BOSTON MEDICAL CENTER HEALTHNet PLAN

bmchp.org | 888-566-0008

WELL SENSE HEALTH PLAN

wellsense.org | 877-957-1300

Medical Policy

Sacroiliac Joint Injections

Policy Number: OCA 3.9642
Version Number: 20
Version Effective Date: 12/01/21

Product Applicability	☒ **All Plan+ Products**
WellSense Health Plan ☒ NH Medicaid ☒ NH Medicare Advantage	**Boston Medical Center HealthNet Plan** ☒ MassHealth ACO ☒ MassHealth MCO ☒ Qualified Health Plans/ConnectorCare/Employer Choice Direct ☒ Senior Care Options

+ Note: Disclaimer and audit information is located at the end of this document.

Policy Summary

The Plan considers diagnostic or therapeutic sacroiliac joint (SIJ) injections to be **medically necessary** when performed under fluoroscopic guidance for the management of chronic low back pain. Chronic sacroiliac joint pain is defined as pain that has lasted longer than three (3) months despite appropriate non-surgical intervention such as non-steroidal anti-inflammatory medications and physical therapy. Sacroiliac joint injection for the treatment of acute back pain is not considered medically necessary. Plan prior authorization is required for diagnostic and/or therapeutic SIJ injections.

Clinical Criteria

The Plan considers diagnostic or therapeutic sacroiliac joint (SIJ) injections to be medically necessary when ALL applicable medical criteria and injection frequency guidelines are met in BOTH items A and B:

+ *Plan* refers to Boston Medical Center Health Plan, Inc. and its affiliates and subsidiaries offering health coverage plans to enrolled members. The Plan operates in Massachusetts under the trade name Boston Medical Center HealthNet Plan and in other states under the trade name WellSense New Health Plan.

A. **Medical Criteria – Diagnostic or Therapeutic Injections:**

Criteria must be met in item 1 (diagnostic SIJ injection or initial injection when the provider does not differentiate phase) or item 2 (therapeutic SIJ injection and injections beyond the initial injection). One (1) session of treatment includes the series of SIJ injections administered by the provider on a date of service for a member.

1. **Criteria for Diagnostic SIJ Injections:**

ALL criteria in in items a through f must be met:

a. Member has experienced severe, non-radicular low back pain (intermittent or continuous pain) that has occurred for at least 3 months and pain is causing functional disability; AND

b. Member's low back pain is thought to be secondary to SIJ disturbance based on clinical history and physical exam, and the sacroiliac physical exam includes **positive results from at least 3** of the following clinical tests listed in items (1) through (16):

(1) Compression test;

(2) Fortin finger test;

(3) Gaenslen test;

(4) Gillet's test (one legged-stork test);

(5) Patrick test (or Faber maneuver);

(6) Piedallu seated flexion test;

(7) Van Durson standing flexion test;

(8) Cranial shear test;

(9) Extension test;

(10) Flamingo test;

(11) Pelvic compression test;

(12) Pelvic distraction test;

(13) Pelvic rock test;

(14) Sacroiliac resisted abduction test (REAB);

(15) Sacroiliac shear test;

(16) Thigh thrust test (POSH); AND

c. Member's symptoms have failed to respond to conservative treatment (including physical therapy) and BOTH criteria are met in item (1) and item (2):

(1) Conservative Treatment (Except Physical Therapy):

Member's symptoms have failed to respond to at least a 3-month course of documented conservative measures including ANY of the following in items (a) through (d):

(a) Activity modification; OR

(b) Correction of postural abnormalities; OR

(c) Pharmacotherapies (e.g., anti-inflammatories, analgesics, or muscle relaxants); OR

(d) The treating physician, and/or treating licensed independent practitioner practicing within the scope of the practitioner's license (i.e., nurse practitioner or physician assistant) has documented the member's inability to undergo or tolerate the conservative treatment specified above in items (a) through (c), with member-specific information to support this determination; AND

(2) Physical Therapy:

ONE (1) of the following criteria is met in item (a) or item (b):

(a) Failed Clinical Response to Physical Therapy:

Within the last 24 calendar months of the prior authorization request, the treating physical therapist has documented BOTH conditions in item i and item ii:

i. The member's symptoms have failed to respond to 6 weeks of physical therapy for the member's condition (i.e., chronic back pain), with member-specific information to support this determination; AND

Note: The 6 weeks of physical therapy may also be included as a component of the 3-month course of required conservative treatment specified above.

ii. No reduction in associated pain or only a minor reduction in pain with physical therapy, with member-specific information to support this determination; OR

