1. Purpose
   The purpose of this policy is to establish the criteria for the medical necessity of sacroiliac joint injections.

2. Definitions
   2.1. Intra-articular sacroiliac joint injection refers to the injection of contrast (absent allergy to contrast), followed by the introduction of a corticosteroid and/or a local anesthetic into the sacroiliac joint under fluoroscopic guidance.

   2.2. Peri-articular injection refers to the introduction of a corticosteroid and/or a local anesthetic to one or more sections of the posterior ligamentous structures of the sacroiliac joint.

   2.3. Sacroiliac joint pain is defined as pain originating from the sacroiliac joint and/or its supporting ligamentous structures as a result of injury, disease or surgery. The most important clinical components required to support the diagnosis of sacroiliac joint pain to avoid unnecessary procedures or treatment include:

   - Pain primarily experienced between the upper level of the iliac crests and the gluteal fold (the pain can refer distally, even below the knee); and
   - A negative neurological examination for the presence of radicular symptoms/radiculopathy; and
   - A negative neurological examination for the presence of radicular symptoms/radiculopathy; and
   - At least three (3) positive provocative tests for pain reproduction. These tests include:
     - Distraction or “Gapping” or Patrick’s Test
     - Thigh Thrust or Posterior Pelvic Pain Provocational Test
     - Gaenslan’s Test
     - Sacroiliac Joint Compression Test
     - Sacral Thrust or Yeoman’s Test.
The presence of pain over the sacroiliac joint in the absence of radicular findings in and of itself does not substantiate the diagnosis of sacroiliac joint pain. There must also be clinical evidence as described above.

3. Statement of Policy

Centers for Medicare & Medicaid Services (CMS)

- National Coverage Determinations (NCD) – none
- Local Coverage Determinations (LCD) – L28240

3.1. The determination of medical necessity for the use of sacroiliac joint injections is always made on a case-by-case basis.

3.2. All intra-articular sacroiliac joint injections should be performed using fluoroscopy and injection of contrast (absent allergy to contrast), for guidance, as it is considered the standard of care. The performance of sacroiliac joint injections under an alternative type of guidance or without the use of fluoroscopic guidance may be considered not medically necessary.

3.3. The performance of peri-articular sacroiliac joint injections with or without the use of fluoroscopic guidance may be considered medically necessary.

3.4. The performance of sacroiliac joint injections may be considered medically necessary for a patient who has been diagnosed with sacroiliac joint pain which has resulted from disease, injury or surgery and has not responded sufficiently to at least four (4) weeks of conservative therapy (exercise, physical methods including physical therapy, chiropractic care, NSAID’s and analgesics).

3.5. To avoid coming to an improper diagnosis or providing unnecessary treatment, the performance of sacroiliac joint injections may be considered not medically necessary on the same day of service as facet joint blocks, epidural steroid injections or lumbar sympathetic chain blocks.

3.6. Based on the limited long-term benefit of performing sacroiliac joint injections as an isolated intervention with regard to pain and improved function, all sacroiliac joint injections should be performed in conjunction with active rehabilitative care/therapeutic exercise. Injections performed in isolation without the patient participating in an active rehabilitation program/home exercise program/functional restoration program may be considered not medically necessary.
3.7. When diagnostic sacroiliac joint injections are performed (anesthetic only), a positive diagnostic response is recorded as 50% for the duration of the local anesthetic. If the first sacroiliac joint block is not positive, a second diagnostic block may be considered not medically necessary.

3.8. When therapeutic sacroiliac joint injections are performed (corticosteroid with or without anesthetic), a repeat injection may be considered medically necessary if the patient has received at least a 50% reduction in the reported pain, documented increase in the patient’s level of function (i.e., return to work), or documented reduction in the use of pain medication and/or additional medical services such as physical therapy/chiropractic care for at least four (4) weeks. The performance of therapeutic sacroiliac joint injections for the treatment of chronic sacroiliac joint pain at a frequency greater than once every two (2) months may be considered not medically necessary. In the patients with chronic sacroiliac joint pain, therapeutic sacroiliac joint injections should be limited to a maximum of four (4) times per year.

4. References
4.1. Scientific:

The following scientific references were utilized in the formulation of this medical policy. Triad Healthcare, Inc. will continue to review clinical evidence surrounding sacroiliac joint injections and may modify this policy at a later date based upon the evolution of the published clinical evidence. Should additional scientific studies become available and they are not included in the list, please forward the reference(s) to Triad Healthcare, Inc. so the information can be reviewed by the Academic Advisory Committee (AAC) and the Medical Quality Improvement Committee (MQIC) to determine if a modification of the policy is in order.


• Don Tigney RL: Function and pathomechanics of the sacroiliac joint. A review. Phys Ther 1985;65 35–44.


- van der Wurff P, Buijs EJ, Groen GJ. A multitest regimen of pain provocation tests as an aid to reduce unnecessary minimally invasive sacroiliac joint procedures.[see comment]. Archives of Physical Medicine & Rehabilitation. 87(1):10-4, 2006 Jan.


4.2. Related Triad Medical Policies:

- **TMMP 18 - Medical Necessity**

### CPT Codes

This policy relates to the use of the following CPT Codes:

<table>
<thead>
<tr>
<th>CPT Codes</th>
<th>Description (AMA CPT Guide)</th>
</tr>
</thead>
<tbody>
<tr>
<td>27096</td>
<td>Injection procedure for sacroiliac joint, arthrography and/or anesthetic/steroid</td>
</tr>
</tbody>
</table>

This list may not be all inclusive and is not intended to be used for coding/billing purposes.

### Table of Revisions

<table>
<thead>
<tr>
<th>Revision Date</th>
<th>Modified By</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>07/25/2011</td>
<td>Level 1, 2, 3</td>
<td>Annual Review. §2.2 removed the following text ‘injection of contrast (absent allergy contrast), followed by the’ AND ‘under fluoroscopic guidance’. §3 added information for Medicare and Medicaid NCD/LCD. 3.2 added the following text ‘as it is considered the standard of care’ AND ‘under an alternative type of guidance or’; deleted the following text ‘and the injection of a contrast material’. New §3.3 added ‘the performance of peri-articular joint injections with or without the use of fluoroscopic guidance may be considered medically necessary’. Removed §5, Attachments and §5.1 Provider Manual as the provider manual has been re-written administratively. Added CPT Code table</td>
</tr>
<tr>
<td>08/16/2010</td>
<td>Level 1, 2, 3</td>
<td>Annual review. No change.</td>
</tr>
<tr>
<td>09/24/2009</td>
<td>Level 1, 2, 3</td>
<td>Annual review. § 3.7 revised to include “documented increase in the patient’s level of function (i.e., return to work), or documented reduction in the use of pain medication and/or additional medical services such as physical therapy/chiropractic care” and additional language for the application of treatment and patients of chronic sacroiliac joint pain.</td>
</tr>
<tr>
<td>11/12/2008</td>
<td>Level 1, 2, 3</td>
<td>New policy.</td>
</tr>
</tbody>
</table>

Triad’s Medical Policies are not recommendations for treatment and providers are expected to exercise their clinical judgment in providing the most appropriate care. Health care providers and patients should not rely on these Medical Policies in making health care decisions. These Medical Policies are guidelines and do not constitute an authorization, certification, explanation of
benefits or guarantee of payment. Applications of Triad’s Medical Policies are determined by the enrollee’s benefit documents and contracts and as such individual benefits must be verified. Determinations of medical necessity apply only if the benefit exists and no contract exclusions are applicable. In the event of a conflict, a participant’s benefit plan document shall supersede the information contained in Triad’s Medical Policies.