohort. Relevant outcomes are symptoms, functional outcomes, quality of life, medication use, and treatment-related morbidity. The prospective cohort study will follow patients for 2 years following implantation of slotted screws filled with autologous bone. Results at 1 year are consistent with findings from the studies using a triangular implant. However, longer follow-up and controlled trials are needed to evaluate this type of implant. The evidence is insufficient to determine the effects of the technology on health outcomes.

Clinical Input

Objective
Clinical input is sought to help determine the appropriate use in clinical practice of sacroiliac joint fusion for patients with sacroiliac joint pain.

Respondents
Clinical input was provided by the following specialty societies and physician members identified by a specialty society or health system:
- American Association of Neurological Surgeons/Congress of Neurological Surgeons (AANS/CNS)
- American Pain Society (APS)
- American Society of Regional Anesthesia and Pain Medicine (ASRA)
- International Society for the Advancement of Spine Surgery (ISASS)
- North American Spine Society/American Academy of Orthopaedic Surgeons (NASS/AAOS)
- Neil Malhotra, MD, Assistant Professor of Neurosurgery, Perelman School of Medicine, University of Pennsylvania (identified by Hospital of the University of Pennsylvania)
- William Welch, MD, Vice Chair (Clinical) and Professor, Department of Neurosurgery, Perelman School of Medicine, University of Pennsylvania (identified by Hospital of the University of Pennsylvania)
- Zachary Gordon, MD, Assistant Professor, Department of Orthopaedics, Case Western Reserve University, identified by University Hospitals Cleveland Medical Center
- Alex Jahangir, MD, MMHC, Medical Director and Associate Professor of Orthopaedic Surgery, identified by Vanderbilt University Medical Center
- Anonymous, MD, Assistant Professor of Orthopaedics and Rehabilitation; identified by Oregon Health and Science University

\(^a\) Indicates that information was not provided regarding conflicts of interest related to the topic where clinical input is being sought.

\(^b\) Indicates that conflicts of interest related to the topic where clinical input is being sought were identified by this respondent (see Appendix 1).

Clinical input provided by the specialty society at an aggregate level is attributed to the specialty society. Clinical input provided by a physician member designated by the specialty society is attributed to the individual physician and is not a statement from the specialty society. Specialty society and physician respondents participating in the Evidence Street® clinical input process provide review, input, and feedback on topics being evaluated by Evidence Street. However, participation in the clinical input process by a specialty society and/or physician member designated by the specialty society or clinical health system does not imply an endorsement or explicit agreement with the Evidence Opinion published by BCBSA or any Blue Plan.
Clinical Input Responses

<table>
<thead>
<tr>
<th>Clinical Indication</th>
<th>Respondent</th>
<th>Identified by</th>
</tr>
</thead>
<tbody>
<tr>
<td>Per ISASS policy statement</td>
<td>ISASS**</td>
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<tr>
<td>See response to Clinical Input Question 1 in Appendix</td>
<td>AANS/CNS</td>
<td></td>
</tr>
<tr>
<td>Per NASS coverage recommendation</td>
<td>NASS/AAOS</td>
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<tr>
<td>See response to Clinical Input Question 1 in Appendix</td>
<td>APS</td>
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<tr>
<td>See response to Clinical Input Question 1 in Appendix</td>
<td>ASRA*</td>
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</tr>
<tr>
<td>Diagnostic and therapeutic injections</td>
<td>Dr. Malhotra</td>
<td>Hospital of Univ.</td>
</tr>
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<td></td>
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<td>Response to image-guided sacroiliac injections</td>
<td>Dr. Welch</td>
<td>Hospital of Univ.</td>
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<td>Science Univ.</td>
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<td>Dr. Jahangir</td>
<td>Vanderbilt University Med Ctr</td>
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<tr>
<td>See response to Clinical Input Question 1 in Appendix</td>
<td>Dr. Gordon</td>
<td>Univ. Hospitals</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Cleveland Med Ctr</td>
</tr>
</tbody>
</table>

With regard to the use of sacroiliac joint fusion in individuals with sacroiliac joint pain who have the objective condition characteristics and who meet the management criteria listed by each respondent:

- **Confidence Level that Evidence Supports Improved Health Outcomes**
  - Low
  - Intermediate
  - High
  - No rating provided

- **Confidence Level that Clinical Use is in Accordance with Generally Accepted Medical Practice**
  - Low
  - Intermediate
  - High
  - No rating provided

* Indicates that information was not provided regarding conflicts of interest related to the topic where clinical input is being sought.
** Indicates that conflicts of interest related to the topic where clinical input is being sought were identified by this respondent (see Appendix).

**Additional Comments**
- “The evaluation of a patient for possible sacroiliac (SI) joint pain involves careful attention to a patient’s history and physical examination. When a patient’s symptoms and signs arouse sufficient clinical suspicion, additional tests are then required to confirm the diagnosis of SI joint dysfunction.” (AANS/CNS)
- “Proper SIJ pain diagnosis is key to appropriate patient management. There is an accepted diagnostic algorithm for SIJ pain that combines medical history, physical examination and confirmatory diagnostic SIJ block.” (ISASS)
- “The North American Spine Society’s coverage recommendations on SI joint fusion provides evidence-based criteria for diagnosing SI joint pain and selection criteria for surgical intervention.” (NASS/AAOS)
- “The North American Spine Society Criteria are the most respected and generally used criteria. Most patients with SI joint pain will respond to the conservative therapies listed. However, one criteria that I think should be added is a reduction in opioid use prior to the fusion.” (APS)
“SI fusion is currently acceptable therapy in patients in whom significant response is noted with injection. SI joint fusion as part of the inferior portion of extensive thoracolumbar fusion (IE SI joint and pelvis) is an accepted approach. Increasing literature on the topic will enhance the knowledge base on this topic.” (Neil Malhotra, MD identified by Hospital of the University of Pennsylvania)

“The only generally accepted objective criteria for the diagnosis of sacroiliac joint pain is response to image-guided sacro-iliac injections. Patients who do not respond to the injections generally do not improve with directed therapies. Patients who do improve with the injections will usually respond to fusion therapies.” (William Welch, MD identified by Hospital of the University of Pennsylvania)

“Although criteria for the diagnosis of SI joint dysfunction is fairly well described, there is significant variability from study to study regarding the application of the diagnostic criteria. It is difficult to assess the efficacy of a treatment such as SI joint fusion when there is not a clearly defined and consistent manner of diagnosis from study to study. The vast majority of literature regarding outcomes following SI joint fusion surgery are low-quality retrospective studies, or small sample size prospective studies with limited follow-up.” (Zachary Gordon, MD identified by University Hospitals Cleveland Medical Center)

“While the evidence is low, I agree with the NASS recommendations as outlined in their report particularly focusing on the fact that a patient has undergone and failed a minimum 6 months of intensive nonoperative treatments, the patient has a complaint and physical exam consistent with SIJ pain, imaging of the SI joint that excludes the presence of destructive lesions, at least 75% reduction of pain for the expected duration of the anesthetic used following an image-guided, contrast-enhanced intra-articular SIJ injection on 2 separate occasions and finally a successful trial of at least one therapeutic intra-articular SIJ injection with a corticosteroid.” (A. Alex Jahangir, MD identified by Vanderbilt University Medical Center)

See Appendices 1 and 2 for details of the clinical input.

