Medical Policy
Diagnosis and Treatment of Sacroiliac Joint Pain

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Policy Number: 320
BCBSA Reference Number: 6.01.23
NCD/LCD:
- Local Coverage Determination (LCD): Pain Management (L33622)
- Local Coverage Determination (LCD): Minimally-invasive Surgical (MIS) Fusion of the Sacroiliac (SI) Joint (L36406)

Related Policies
- Facet Joint Denervation, #140
- Percutaneous Vertebroplasty and Sacroplasty, 484
- Prolotherapy, Joint Sclerotherapy and Ligamentous Injections with Sclerosing Agents, #183

Policy
Commercial Members: Managed Care (HMO and POS), PPO, and Indemnity

Arthrography of the sacroiliac joint is INVESTIGATIONAL.

Injection of anesthet for diagnosing sacroiliac joint pain may be considered MEDICALLY NECESSARY when the following criteria have been met:
- Pain has failed to respond to 3 months of conservative management, which may consist of therapies such as nonsteroidal anti-inflammatory medications, acetaminophen, manipulation, physical therapy, and a home exercise program; AND
- Dual (controlled) diagnostic blocks with 2 anesthetic agents with differing duration of action are used; AND
- The injections are performed under imaging guidance.

Injection of corticosteroid may be considered MEDICALLY NECESSARY for the treatment of sacroiliac joint pain when the following criteria have been met:
- Pain has failed to respond to 3 months of conservative management, which may consist of therapies such as nonsteroidal anti-inflammatory medications, acetaminophen, manipulation, physical therapy, and a home exercise program; AND
- The injection is performed under imaging guidance; AND
- No more than 3 injections are given in one year.
Radiofrequency denervation of the sacroiliac joint is INVESTIGATIONAL.

Fusion/stabilization of the sacroiliac joint for the treatment of back pain presumed to originate from the sacroiliac joint is INVESTIGATIONAL, including but not limited to percutaneous and minimally invasive techniques.

Medicare HMO BlueSM and Medicare PPO BlueSM Members

Medical necessity criteria and coding guidance for Medicare Advantage members living in Massachusetts can be found through the links below.

Local Coverage Determination (LCD): Pain Management (L33622)

Local Coverage Determination (LCD): Minimally-invasive Surgical (MIS) Fusion of the Sacroiliac (SI) Joint (L36406)

For medical necessity criteria and coding guidance for Medicare Advantage members living outside of Massachusetts, please see the Centers for Medicare and Medicaid Services website for information regarding your specific jurisdiction at https://www.cms.gov.

Prior Authorization Information

Pre-service approval is required for all inpatient services for all products. See below for situations where prior authorization may be required or may not be required.

Yes indicates that prior authorization is required.

No indicates that prior authorization is not required.

N/A indicates that this service is primarily performed in an inpatient setting.

<table>
<thead>
<tr>
<th></th>
<th>Outpatient</th>
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<tbody>
<tr>
<td>Commercial Managed Care (HMO and POS)</td>
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<tr>
<td>Commercial PPO and Indemnity</td>
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<tr>
<td>Medicare HMO BlueSM</td>
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<tr>
<td>Medicare PPO BlueSM</td>
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CPT Codes / HCPCS Codes / ICD Codes

Inclusion or exclusion of a code does not constitute or imply member coverage or provider reimbursement. Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage as it applies to an individual member.

Providers should report all services using the most up-to-date industry-standard procedure, revenue, and diagnosis codes, including modifiers where applicable.

The following codes are included below for informational purposes only; this is not an all-inclusive list.

The above medical necessity criteria MUST be met for the following codes to be covered for Commercial Members: Managed Care (HMO and POS), PPO and Indemnity:

CPT Codes

<table>
<thead>
<tr>
<th>CPT codes: codes:</th>
<th>Code Description</th>
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<tbody>
<tr>
<td>27096</td>
<td>Injection procedure for sacroiliac joint, anesthetic/steroid, with image guidance (fluoroscopy or CT) including arthrography when performed</td>
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HCPCS Codes

<table>
<thead>
<tr>
<th>HCPCS codes:</th>
<th>Code Description</th>
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<tbody>
<tr>
<td>G0259</td>
<td>Injection procedure for sacroiliac joint; arthrography</td>
</tr>
<tr>
<td>G0260</td>
<td>Injection procedure for sacroiliac joint; provision of anesthetic, steroid and/or other therapeutic agent, with or without arthrography</td>
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The following CPT code is considered investigational for Commercial Members: Managed Care (HMO and POS), PPO, and Indemnity:

CPT Codes

<table>
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<tr>
<th>CPT codes: codes:</th>
<th>Code Description</th>
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<tbody>
<tr>
<td>27279</td>
<td>Arthrodesis, sacroiliac joint, percutaneous or minimally invasive (indirect visualization), with image guidance, includes obtaining bone graft when performed, and placement of transfixing device</td>
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Description

Similar to other structures in the spine, it is assumed that the sacroiliac joint (SIJ) may be a source of low back pain. In fact, before 1928, the SIJ was thought to be the most common cause of sciatica. In 1928, the role of the intervertebral disc was elucidated, and from that point forward, the SIJ received less research attention.