(b) Inability to Tolerate Physical Therapy:

The treating physical therapist, treating physician, and/or treating licensed independent practitioner practicing within the scope of the practitioner's license (i.e., nurse practitioner or physician assistant) has documented in the member's medical record within the last 24 calendar months the member's inability to physically tolerate physical therapy for this condition (including documentation of the member's pain levels, member's functional limitations due to the pain, member's physical exam findings, and provider's description of why the member was unable to tolerate physical therapy); AND

d. The SIJ injection is performed under fluoroscopic guidance; AND

e. The member is **age 18 or older** on the date of service; AND

f. The number of diagnostic sessions does not BOTH exceed guidelines in items (1) and (2):

(1) Number of diagnostic sessions does NOT exceed 2 series of injections to diagnose the member's pain and achieve a therapeutic effect in a 12-month period (with the 12-month timeframe beginning on the date of the first injection); AND

(2) Number of sessions does NOT exceed the Plan's frequency guidelines (including timeframe between injections, number of injections per side, and maximum number of sessions in a 12-month period beginning on the date of the first injection), as specified in item B1 of this section (Guidelines for Frequency and Number of Injections - Diagnostic or Therapeutic Injections /Diagnostic Phase); OR

2. **Criteria for Therapeutic SIJ Injections:**

ALL criteria must be met in items a through d:

a. ALL criteria must be met for diagnostic SIJ injections specified in item A1 (Criteria for Diagnostic SIJ Injections Criteria for Diagnostic SIJ Injections); AND

b. A previous diagnostic SIJ injection identifies SIJ disturbance as the source of pain with BOTH of the following results, as specified below in items (1) and (2):

   (1) **Greater than 70% pain relief** from baseline pain after the diagnostic* injection; AND

   (2) Demonstrate objective functional improvement without deterioration of pain relief; AND

c. The therapeutic SIJ injection is provided as part of a comprehensive pain management program and includes ALL components listed in items (1) through (4):

   (1) An individualized treatment plan has been developed for the member by the treating provider; AND

   (2) As part of the treatment plan, the treating provider reviews previous and current services and documents in the medical record a physical exam (when appropriate); AND

   (3) The treating provider evaluates the results of each SIJ injection and documents the member's pain condition, duration of clinical response, and functional improvement in activities, including ANY of the following listed in items (a) through (e):

      (a) Increased social activities; OR

      (b) Decreased need for pain medication; OR

      (c) Performing activities of daily living; OR

      (d) Returning to work; OR

      (e) Sleeping; AND

   (4) The treating provider coordinates a medically necessary service or treatment (as defined in the Plan's *Medically Necessary* policy, policy number OCA 3.14) to maximize physical functioning for the member, while complying with the Plan's prior authorization guidelines; AND

d. The number of injections does not exceed the Plan's frequency guidelines specified in item B2 of this section (Guidelines for Frequency and Number of Injections/Treatment or Therapeutic Phase); AND

B. **Guidelines for Frequency and Number of Injections – Diagnostic or Therapeutic Injections:**

1. **Diagnostic Phase:**

   ALL criteria must be met in items a through d:

   a. Applicable criteria are met for diagnostic SIJ injections, as specified above in item A1 (Criteria for Diagnostic SIJ Injection); AND

   b. Diagnostic SIJ injections are performed at least 1 week apart with no more than 2 injections allowed in a **14-day period** (i.e., each series of injections within this guideline counts as 1 session of treatment); AND

   c. No more than **1 injection is given per side per session** (and bilateral injections will be approved by the Plan in the same session when criteria are met); AND

   d. The member has received **no more than 4 sessions◊ of injections** (for all SIJ injections administered to the member, including injections administered in BOTH the diagnostic phase and the therapeutic phase) **in a 12-month period** (with the 12-month timeframe beginning on the date of the first injection); OR

2. **Treatment or Therapeutic Phase:**

   ALL criteria must be met in items a through e:

   a. Applicable criteria are met for therapeutic SIJ injections phase, as specified above in item A2 (Criteria for Therapeutic SIJ Injection); AND

   b. If the diagnostic phase was conducted and completed, applicable criteria were met for the diagnostic phase included in BOTH item A1 (Criteria for Diagnostic SIJ Injection) and item B1 (Guidelines for Frequency and Number of Injections/Diagnostic Phase); AND

   c. A previous diagnostic SIJ injection identifies sacroiliac joint disturbance as the source of pain with BOTH results in items (1) and (2) documented:

