| | |
|---|---|
| **Policy Number** | **SUR705.043** |
| **Policy Effective Date** | **02/01/2025** |
| **Policy End Date** | **12/31/2025** |

# Sacroiliac Joint Injections

| Table of Contents |
|---|
|  |
|  |
|  |
|  |
|  |
|  |
|  |

| Related Policies (if applicable) |
|---|
| SUR705.033 Sacroiliac Joint Fusion or Stabilization |
| MED201.013 Prolotherapy |
| |
| |
| |
| |
| |

## Disclaimer

**Carefully check state regulations and/or the member contract.**
Each benefit plan, summary plan description or contract defines which services are covered, which services are excluded, and which services are subject to dollar caps or other limitations, conditions or exclusions. Members and their providers have the responsibility for consulting the member's benefit plan, summary plan description or contract to determine if there are any exclusions or other benefit limitations applicable to this service or supply. **If there is a discrepancy between a Medical Policy and a member's benefit plan, summary plan description or contract, the benefit plan, summary plan description or contract will govern.**

## Coverage

Injection of anesthetic for diagnosing sacroiliac joint pain **may be considered medically necessary** when **ALL** 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 (See **NOTE 1**); **and**
- Dual (controlled) diagnostic blocks with 2 anesthetic agents with differing duration of action are used (See **NOTE 2**); **and**
- The injections are performed under imaging guidance.

Injection of corticosteroid **may be considered medically necessary** for the treatment of sacroiliac joint pain when **ALL** 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 (See **NOTE 1**); **and**

- The injection is performed under imaging guidance; **and**
- No more than 3 injections are given in 1 year.

**NOTE 1:** Conservative nonsurgical therapy for the duration specified should include the following:

- Use of prescription-strength analgesics for several weeks at a dose sufficient to induce a therapeutic response. Analgesics should include anti-inflammatory medications with or without adjunctive medications such as nerve membrane stabilizers or muscle relaxants, and
- Participation in at least 6 weeks of physical therapy (including active exercise) or documentation of why the patient could not tolerate physical therapy, and
- Evaluation and appropriate management of associated cognitive, behavioral, or addiction issues, and
- Documentation of compliance with the preceding criteria.

**NOTE 2:** A successful trial of controlled diagnostic lateral branch blocks consists of 2 separate positive blocks on different days with local anesthetic only (no steroids or other drugs), or a placebo-controlled series of blocks, under fluoroscopic guidance, that has resulted in a reduction in pain for the duration of the local anesthetic used (e.g., 3 hours longer with bupivacaine than lidocaine). There is no consensus on whether a minimum of 50% or 75% reduction in pain would be required to be considered a successful diagnostic block, although evidence supported a criterion standard of 75% to 100% reduction in pain with dual blocks. No therapeutic intra-articular injections (i.e., steroids, saline, other substances) should be administered for a period of at least 4 weeks before the diagnostic block. The diagnostic blocks should not be conducted under intravenous sedation unless specifically indicated (e.g., the patient is unable to cooperate with the procedure).

## Policy Guidelines

None.

## Description

**Sacroiliac Joint Pain**

Similar to other structures in the spine, it is assumed 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.

Diagnosis

Research into SIJ pain has been plagued by a 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 the study of the SIJ is that multiple structures, (e.g., 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.

## Rationale

This medical policy was created in September 2020 and has been updated regularly with searches of the PubMed database. The most recent literature update was performed through October 4, 2022.

**Diagnosis of Sacroiliac Joint Pain**
Medical policies assess whether a medical test is clinically useful. A useful test provides information to make a clinical management decision that improves the net health outcome. That is, the balance of benefits and harms is better when the test is used to manage the condition than when another test or no test is used to manage the condition.

The first step in assessing a medical test is to formulate the clinical context and purpose of the test. The test must be technically reliable, clinically valid, and clinically useful for that purpose. Medical policies assess the evidence on whether a test is clinically valid and clinically useful. Technical reliability is outside the scope of these policies, and credible information on technical reliability is available from other sources.