Supplemental Information

Clinical Input From Physician Specialty Societies and Academic Medical Centers
While the various physician specialty societies and academic medical centers may collaborate with and make recommendations during this process, through the provision of appropriate reviewers, input received does not represent an endorsement or position statement by the physician specialty societies or academic medical centers, unless otherwise noted.

2017 Input
In response to requests, clinical input focused on sacroiliac joint (SIJ) fusion was received from 10 respondents, including 5 specialty society-level responses from 7 specialty societies (2 were joint society responses) and 5 physician-level responses
from 4 academic centers while this policy was under review in 2017. Based on the
evidence and independent clinical input, the clinical input supports that the
following indication provides a clinically meaningful improvement in the net health
outcome and is consistent with generally accepted medical practice:

- Use of fusion/stabilization of the SIJ using percutaneous and minimally
  invasive techniques for carefully selected patients as outlined in statements
  from the North American Spine Society.

2015 Input
In response to requests, focused input on SIJ fusion was received from 5 physician
specialty societies and 3 academic medical centers while this policy was under
review in 2015. Most reviewers considered SIJ fusion to be investigational.

2014 Input
In response to requests, input was received from 4 physician specialty societies
and 4 academic medical centers (5 responses) while this policy was under
review in 2014. Input was mixed on the use of arthrography, radiofrequency ablation, and
fusion of the SIJ. Most reviewers considered injection for diagnostic purposes to be
medically necessary when using controlled blocks with at least 75% pain relief,
and for injection of corticosteroids for treatment purposes. Treatment with
prolotherapy, periarticular corticosteroid, and periarticular botulinum toxin were
considered investigational by most reviewers.

2010 Input
In response to requests, input was received from 4 physician specialty societies (6
responses) and 3 academic medical centers (5 responses) while this policy was
under review in 2010. Input was mixed. There was general agreement that the
evidence for SIJ injections is limited, although most reviewers considered
sacroiliac injections to be the best available approach for diagnosis and treatment
in defined situations.

Practice Guidelines and Position Statements

North American Spine Society
The North American Spine Society (NASS) published coverage recommendations
for percutaneous sacroiliac joint (SIJ) fusion in 2015. NASS indicated that there
was relatively moderate evidence. In the absence of high-level data, NASS policies
reflect the multidisciplinary experience and expertise of the committee members in
order to present reasonable standard practice indications in the United States.
NASS recommended coverage when all of the following criteria are met:

1. “[Patients] have undergone and failed a minimum 6 months of intensive
   nonoperative treatment that must include medication optimization, activity
   modification, bracing and active therapeutic exercise targeted at the lumbar
   spine, pelvis, SIJ and hip including a home exercise program.
2. Patient’s report of typically unilateral pain that is caudal to the lumbar spine (L5
   vertebra), localized over the posterior SIJ, and consistent with SIJ pain.
3. A thorough physical examination 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) in the absence of tenderness of similar severity elsewhere (eg, greater trochanter, lumbar spine, coccyx) and that other obvious sources for their pain do not exist.

4. Positive response to a cluster of 3 provocative tests (eg, thigh thrust test, compression test, Gaenslen’s test, distraction test, Patrick’s sign, posterior provocation test). *Note that the thrust test is not recommended in pregnant patients or those with connective tissue disorders.*

5. Absence of generalized pain behavior (eg, somatoform disorder) or generalized pain disorders (eg, fibromyalgia).

6. Diagnostic imaging studies that include ALL of the following:
   a. Imaging (plain radiographs and a CT [computed tomography] or MRI [magnetic resonance imaging]) of the SI joint that excludes the presence of destructive lesions (eg, tumor, infection) or inflammatory arthropathy that would not be properly addressed by percutaneous SIJ fusion.
   b. Imaging of the pelvis (AP [anteroposterior] plain radiograph) to rule out concomitant hip pathology.
   c. Imaging of the lumbar spine (CT or MRI) to rule out neural compression or other degenerative condition that can be causing low back or buttock pain.
   d. Imaging of the SI joint that indicates evidence of injury and/or degeneration.

7. At least 75% reduction of pain for the expected duration of the anesthetic used following an image-guided, contrast-enhanced intra-articular SIJ injection on 2 separate occasions.

8. A trial of at least one therapeutic intra-articular SIJ injection (ie, corticosteroid injection).”

**American Society of Interventional Pain Physicians**

American Society of Interventional Pain Physicians guidelines were updated in 2013. The updated guidelines recommend the use of controlled SIJ blocks with placebo or controlled comparative local anesthetic block when indications are satisfied with suspicion of SIJ pain. A positive response to a joint block is considered to be at least a 75% improvement in pain or in the ability to perform previously painful movements. For therapeutic interventions, the only effective modality with fair evidence was cooled radiofrequency neurotomy, when used after the appropriate diagnosis was confirmed by diagnostic SIJ injections.

**American Society of Anesthesiologists et al**

In 2010, the American Society of Anesthesiologists and the American Society of Regional Anesthesia and Pain Medicine updated their joint guidelines for chronic pain management. The guidelines recommended that “Diagnostic sacroiliac joint injections or lateral branch blocks may be considered for the evaluation of patients with suspected sacroiliac joint pain.” Based on opinions of consultants and society members, the guidelines recommend that “Water-cooled radiofrequency ablation may be used for chronic sacroiliac joint pain.”
**American Pain Society**
The 2009 practice guidelines from the American Pain Society were based on a systematic review commissioned by the Society. The guidelines stated that there is insufficient evidence to evaluate validity or utility of diagnostic SIJ block as a diagnostic procedure for low back pain with or without radiculopathy; the guidelines further stated that there is insufficient evidence to adequately evaluate benefits of SIJ steroid injection for nonradicular low back pain.

**International Society for the Advancement of Spine Surgery**
The International Society for the Advancement of Spine Surgery first published a policy statement on minimally invasive SIJ fusion in 2014. These recommendations were updated in a 2016 statement. Society recommendations indicated that patients who have all of the following criteria may be eligible for minimally invasive SIJ fusion:

- “Significant SI [sacroiliac] joint pain ... or significantly limitations in activities of daily living because of pain from the SI joint(s).
- “SI joint pain confirmed with ... at least 3 positive physical provocation examination maneuvers that stress the SI joint.
- “Confirmation of the SI joint as a pain generator with ≥ 75% acute decrease in pain immediately following fluoroscopically guided diagnostic intra-articular SI joint 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 ... one or more of the following: ... physical therapy.... 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 considered, investigated and ruled out.”