      (1) **Greater than 70% pain relief** from baseline pain from last diagnostic SIJ injection; AND

      (2) Ability to perform previously painful movement without deterioration of pain relief; AND

d. A maximum of **4 sessions** for SIJ injections (including all SIJ injections administered to the member, including the diagnostic phase and therapeutic phase) is allowed in a **12-month period** and must also comply with ALL parameters in items (1) through (3):

   (1) It has also been at least **2 months or longer between injections** (i.e., each session of treatment); AND

   (2) **No more than 1 injection is given per side per session** (i.e., bilateral injections will be approved by the Plan in the same session◊ when all applicable criteria are met); AND

   (3) The 12-month timeframe begins on the date of the first injection; AND

e. For a **repeat** therapeutic SIJ injection, the previous SIJ injection has provided **greater than 50% pain relief from baseline pain for at least six (6) weeks**.

Limitations and Exclusions

ANY of the following indications for sacroiliac joint (SIJ) injections is considered experimental and investigational or NOT medically necessary due to limited evidence demonstrating the clinical utility and clinical validity of treatment and Medical Director review is required for individual consideration:

1. SIJ for any indication other than chronic low back pain (e.g., acute back pain) and/or when applicable Plan criteria are NOT met

3. SIJ injections for member less than age 18 on the date of service.

4. SIJ injection for a member with a malignancy at the injection site.

5. When the member has exceeded the maximum allowable number of injections specified in the Clinical Criteria section.

6. SIJ injection conducted without fluoroscopic guided imaging (i.e., blinded), including injections guided by CT, ultrasonography, or MRI (rather than fluoroscopic guidance).

7. SIJ injection when facet injection or epidural is performed at the same session.

8. Contraindications to SIJ injections include ANY of the following listed in items a through f:

   a. Patient with systemic infection or a local infection near the injection site (due to the risk of spreading the infection); OR

   b. Patient with an unstable medical condition; OR

c. Patient with a history of significant allergic reaction to the injected solution (which is more prevalent in a multi-use container when a preservative is used); OR

d. Patient is pregnant; OR

e. Patient with a coagulation disorder (coagulopathy); OR

f. Patient with a malignancy at the injection site.

Variations

The Plan uses guidance from the Centers for Medicare & Medicaid Services (CMS) for medical necessity and coverage determinations for Senior Care Options (SCO) members and WellSense Medicare Advantage HOM members, including but not limited to national coverage determinations (NCDs), local coverage determinations (LCDs), local coverage articles (LCAs), and documentation included in Medicare manuals. At the time of the Plan's most recent policy review, no guidelines were found for sacroiliac joint injections. Verify CMS criteria in effect for the requested service on the date of the prior authorization request for a SCO or WellSense Medicare Advantage HMO member. When there is no guidance from CMS for the requested service for the specified indication on the date of the prior authorization request, Plan-adopted clinical review criteria will be used to determine the medical necessity of the service.

Applicable Coding

The Plan uses and adopts up-to-date Current Procedural Terminology (CPT) codes from the American Medical Association (AMA), International Statistical Classification of Diseases and Related Health Problems, 10th revision (ICD-10) diagnosis codes developed by the World Health Organization and adapted in the United Stated by the National Center for Health Statistics (NCHS) of the Centers for Disease Control under the U.S. Department of Health and Human Services, and the Health Care Common Procedure Coding System (HCPCS) established and maintained by the Centers for Medicare & Medicaid Services (CMS). Since the AMA, NCHS, and CMS may update codes more frequently or at different intervals than Plan policy updates, the list of applicable codes included in this Plan policy is for informational purposes only, may not be all inclusive, and is subject to change without prior notification. Whether a code is listed in the Applicable Coding section of this Plan policy does not constitute or imply member coverage or provider reimbursement. Providers are responsible for reporting all services using the most up-to-date industry-standard procedure and diagnosis codes as published by the AMA, NCHS, and CMS at the time of the service.

Providers are responsible for obtaining prior authorization for the services specified in the Clinical Criteria section and Limitations and Exclusions section, even if an applicable code appropriately describing the service that is the subject of this Plan policy is not included in the Applicable Coding section of this Plan policy. Review the Plan's reimbursement policies for Plan billing guidelines. Coverage for services is subject to benefit eligibility under the member's benefit plan in effect at the time of the service. Member benefit documents are available at the following websites:

www.bmchp.org for BMC HealthNet Plan members, www.SeniorsGetMore.org for Senior Care Options members, www.wellsense.org for WellSense New Hampshire Medicaid members, and www.WellSense.org/Medicare for WellSense Medicare Advantage HMO members.