Research into SIJ pain has been plagued by lack of a criterion standard to measure its prevalence and against which various clinical examinations can be validated. For example, SIJ pain is typically without any consistent, demonstrable radiographic or laboratory features and most commonly exists in the setting of morphologically normal joints. Clinical tests for SIJ pain may include various movement tests, palpation to detect tenderness, and pain descriptions by the patient. Further confounding study of the sacroiliac joint is that multiple structures, (eg, posterior facet joints, lumbar discs) may refer pain to the area surrounding the SIJ.

Because of inconsistent information obtained from history and physical examination, some have proposed the use of image-guided anesthetic injection into the SIJ for the diagnosis of SIJ pain. Treatments being investigated for SIJ pain include prolotherapy, corticosteroid injection, radiofrequency ablation, stabilization, and arthrodesis.

Summary

Sacroiliac joint arthrography using fluoroscopic guidance with injection of an anesthetic has been explored as a diagnostic test for sacroiliac joint (SIJ) pain. Duplication of the patient’s pain pattern with the injection of contrast medium suggests a sacroiliac etiology, as does relief of chronic back pain with injection of local anesthetic. Treatment of SIJ pain with corticosteroids, radiofrequency ablation (RFA), stabilization, or minimally invasive SIJ fusion has also been explored.

For individuals who have SIJ pain who receive therapeutic corticosteroid injections, the evidence includes small randomized controlled trials (RCTs) and case series. Relevant outcomes are symptoms, functional outcomes, quality of life, medication use, and treatment-related morbidity. In general, the literature on injection therapy of joints in the back is of poor quality. Results from 2 small RCTs showed that therapeutic SIJ steroid injections were not as effective as other active treatments. Larger trials, preferably using sham injections, are needed to determine the degree of benefit of corticosteroid injections over placebo. The evidence is insufficient to determine the effects of the technology on health outcomes. For individuals who have SIJ pain who receive RFA, the evidence includes 4 small RCTs using different techniques of applying radiofrequency and case series. Relevant outcomes are symptoms, functional outcomes, quality of life, medication use, and treatment-related morbidity. For RFA with a cooled probe, the 2 small RCTs reported short-term benefits, but these are insufficient to determine the overall effect on
health outcomes. The RCT on palisade RFA of the sacroiliac joint did not include a sham control. Another sham-controlled RCT showed no benefit of RFA. Further high-quality controlled trials are needed that compare this procedure in defined populations with sham control and with alternative treatments. The evidence is insufficient to determine the effects of the technology on health outcomes.

For individuals who have SIJ pain who receive SIJ fusion, the evidence includes 2 RCTs of minimally invasive fusion and a number of case series. Relevant outcomes are symptoms, functional outcomes, quality of life, medication use, and treatment-related morbidity. Both nonblinded RCTs reported superior short-term results for fusion, but there is potential for bias because these trials lacked sham controls and used subjective outcome measures. Two case series of reasonable size and good follow-up showed that benefits obtained at 6 months persist to 2 years. One small case series showed good outcomes persist to 5 years. The case series are consistent with durability of treatment benefit, but only if there is a true benefit of treatment. The evidence is insufficient to determine the effects of the technology on health outcomes.

Clinical input has supported the use of controlled diagnostic blocks with at least 75% pain reduction for diagnosis of sacroiliac pain. Clinical input supported the use of corticosteroids for the treatment of SIJ pain. Based on clinical input and the established use of injections to diagnose and treat pain in other joints, controlled diagnostic (2 blocks with anesthetics of different duration) and therapeutic (corticosteroid) injections may be considered medically necessary for the diagnosis and treatment of SIJ pain.

**Policy History**

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**Information Pertaining to All Blue Cross Blue Shield Medical Policies**

Click on any of the following terms to access the relevant information:

- Medical Policy Terms of Use
- Managed Care Guidelines
- Indemnity/PPO Guidelines
- Clinical Exception Process
- Medical Technology Assessment Guidelines

**References**


30. Cher DJ, Reckling WC, Capobianco RA. Implant survivorship analysis after minimally invasive sacroiliac joint fusion using the iFuse Implant System((R)). Med Devices (Auckl). 2015;8:485-492. PMID 26648762


