

American Society of Interventional Pain Physicians

" The Voice of Interventional Pain Management "

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Starla Scruggs, Provider Dispute Coordinator
On Behalf of the Provider Appeal Committee
BlueCross BlueShield of Tennessee
1 Cameron Hill Circle
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RE: BlueCross BlueShield of Tennessee's Medical Policy regarding Sacroiliac Joint Interventions

On behalf of the American Society of Interventional Pain Physicians (ASIPP) and Tennessee Society of Interventional Pain Physicians, we would like to thank you for publishing the medical policy regarding sacroiliac joint interventions. However, this policy has elicited significant confusion and the societies have received multiple requests to comment and provide the evidence and also express the concern on the lack of appropriateness of these policies and access to the insured population by BlueCross BlueShield. The Executive Committee of ASIPP, on behalf of the ASIPP board, the entire membership, and the Tennessee Society of Interventional Pain Physicians and their membership, would like to provide comments for medical policy regarding sacroiliac joint interventions. The primary objectives of these comments are to ensure that these procedures are provided appropriately and that patients insured by BlueCross BlueShield maintain access to care. We are hopeful that you will reconsider these policies and re-evaluate the evidence.

ASIPP is a not-for-profit professional organization comprised of over 4,500 interventional pain physicians and other practitioners who are dedicated to ensuring safe, appropriate, and equal access to essential pain management services for patients across the country suffering with chronic and acute pain. There are approximately 7,000 appropriately trained and qualified physicians practicing interventional pain management in the United States. ASIPP is also represented by societies in each state.

Controlled studies have established intervertebral discs, facet joints, and sacroiliac joints as potential sources of low back and lower extremity pain. The sacroiliac joint is accepted as a potential source of low back and/or buttock pain with or without lower extremity pain. It has been implicated as a primary source of pain in 10% to 27% of patients with suspected sacroiliac joint pain utilizing controlled comparative local anesthetic blocks (1-23). Most of the articles consider controlled diagnostic blocks as gold standard. In fact, Rubinstein and van Tulder (24) who are frequent authors of Cochrane reviews based on even old reviews have concluded that there was moderate evidence for sacroiliac joint injections for diagnostic purposes. Now the evidence has improved with multiple new manuscripts (6-23). Thus, there should not be any question that sacroiliac joint pain does exist. Further, multiple studies have illustrated that the diagnosis of sacroiliac joint pain may be made only by controlled diagnostic blocks rather than various other means.

In reference to the various treatment modalities, we understand that the systematic review by Rupert et al (1) illustrated limited evidence for therapeutic intraarticular injections. At the time of this evaluation, there were not many studies. However, the literature on these is emerging. Liliang et al (23) evaluated

therapeutic efficacy of sacroiliac joint blocks with triamcinolone acetonide in the treatment of sacroiliac joint dysfunction with spondyloarthropathy. They confirmed the presence of sacroiliac joint pain in 26% of the patients from an evaluation of 150 patients. Following this, they reported that 26 patients (66.7%) experienced significant pain reduction for more than 6 weeks; the overall mean duration of pain reduction in these responders was 36.8 ± 9.9 weeks. They concluded that SI joint blocks with triamcinolone acetonide were beneficial for some (66.7%) patients with SI joint pain with spondyloarthropathy. Further, the SI joint blocks showed a long-lasting efficacy in two-thirds of patients; however, the duration of its efficacy was shorter in patients with a history of lumbosacral fusion. This study illustrates that SI joint blocks are effective if they are utilized as recommended per ASIPP guidelines with repeating them to a maximum of 4 times per year after diagnostic phase with 2 blocks. These would provide long-lasting relief with appropriate selection.

In a manuscript comparing intraarticular prolotherapy versus steroid injection for sacroiliac joint pain, Kim et al (25) showed that both prolotherapy and steroid injections were effective, even though prolotherapy injections were significantly more effective than steroid injections. However, basically this study also shows that steroid injections are effective again, may not be long-term but in short-term, with long-term effect being achieved with repeat injections with appropriate duration and follow-up.

Hawkins and Schofferman (26) in a report of serial therapeutic sacroiliac joint injections of a practice audit showed that sacroiliac joint corticosteroid injections appear to be an effective palliative treatment for selected patients with sacroiliac joint pain. Most patients in this study whose pain was responsive to sacroiliac joint steroid injections improved sufficiently and remained well after one to 3 injections, but some required frequent injections on a long-term basis. The results were good despite that 69 patients of 155 had prior lumbar surgery. Lumbar surgery is expected to cause significant sacroiliac joint dysfunction (27,28). Over a period of almost 2 year follow-up of the 155 patients, 77% were positive responders. Of the 118 positive responders, received a mean of 2.7 injections per patient, 40 patients received only one injection, 29 required 2, 22 required 3, and 27 required 4 or more. The mean duration of response for those receiving more than one injection was 9.3 months per injection with no adverse events.

Lee et al (29) also evaluated clinical effectiveness of botulinum toxin compared to a mixture of steroid and local anesthetics as a treatment for sacroiliac joint pain. Even though they illustrated that treatment with Botox was more effective than intraarticular steroid injection, both were effective, specifically in the short-term. Thus, once again, repeat injections can be helpful or Botox could be substituted. However, the inclusion criteria did not include dual controlled diagnostic blocks prior to therapeutic modalities. The evidence-based medicine review of sacroiliac joint pain by Vanelderden et al (30) showed evidence 1 B+ for therapeutic intraarticular injections with corticosteroids and local anesthetic. This translates into one randomized controlled trial (RCT) or more RCTs with methodologic weaknesses, demonstrate effectiveness. The benefits clearly outweigh the risks and burdens with a positive recommendation.

Further, these injections must be performed under fluoroscopy even though some have reported effectiveness with unguided sacroiliac joint injections or ultrasound-guided injections. Fluoroscopy or CT scan is essential.

Blue Cross Blue Shield of Tennessee policy also mentions Wisconsin Physician Services, or WPS, policies; however, based on this policy, sacroiliac joint injections are covered as diagnostic procedures, plus they are also covered as therapeutic injections 3 times a year. However, almost all Medicare carriers approve them 4 times a year in the therapeutic phase.

Based on the present literature, the indications for sacroiliac joint injections are as follows (1,2):

Controlled sacroiliac joint blocks with placebo or controlled comparative local anesthetic blocks are recommended when indications are satisfied. A positive response is considered $\geq 80\%$ relief with ability to perform previously painful movements.

- ◆ The primary indication for sacroiliac joint blocks is the need to know if a patient's pain is arising from the sacroiliac joint or not.
- ◆ Sacroiliac joint injections are indicated in patients
 - with chronic low back pain that is maximal below the level of L5 vertebra
 - with or without somatic referred pain in the lower limb, in whom no other diagnosis is readily apparent
 - no other possible diagnosis is more likely
 - a diagnosis has been made or cannot be made using less invasive options
 - lack of resolution of pain with the passage of time or conservative therapy.

Common indications for therapeutic sacroiliac joint injections are the same as for diagnostic sacroiliac joint. In addition, the joint should have been positive utilizing controlled diagnostic blocks with 80% relief.

Thank you for your attention to this matter. If you have any further questions, please feel free to contact us.

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To view some of Dr. Manchikanti's publications go to:

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"The world is run by those who show up."

"There is no limit to what a man can do or where he can go if he doesn't mind who gets the credit."

Ronald Reagan

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