The use of diagnostic blocks to evaluate sacroiliac joint (SIJ) pain builds on the use of diagnostic blocks to evaluate pain in other joints. Blinded studies with placebo controls, although difficult to conduct when dealing with invasive procedures, are ideally required for scientific validation of SIJ blocks, particularly when dealing with pain relief well-known to respond to placebo controls. In the typical evaluation of a diagnostic test, the results of the sacroiliac diagnostic block would then be compared with a criterion standard. However, no current criterion standard for SIJ disease exists. In fact, some have positioned SIJ injection as the criterion standard against which other diagnostic tests and physical exam may be measured. (1) Ultimately, the point of diagnosis is to select patients appropriately for treatment that improves outcomes. Diagnostic tests that differentiate patients who do or do not benefit from a particular treatment are clinically useful.

<u>Clinical Context and Test Purpose</u>

The purpose of diagnostic SIJ block in patients who have suspected SIJ pain is to inform a decision whether to proceed to appropriate treatment.

The question addressed in this medical policy is: Does the use of a diagnostic SIJ block improve the net health outcome in patients who have suspected SIJ pain?

The following PICO was used to select literature to inform this policy.

*Populations*
The relevant population of interest are individuals with suspected SIJ pain.

*Interventions*
The test being considered is a diagnostic SIJ block. Sacroiliac blocks are administered under imaging guidance using a local anesthetic in an outpatient setting.

*Comparators*
The following practice is currently being used to diagnose SIJ pain: standard of care, which can include physical provocative tests to induce pain and diagnostic imaging. SIJ pain confirmed with at least 3 physical provocative tests and ≥50% acute decrease in pain upon SIJ diagnostic block following failed conservative management reflect typical criteria.

*Outcomes*
The general outcomes of interest are an accurate diagnosis, reductions in pain and medication usage, improvement in functional outcomes (e.g., activities of daily living), improvement in the quality of life (QOL), and adverse events. A diagnostic result should be available within one to two hours post injection.

Study Selection Criteria
For the evaluation of the clinical validity of a diagnostic SIJ block, studies that meet the following eligibility criteria were considered:

- Reported on the accuracy of the marketed version of the technology (including any algorithms used to calculate scores);
- Included a suitable reference standard (including a description of the reference standard);
- Patient/sample clinical characteristics were described;
- Patient/sample selection criteria were described.

Clinically Valid
A test must detect the presence or absence of a condition, the risk of developing a condition in the future, or treatment response (beneficial or adverse).

*Systematic Reviews*
Simopoulous et al. (2015) conducted a systematic review evaluating 11 diagnostic accuracy studies. (2) Studies were heterogeneous in-patient selection, SIJ block procedure, assessment, and pain relief cutoff thresholds for diagnosis confirmation, which ranged from 50 to 90%

reduction in pain. Four studies utilizing single blocks assessed at a cutoff threshold of at least a 75% decrease in pain score were found to have variable SIJ pain prevalence estimates of 10% to 64%. Eight studies utilizing dual blocks assessed at a cutoff threshold of at least a 70% decrease in pain score were found to have variable SIJ pain prevalence estimates of 10% to 40.4% with corresponding false-positive rates of 22% to 26%. The evidence for dual blocks was graded Level II.

Manchikanti et al. (2013) updated an evidence review with guidelines on the diagnosis of SIJ pain for the American Society of Interventional Pain Physicians. (3) Various studies evaluating diagnostic blocks were reviewed in which the criteria for a positive test varied from 50% to 100% relief from either single or dual blocks. The most stringent criterion (75% to 100% relief with dual blocks) was evaluated in 7 studies. The prevalence of a positive test in the 7 studies ranged from 10% to 44.4% in patients with suspected sacroiliac disease. The evidence for diagnostic sacroiliac intra-articular injections was considered to be good using 75% to 100% pain relief with single or dual blocks as the criterion standard.

