Medical Affairs Policy

Service: Back Pain: Sacroiliac and Coccydynia Treatments

PUM 250-0024-1706

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<tr>
<th>Medical Policy Committee Approval</th>
<th>06/16/17</th>
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<td>Effective Date</td>
<td>08/21/17</td>
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<tr>
<td>Prior Authorization Needed</td>
<td>Yes</td>
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Disclaimer: This policy is for informational purposes only and does not constitute medical advice, plan authorization, an explanation of benefits, or a guarantee of payment. Benefit plans vary in coverage and some plans may not provide coverage for all services listed in this policy. Coverage decisions are subject to all terms and conditions of the applicable benefit plan, including specific exclusions and limitations, and to applicable state and federal law. Some benefit plans administered by the organization may not utilize Medical Affairs medical policy in all their coverage determinations. Contact customer services as listed on the member card for specific plan, benefit, and network status information.

Medical policies are based on constantly changing medical science and are reviewed annually and subject to change. The organization uses tools developed by third parties, such as the evidence-based clinical guidelines developed by MCG to assist in administering health benefits. This medical policy and MCG guidelines are intended to be used in conjunction with the independent professional medical judgment of a qualified health care provider. To obtain additional information about MCG, email medical.policies@wpsic.com.

Many member health plans have set maximum limits for pain injections per plan year or calendar year. These services are covered subject to medical necessity review. If a limit is not specified in the member health plan, the maximum follows the medical necessity guidelines in this policy. If a year is not described in the member health plan (e.g. per calendar year), a year is defined as the 12-month period starting from the date of service of the first approved injection.

Related Medical Policies:
• Back Pain: Epidural Injections
• Back and Nerve Pain: Radiofrequency Ablation, Facet Joint, and other Injections
• Non-covered Services and Procedures

Description:
Sacroiliac (SI) joint injection is an injection of local anesthetic and / or a steroid into the articular space between the spinal column and pelvis Sacroiliac (SI) joint pain is usually described as low back and buttock pain. The symptoms are believed to be related to an inflammatory process in the joint between the spinal column and pelvis. Injections have been performed for both diagnostic and therapeutic purposes. Although evidence is limited due to the low number of randomized controlled clinical trials, inconsistencies between trials, and flaws in design and conduct of studies documenting the effectiveness of sacroiliac joint injections for the management of low back pain, these injections have become widely used. There is insufficient evidence of the efficacy, superiority over conservative treatments, or long-term outcomes of SI ablation or fusion procedures in the treatment of SI Joint related back pain.
Coccydynia/ coccyodynia (pain in the coccyx) is most commonly the result of a falling backwards into a sitting position. Most cases resolve without medical care or with conservative management. A minority of patients develop chronic coccydynia and may be referred to pain management specialists who may offer injections. Injections of coccygeal structures, guided by fluoroscopy or computerized tomography (CT), with either local anesthetic or local anesthetic plus corticosteroids are directed at the sacrococcygeal junction, individual coccygeal joints, the caudal epidural space, or the ganglion impar, a midline sympathetic ganglion located just anterior to the sacro-coccygeal junction.

Other interventions that have been proposed to treat SI joint pain include Sacroiliac Joint Ablation, Sacroiliac Neuroablation, Sacroiliac Fusion, and Lateral (Sacral) Branch Nerve Blocks.

**Indications of Coverage:**

**A. Sacroiliac joint injections** are considered medically necessary if all the following conditions are met:

1. Chronic back and buttock pain symptoms (at least three months in duration). Physical exam findings consistent with SIJ symptoms (e.g. thigh thrust test, distraction test, compression test, FABER [Flexion, Abduction, and External Rotation] also known as “Patrick’s test”, and/or Gaenslen’s maneuver point to SIJ etiology). The nerve root tension test (straight leg raise), if performed, must be negative. If bilateral injections are requested, the symptoms must be bilateral.

2. Symptoms that have failed to respond to six (6) week trial of more conservative therapies including anti-inflammatory medications (or other analgesic medication if the anti-inflammatory medication is contraindicated) used on a regular basis and physical and/or chiropractic therapy performed at some point after the onset of the current episode of symptoms. If the symptoms are severe (requiring urgent medical care), the trial of conservative therapy may not be required.

- If the above criteria are met, allow an initial sacroiliac joint injection.
- If the individual has experienced a reduction in pain symptoms of at least 50% for at least one week following the initial sacroiliac joint injection, and the member health plan allows, a second injection can be approved. The second sacroiliac joint injection must be given at least one week after the previous injection.
- If a limit is not specified in the member health plan, a maximum of two (2) sacroiliac joint injections (including intra-articular steroid injections, and periarticular injections), regardless of location (left or right), whether diagnostic or therapeutic, will be considered medically necessary when criteria are met for each injection. Note that bilateral injections will count as 2 injections.
Fluoroscopic or CT guidance is required for sacroiliac joint injections.

