**Supplementary Data File 1**

**FLUOROSCOPICALLY-GUIDED DIAGNOSTIC AND THERAPEUTIC SACROILIAC INTERVENTIONS**

**AUC ASSUMPTIONS AND DISCLAIMER**  
The purpose of this AUC is to provide guidance to physicians, based on best available evidence and expert consensus, on the appropriate use of fluoroscopically-guided diagnostic and therapeutic procedures for sacroiliac joint pain and pain arising from the posterior sacroiliac complex. For the purpose of this AUC, it is assumed that the patient has sufficient pain and/or dysfunction to merit seeking the opinion of a specialist and that the treating clinician is trained and capable of effectively performing the recommended treatment(s). This AUC is not meant to be used as a standalone algorithm and should be used in conjunction with clinical evaluation, clinician judgment, and patient preference. Confounding factors and concurrent diagnoses may alter the treatment.   
  
The clinician has to take a full history, as well as conduct a thorough physical exam. In addition it is expected that the clinician is capable of reviewing and interpreting the appropriate region-specific imaging studies. Cauda equina red flags (i.e., neurogenic bowel or bladder, saddle anesthesia, bilateral lower extremity weakness or numbness, progressive neurologic deficit) are assumed not to be present. Further, cancer-related red flags (e.g., history of cancer, unexplained weight loss, night pain), infection-related red flags (e.g., persistent fever, history of IV drug abuse, immunocompromised status, recent bacterial infection), and fractures are also assumed not to be present. It is assumed that the scenarios do not apply to pregnant women, for whom exposure to ionizing radiation would not be appropriate. Injections of contrast medium, local anesthetics, or corticosteroids are assumed to be contraindicated in patients who have allergies to these agents. Patients with contraindications to injections of these agents for other reasons are also excluded (*e.g.,* steroid injections in brittle diabetics). Finally, this AUC is not applicable to patients with positive spine (excluding SIJ) or hip diagnostic injections.

It is assumed that the clinical scenarios are a snapshot in time. The clinical scenarios do not account for changes in symptoms and other findings that may occur during follow-up. That is, a patient presenting initially in one scenario may subsequently present in a different scenario on follow-up. Furthermore, the AUC rating panel acknowledges that each AUC scenario is a generalization based only on a handful of prognostic factors and only these factors were considered when voting was conducted. It is assumed that the scenarios apply to an average patient presenting to an average physician who performs the procedure in an average facility. Additional factors, such as patient age and participation in competitive sports might alter the vote for any specific scenario.

It is important to highlight that the modules addressing Clinical Indications and Imaging (1.1-1.5) and Timing of Interventions (3) address the appropriateness of the procedure(s) as a first procedure(s) in confirming the presence of SIJ or posterior sacroiliac complex pain. Reference to provocation testing throughout these modules is assumed to address sacroiliac joint maneuvers, unless otherwise stipulated as hip. In addition, the AUC rating panel wishes to suggest that lateral branch blocks are not appropriate as a first intervention. The modules on Number of Injections (4.1-4.3) and Lateral Branch Radiofrequency Neurotomy (5.1-5.2) address the appropriateness of subsequent diagnostic and treatment procedures based upon findings of the initial procedures.

The AUC rating panel notes that there are geographic practice variations that come into play, and are a matter of preference for both the treating physician and patient. In the U.S., many physicians add steroid to diagnostic injections to treat those patients who will have a positive response to the block. This reduces the number of office visits, number of injections required, and potentially minimizes risk of complications from additional injections. This is not common practice in other countries where the standard of care involves first administering a diagnostic block of pure local anesthetic, and treating with an injection of steroid only those patients who obtain positive responses to the previous diagnostic block(s). This minimizes exposure to steroid for patients that would not benefit from a therapeutic injection. The panel members acknowledge that there are risks and benefits to both practices.  
  
**CONDITIONS NOT COVERED WITHIN THIS DOCUMENT**  
These conditions listed below are specifically not addressed in this AUC; there is no comment regarding recommendations for treatment or non-treatment for these patients:

* Lumbar radiculopathy
* Lumbar stenosis
* Lumbar compression fracture
* Severe multilevel lumbar degenerative disc disease with or without spinal deformity

**Disclaimer**  
Volunteer physicians from multiple medical specialties created and categorized these Appropriate Use Criteria. These Appropriate Use Criteria are not intended to be comprehensive or a fixed protocol, as some patients may require more or less treatment or different means of diagnosis. These Appropriate Use Criteria represent patients and situations that clinicians treating or diagnosing musculoskeletal conditions are most likely to encounter. The clinician’s independent medical judgment, given the individual patient’s clinical circumstances and preferences, should always determine patient care and treatment. Practitioners are advised to consider management options in the context of their own training and background and institutional capabilities when selecting recommended treatment options.