CPT Code	Description: Code Covered When Medically Necessary (Using Fluoroscopy or CT)
27096	Injection procedure for sacroiliac joint, anesthetic/steroid, with image guidance (fluoroscopy or CT) including arthrography when performed Plan notes: This code should only be used for the professional component of the service. Code 27096 is a unilateral procedure; for bilateral procedure, use modifier 50.
HCPCS Code	**Description: Code Covered When Medically Necessary**
G0260	Injection procedure for sacroiliac joint; provision of anesthetic, steroid and/or other therapeutic agent, with or without arthrography Plan notes: This code should only be used for the technical component of the service. Code is NOT payable for the MassHealth or Qualified Health Plan products.

References

Allegri M, Montella S, Salici F, Valente A, Marchesini M, Compagnone C, Baciarello M, Manferdini ME, Fanelli G. Mechanisms of low back pain: a guide for diagnosis and therapy. Version 2. F1000Res. 2016 Jun 28 [revised 2016 Jan 1];5. pii: F1000 Faculty Rev-1530. eCollection 2016. doi: 10.12688/f1000research.8105.2. PMID: 27408698.

American Academy of Orthopaedic Surgeons (AAOS). OrthoInfo. Spinal Injections.

American Association of Neurological Surgeons (AANS). AANS Position Statements.

American College of Occupational and Environmental Medicine (ACOEM). Occupational Medicine Practice Guidelines.

American College of Physicians (ACP), American Pain Society (APS). Chou R, Qaseem A, Snow V, Casey D, Cross JT Jr, Shekelle P, Owens DK; Clinical Efficacy Assessment Committee of the ACP; ACP; APS Low Back Pain Guidelines Panel. Diagnosis and treatment of low back pain: a joint clinical practice guideline from the ACP and the APS. Ann Intern Med. 2007 Oct 2;147(7):478-91. Erratum in: Ann Intern Med. 2008 Feb 5;148(3):247-8. PMID: 17909209.

American College of Physicians (ACP). Clinical Guidelines & Recommendations.

American College of Radiology (ACR). ACR Appropriateness Criteria.

[+] *Plan* refers to Boston Medical Center Health Plan, Inc. and its affiliates and subsidiaries offering health coverage plans to enrolled members. The Plan operates in Massachusetts under the trade name Boston Medical Center HealthNet Plan and in other states under the trade name WellSense New Health Plan.

American College of Radiology (ACR). ACR Appropriateness Criteria. Cervical Neck Pain or Cervical Radiculopathy. 2018.

American College of Radiology (ACR). ACR Appropriateness Criteria. Chronic Back Pain: Suspected Sarcoilitis/Spondyloarthropasty. 2016.

American College of Radiology (ACR). ACR Appropriateness Criteria. Low Back Pain. 2015.

American Pain Society (APS). Chou R, Atlas SJ, Stanos SP, Rosenquist RW. Nonsurgical Interventional Therapies for Low Back Pain: a Review of the Evidence for an American Pain Society Clinical Practice Guideline. Spine. 2009 May 1;34(10):1078-93. doi: 10.1097/BRS.0b013e3181a103b1. PMID: 19363456.

American Pain Society (APS). Chou R, Loeser JD, Owens DK, Rosenquist RW, Atlas SJ, Baisden J, Carragee EJ, Grabois M, Murphy DR, Resnick DK, Stanos SP, Shaffer WO, Wall EM; APS Low Back Pain Guideline Panel. Interventional therapies, surgery, and interdisciplinary rehabilitation for low back pain: an evidence-based clinical practice guideline from the APS. Spine (Phila Pa 1976). 2009 May 1;34(10):1066-77. doi: 10.1097/BRS.0b013e3181a1390d. PMID: 19363457.

American Society of Anesthesiologists (ASA), American Society of Regional Anesthesia and Pain Medicine (ASRA). Rosenquist RW, Benzon HT, Connis RT, De Leon-Casasola OA, Glass D, Korevaar WC, Cynwyd B, Mekhail NA, Merrill DG, NIckinovich DG, Rathnmell JP, Nai-Mei Sang C, Simon DL; ASA Task Force on Chronic Pain Management. Practice guidelines for chronic pain management: an updated report by the ASA Task Force on Chronic Pain Management and the ASRA. Anesthesiology. 2010 Apr;112(4):810-33. doi: 10.1097/ALN.0b013e3181c43103. PMID: 20124882.

