

Clinical Policy: Sacroiliac Joint Interventions for Pain Management

Reference Number: CP.MP.166

Date of Last Revision: 08/22

[Coding Implications](#)

[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

Description

Treatment for sacroiliac joint (SIJ) dysfunction is usually conservative (non-surgical) and focuses on trying to restore normal motion in the joint. In patients who have failed to respond to conservative therapy, an SIJ injection can be helpful for both diagnostic and therapeutic purposes. SIJ injections into the synovial sac of the SIJ may provide immediate and significant pain relief.

Policy/Criteria

It is the policy of health plans affiliated with Centene Corporation[®] that invasive pain management procedures performed by a physician are **medically necessary** when *the relevant criteria are met and the patient receives only one procedure per visit, with or without radiographic guidance.*

- I. Sacroiliac joint injections are **medically necessary** for the following indications:
 - A. *One diagnostic or therapeutic sacroiliac joint (SIJ) injection* for SIJ pain, all of the following:
 1. Somatic or nonradicular low back and lower extremity pain below the level of L5 vertebra that interferes with activities of daily living (ADLs) for at least 3 months;
 2. Tenderness by palpation present over SIJ;
 3. There is a positive response to at least three SIJ pain provocation tests (distraction, compression, thigh thrust, Gaenslen's, Patrick's test/FABER test, or sacral thrust);
 4. The member/enrollee has failed to respond to conservative therapy including all of the following:
 - a. ≥ 6 weeks chiropractic, physical therapy or prescribed home exercise program;
 - b. Nonsteroidal anti-inflammatory drugs (NSAIDs) ≥ 3 weeks or NSAIDs contraindicated or not tolerated;
 - c. ≥ 6 weeks activity modification;
 5. Clinical findings and imaging studies, when available, lack obvious evidence for disc-related or facet joint pain;
 6. No other possible diagnosis is more likely.
 - B. *A second diagnostic or confirmatory sacroiliac joint injection* when pain was improved by at least 75% after the first diagnostic SIJ injection and at least 2 weeks have passed since the initial injection.
 - C. *Subsequent therapeutic SIJ injections* for recurrence of pain, all of the following:
 1. Initial therapeutic injection(s) led to $\geq 50\%$ relief and functional improvement for at least 2 months;

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2. Request is for SIJ administered for temporary relief of lower back pain in conjunction with other noninvasive treatment methods (e.g., to participate in physical therapy), and not as a stand-alone therapy;
3. SIJ injection is given at intervals at least 2 months apart;
4. Less than 4 therapeutic SIJ injections have been given at the same site in the last 12 months.

II. It is the policy of health plans affiliated with Centene Corporation that if pain does not improve by $\geq 75\%$ after the second diagnostic SIJ injection, *subsequent SIJ injections* are **not medically necessary** because effectiveness has not been established.

III. It is the policy of health plans affiliated with Centene Corporation that *continuation of injections* beyond 12 months is considered **not medically necessary** because effectiveness and safety have not been established. When more definitive therapies cannot be tolerated or provided, consideration will be made on a case by case basis.

IV. It is the policy of health plans affiliated with Centene Corporation that *sacroiliac nerve blocks* are considered **not medically necessary** because effectiveness has not been established.

V. It is the policy of health plans affiliated with Centene Corporation that *radiofrequency neurotomy (conventional, cooled, and pulsed)* of the SIJ is considered **not medically necessary** because effectiveness has not been established. High-quality studies are lacking for conventional and pulsed radiofrequency neurotomy of the SIJ. For cooled radiofrequency neurotomy, additional well-designed studies are needed to evaluate effectiveness.

Background

Sacroiliac Joint Injections

Treatment for sacroiliac joint dysfunction is usually conservative (non-surgical) and focuses on trying to restore normal motion in the joint. In patients who have failed 4 to 6 weeks of a comprehensive exercise program, local icing, mobilization/manipulation and NSAIDs, an SIJ injection can be helpful for both diagnostic and therapeutic purposes. SIJ injections into the synovial sac of the SIJ may provide immediate and significant pain relief. Adding a steroid to the solution injected may help to reduce any inflammation that may exist within the joint(s) and result in a prolonged period of freedom from pain.⁸

A study by Visser et al. evaluated the effect of manual therapy and physiotherapy versus SIJ injection for low back and leg pain using a single-blinded randomized trial of treatment for 51 patients with SIJ-related leg pain. The effect of the treatment was evaluated after 6 and 12 weeks. Manual therapy had a significantly better success rate than physiotherapy ($p = 0.003$). The authors concluded in the small single-blinded prospective study, manual therapy appeared to be the choice of treatment for patients with SIJ-related leg pain.¹ A second choice of treatment to be considered is an intra-articular injection.^{1,22}

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SIJ Radiofrequency Neurotomy