Manchikanti et al. (2010) published 2 systematic reviews for interventional techniques for treatment and diagnosis of low back pain. (4, 5) Evidence for diagnostic sacroiliac injections was considered to be fair to poor, and no additional literature was identified since a systematic review by Rupert et al. (2009). (6)

Chou et al. (2009) conducted 2 systematic reviews at the Oregon Evidence-based Practice Center that informed practice guidelines from the American Pain Society. (7, 8) The systematic reviews concluded that no reliable evidence existed to evaluate the validity or utility of diagnostic SIJ block as a diagnostic procedure for low back pain with or without radiculopathy, with a resulting guideline recommendation of insufficient evidence. Data on SIJ steroid injection were limited to a small controlled trial, resulting in a recommendation of insufficient evidence for therapeutic injection of this joint.

Clinically Useful

A test is clinically useful if the use of the results informs management decisions that improve the net health outcome of care. The net health outcome can be improved if patients receive correct therapy, or more effective therapy, or avoid unnecessary therapy, or avoid unnecessary testing.

*Direct Evidence*

Direct evidence of clinical utility is provided by studies that have compared health outcomes for patients managed with and without the test. Because these are intervention studies, the preferred evidence would be from randomized controlled trials (RCTs).

Direct evidence supporting the clinical utility of using diagnostic SIJ blocks in this population was not identified.

*Chain of Evidence*

Indirect evidence on clinical utility rests on clinical validity. If the evidence is insufficient to demonstrate test performance, no inferences can be made about clinical utility.

Because the clinical validity of diagnostic SIJ blocks has not been established, a chain of evidence cannot be constructed.

Section Summary: Diagnosis of Sacroiliac Joint Pain

Findings from systematic reviews assessing the utility of diagnostic SIJ blocks are conflicting. In addition, there is no independent reference standard for the diagnosis of SIJ pain.

**Treatment of SIJ Pain**

Medical policies assess the clinical evidence to determine whether the use of technology improves the net health outcome. Broadly defined, health outcomes are the length of life, quality of life (QOL), and ability to function-including benefits and harms. Every clinical condition has specific outcomes that are important to patients and managing the course of that condition. Validated outcome measures are necessary to ascertain whether a condition improves or worsens; and whether the magnitude of that change is clinically significant. The net health outcome is a balance of benefits and harms.

To assess whether the evidence is sufficient to draw conclusions about the net health outcome of technology, two domains are examined: the relevance, and quality and credibility. To be relevant, studies must represent one or more intended clinical use of the technology in the intended population and compare an effective and appropriate alternative at a comparable intensity. For some conditions, the alternative will be supportive care or surveillance. The quality and credibility of the evidence depend on study design and conduct, minimizing bias and confounding that can generate incorrect findings. The RCT is preferred to assess efficacy; however, in some circumstances, nonrandomized studies may be adequate. RCTs are rarely large enough or long enough to capture less common adverse events and long-term effects. Other types of studies can be used for these purposes and to assess generalizability to broader clinical populations and settings of clinical practice.

**Treatment of SIJ Pain: Therapeutic Corticosteroid Injections**

Clinical Context and Therapy Purpose

The purpose of therapeutic corticosteroid injections is to provide a treatment option that is an alternative to or an improvement on existing therapies in patients with SIJ pain.

The question addressed in this medical policy is: Does the use of therapeutic corticosteroid injections improve the net health outcome in individuals with SIJ pain?

The following PICO was used to select literature to inform this policy.

*Populations*

The relevant population of interest are individuals with SIJ pain.

*Interventions*
The therapy being considered is a therapeutic corticosteroid injection.

*Comparators*
The following therapy is currently being used to treat SIJ: conservative management, including physical therapy.

*Outcomes*
The general outcomes of interest are symptoms (e.g., reductions in pain), functional outcomes, QOL, reductions in medication use, and treatment related morbidity. Follow-up at 3 to 15 months is of interest to monitor outcomes.

Study Selection Criteria
Methodologically credible studies were selected using the following principles:

- Reported on the accuracy of the marketed version of the technology (including any algorithms used to calculate scores);
- Included a suitable reference standard (including a description of the reference standard);
- Patient/sample clinical characteristics were described;
- Patient/sample selection criteria were described.