**National Institute for Health and Care Excellence**
National Institute for Health and Care Excellence guidance was published in 2017 on minimally invasive SIJ fusion surgery for chronic sacroiliac pain. The recommendations included:

1.1 “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.... provided that standard arrangements are in place for clinical governance, consent and audit.
1.2 Patients having this procedure should have a confirmed diagnosis of unilateral or bilateral SI joint dysfunction due to degenerative sacroiliitis or SI joint disruption.
1.3 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.”
U.S. Preventive Services Task Force Recommendations
Not applicable.

Medicare National Coverage
There is no national coverage determination. In the absence of a national coverage determination, coverage decisions are left to the discretion of local Medicare carriers.

Ongoing and Unpublished Clinical Trials
Some currently unpublished trials that might influence this policy are listed in Table 5.

Table 5. Summary of Key Trials

<table>
<thead>
<tr>
<th>NCT No.</th>
<th>Trial Name</th>
<th>Planned Enrollment</th>
<th>Completion Date</th>
</tr>
</thead>
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<tr>
<td>Ongoing</td>
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<tr>
<td>NCT01861899</td>
<td>Treatment of Sacroiliac Dysfunction With SI-LOK® Sacroiliac Joint Fixation System</td>
<td>55</td>
<td>Aug 2018</td>
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<tr>
<td>NCT02270203a</td>
<td>LOIS: Long-Term Follow-Up in INSITE/SIFI</td>
<td>103</td>
<td>Dec 2019</td>
</tr>
<tr>
<td>NCT02074761a</td>
<td>Evolucion Study Using the Zyga Siometry Sacroiliac Joint Fusion System</td>
<td>250</td>
<td>Dec 2019</td>
</tr>
<tr>
<td>NCT03230279a</td>
<td>Randomized Controlled Trial Of Minimally Invasive Sacroiliac Joint Fusion Compared To Radiofrequency Ablation For Sacroiliac Joint Dysfunction</td>
<td>84</td>
<td>Sep 2023</td>
</tr>
</tbody>
</table>

NCT: national clinical trial.

a Denotes industry-sponsored or cosponsored trial.

References


33. Cher DJ, Reckling WC, Capobianco RA. Implant survivorship analysis after minimally invasive sacroiliac joint fusion using the iFuse Implant System((R)). Med Devices (Auckl). Dec 2015;8:485-492. PMID 26648762


**Billing Coding/Physician Documentation Information**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>27279</td>
<td>Arthrodesis, sacroiliac joint, percutaneous or minimally invasive (indirect visualization), with image guidance, includes obtaining bone graft when performed, and placement of transfixing device</td>
<td></td>
</tr>
<tr>
<td>27280</td>
<td>Arthrodesis, sacroiliac joint (including obtaining graft)</td>
<td></td>
</tr>
<tr>
<td>G0259</td>
<td>Injection procedure for sacroiliac joint; arthrography</td>
<td></td>
</tr>
<tr>
<td>G0260</td>
<td>Injection procedure for sacroiliac joint; provision of anesthetic, steroid and/or other therapeutic agent, with or without arthrography</td>
<td></td>
</tr>
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**ICD-10 Codes**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>M46.1</td>
<td>Sacroiliitis, not elsewhere classified</td>
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<tr>
<td>M47.898</td>
<td>Other spondylosis, sacral and sacrococcygeal region</td>
</tr>
<tr>
<td>M47.899</td>
<td>Other spondylosis, site unspecified</td>
</tr>
<tr>
<td>M48.08</td>
<td>Spinal stenosis, sacral and sacrococcygeal region</td>
</tr>
<tr>
<td>M53.2X8</td>
<td>Spinal instabilities, sacral and sacrococcygeal region</td>
</tr>
</tbody>
</table>
The CPT code for injection into the sacroiliac joint is:

27096: Injection procedure for sacroiliac joint, anesthetic/steroid, with image guidance (fluoroscopy or CT) including arthrography when performed

Code 27096 is used only if the computed tomography or fluoroscopic imaging is used to confirm the intra-articular needle positioning.

If the procedure is performed without computed tomography or fluoroscopic imaging guidance, it would be reported using code 20552 – Injection(s); single or multiple trigger point(s), 1 or 2 muscle(s).

There is no specific CPT code for radiofrequency ablation of the sacroiliac joint. Code 27299 – unlisted procedure, pelvis or hip joint – would likely be used.

There is a CPT category I code for percutaneous or minimally invasive stabilization:

27279: Arthrodesis, sacroiliac joint, percutaneous or minimally invasive (indirect visualization), with image guidance, includes obtaining bone graft when performed, and placement of transfixing device.

Open sacroiliac joint arthrodesis would be reported with CPT code 27280 – Arthrodesis, open, sacroiliac joint, including obtaining bone graft, including instrumentation, when performed.

For both codes 27279 and 27280, if the procedure is performed bilaterally, the codes would be reported with a -50 modifier.

Additional Policy Key Words
N/A

Policy Implementation/Update Information
5/1/13 New policy; considered investigational. Policy statement regarding sacroiliac joint fusion included from previous policy 7.01.509 Sacroiliac Joint Fusion for the Treatment of Low Back Pain.
5/1/14 No policy statement changes.
3/1/15  Titled changed from Surgical Treatment for Sacroiliac Joint Pain to Diagnosis and Treatment of Sacroiliac Joint Pain. Added medically necessary policy statement for controlled diagnostic injections and for therapeutic injections with corticosteroid. Added investigational statement regarding Arthrography. CPT and HCPCS coding update.

7/1/15  No policy statement changes.
7/1/16  No policy statement changes.
7/1/17  No policy statement changes.
2/1/18  SIJ fusion/stabilization with a titanium triangular implant is considered medically necessary under the specific conditions outlined by NASS.

