Clinical Policy: Sacroiliac Joint Interventions for Pain Management

Reference Number: CP.MP.166 Coding Implications
Date of Last Revision: 07/25 Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

Treatment for sacroiliac joint (SIJ) pain and dysfunction is usually conservative (non-surgical) and focuses on pain relief. 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.

Note: For criteria applicable to Medicare plans, please see MC.CP.MP.166 Sacroiliac Joint Interventions.

Policy/Criteria

I. 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 member/enrollee receives only one procedure per visit, with fluoroscopic or computed tomography (CT) guidance.*

A. Sacroiliac joint injections are medically necessary for the following indications:

1. *One diagnostic or therapeutic sacroiliac joint (SIJ) injection* for SIJ pain, all of the following:
   a. 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 three months;
   b. Tenderness by palpation present over SIJ;
   c. There is a positive response to at least three SIJ pain provocation tests (distraction, compression, thigh thrust/posterior pelvic pain provocation test, Gaenslen's, Patrick's test/FABER test, or sacral thrust [thrust tests may not be recommended in pregnant members/enrollees or those with connective tissue disorders];
   d. The member/enrollee has failed to respond to conservative therapy including all of the following:
      i. Chiropractic, physical therapy, or prescribed home exercise program ≥ four weeks;
      ii. Nonsteroidal anti-inflammatory drugs (NSAIDs) ≥ 3 weeks or NSAIDs contraindicated or not tolerated;
      iii. Activity modification ≥ four weeks;
   e. Clinical findings and imaging studies, when available, lack obvious evidence for disc-related or facet joint pain;
   f. No other possible diagnosis is more likely.

2. *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 two weeks have passed since the initial injection.

3. *Subsequent therapeutic SIJ injections* for recurrence of pain, all of the following:
   a. Initial therapeutic injection(s) led to ≥ 50% relief and functional improvement for at least two months;
   b. Request is for SIJ injection 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;
   c. SIJ injection is given at intervals at least two months apart;
   d. Less than four 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 ≥ 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 c*ontinuation 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 r*adiofrequency 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 (SIJ) Injections

Low back pain is the leading cause of disability globally with the sacroiliac joint (SIJ) being an identifiable cause of chronic low back pain in 15 to 30% of patients.[27,29] Treatment for SIJ dysfunction and pain is usually conservative and focuses on pain relief. In patients who have failed four to six weeks of a comprehensive exercise program, local icing, mobilization/manipulation and nonsteroidal anti-inflammatory durgs (NSAIDs), an SIJ injection can be helpful for both diagnostic and therapeutic purposes.[8,29] The International Association for the Study of Pain (IASP) advised the following criteria for confirming a diagnosis of SIJ pain: pain is present in the SIJ region; stressing the SIJ by performing clinical tests that are selective for the joint replicates the patient's pain; and selectively infiltrating the presumptive symptomatic joint with local anesthetic provides complete relief of the patient's pain.[28] SIJ injections into the synovial sac of the SIJ may provide immediate and significant pain relief. Adding a steroid to the solution injected may reduce any inflammation that may exist within the joint(s) and result in a prolonged period of freedom from pain.[8,29]

A study by Visser et al. (2013) 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 six 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 that 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]

The recommended treatment duration is generally no more than four therapeutic SIJ injection sessions per rolling 12 months; however, when requests are made for continued treatment beyond 12 months, the following documentation can assist with determining medical necessity:

- Pain is severe enough to cause a significant degree of functional disability or vocational disability and providers use established and measurable goals and objective scales to assess functionality and activities of daily living (ADLs) measures.
- SIJ injections provide at least 50% sustained and consistent improvement of pain and/or 50% sustained and consistent objective improvement in function (using same scale as baseline) for at least three months.
- Rationale for the continuation of SIJ injections including but not limited to patients who are high-risk surgical candidates, do not desire surgery, and/or the recurrence of pain in the same location was sustained and consistently relieved with the SIJ injections for at least three months.[26]

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 RFD 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 systematic review evaluating cooled RFA procedures indicated cooled RFA demonstrated short term outcomes improvements of moderate strength of evidence for pain at three months and low for function at one month with no serious complications reported with strength of evidence low.[26] An Agency for Healthcare Research and Quality (AHRQ) report noted that cooled radiofrequency denervation is probably moderately more effective for reducing pain and improving function than sham for sacroiliac pain in younger populations when compared to conventional radiofrequency for presumed facet joint pain.[25] A 2017 publication of three 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 et al. (2013) noted that radiofrequency denervation of the SIJ has 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 as well as trials with greater than 12 months of follow-up for evaluation of long-term pain relief via functional ability and quality of life.[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 2024, 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 codes that do not support coverage criteria

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

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
Updated I.A. to specify that the criteria apply to therapeutic injections as well as diagnostic. Updated I.B. to state "A second diagnostic or	06/21	06/21

Reviews, Revisions, and Approvals	Revision Date	Approval Date
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."		
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
Annual review completed. Added [thrust tests may not be recommended in pregnant members/enrollees or those with connective tissue disorders] to I.A.1.c. for clarity. Updated time requirements in I.A.1.d.i. and iii. to reflect 4 weeks. Minor rewording with no clinical significance. Background updated. ICD-10 Diagnosis Code table removed. References reviewed and updated. Internal specialist reviewed.	08/23	08/23
Annual review. References reviewed and updated. Reviewed by external specialist.	07/24	07/24
Annual review. Description and background updated with no clinical significance. Added note regarding criteria applicable to Medicare plans. Updated I. to specify that imaging guidance must be fluoroscopic or computed tomography. Added "posterior pelvic pain provocation test" to I.A.1.c. for clarity. Coding reviewed. References reviewed and updated.	07/25	07/25

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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

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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.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

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.