A growing number of studies have assessed the effect of treatment with radiofrequency denervation on SIJ pain, with mixed results. Radiofrequency denervation, also known as RFA or radiofrequency neurotomy, describes the use of radiofrequency energy to stop the transmission of pain signals to the central nervous system.⁵ One study found no difference between conventional radiofrequency ablation (RFA) and a sham treatment on pain relief.² A 2017 publication of 3 randomized controlled trials of 681 participants with chronic low back pain found no statistically significant improvement in pain from treatment with a standardized exercise program plus RFA, versus the standardized exercise program alone.³ A systematic review of 12 randomized controlled trials measuring the efficacy of radiofrequency neurotomy to manage chronic low back pain showed moderate evidence for both short-term and long-term improvement.²³ Ho and colleagues noted that radiofrequency denervation of the sacroiliac joint (SIJ) have been inconsistent because the variable sensory supply to the SIJ is difficult to disrupt completely using conventional ablation. The authors concluded that denervation showed long-term effectiveness for up to two years in the treatment of SIJ pain. However, there are limitations of this study included with small sample size with a retrospective review with no placebo-control or sham-control group.²⁴ The American Society of Interventional Pain Physicians 2013 guidelines rate the evidence for cooled RFA as fair, and limited for conventional and pulsed RFA.⁵ The North American Spine Society (NASS) guidelines indicate that consideration can be given to cooled RFA of the sacral lateral branch nerves and dorsal ramus of L₅ for patients with sacroiliac joint pain diagnosed with dual diagnostic blocks. Additional randomized trials are required to compare the various nerve ablation techniques of the lateral branch nerves for sacroiliac joint pain.^{5,22}

Coding Implications

This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2020, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

CPT Code that supports coverage criteria

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

CPT code that does not support coverage criteria

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CPT® Codes	Description
64451	Injection(s), anesthetic agent(s) and/or steroid; nerves innervating the sacroiliac joint, with image guidance (ie, fluoroscopy or computed tomography)
64625	Radiofrequency ablation, nerves innervating the sacroiliac joint, with image guidance (ie, fluoroscopy or computed tomography)

HCPCS code that supports coverage criteria

HCPCS Codes	Description
G0260	Injection procedure for sacroiliac joint; provision of anesthetic, steroid and/or other therapeutic agent, with or without arthrography

ICD-10-CM diagnosis codes that support coverage criteria

+ Indicates a code requiring an additional character

ICD 10 CM Code	Description
M43.08	Spondylolysis, sacral and sacrococcygeal region
M46.1	Sacroiliitis, not elsewhere classified
M47.818	Spondylosis without myelopathy or radiculopathy, sacral and sacrococcygeal region
M53.3	Sacrococcygeal disorders, not elsewhere classified
M53.87	Other specified dorsopathies, lumbosacral region
M53.88	Other specified dorsopathies, sacral and sacrococcygeal region
M54.30 through M54.32	Sciatica
M54.40 through M54.42	Lumbago with sciatica
M54.5	Low back pain
M54.89	Other dorsalgia
M54.9	Dorsalgia, unspecified

Reviews, Revisions, and Approvals	Revision Date	Approval Date
Policy split from CP.MP.118 Injections for Pain Management. Minor rewording for clarity. Clarified II. by adding “≥ 50%” to the statement. Background updated.	08/18	08/18
Annual review of policy. Minor wording changes to match language in other pain injection policies. References reviewed and updated, with two additional references added. Specialty review completed. Reworded II. for clarity.	08/19	08/19
Added New 2020 CPT code- 64625 as not medically necessary. Added criteria stating SIJ nerve blocks as not medically necessary, along with code 64451.	01/20	02/20

Reviews, Revisions, and Approvals	Revision Date	Approval Date
Added Patrick’s test/FABER test as an acceptable pain provocation test in I.A3. References reviewed and updated.	07/20	08/20
Updated I.A. to specify that the criteria applies to therapeutic injections as well as diagnostic. Updated I.B. to state “A second diagnostic or confirmatory sacroiliac joint injection when pain was improved by at least 75% after the first diagnostic SIJ injection”, rather than that pain did not improve. I.C. updated to specify “therapeutic” SIJ injection. II was changed from 50% to 75%. Updated background. Replaced member with member/enrollee in all instances. Changed “review date” in the header to “date of last revision” and “date” in the revision log header to “revision date.”	06/21	06/21
Annual review completed. References reviewed, updated, and reformatted.	08/21	08/21
Annual review completed. Background updated with no impact to criteria. References reviewed and updated. Specialist reviewed.	08/22	08/22

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Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

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This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of member/enrollees. This clinical policy is not intended to recommend treatment for member/enrollees. Member/enrollees should consult with their treating physician in connection with diagnosis and treatment decisions.

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Note: For Medicaid member/enrollees, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Note: For Medicare member/enrollees, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at <http://www.cms.gov> for additional information.

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