APPENDIX

APPENDIX 1: CLINICAL INPUT

Appendix Table 1. Respondent Profile

<table>
<thead>
<tr>
<th>No.</th>
<th>Specialty Society</th>
<th>Name of Organization</th>
<th>Clinical Specialty</th>
</tr>
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<tbody>
<tr>
<td>1</td>
<td>American Association of Neurological Surgeons / Congress of Neurological Surgeons</td>
<td>Neurosurgery</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>International Society for the Advancement of Spine Surgery</td>
<td>Spine Surgery</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>American Society of Regional Anesthesia and Pain Medicine</td>
<td>Regional Anesthesia and Pain Medicine</td>
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</tr>
<tr>
<td>5</td>
<td>American Pain Society</td>
<td>Pain Medicine</td>
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<table>
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<tr>
<td>6</td>
<td>Neil R. Malhotra</td>
<td>MD</td>
<td>Hospital of the University of Pennsylvania</td>
<td>Neurosurgery</td>
</tr>
<tr>
<td>7</td>
<td>William Welch</td>
<td>MD</td>
<td>Hospital of the University of Pennsylvania</td>
<td>Neurosurgery, Spinal Surgery</td>
</tr>
<tr>
<td>8</td>
<td>Zachary L. Gordon</td>
<td>MD</td>
<td>University Hospitals Cleveland Medical Center</td>
<td>Spine Surgery</td>
</tr>
<tr>
<td>9</td>
<td>A. Alex Jahangir</td>
<td>MD</td>
<td>Vanderbilt University Medical Center</td>
<td>Orthopaedic Surgery</td>
</tr>
<tr>
<td>10</td>
<td>Anonymous</td>
<td>MD</td>
<td>Oregon Health and Science University</td>
<td>Orthopaedic Surgery</td>
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<th>Board Certification and Fellowship Training</th>
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<td>Hospital of the University of Pennsylvania</td>
<td>Neurosurgery</td>
<td>Neurosurgery, Spinal Surgery</td>
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<tr>
<td>8</td>
<td>Zachary L. Gordon University Hospitals Cleveland Medical Center</td>
<td>University Hospitals Cleveland Medical Center</td>
<td>Spine Surgery</td>
<td>ABOS Certified, Fellowship Spine Surgery at University of Pittsburgh Medical Center</td>
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</tr>
<tr>
<td>9</td>
<td>A. Alex Jahangir Vanderbilt University Medical Center</td>
<td>Vanderbilt University Medical Center</td>
<td>Orthopaedic Surgery</td>
<td>Orthopaedic Surgery / Orthopaedic Trauma</td>
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<td>Anonymous Oregon Health and Science University</td>
<td>Oregon Health and Science University</td>
<td>Orthopaedic Surgery</td>
<td>ABOS, AOSpine Fellowship</td>
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Appendix Table 2. Respondent Conflict of Interest Disclosure

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<tr>
<th>No.</th>
<th>1. Research support related to the topic where clinical input is being sought</th>
<th>2. Positions, paid or unpaid, related to the topic where clinical input is being sought</th>
<th>3. Reportable, more than $1,000, health care–related assets or sources of income for myself, my spouse, or my dependent children related to the topic where clinical input is being sought</th>
<th>4. Reportable, more than $350, gifts or travel reimbursements for myself, my spouse, or my dependent children related to the topic where clinical input is being sought</th>
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<tr>
<td>1</td>
<td>No</td>
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<td>Explanation</td>
<td>Yes/No</td>
<td>Yes/No</td>
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<td>Yes</td>
<td>No</td>
<td>Yes/No</td>
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</tr>
</tbody>
</table>

3 Yes
2 No
Participated in INSITE, an SI-BONE sponsored
1 Yes
4 No
Paid for teaching courses for Zyga.
1 Yes
4 No
Owned intellectual property in Transformer Spine.
APPENDIX 2: CLINICAL INPUT RESPONSES

Objective
Clinical input is sought to help determine the appropriate use in clinical practice of sacroiliac joint (SIJ) fusion for patients with SIJ pain.

1. For individuals with sacroiliac joint pain, are there objective condition characteristics (i.e., patient selection criteria) and management criteria (i.e., regarding prior trial of standard treatment options) that would describe use of SIJ fusion that improves health outcomes and is considered in accordance with generally accepted medical practice? If Yes, please explain:

<table>
<thead>
<tr>
<th>No.</th>
<th>Yes/No</th>
<th>Research support related to the topic where clinical input is being sought</th>
<th>2. Positions, paid or unpaid, related to the topic where clinical input is being sought</th>
<th>3. Reportable, more than $1,000, health care–related assets or sources of income for myself, my spouse, or my dependent children related to the topic where clinical input is being sought</th>
<th>4. Reportable, more than $350, gifts or travel reimbursements for myself, my spouse, or my dependent children related to the topic where clinical input is being sought</th>
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<tbody>
<tr>
<td>4</td>
<td>NR</td>
<td>randomized trials. Institution received support for trial but no personal support received.</td>
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<td>NR</td>
<td>NR</td>
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<td>5</td>
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</table>

**Conflict of Interest Policy Statement**

The North American Spine Society (NASS) employs rigorous checks and balances to ensure that its comments and recommendations on payors’ coverage policies/clinical evidence reports are scientifically sound and unbiased. These checks and balances include requiring all individuals involved in drafting, reviewing, revising and approving the comments to disclose any conflicts of interest he or she may have. Using an evidence-based approach when possible, the multi-disciplinary team works together to develop the comments which requires multiple levels of review. The individuals who provide the final reviews and approvals are further required to divest themselves of most financial interests in any medical industry-related concerns. For more information on NASS’ Level 1 disclosure policy, please visit NASS website.

Individual physician respondents answered at individual level. Specialty Society respondents provided aggregate information that may be relevant to the group of clinicians who provided input to the Society-level response. NR: not reported.
<table>
<thead>
<tr>
<th>No.</th>
<th>Yes/No</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>Yes</td>
<td>Reference numbers cited in parentheses refer to list of publications included in response to Question 4.</td>
</tr>
</tbody>
</table>

Proper SIJ pain diagnosis is key to appropriate patient management. There is an accepted diagnostic algorithm for SIJ pain that combines medical history, physical examination and confirmatory diagnostic SIJ block.

Medical History

Patients with SIJ pain typically report pain in the buttock(s), with possible radiation into the groin or upper legs. The spectrum of pain and disability from SIJ dysfunction is wide. Patients may be affected mildly or may have substantial functional impairment (eg, cannot sit or stand for more than five minutes, cannot perform normal activities of daily living (ADLs), cannot walk up or down stairs, may require a wheelchair). Patients report the following activities to worsen pain:

- Sitting on affected side
- Lying on affected side
- Rolling over in bed
- Ascending or descending stairs
- Getting in/out of a car

Patients with chronic SIJ dysfunction seeking surgical treatment have marked impairment of quality of life,(1) similar to that observed in other conditions commonly treated surgically.(2)
Patients often have a history of prior lumbar fusion, either because the condition was misdiagnosed (the wrong joint was operated on) or as a result of adjacent segment degeneration of the SI joint.

### Physical Examination

Specific physical examination tests that stress the SIJ (eg, distraction test, compression test, thigh thrust, FABER (Patrick’s) test, Gaenslen’s maneuver) are typically performed in the physician’s office. A meta-analysis of physical examination tests suggests that having 3 or more positive tests is highly predictive of a positive diagnostic SI joint block.(3)

### Diagnostic SIJ Block

The diagnosis of SIJ pain is confirmed by performing a fluoroscopy-guided percutaneous SIJ block with local anesthetic (eg, lidocaine). An acute reduction in typical pain indicates a positive test, suggesting that the injected joint is a pain generator. A study of patients undergoing blinded injection of saline or local anesthetic showed markedly high responses to the latter, validating the test.(4) Because other pathologic processes can coexist with SIJ pain, physicians should discuss with patients the degree to which treatment of the SIJ may relieve overall pain and disability without addressing other pain generators.