Systematic Reviews
Hansen et al. (2012) published a systematic review of SIJ interventions. (9) The primary outcome was short-term (≤6 months) or long-term (>6 months) pain relief. Evidence was classified as good, fair, or limited/poor based on the quality of evidence. Eleven studies (six randomized, five nonrandomized trials) met the inclusion criteria. Reviewers found that evidence for intra-articular steroid injections was limited or poor, as was the evidence for periarticular injections (local anesthetic and steroid or botulinum toxin). The American Society of Interventional Pain Physicians' (2013) evidence review by Manchikanti et al. (2013) (3) found no additional studies on intra-articular or periarticular injections besides those identified by Hansen et al. (2012).

Randomized Controlled Trials
Tables 1 and 2 summarize the characteristics and results of select RCTs.

A trial by Visser et al. (2013) randomized 51 patients with SIJ and leg pain to physical therapy, manual therapy, or intra-articular injection of corticosteroid. (10) Diagnosis of SIJ pain was based on provocation tests and not SIJ injections. In a blinded assessment, 25 (56%) patients were considered to be successfully treated at the 12-week follow-up visit based on complete relief of pain and improvement in the visual analog scale (VAS) score for pain.

Kim et al. (2010) reported a randomized, double-blind, controlled trial of intra-articular prolotherapy compared with steroid injection for SIJ pain. (11) The trial included 48 patients with SIJ pain. Intra-articular dextrose water prolotherapy or steroid injections were administered under fluoroscopic guidance on a biweekly schedule, with a maximum of 3

injections. Injections were stopped when pain relief was 90% or greater, which required a mean of 2.7 prolotherapy injections and 1.5 steroid injections. Pain (numeric rating scale) and disability (Oswestry Disability Index [ODI]) scores were assessed at baseline, two weeks, and then monthly on completing treatment. At the two-week follow-up, pain and disability scores were significantly improved in both groups, with no significant difference between groups. The numeric rating scale pain score improved from 6.3 to 1.4 in the prolotherapy group and from 6.7 to 1.9 in the steroid group. At 6 months after treatment, 63.6% of patients in the prolotherapy group remained improved from baseline (≥50%), compared with 27.2% in the steroid group. At the 15-month follow-up, the cumulative incidence of sustained pain relief was 58.7% in the prolotherapy group compared with 10.2% in the steroid group. The median duration of the recurrence of severe SIJ pain was three months for the steroid group.

**Table 1. Characteristics of Key RCTs Assessing Therapeutic Corticosteroid Injection**

| Study | Countries | Sites | Dates | Participants | Interventions | |
|---|---|---|---|---|---|---|
| | | | | | ***Active*** | ***Comparator*** |
| Visser et al. (2013) (10) | NL | 1 | NR | Diagnosed with SIJ pain and/or leg pain between 4 weeks and 1 year in duration | 18 patients randomized to IA injection | 15 patients randomized to PT and 18 to manual therapy |
| Kim et al. (2010) (11) | Korea | 1 | NR | Diagnosed with SIJ pain[a] who failed additional 1-month treatment | 24 patients randomized to IA prolotherapy; 23 analyzed | 26 patients randomized to steroid; 26 analyzed |

IA: intra-articular; NL: The Netherlands; NR: not reported; PT: physical therapy; RCT randomized controlled trial; SIJ: sacroiliac joint.

[a] Confirmed by ≥50% improvement in response to a single local anesthetic block.

**Table 2. Results of Key RCTs Assessing Therapeutic Corticosteroid Injection**

| Study | Pain Outcomes | | Functional Outcomes | |
|---|---|---|---|---|
| **Visser et al. (2013) (10)** | **VAS (SD)** | | **RAND-36 Physical Functioning[1]** | |
| | **Baseline** | **3 Months** | **Baseline** | **3 Months** |
| Intra-articular corticosteroid injection | 5.7 (1.7) | 5.0 (1.9) | 45.3 (16.8) | 37.9 (15.4) |
| Physical Therapy | 4.3 (1.2) | 3.9 (1.4) | 27.5 (6.5) | 51.25 (28.7) |
| Manual Therapy | 5.21 (1.4) | 3.3 (2.3) | 30.0 (18.6) | 60.5 (24.3) |
| **Kim et al. (2010) (11)** | **NRS (SD)** | | **ODI (SD)** | |
| | **Baseline** | **2 Weeks** | **Baseline** | **2 Weeks** |
| Steroid | 6.7 (1.0) | 1.4 (1.1) | 36.7 (20.4) | 15.5 (10.7) |
| Prolotherapy | 6.3 (1.1) | 1.4 (1.1) | 33.9 (15.5) | 11.1 (10) |

NRS: Numerical Rating Scale; ODI: Oswestry Disability Index; RCT: randomized controlled trial; VAS: Visual Analog Scale; SD: standard deviation
[1] Survey measures of health-related quality of life scored on a scale from 0 to 100, with 100 representing the highest level of functioning in a given category.