American Society of Interventional Pain Physicians (ASIPP). Boswell MV, Trescot AM, Datta S, Schultz DM, Hansen HC, Abdi S, Sehgal N, Shah RV, Singh V, Benyamin RM, Patel VB, Buenaventura RM, Colson JD, Cordner HJ, Epter RS, Jasper JF, Dunbar EE, Atluri SL, Bowman RC, Deer TR, Swicegood JR, Staats PS, Smith HS, Burton AW, Kloth DS, Giordano J, Manchikanti L; ASIPP. Interventional techniques: evidence-based practice guidelines in the management of chronic spinal pain. Pain Physician. 2007 Jan;10(1):7-111. PMID: 17256025.

American Society of Interventional Pain Physicians (ASIPP). Interventional Pain Management (IPM) Practice Guidelines.

American Society of Interventional Pain Physicians (ASIPP). Manchikanti L, Abdi S, Atluri S, Benyamin RM, Boswell MV, Buenaventura RM, Bryce DA, Burks TA, Caraway DL, Calodney AK, Cash KA, Christo PJ, Cohen SP, Colson J, Conn A, Cordner HJ, Coubarous S, Datta S, Deer TR, Diwan SA, Falco FJE, Fellows B, Geffert SC, Grider JS, Gupta S, Hameed H, Hameed M, Hansen H, Helm II S, Janata JW, Justiz R, Kaye AD, Lee M, Manchikanti KN, McManus CD, Onyewu O, Parr AT, Patel V, Racz GB, Sehgal N, Sharma M, Simopoulos TT, Singh V, Smith HS, Snook LT, Swicegood J, Vallejo R, Ward SP, Wargo BW, Zhu J, Hirsch JA. Interventional Pain Management (IPM) Practice Guideline. An Update of Comprehensive Evidence-

Based Guidelines for Interventional Techniques in Chronic Spinal Pain. Part 2: Guidance and Recommendations. Pain Physician. 2013;16:S49-283.

American Society of Interventional Pain Physicians (ASIPP). Manchikanti L, Falco FJE, Singh V, Benyamin RM, Racz GB, Helm II S, Caraway DL, Calodney AK, Snook LT, Smith HS, Gupta S, Ward SP, Grider JS, Hirsch JA. An update of comprehensive evidence-based guidelines for interventional techniques in chronic spinal pain. Part I: introduction and general considerations. Pain Physician 2013 Apr;16(2 Suppl):S1-48. PMID: 23615882.

American Society of Regional Anesthesia and Pain Medicine (ASRA), European Society of Regional Anaesthesia and Pain Therapy (ESRA), the American Academy of Pain Medicine (AAPM), International Neuromodulation Society (INS), North American Neuromodulation Society (NANS), World Institute of Pain (WIP). Narouze S, Benzon HT, Provenzano D, Buvanendran A, De Andres J, Deer T, Rauck R, Huntoon MA. Interventional Spine and Pain Procedures in Patients on Antiplatelet and Anticoagulant Medications (Second Edition): Guidelines from the ASRA, the ESRA, the AAPM, the INS, the NANS, and the WIP. Reg Anesth Pain Med. 2018 Apr;43(3):225-262. doi: 10.1097/AAP.0000000000000700. PMID: 29278603.

American Society of Regional Anesthesia and Pain Medicine (ASRA). The specialty of chronic pain management.

Assessment of SpondyloArthritis international Society (ASAS), European League Against Rheumatism (EULAR). van der Heijde D, Ramiro S, Landewé R, Baraliakos X, Van den Bosch F, Sepriano A, Regel A, Ciurea A, Dagfinrud H, Dougados M, van Gaalen F, Géher P, van der Horst-Bruinsma I, Inman RD, Jongkees M, Kiltz U, Kvien TK, Machado PM, Marzo-Ortega H, Molto A, Navarro-Compàn V, Ozgocmen S, Pimentel-Santos FM, Reveille , Rudwaleit M, Sieper J, Sampaio-Barros P, Wiek D, Braun J. 2016 update of the ASAS-EULAR management recommendations for axial spondyloarthritis. Ann Rheum Dis. 2017 Jun;76(6):978-91. doi: 10.1136/annrheumdis-2016-210770. Epub 2017 Jan 13. PMID: 28087505.

Baber Z, Erdek MA. Failed back surgery syndrome: current perspectives. J Pain Res. 2016 Nov 7;9:979–87. eCollection 2016. doi: 10.2147/JPR.S92776. PMID: 27853391.