While a marked response to SIJ block might be predicted to reassure the physician that treatment will produce larger responses to anatomic-based treatment, published data suggest little, if any, relationship. In two large prospective clinical trials of SIJ fusion, patients with suspected SIJ pain were included only if intra-articular SIJ block resulted in a 50% or greater amount of acute pain relief within 60 minutes after the block. The degree of improvement at 6 and 12 months after SIJ fusion was unrelated to the degree of acute pain relief during the block.(5)

### Imaging

Apart from ankylosing spondylitis, in which MRI can show edema consistent with inflammation, imaging of the SIJ typically does not provide valuable diagnostic information. In many cases, imaging can show non-specific findings in the SIJ.6 Rather, imaging is used to ensure that the patient does not have alternative diagnoses that could mimic SIJ pain (eg, hip osteoarthritis, occasionally L5/S1 spine degeneration).

### Bilateral SIJ Pain

Bilateral SIJ pain is not uncommon. Diagnosis of bilateral SIJ pain must be made on the basis of a history of bilateral pain, bilateral elicitation of pain on physical examination maneuvers that stress each SIJ, and acute bilateral decrease in pain upon CT or fluoroscopy-guided intra-articular SIJ block with local anesthetic. Bilateral SIJ fusion is probably best performed serially as successful treatment of one side may improve pain/disability to a degree acceptable by the patient. SIJ fusion of the contralateral side may be necessary if contralateral SIJ pain continues and disability is significant for the patient.

It is expected that a person would not undergo more than one SIJ fusion per side per lifetime except in the rare case that a revision is needed.

### Indications/Limitations for MIS SIJ Fusion

Per the ISASS Policy Statement(7) on minimally invasive sacroiliac joint (MIS SIJ) fusion surgery, patients who have all of the following criteria may be eligible for MIS SIJ fusion:

- Significant SIJ pain that impacts quality of life or significantly limits activities of daily living;
- SIJ pain confirmed with at least 3 physical examination maneuvers that stress the SIJ (see list provided above) and reproduce the patient’s typical pain;
- Confirmation of the SIJ as a pain generator with ≥50% acute decrease in pain upon fluoroscopically-guided diagnostic intra-articular SIJ block using local anesthetic. Prospective trials have shown that patients with SIJ pain responses of 50-75% respond to MIS SIJ fusion as well as those with 75-100% acute responses. (There is no evidence that the SIJ block provides long-term pain relief and should be conducted for diagnostic, not therapeutic, purposes.)
- Failure to respond to at least 6 months of non-surgical treatment consisting of non-steroidal anti-inflammatory drugs and physical therapy. 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 considered. Physicians should take into account that patients can have multiple pain generators and addressing just one pain generator may not adequately relieve disability or all back pain.

MIS SIJ fusion is NOT indicated for patients with the following:

- Less than 6 months of SIJ pain and/or functional impairment
- Failure to pursue conservative treatment of the SIJ (unless contra-indicated);
- Pain not confirmed with a diagnostic SIJ block;
- Presence of other pathology that would substantially prevent the patient from deriving benefit from SIJ fusion.

### MIS SIJ fusion

The North American Spine Society’s coverage recommendations on SI joint fusion provides evidence-based criteria for diagnosing SI joint pain and selection criteria for surgical intervention. The excerpt below is from the NASS statement:

1. Patients have undergone and failed a minimum 6 months of intensive nonoperative treatment that must include medication optimization, activity modification, bracing and active therapeutic exercise targeted at the lumbar spine, pelvis, SIJ and hip including a home exercise program.
2. Patients report typically unilateral pain that is causal to the lumbar spine (L5 vertebrae), localized over the posterior SIJ, and consistent with SIJ pain.
3. A thorough physical examination 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) in the absence of tenderness of similar severity elsewhere (eg, greater trochanter, lumbar spine, coccyx) and other obvious sources for their pain do not exist.
4. Positive response to a cluster of 3 provocative tests (eg, thigh thrust test, compression test, Gaenslen’s test, distraction test, Patrick’s sign, posterior provocation test). Note that the thrust test is not recommended in pregnant patients or those with connective tissue disorders.
<table>
<thead>
<tr>
<th>No.</th>
<th>Yes/No</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>Yes</td>
<td>The North American Spine Society Criteria are the most respected and generally used criteria. Most patients with SI joint pain will respond to the conservative therapies listed. However, one criteria that I think should be added is a reduction in opioid use prior to the fusion. The literature does not show much reduction in opioids after fusion. This is because one must demonstrate that the patient can tolerate an opioid reduction before performing an advanced invasive procedure like percutaneous fusion. If the patient can tolerate at least a 50% reduction without aberrant behaviors, they are likely to be able to go off the opioid after the fusion. For those that show significant aberrant behaviors, psychosocial therapies should be the mainstay of therapy. Opioid taper take a lot of effort on the part of the patient and physician. If neither is willing, it will not be successful.</td>
</tr>
<tr>
<td>6</td>
<td>Yes</td>
<td>Diagnostic and therapeutic injections.</td>
</tr>
<tr>
<td>7</td>
<td>Yes</td>
<td>The only generally accepted objective criteria for the diagnosis of sacroiliac joint pain is response to image-guided sacro-iliac injections. Patients who do not respond to the injections generally do not improve with directed therapies. Patients who do improve with the injections will usually respond to fusion therapies.</td>
</tr>
<tr>
<td>8</td>
<td>Yes</td>
<td>Diagnosis of SI joint pain/dysfunction is typically based on meeting a set of clinical criteria for location of pain, positive provocative maneuvers, and diagnostic injections. While the evidence is low, I agree with the NASS recommendations as outlined in their report particularly focusing on the fact that a patient has undergone and failed a minimum 6 months of intensive nonoperative treatments, the patient has a complaint and physical exam consistent with SIJ pain, Imaging of the SI joint that excludes the presence of destructive lesions, at least 75% reduction of pain for the expected duration of the anesthetic used following an image-guided, contrast-enhanced intra-articular SIJ injection on 2 separate occasions and finally a successful trial of at least one therapeutic intra-articular SIJ injection with a corticosteroid.</td>
</tr>
<tr>
<td>9</td>
<td>Yes</td>
<td>I would agree with the NASS guidelines.</td>
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<tr>
<td>10</td>
<td>Yes</td>
<td>The authors also state that there is no reference standard besides injections, but multiple investigators have found a strong correlation (&gt; 80% sensitivity and &gt;75% specificity) between response to blocks and &gt;3 positive provocation maneuvers (references: 25, 26, 14, 31, 2, 24). This provides indirect confirmatory evidence for the validity of diagnostic injections.</td>
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We have reviewed the BlueCross BlueShield Diagnosis and Treatment of Sacroiliac Joint Pain, Summary of Evidence. In general, this is a well-written, comprehensive review, but we have the following comments that should be considered.