The purpose of the study relevance, conduct, and design limitations tables (see Tables 3 and 4) is to display notable limitations identified in each study. This information is synthesized as a summary of the body of evidence following each table and provides the conclusions on the sufficiency of the evidence supporting the coverage statement.

**Table 3. Relevance Limitations**

| Study | Population[a] | Intervention[b] | Comparator[c] | Outcomes[d] | Follow-up[e] |
|---|---|---|---|---|---|
| Visser et al. (2013) (10) | 4. Patients were recruited on the basis of SIJ-related leg pain with short duration and symptoms. | 2. Unclear which if any patients received a second injection. | | 4-5. Definition of successful treatment did not utilize standard pain relief threshold cutoff of at least 50%. | |
| Kim et al. (2010) (11) | NA | NA | NA | NA | NA |

The study limitations stated in this table are those notable in the current literature review; this is not a comprehensive limitations assessment.
[a] Population key: 1. Intended use population unclear; 2. Clinical context is unclear; 3. Study population is unclear; 4. Study population not representative of intended use.
[b] Intervention key: 1. Not clearly defined; 2. Version used unclear; 3. Delivery not similar intensity as comparator; 4. Not the intervention of interest.
[C] Comparator key: 1. Not clearly defined; 2. Not standard or optimal; 3. Delivery not similar intensity as intervention; 4. Not delivered effectively.
[d] Outcomes key: 1. Key health outcomes not addressed; 2. Physiologic measures, not validated surrogates; 3. No CONSORT reporting of harms; 4. Not establish and validated measurements; 5. Clinical significant difference not prespecified; 6. Clinical significant difference not supported.
[e] Follow-Up key: 1. Not sufficient duration for benefit; 2. Not sufficient duration for harms.

**Table 4. Study Design and Conduct Limitations**

| Study | Allocation[a] | Blinding[b] | Selective Reporting[c] | Data Completeness[d] | Power[e] | Statistical[f] |
|---|---|---|---|---|---|---|
| Visser et al. (2013) (10) | 3. Allocation not described. | 1. Trial was single-blinded. | 1. Not registered. | | 2. Power not calculated for | 3. Confidence intervals and/or *p* |

| | | | | | | |
|---|---|---|---|---|---|---|
| | | | | | primary outcome. | values not reported. |
| Kim et al. (2010) (11) | 3. Allocation not described. | | 1. Not registered. | | | |

The study limitations stated in this table are those notable in the current literature review; this is not a comprehensive limitations assessment.

[a] Allocation key: 1. Participants not randomly allocated; 2. Allocation not concealed; 3. Allocation concealment unclear; 4. Inadequate control for selection bias.

[b] Blinding key: 1. Not blinded to treatment assignment; 2. Not blinded outcome assessment; 3. Outcome assessed by treating physician.

[c] Selective Reporting key: 1. Not registered; 2. Evidence of selective reporting; 3. Evidence of selective publication.

[d] Data Completeness key: 1. High loss to follow-up or missing data; 2. Inadequate handling of missing data; 3. High number of crossovers; 4. Inadequate handling of crossovers; 5. Inappropriate exclusions; 6. No intent to treat analysis (per protocol for noninferiority trials).

[e] Power key: 1. Power calculations not reported; 2. Power not calculated for primary outcome; 3. Power not based on clinically important difference.

[f] Statistical key: 1. Intervention is not appropriate for outcome type: (a) continuous; (b) binary; (c) time to event; 2. Intervention is not appropriate for multiple observations per patient; 3. Confidence intervals and/or p values not reported; 4. Comparative treatment effects not calculated.