**B. Coccyx injections** are considered medically necessary if both of the following conditions are met.

1. Chronic coccyx pain at least 3 months in duration: focal external palpation of the coccyx that reproduces symptoms locally without pain, erythema, or swelling in the surrounding area) and

2. Symptoms that have failed to respond to a six-week trial of more conservative therapies including anti-inflammatory medications (or other analgesic medication if the anti-inflammatory medication is contraindicated) used on a regular basis; donut or wedge cushions; and physical and/or chiropractic therapy after the current episode of symptoms.

If the above criteria are met, allow an initial coccyx injection.

If the individual has experienced a reduction in pain symptoms of at least 50% for at least two weeks following the initial coccyx injection, a second injection can be approved. The second coccyx injection must be given at least one month after the previous injection.

If a limit is not specified in the member health plan, a maximum of two coccyx injections in a twelve-month period is considered medically necessary when criteria are met for each injection. There must be a reduction in pain symptoms of at least 50% for at least two weeks following the previous coccyx injection.

**C. Sacroiliac joint fusion** (arthrodesis) procedures are considered medically necessary:

1. As an adjunct to sacrectomy procedures related to tumors involving the sacrum

2. As adjunct to surgical treatment of SI joint infections

3. For treatment of severe trauma (e.g. pelvic ring fracture)

4. During surgical procedures such as correction of scoliosis extending to the ileum

**Limitations of Coverage:**

**A.** Review health plan and endorsements for exclusions and prior authorization or benefit requirements.

**B.** If used for a condition/diagnosis other than is listed in the Indications of Coverage, deny as experimental, investigational, and unproven to affect health outcomes.
C. If used for a condition/diagnosis that is listed in the Indications of Coverage, but the criteria are not met, deny as not medically necessary.

D. If the previous sacroiliac joint injection OR coccyx injection was not effective (symptoms reduced by at least 50 percent), a subsequent injection is not medically necessary.

E. A second coccyx injection provided less than one month after the initial injection is considered not medically necessary.

F. Ultrasound treatment, short wave diathermy, and transcutaneous nerve stimulation for treatment of coccydynia is considered experimental, investigational, and unproven to affect health outcomes.

G. More than two (2) sacroiliac joint injections (including intra-articular steroid injections, lateral sacral and periarticular injections) regardless of location (left or right) whether diagnostic or therapeutic, in one year* are considered not medically necessary. Note that bilateral injections will count as 2 injections.

H. Sacroiliac joint injections provided without the use of fluoroscopic or CT guidance are not current standard medical practice and would be considered not medically necessary.

I. Performing a sacroiliac joint arthrogram in conjunction with a sacroiliac joint injection is considered not medically necessary unless the joint is being evaluated for damage due to trauma.

J. Nerve blocks (e.g. lumbar and sacral medial branch blocks and/or lateral branch blocks) for diagnosis or treatment of sacroiliac joint pain or pain resulting from SI joint derangement / dysfunction are considered experimental, investigational, and unproven to affect health outcomes.

K. Sacroiliac joint ablation (includes water cooled and pulsed RFA), sacral branch neuroablations (e.g. lateral sacral branch neuroablation) or fusion/ arthrodesis are considered experimental or investigational for management of back/buttocks pain or SI joint dysfunction. Diagnostic sacroiliac joint injections done in preparation for SI joint ablation or fusion/ arthrodesis are not covered as they would be related to the non-covered ablation/ fusion service.

L. Injection of a caustic agent such as phenol or alcohol into a sacroiliac joint is considered experimental, investigational, and unproven to affect health outcomes

M. Percutaneous sacroplasty is considered experimental, investigational, and unproven to affect health outcomes/non-covered. (See also Non-covered Services Policy).
N. SI Joint fusion/ minimally invasive SIJ fusion (e.g. iFuse implant) for SIJ Dysfunction is considered experimental, investigational, and unproven to affect health outcomes.

O. If more than one type of pain treatment is requested/ performed on the same day, only one type will be considered medically necessary at the discretion of the health plan.

Documentation Required:

- History and physical, office notes and relevant reports of prior procedures

References added 2017


2. Hayes Medical Technology Directory. Radiofrequency Ablation for Sacroiliac Joint Denervation for Chronic Low Back Pain


5. Up to Date. Coccydynia (coccygodynia). Literature review current through: Apr 2017. This topic last updated: Apr 05, 2016

Archived References


**WPS/Arise Review History:**

| Implemented | 08/21/17 |
| Medical Policy Committee Approval | 09/12/14, 09/11/15, PUM 250-0024 retired 06/03/16 effective 09/30/16 to Radiofrequency Ablation, Facet Joint Injection, and others. Coccydynia Injections retired to Back Pain Procedures – Epidural Injections. Policy reinstated 06/16/17 as PUM 250-0024-1706 |
| Reviewed | 09/12/14, 09/11/15, 06/03/16, 06/16/17 |
| Developed | 06/16/17 |

*Approved by the Medical Director*