**Diagnosis:** The document is correct in asserting that there is no other “reference standard” for identifying a painful sacroiliac (SI) joint besides a diagnostic injection. Many pain medicine organizations consider it to be “self-evident” that a positive response to a diagnostic block indicates a painful joint (eg, Spine Intervention Society, American Society of Interventional Pain Physicians), but we know from multiple studies performed for not only SI joint pain (references: 10, 14, 19, 18, 26, 15), but also lumbar and cervical facet pain, that there is a considerable false-positive rate for uncontrolled blocks. These studies have mostly considered failure of a 2nd block to provide adequate relief after a 1st block did provide relief or evidence of a false-positive response, but without another reference standard, one cannot ascertain whether the positive block was a false-positive, or the negative block was a false-negative.

The authors also state that there is no reference standard besides injections, but multiple investigators have found a strong correlation (> 80% sensitivity and >75% specificity) between response to blocks and >3 positive provocation maneuvers (references: 25, 26, 14, 31, 2, 24). This provides indirect confirmatory evidence for the validity of diagnostic injections.

**iFUSE:** This is a minimally-invasive surgical technique designed to treat degenerative SIJ arthritis and instability: it is not intended to treat extra-articular SIJ joint pain, which is the target population of radiofrequency ablation (the lateral branches innervate the SI joint ligaments, not the joint capsule; reference 5). The SI joint is designed for stability and there is relatively little motion at the joint. Patients in the study were diagnosed via intra-articular injections, though the characteristics of those injections were not noted (the capacity of the SI joint is < 2.5 ml, so high volumes will anesthetize the ligaments or rupture the capsule). In two studies (references 29, 21), they considered patients with contrast extravasation during the injection as having “disruption”, and included them in the study. However, this is quite common (a, and capsular disruption is different than “instability”, and is probably not a good indication for surgery (ie, how would fusion heal rupture of a fibrous capsule?). All RCTs reported outstanding results at >1-year follow-up, which were much better than for non-industry RCTs that previously studied SI fusion (references: 22, 28, 3), and RCTs evaluating fusion surgery for lumbar degenerative conditions (reference 8) or cervical degenerative conditions (references 30, 9). These discrepancies may be due to either the rationale for iFuse (ie, fusion works, but people often do poorly because of the trauma associated with such a large operation) or methodological flaws inherent in randomized surgical trials (eg, inability to blind evaluators or patients, patients allocated to non-surgical therapy already failed non-surgical therapy, bias). In all studies, the large majority of patients were fused for degenerative conditions (which the authors termed “degenerative sacroiliitis”), rather than SI joint disruption or instability. Yet, it is not clear how active inflammation was identified, or why fusion might be an effective treatment for active inflammation. There was also considerable overlap between investigators in the 3 RCTs evaluating iFuse, which raises questions regarding generalizability.

In summary, SI joint pain is a common condition, and there are no long-term treatment options for either intra-articular SI joint pain or disruption. The evidence supporting fusion for other degenerative conditions is very weak, and most of the patients in the RCTs were fused for degenerative conditions. The reported results were extraordinary, much better than any RCT evaluating cervical or lumbar fusion, or SI joint fusion using an open surgical technique, but there were significant methodological flaws in the studies. There is little doubt that iFuse might be effective for individuals with true instability at the joint (ie, increased motion, rather than contrast extravasation indicating capsular disruption), and may provide some improvement for patients with degenerative joint pain, though these patients need to be better identified.
2. For those who answered Yes to Question 1 regarding individuals with SIJ pain who have the objective condition characteristics and who meet the management criteria you listed and receive SIJ fusion,
   a. Use the 1 to 5 scale outlined below to indicate your level of confidence that there is adequate evidence supporting an improvement in health outcomes.

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b. Use the 1 to 5 scale outlined below to indicate your level of confidence that this clinical use is in accordance with generally accepted medical practice.

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3. Additional comments and/or any citations supporting your clinical input on the use of SIJ fusion for individuals with SIJ pain.

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Patients experiencing persistent or recurrent pain after lumbar fusion underwent SI blocks. 35% had a positive result to SI block (>75% improvement). Predictive criteria of response to SI block was pain different from pre-operative symptoms and those having a pain-free interval after lumbar fusion of >3 months.  
Higher rates of SI joint pain after lumbar fusion in patients with greater pelvic tilt and inadequately restored lumbar lordosis.  
Patients with SI joint pain after lumbar fusion tended to have more pelvic retroversion than asymptomatic controls.  
Fusion of multiple segments (>3) can increase the incidence of SI joint pain after lumbar or lumbosacral fusion.  
Patients with low back pain after lumbar fusion had positive responses to injections to SI joint, fusion hardware, zygohypophyseal joint, or provocation discography. Of these different potential sources of back pain after lumbar fusion, SI joint was the most common source with 43% compared to 13% in patients with back pain without fusion. |
Diagnosis and Treatment of Sacroiliac Joint Pain 6.01.23

- Liliang P, Lu K, Liang C, et al. Sacroiliac joint pain after lumbar and lumbosacral fusion: findings using dual sacroiliac joint blocks. Pain Med. 2011 Apr; 12(4):565-70. PMID 21463470. Patients with lumbar/lumbosacral fusions were evaluated for SI joint pain with physical examination. 52 had positive response to at least three provocative tests and selected to receive diagnostic blocks. 40% had a positive response and the characteristics of these patients most likely to respond included unilateral pain complaints, more than 3 positive responses to provocative maneuvers, and post-operative pain characteristics different from pre-operative complaints.

- Polly D, Cher D, Whang P, et al. Does level of response to SI joint block predict response to SI joint fusion? Int J Spine Surg. 2016 Jan 21; 10:4. PMID 26913224. This study is a subgroup analysis of INSITE and SIFI prospective SI joint fusion showing that the degree of pain relief from a SI joint block did not predict outcome after fusion. Successful outcomes from SI joint fusion were comparable in those patients experiencing >75% pain relief from SI block as those with 50-75% relief. This suggests that the higher 75% relief standard may be overly aggressive in discerning patients likely to benefit from SI joint fusion.