Case Series

Case series studies evaluating corticosteroid injections, described in systematic reviews, have shown variable findings at generally short-term follow up. (9, 12)

Section Summary: Therapeutic Corticosteroid Injections

Results from two small trials are insufficient to permit conclusions on the effect of this procedure on health outcomes. Steroid injections were not the most effective treatment in either trial, and the degree of pain relief was limited. Larger trials with rigorous designs, preferably using sham injections, are needed to determine whether the treatment is effective.

**Summary of Evidence**

Diagnostic Injections

For individuals who have suspected sacroiliac joint (SIJ) pain who receive a diagnostic sacroiliac block, the evidence includes systematic reviews. Relevant outcomes are test validity, symptoms, functional outcomes, quality of life (QOL), medication use, and treatment-related morbidity. Current evidence is conflicting on the diagnostic utility of SIJ blocks. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

Therapeutic

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, QOL, medication use, and treatment-related morbidity. In general, the literature on injection therapy of joints in the back is of poor quality. Results from two 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 that the technology results in an improvement in the net health outcome.

**Practice Guidelines and Position Statements**

American Society of Interventional Pain Physicians

In 2013, the American Society of Interventional Pain Physicians guidelines recommend the use of controlled SIJ blocks with placebo or controlled comparative local anesthetic block when indications are satisfied with suspicion of SIJ pain. (3) A positive response to a joint block is considered to be at least a 75% improvement in pain or in the ability to perform previously painful movements. For therapeutic interventions, the only effective modality with fair evidence was cooled radiofrequency neurotomy, when used after the appropriate diagnosis was confirmed by diagnostic SIJ injections.

American Society of Anesthesiologists & American Society of Regional Anesthesia and Pain Medicine

The American Society of Anesthesiologists and the American Society of Regional Anesthesia and Pain Medicine have 2010 guidelines for chronic pain management. (13) The guidelines recommended that "Diagnostic sacroiliac joint injections or lateral branch blocks may be considered for the evaluation of patients with suspected sacroiliac joint pain." Based on the opinions of consultants and society members, the guidelines recommend that "Water-cooled radiofrequency ablation may be used for chronic sacroiliac joint pain."

American Society of Pain and Neuroscience

In 2021, the American Society of Pain and Neuroscience published practice a guideline on radiofrequency neurotomy. (14) All of the workgroup members utilized radiofrequency neurotomy in clinical practice. A consensus statement, based on Grade II-1 evidence (well-designed, controlled, nonrandomized clinical trial), was that "lateral branch radiofrequency neurotomy may be used for the treatment of posterior sacral ligament and joint pain following positive response to appropriately placed diagnostic blocks."

## Coding

Procedure codes on Medical Policy documents are included **only** as a general reference tool for each policy. **They may not be all-inclusive.**

The presence or absence of procedure, service, supply, or device codes in a Medical Policy document has no relevance for determination of benefit coverage for members or reimbursement for providers. **Only the written coverage position in a Medical Policy should be used for such determinations.**

Benefit coverage determinations based on written Medical Policy coverage positions must include review of the member's benefit contract or Summary Plan Description (SPD) for defined coverage vs. non-coverage, benefit exclusions, and benefit limitations such as dollar or duration caps.

| | |
|---|---|
| **CPT Codes** | 27096 |
| **HCPCS Codes** | G0260 |

*Current Procedural Terminology (CPT®) ©2024 American Medical Association: Chicago, IL.

