American Society *of* Interventional Pain Physicians®
"The Voice of Interventional Pain Management"
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October 14, 2022

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National Government Services Medical Policy Unit
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Noridian Healthcare Solutions, LLC JE Part B Contractor Medical Director(s)
Attention: Draft LCD Comments
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Part A Policy
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Re: Proposed LCD-Sacroiliac Joint Injections and Procedures

Dear Medical Directors:

On behalf of American Society of Interventional Pain Physicians (ASIPP), the Society of Interventional Pain Management Surgery Centers (SIPMS), and 49 state societies of interventional pain physicians and

Puerto Rico Society of Interventional Pain Physicians, we appreciate the effort and the work performed in preparing sacroiliac joint injections and procedures.

The majority of the requirements are evidence-based and improve patient care. To further improve patient access and quality of care, we request for inclusion of sacroiliac joint nerve blocks for diagnostic and therapeutic purposes, and reconsideration of present determination of experimental or investigational of sacroiliac joint denervation or radiofrequency ablation.

Inclusion of sacroiliac joint nerve blocks including L5 dorsal ramus and sacral lateral branches:

Diagnostic L5 dorsal ramus and sacral lateral branch blocks (CPT 64451) involve injecting 0.5 mL of local anesthetic onto the L5 dorsal ramus and S1 to S3 dorsal rami lateral branches. These injections are similar to medial branch blocks and L5 dorsal ramus block. These injections are used as an alternate to intraarticular injections in the diagnosis and the treatment of sacroiliac joint pain.

All of the requirements are similar to sacroiliac joint injections with comparative controlled diagnostic blocks utilizing a short-acting and long-acting local anesthetic.

Positive response may be based on the same criteria as sacroiliac joint intraarticular injections.

Therapeutic L5 dorsal ramus and sacral lateral branch joint procedures are similar to intraarticular injections. As of now, there are no significant studies either standalone or comparative. Even then, this is an extremely useful modality, specifically in patients with inability to enter the joint.

Low back pain is incredibly complex and one of the largest drivers of health care costs and lost wages. The elimination of a diagnostic sacroiliac joint injection would significantly limit a physicians ability to properly diagnose and treat low back pain as we would lose a helpful diagnostic tool.

Sacroiliac joint radiofrequency neurotomy (CPT 64625), L5 dorsal ramus, and sacral lateral branches is determined as investigational in the policy. This procedure has been shown to be effective in managing sacroiliac joint pain.

We request that the procedure be added with similar criteria of 2 positive diagnostic blocks with concordant relief and providing 6 months of relief with each radiofrequency neurotomy with limiting for 2 per year in the therapeutic phase.

As shown in the evidence synthesis of Contractor Advisory Committee meeting of 3/10/2022, sacroiliac joint denervation does provide moderate evidence. 2020 data shows sacroiliac joint radiofrequency thermoneurolysis, CPT 64625, was provided 20,022 times, whereas during the same year, 278,923 times was provided in fee-for-service Medicare population. Based on this, utilization seems to be appropriate. Approval of sacroiliac joint radiofrequency neurotomy in essence may reduce the utilization of sacroiliac joint injections considering double the price of radiofrequency neurotomy of therapeutic facet joint nerve blocks with twice the relief. It seems to be cost effective and should not increase the cost for Medicare (Manchikanti L, et al. Impact of COVID-19 pandemic and updated utilization patterns of sacroiliac joint injections from 2000 to 2020 in the fee-for-service (FFS) Medicare population. *Pain Physician* 2022; 25:239-250).

Consequently, we request that sacroiliac joint denervation should be added to the policy with selection criteria of 2 positive diagnostic blocks and 6 months of relief of 50% or more.

1. Denying patient access to sacroiliac joint radiofrequency ablation leaves a significant treatment gap between conservative medical management (NSAIDs, physical therapy, injection) and surgical intervention (sacroiliac joint fusion)
2. Patients refractory to conservative medical management or poor candidates for surgery will have limited options and may be forced to opioids
3. The over 65 population are particularly susceptible to opioid related adverse events, including increased risk of falls
4. Lack of intermediate options also has the potential to drive more patients to costly surgeries
5. A recently published systematic review of 16 randomized controlled trials, not included in the LCD, found that in aggregate, the total body of research supports sacroiliac joint radiofrequency ablation as an intervention. (Lowe M, et al Radiofrequency Ablation as an Effective Long-Term Treatment for Chronic Sacroiliac Joint Pain: A Systematic Review of Randomized Controlled Trials. *Cureus* 2022;14:e26327.)
6. Sacroiliac joint radiofrequency ablation is a safe, effective, medically necessary intervention that has been performed for nearly two decades

SCALES USED

Our other comments relate to scales used. We request that Pain Disability Index which has been studied in chronic pain patients, should be added, which would be extremely useful in assessing pain disability. (https://www.nhms.org/Portals/96/Documents/Resources/Pain_Disability_Index.pdf)

BACKGROUND

ASIPP is a not-for-profit professional organization founded in 1998 now comprising 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 8,500 appropriately trained and qualified physicians practicing interventional pain management in the United States.

SIPMS is a not-for-profit professional organization founded in 2005, with membership involving surgical centers focusing on interventional pain management, dedicated to ensuring safe, appropriate, and equal access to essential pain management services for patients across the country suffering with chronic pain. There are approximately 500 surgery centers across the nation approved by Medicare providing or solely or an overwhelming majority of interventional pain management services.

Interventional pain management is defined as the discipline of medicine devoted to the diagnosis and treatment of pain related disorders principally with the application of interventional techniques in managing sub-acute, chronic, persistent, and intractable pain, independently or in conjunction with other modalities of treatment (The National Uniform Claims Committee. Specialty Designation for Interventional Pain Management- 09, www.cms.hhs.gov/transmittals/Downloads/r1779b3.pdf).

Interventional pain management techniques are minimally invasive procedures including, percutaneous precision needle placement, with placement of drugs in targeted areas or ablation of targeted nerves; and some surgical techniques such as laser or endoscopic diskectomy, intrathecal infusion pumps and spinal cord stimulators, for the diagnosis and management of chronic, persistent, or intractable pain (Medicare Payment Advisory Commission. Report to the Congress: Paying for interventional pain services in ambulatory settings. Washington, DC: MedPAC. December. 2001. http://www.medpac.gov/documents/reports/december-2001-report-to-the-congress-paying-for-interventional-pain-services-in-ambulatory-settings.pdf?sfvrsn=0

If you have any questions, please feel free to contact us.

Thank you again.

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