Beinart NA, Goodchild CE, Weinman JA, Ayis S, Godfrey EL. Individual and intervention-related factors associated with adherence to home exercise in chronic low back pain: a systematic review. Spine J. 2013 Dec;13(12):1940-50. doi: 10.1016/j.spinee.2013.08.027. Epub 2013 Oct 26. PMID: 24169445.

Büker N, Akkaya S, Gökalp O, Kıtış A, Savkın R, Kıter AE. Middle-term therapeutic effect of the sacroiliac joint blockade in patients with lumbosacral fusion-related sacroiliac pain. Acta Orthop Traumatol Turc. 2014;48(1):61-6. doi: 10.3944/AOTT.2014.3190. PMID: 24643102.

Burgos-Vargas R. The assessment of the spondyloarthritis international society concept and criteria for the classification of axial spondyloarthritis and peripheral spondyloarthritis: A critical appraisal for the pediatric rheumatologist. Pediatr Rheumatol Online J. 2012 May 31;10:14. doi: 10.1186/1546-0096-10-14. PMID: 22650358.

Centers for Medicare & Medicaid Services (CMS). Local Coverage Determination (LCD). Facet Joint Injections, Medial Branch Blocks, and Facet Joint Radiofrequency Neurotomy (L35936). National Government Services, Inc.

Change Healthcare. InterQual® Criteria. Sacroiliac Joint Injections.

Commonwealth of Massachusetts. MassHealth Provider Bulletins

Commonwealth of Massachusetts. MassHealth Provider Manuals

Cimolin V, Vismara L, Galli M, Zaina F, Negrini S, Capodaglio P. Effects of obesity and chronic low back pain on gait. J Neuroeng Rehabil. 2011 Sep 26;8:55. doi: 10.1186/1743-0003-8-55. PMID: 21943156.

Cohen SP, Chen Y, Neufeld NJ. Sacroiliac joint pain: a comprehensive review of epidemiology, diagnosis and treatment. Expert Rev Neurother. 2013 Jan;13(1):99-116. doi: 10.1586/ern.12.148. PMID: 23253394.

Cook KM, Heiderscheit B. Conservative management of a young adult with hip arthrosis. J Orthop Sports Phys Ther. 2009 Dec;39(12):858-66. doi: 10.2519/jospt.2009.3207. PMID: 20026881.

Cousins MJ, Bridenbaugh PO, Horlocker TT, Carr DB. Cousins and Bridenbaugh's Neural Blockade in Clinical Anesthesia and Pain Medicine. 4th edition. 2012.

Datta S, Manchikanti L, Falco FJ, Calodney AK, Atluri S, Benyamin RM, Buenaventura RM, Cohen SP. Diagnostic utility of selective nerve root blocks in the diagnosis of lumbosacral radicular pain: systematic review and update of current evidence. Pain Physician. 2013 Apr;16(2 Suppl):SE97-124. PMID: 23615888.

Dreyfuss P, Snyder BD, Park K, Willard F, Carreiro J, Bogduk N. The ability of single site, single depth sacral lateral branch blocks to anesthetize the sacroiliac joint complex. Pain Med. 2008 Oct;9(7):844-50. doi: 10.1111/j.1526-4637.2008.00517.x. PMID: 18950439.

Forst SL, Wheeler MT, Fortin JD, Vilensky JA. The sacroiliac joint: anatomy, physiology and clinical significance. Pain Physician. 2006 Jan;9(1):61-7. PMID: 16700283.

Fritz J, Sequeiros RB, Carrino JA. Magnetic resonance imaging-guided spine injections. Top Magn Reson Imaging. 2011 Aug;22(4):143-51. doi: 10.1097/RMR.0b013e31827e5de1. PMID: 23514922.

Hansen H, Manchikanti L, Simopoulos TT, Christo PJ, Gupta S, Smith HS, Hameed H, Cohen SP. A systematic evaluation of the therapeutic effectiveness of sacroiliac joint interventions. Pain Physician. 2012 May-Jun;15(3):E247-78. PMID: 22622913.

Hartung W, Ross CJ, Straub R, Feuerbach S, Schölmerich J, Fleck M, Herold T. Ultrasound-guided sacroiliac joint injection in patients with established sacroiliitis: precise IA injection verified by MRI scanning does not predict clinical outcome. Rheumatology (Oxford). 2010 Aug;49(8):1479-82. doi: 10.1093/rheumatology/kep424. Epub 2009 Dec 17. PMID: 20019067.