## References


1. Dreyfuss P, Michaelson M, Pauza K, et al. The value of medical history and physical examination in diagnosing sacroiliac joint pain. Spine (Phila Pa 1976). Nov 15 1996; 21(22):2594-2602. PMID 8961447
2. Simopoulos TT, Manchikanti L, Gupta S. et al. Systematic Review of the Diagnostic Accuracy and Therapeutic Effectiveness of Sacroiliac Joint Interventions. Pain Physician. Oct 3 2015; 18(5). PMID 26431129
3. Manchikanti L, Abdi S, Atluri S, et al. An update of comprehensive evidence-based guidelines for interventional techniques in chronic spinal pain. Part II: guidance and recommendations. Pain Physician. Apr 2013; 16(2 Suppl):S49-283. PMID 23615883
4. Manchikanti L, Datta S, Derby R, et al. A critical review of the American Pain Society clinical practice guidelines for interventional techniques: part 1. Diagnostic interventions. Pain Physician. May-Jun 2010; 13(3):E141-174. PMID 20495596
5. Manchikanti L, Datta S, Gupta S, et al. A critical review of the American Pain Society clinical practice guidelines for interventional techniques: part 2. Therapeutic interventions. Pain Physician. Jul-Aug 2010; 13(4):E215-264. PMID 20648212
6. Rupert MP, Lee M, Manchikanti L, et al. Evaluation of sacroiliac joint interventions: a systematic appraisal of the literature. Pain Physician. Mar-Apr 2009; 12(2):399-418. PMID 19305487
7. Chou R, Atlas SJ, Stanos SP, et al. Nonsurgical interventional therapies for low back pain: a review of the evidence for an American Pain Society clinical practice guideline. Spine (Phila Pa 1976). May 1 2009; 34(10):1078-1093. PMID 19363456
8. Chou R, Loeser JD, Owens DK, et al. Interventional therapies, surgery, and interdisciplinary rehabilitation for low back pain: an evidence-based clinical practice guideline from the American Pain Society. Spine (Phila Pa 1976). May 1 2009; 34(10):1066-1077. PMID 19363457
9. Hansen H, Manchikanti L, Simopoulos TT, et al. A systematic evaluation of the therapeutic effectiveness of sacroiliac joint interventions. Pain Physician. May-Jun 2012; 15(3):E247-278. PMID 22622913
10. Visser LH, Woudenberg NP, de Boni J, et al. Treatment of the sacroiliac joint in patients with leg pain: a randomized controlled trial. Eur Spine J. Oct 2013; 22(10):2310-2317. PMID 23720124
11. Kim WM, Lee HG, Jeong CW, et al. A randomized controlled trial of intra-articular prolotherapy versus steroid injection for sacroiliac joint pain. J Altern Complement Med. Dec 2010; 16(12):1285-1290. PMID 21138388
12. Kennedy DJ, Engel A, Kreiner DS, et al. Fluoroscopically Guided Diagnostic and Therapeutic Intra-Articular Sacroiliac Joint Injections: A Systematic Review. Pain Med. Aug 2015; 16(8): 1500-1518. PMID 26178855

13. American Society of Anesthesiologists Task Force on Chronic Pain Management, American Society of Regional Anesthesia and Pain Medicine. Practice guidelines for chronic pain management: an updated report by the American Society of Anesthesiologists Task Force on Chronic Pain Management and the American Society of Regional Anesthesia and Pain Medicine. Anesthesiology. Apr 2010; 112(4):810-833. PMID 20124882
14. Lee DW, Pritzlaff S, Jung MJ, et al. Latest Evidence-Based Application for Radiofrequency Neurotomy (LEARN): Best Practice Guidelines from the American Society of Pain and Neuroscience (ASPN). J Pain Res. 2021; 14:2807-2831. PMID 34526815

## Centers for Medicare and Medicaid Services (CMS)

The information contained in this section is for informational purposes only. HCSC makes no representation as to the accuracy of this information. It is not to be used for claims adjudication for HCSC Plans.

The Centers for Medicare and Medicaid Services (CMS) does not have a national Medicare coverage position. Coverage may be subject to local carrier discretion.

A national coverage position for Medicare may have been developed since this medical policy document was written. See Medicare's National Coverage at <https://www.cms.hhs.gov>.

## Policy History/Revision

| Date | Description of Change |
|---|---|
| 02/01/2025 | Reviewed. No changes. |
| 07/01/2023 | Document updated with literature review. Coverage unchanged. References 12 and 14 added; others removed. |
| 04/15/2022 | Reviewed. No changes. |
| 04/01/2021 | Document reviewed with literature update. Coverage unchanged. |
| 09/15/2020 | New medical document. Injection of anesthetic for diagnosing sacroiliac joint pain may be considered medically necessary when all 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 all 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 1 year. |