- Vanaclocha V, Herrera J, Saiz-Sapena N, et al. Minimally invasive sacroiliac joint fusion, radiofrequency denervation, and conservative management for sacroiliac joint pain: 6-year comparative case series. Neurosurgery. 2017 Apr 20. [Epub ahead of print]. PMID: 28431026. This study is a retrospective analysis of patients with SI joint pain and up to 6 years of follow up. Patients were managed with either conservative management, SI joint steroid injections, sacroiliac denervation, or SI joint fusion. Conservative management and injections showed no long-term improvement in pain or disability. SI joint denervation offered mild pain and disability improvements. SI joint fusion offered better long-term pain relief compared to all other treatments with lower opioid use and better work status.

Reference numbers cited in parentheses refer to list of publications included in response to Question 4.

After performing a thorough review of all available data and literature on the procedure, in March 2014, ISASS issued a comprehensive policy statement on MIS SIJ fusion and updated that policy in March 2015, December 2015 and July 2016.(7) The Policy Statement includes a discussion on the SIJ as a pain generator, information on diagnosing the SIJ as the primary source of pain, a discussion of non-surgical and surgical treatment options and recommended coverage criteria for MIS SIJ fusion. Please note, the ISASS Policy does not endorse any specific MIS SIJ fusion system. There are numerous devices available that have received FDA 510(k) clearance for use in MIS SIJ fusion surgery. ISASS maintains that the instrumented utilization of a MIS SIJ fusion procedure is the purview of surgeon preference.

In 2008, the U.S. Food and Drug Administration approved the first minimally invasive device for sacroiliac joint fusion and MIS SIJ fusion surgery obtained a Category I CPT® code effective January 1, 2015. The body of literature on MIS SIJ fusion has grown substantially and continues to show positive outcomes for patients who receive the surgery. In addition to outcomes published of multiple retrospective case series(8-14) and comparative series(15-17), published results from two prospective, multi-center, randomized controlled trials of MIS SIJ fusion vs. non-surgical management (NSM)(18, 19) and a prospective multi-center single arm trial(20) have substantiated high rates of pain relief, improvement in functional measures (Oswestry Disability Index (ODI), SF-36, and EQ-5D) and a low rate of both revisions and serious adverse events.

In both prospective, multi-center, randomized controlled trials of MIS SIJ fusion vs. NSM,(18, 19) pain relief, disability reduction and improvement in quality of life were markedly higher in MIS SIJ fusion subjects compared to NSM subjects. Polly et al.(18) found in the MIS SIJ fusion group, mean SIJ pain improved rapidly and was sustained (mean improvement of 55.4 points, 0-100 scale) at month 24. The 6-month mean change in the NSM group (12.2 points on the 0-100 scale) was substantially smaller than that in the MIS SIJ fusion group (by 38.3 points, p < 0.0001 for superiority). By month 24, 83.1% and 82.0% received either clinical improvement or substantial clinical benefit in VAS SIJ pain score. Similarly, 68.2% and 65.9% had received clinical improvement or substantial clinical benefit in ODI score at month 24. In the NSM group, these proportions were <10% with non-surgical treatment only. Parallel changes were seen for EQ-5D and SF-36, with larger changes in the surgery group at 6 months compared to NSM. The rate of adverse events related to MIS SIJ fusion was low and only 3 subjects assigned to MIS SIJ fusion underwent revision surgery within the 24-month follow-up period. In the other randomized trial, Sturesson et al.(19) found mean self-rated low back pain improved by 43.3 points (0-100 scale) in the MIS SIJ fusion group and 8.7 points in the NSM group (difference of 38.1 points, p < 0.0001) at 6 months. Mean ODI improved by 26 points in the MIS SIJ fusion group and 6 points in the NSM group (p < 0.0001). Active straight leg raise test, EQ-5D-3L, walking distance and satisfaction were statistically superior in the MIS SIJ fusion group. The frequency of adverse events did not differ between groups.

Other relevant peer-reviewed published papers adding to the evidence base on MIS SIJ fusion include safety analyses,(21, 22) economic analyses,(23-25) cost analyses,(26, 27) a validation study,(28) burden of disease analyses,(29, 30) and a systematic review.(31)

A recently published 6-year case series(36) comparing MIS SIJ fusion, radiofrequency denervation and conservative management for SIJ pain showed very good patient outcomes (ie, improved pain and disability, decreased in opioid use and good final work status) after MIS SIJ fusion and poor health outcomes (ie, worsening pain and disability, increased use of opioids and poor long-term work status) after conservative management. The poor long-term response, higher opioid use, and poor work status for conservative management contrasts significantly to improvements from MIS SIJ fusion.

In terms of bone growth and fusion rates for MIS SIJ fusion, independent analysis showed bridging of bone to the iFuse implant (SI-Bone Inc., San Jose, CA) in nearly 100% of cases.(37) The surface's device design is similar to other orthopedic implants (eg, hip implants) where bone binding has been shown. A 5-year study shows bridging bone across the SIJ in 87% of cases.(11) Kube and Muir(38) demonstrated an analogous fusion rate of 88% bridging bone at 1 year using Symmetry (Zyga, Minnetonka, MN), a screw based technology.

Taken together, these studies represent a substantial amount of evidence supporting MIS SIJ fusion as a safe and effective treatment option. In addition, the National Institute for Health and Care Excellence (NICE) reviewed MIS SIJ fusion and concluded, “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 provided that standard arrangements are in place for clinical governance, consent and audit.” (https://www.nice.org.uk/guidance/IPG578/chapter/1-Recommendations)
Please see the following attachments to this form:

1. The ISASS Policy Statement on MIS SIJ Fusion (Available online at: https://www.isass.org/public-policy/isass-policy-statement-minimally-invasive-sacroiliac-joint-fusion-july-2016); and

2. A letter submitted by ISASS to BCBSA Evidence Street on February 20, 2017 outlining additional concerns with the Evidence Review on the Diagnosis and Treatment of Sacroiliac Joint Pain (6.01.23).

It is the opinion of NASS that the peer reviewed published evidence supporting the efficacy of percutaneous SI joint fusion continues to accumulate. The BCBSA Evidence Street review identifies that there are now 2 randomized controlled trials as well as several well-designed case series and multiple other peer reviewed publications that all demonstrate the efficacy of percutaneous SI joint fusion. The magnitude of the effect in both RCTs was quite significant. At 6 month follow-up, Whang found a >15 point improvement in ODI in 75% of fusion patients vs 27% in controls. At 9 months, Sturesson found that VAS pain improved 43.4 points in the fusion group vs 5.7 points in the control group and that ODI improved 25.5 points in the fusion group vs 5.8 points in the control group. The results of both studies were also noted to be highly statistically significant. The longer-term follow-up studies demonstrate the durability of the results at 2 years. Adverse effects and revision rates have been reported and are consistent with those reported for other surgical interventions.