Jee H, Lee JH, Park KD, Ahn J, Park Y. Ultrasound-guided versus fluoroscopy-guided sacroiliac joint intra-articular injections in the noninflammatory sacroiliac joint dysfunction: A prospective, randomized, single-blinded study. Arch Phys Med Rehabil. 2014 Feb;95(2):330-7. doi: 10.1016/j.apmr.2013.09.021. Epub 2013 Oct 9. PMID: 24121083.

Kennedy DJ, Shokat M, Visco CJ. Sacroiliac joint and lumbar zygapophysial joint corticosteroid injections. Phys Med Rehabil Clin N Am. 2010 Nov;21(4):835-42. doi: 10.1016/j.pmr.2010.06.009. PMID: 20977966.

Kim WM, Lee HG, Jeong CW, Kim CM, Yoon MH. A randomized controlled trial of intra-articular prolotherapy versus steroid injection for sacroiliac joint pain. J Altern Complement Med. 2010;16:1285-90. 2010 Dec;16(12):1285-90. doi: 10.1089/acm.2010.0031. PMID: 21138388.

Kotsenas AL. Imaging of posterior element axial pain generators: facet joints, pedicles, spinous processes, sacroiliac joints, and transitional segments. Radiol Clin North Am 2012 Jul;50(4):705-30. doi: 10.1016/j.rcl.2012.04.008. PMID: 22643392.

Krawczyk-Wasielewska A, Skorupska E, Samborski W. Sacroiliac joint pain as an important element of psoriatic arthritis diagnosis. Postepy Dermatol Alergol. 2013 Apr;30(2):108-12. doi: 10.5114/pdia.2013.34161. Epub 2013 Apr 12. PMID: 24278057.

Manchikanti L, Falco FJ, Benyamin RM, Caraway DL, Kaye AD, Helm S 2nd, Wargo BW, Hansen H, Parr AT, Singh V, Swicegood JR, Smith HS, Schultz DM, Malla Y, Hirsch JA. Assessment of bleeding risk of interventional techniques: a best evidence synthesis of practice patterns and perioperative management of anticoagulant and antithrombotic therapy. Pain Physician. 2013 Apr;16(2 Suppl):SE261-318. PMID: 23615893.

Manchikanti L, Hirsch JA, Pampati V, Boswell MV. Utilization of Facet Joint and Sacroiliac Joint Interventions in Medicare Population from 2000 to 2014: Explosive Growth Continues! Curr Pain Headache Rep. 2016 Oct;20(10):58. doi: 10.1007/s11916-016-0588-2. PMID: 27646014.

Manchikanti L, Pampati V, Falco FJ, Hirsch JA. Growth of spinal interventional pain management techniques: analysis of utilization trends and Medicare expenditures 2000 to 2008. Spine (Phila Pa 1976). 2013 Jan 15;38(2):157-68. doi: 10.1097/BRS.0b013e318267f463. PMID: 22781007.

Masala S, Fiori R, Bartolucci DA, Mammucari M, Angelopoulos G, Massari F, Simonetti G. Diagnostic and therapeutic joint injections. Semin Intervent Radiol. 2010 Jun;27(2):160-71. doi: 10.1055/s-0030-1253514. PMID: 21629405.

Meucci RD, Fassa AG, Faria NM. Prevalence of chronic low back pain: systemic review. Rev Saude Publica. 2015;49:1. Published online 2015;49. pii: S0034-89102015000100408. doi: 10.1590/S0034-8910.2015049005874. Epub 2015 Oct 20. PMID: 26487293,

National Institute for Health and Clinical Excellence (NICE). Low back pain and sciatica in over 16s: assessment and management. NICE guideline NG59. 2016 Nov.

New Hampshire Department of Health and Human Services. Billing Manuals.

New Hampshire Department of Health and Human Services. Provider Notices.

North American Spine Society (NASS). Clinical Guidelines.

North American Spine Society (NASS). Current Coverage Policy Recommendations. Sacroiliac Joint Injections.

North American Spine Society (NASS). Evidence-Based Clinical Guidelines for Multidisciplinary Spine Care. Diagnosis and Treatment of Low Back Pain. 2020. Endorsed by the American Academy of Physical Medicine and Rehabilitation (AAPM&R) and American Association of Neurological Surgeons and Congress of Neurological Surgeons (AANS/CNS

Official Disability Guidelines (ODG). Treatment Guidelines.

Patel DR, Kinsella E. Evaluation and management of lower back pain in young athletes. Transl Pediatr. 2017 Jul;6(3):225–35. doi: 10.21037/tp.2017.06.01. PMID: 28795014.