NASS would like to raise concerns regarding BCBSA’s criticism of the RCTs as being non-blinded. Patient blinding in surgery requires a sham procedure arm. Sham surgery, especially in the spine, exposes the patient to direct harm and risk. For this reason, many Institutional Review Boards will not accept sham-blinded studies. Even when accepted, patient enrollment is difficult and selection bias occurs in that patients with more severe symptoms will not participate. NASS is also perplexed by and disagrees with criticism of self-reported outcomes in the studies cited. Validated patient reported outcomes measures are the gold standard assessment tool for interventions designed to address a patient’s pain or functional limitations.

References (this list is not comprehensive and the studies were already identified in the Evidence Street Review):


Also see information in response to Question 1. Reference numbers cited in parentheses refer to list of publications included in response to Question 4.

**Therapeutic value of sacroiliac joint injections:** The sacroiliac joint is by far the largest “spinal joint”, and contains both extra- (eg, ligaments, muscles) and intra-articular portions. The extra-articular portion could also be classified into dorsal and ventral components, with the latter not amenable to blockade. When considering the evidence for blocks, we believe that the placebo-controlled trials showing benefit for steroid injections (in spondyloarthopathy patients [reference 20] in patients with and without spondyloarthopathy [references 16,17]) should be considered. The 2 Luukainen et al. studies were included in the Hansen et al. systematic review cited in the summary of evidence (7), but the Maugars et al. study was not. Although spondyloarthopathy generally refers to a group of inflammatory rheumatic diseases (eg, ankylosing spondylitis), many patients who present with signs and symptoms consistent with sacroiliac joint disease have evidence of inflammation (sacroilitis). Whereas the small Hanly et al. study (6) followed individuals through 6 months and reported persistent benefit in over half of the patients, the 2 Luukainen et al. studies (16,17) followed patients for only 1 and 2 months, and did not report secondary outcome measures.

**Radiofrequency denervation:** The Cohen et al. (4) study used intra-articular injections without prognostic lateral branch blocks to select patients for a treatment that targets extra-articular pain, though the high volume used likely anesthetized the SI joint ligaments as well. This study also treated L5-S1 facet joint pain (since the L4 and L5 nerves innervate the L5-S1 facet joint). The negative Tilburg et al. study evaluated a newer procedure which is essentially designed to significantly reduce the time required to perform the procedure (one cannula insertion to ablate multiple nerves), which comes at the expense of precision. The authors screened only 79 patients to enroll 60 subjects, and considering that 15%-30% of people with predominantly axial low back pain have the SI joint as their primary pain generator, it is likely that few patients enrolled actually had SI joint pain. The authors acknowledged enrolling patients with “sciatica”, which should not respond to any SI joint intervention. The screening test (> 2-point decrease in pain following
the diagnostic injection) also was insufficient, because even individuals without the index condition will often obtain some benefit from an injection (ie, higher placebo response rates for injections than pills (references 11,12,13), local anesthetic injected into the muscles (1), and extravasation of the injectate into other potential pain generators).

5 My confidence in the therapy is based on my comments in section one. It requires a high level of patient selection. For those that fail conservative therapy, a detailed psychosocial assessment is required. And for those on opioids, an opioid taper as described above. Also, there is too much emphasis on the need for blinded sham-controlled trials for interventional therapies. These are extremely challenging to do and because of this, we cannot ignore our clinical experience. Real world observational studies are helpful in these situations.

NICE recently published an thorough review of percutaneous SI joint fusion (April 5, 2017 – available online at https://www.nice.org.uk/guidance/gs0578/resources/minimally-invasive-sacroiliac-joint-fusion-surgery-for-chronic-sacroiliac-pain-pdf-1899872114909893). They included randomized controlled trials and systematic reviews which were very favorable.

Overall, percutaneous SI joint fusion has more evidence than corticosteroid injections and RFA with proper patient selection.

6 SI fusion is currently acceptable therapy in patients in whom significant response is noted with injection. SI joint fusion as part of the inferior portion of extensive thoracolumbar fusion (i.e., SI joint and pelvis) is an accepted approach. Increasing literature on the topic will enhance the knowledge base on this topic.

7 No additional comments listed.

8 Although criteria for the diagnosis of SI joint dysfunction is fairly well described, there is significant variability from study to study regarding the application of the diagnostic criteria. It is difficult to assess the efficacy of a treatment such as SI joint fusion when there is not a clearly defined and consistent manner of diagnosis from study to study.

The vast majority of literature regarding outcomes following SI joint fusion surgery are low-quality retrospective studies, or small sample size prospective studies with limited follow-up.

9 I believe the draft review of evidence is well written and highlights the challenge of the gathering high level clinical guidelines as there are minimal non industry supported studies for this intervention. This review also highlights the challenges present in conducting blinded high volume studies as this is not a common condition and fusion may help a selected group of patients.


4. Is there any evidence missing from the attached draft review of evidence?

No. Yes/No  Citations of Missing Evidence
1  NR
2  Yes

The literature review appears to be incomplete, with missing comparative studies, (15-17) missing case series, (8, 10, 12, 14, 32, 33, 34, 35, 36) missing systematic reviews, (31, 39, 40) a missing meta-analysis of prospective studies, (41) missing outcomes studies, (1, 28, 30, 42, 43, 44) missing economic studies, (23, 24, 25, 26, 27, 45) and missing biomechanical studies. (46, 47, 48)

References
2. Cher DJ, Reckling WC. Quality of life in preoperative patients with sacroiliac joint dysfunction is at least as depressed as in other lumbar spinal conditions. Med Devices (Auckl). 2015 Sep 16; 8:395-403. PMID: 26396547.


We have reviewed the BlueCross BlueShield Diagnosis and Treatment of Sacroiliac Joint Pain, Summary of Evidence. In general, this is a well-written, comprehensive review, but we have the following comments that should be considered also see responses included above in Questions 1 and 3. Although this was not included in the evidence synthesis, and no randomized controlled trials have evaluated psychological interventions such as cognitive-behavioral therapy in individuals with SI joint pain, there is strong evidence supporting these treatments in individuals with nonspecific low back pain (Richmond H, Hall AM, Cossey B, et al. The effectiveness of cognitive behavioural treatment for non-specific low back pain: a systematic review and meta-analysis. PLoS One. 2015 Aug 5; 10(8):e0134192. PMID: 26244668), some of whom undoubtedly have SI joint pain. Therefore, incorporating these therapies, either before procedural interventions or in addition to interventions (ie, multimodal therapy), should be strongly considered.

Reference list for articles mentioned in the ASRA response to questions 1 and 3:

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NR: no response.

State and Federal mandates and health plan contract language, including specific provisions/exclusions, take precedence over Medical Policy and must be considered first in determining eligibility for coverage. The medical policies contained herein are for informational purposes. The medical policies do not constitute medical advice or medical care. Treating health care providers are independent contractors and are neither employees nor agents Blue KC and are solely responsible for diagnosis, treatment and medical advice. No part of this publication may be reproduced, stored in a retrieval system or transmitted, in any form or by any means, electronic, photocopying, or otherwise, without permission from Blue KC.