Rashbaum RF, Ohnmeiss DD, Lindley EM, Kitchel SH, Patel VV. Sacroiliac Joint Pain and Its Treatment. Clin Spine Surg. 2016 Mar;29(2):42-8. doi: 10.1097/BSD.0000000000000359. PMID: 26889985.

Savran Sahin B, Aktas E, Haberal B, Harman A, Canan Yazici A, Kaygusuz H, Aribas BK. Sacroiliac pain and CT-guided steroid injection treatment: high-grade arthritis has an adverse effect on outcomes in long-term follow-up. Eur Rev Med Pharmacol Sci. 2015 Aug;19(15):2804-11. PMID: 26241533.

Scholten PM, Patel SI, Christos PJ, Singh JR. Short-term efficacy of sacroiliac joint corticosteroid injection based on arthrographic contrast patterns. PM R. 2015 Apr;7(4):385–91. doi: 10.1016/j.pmrj.2014.10.007. PMID: 25452127.

Simopoulos TT, Manchikanti L, Gupta S, Aydin SM, Kim CH, Solanki D, Nampiaparampil DE, Singh V, Staats PS, Hirsch JA. Systematic Review of the Diagnostic Accuracy and Therapeutic Effectiveness of Sacroiliac Joint Interventions. Pain Physician. 2015 Sep-Oct;18(5):E713-56. PMID: 26431129.

Simopoulos TT, Manchikanti L, Singh V, Gupta S, Hameed H, Diwan S, Cohen SP. A systematic evaluation of prevalence and diagnostic accuracy of sacroiliac joint interventions. Pain Physician. 2012 May-Jun;15(3):E305-44. PMID: 22622915.

Soto Quijano DA, Otero Loperena E. Sacroiliac Joint Interventions. Phys Med Rehabil Clin N Am. 2018 Feb;29(1):171-183. doi: 10.1016/j.pmr.2017.09.004. PMID: 29173661.

Spine Intervention Society (SIS). Bogduk N, ed. ISIS Practice Guidelines. Practice Guidelines for the Spinal Diagnostic and Treatment Procedures. (Formerly known as International Spine Intervention Society/ISIS.) Second Edition. San Francisco. 2013.

Staal JB, de Bie RA, de Vet HC, Hildebrandt J, Nelemans P. Injection therapy for subacute and chronic low back pain: an updated Cochrane review. Spine (Phila Pa 1976). 2009 Jan 1;34(1):49-59. doi: 10.1097/BRS.0b013e3181909558. PMID: 19127161.

Sudol-Szopinska I, Urbanik A. Diagnostic imaging of sacroiliac joints and the spine in the course of spondyloarthropathies. Pol J Radiol. 2013 Apr-Jun;78(2):43–9. doi: 10.12659/PJR.889039. PMID: 23807884.

Vanaclocha V, Herrera JM, Sáiz-Sapena N, Rivera-Paz M, Verdú-López F. Minimally Invasive Sacroiliac Joint Fusion, Radiofrequency Denervation, and Conservative Management for Sacroiliac Joint Pain: 6-Year Comparative Case Series. Neurosurgery. 2018 Jan 1;82(1):48-55. doi: 10.1093/neuros/nyx185. PMID: 28431026.

Visser LH, Woudenberg NP, de Bont J, van Eijs F, Verwer K, Jenniskens H, Den Oudsten BL. Treatment of the sacroiliac joint in patients with leg pain: a randomized-controlled trial. Eur Spine J. 2013 Oct;22(10):2310-7. doi: 10.1007/s00586-013-2833-2. Epub 2013 May 30. PMID: 23720124.

Policy History

Original Approval Date*	Original Effective Date and Version Number	Policy Owner	Original Policy Approved by
Regulatory Approval: N/A Internal Approval: 06/10/08: Medical Policy, Criteria, and Technology Assessment Committee (MPCTAC) 06/24/08: Utilization Management Committee (UMC) 08/13/08: Quality Improvement Committee (QIC)	11/01/08 Version 1	Medical Policy Manager as Chair of MPCTAC	MPCTAC , UMC, and QIC

*Effective Date for the BMC HealthNet Plan Commercial Product: 01/01/12
*Effective Date for the WellSense New Hampshire Medicaid Product: 01/01/13
*Effective Date for the Senior Care Options Product: 01/01/16
*Effective Date for the WellSense Medicare Advantage HMO Product: 01/01/22

Effective 06/01/13, this policy replaced the *Facet Joint Nerve Injections and Sacroiliac Joint Injections for Chronic Neck Pain and Chronic Back Pain* policy (policy number OCA 3.964) which was effective from 11/01/08 to 05/31/13. Also, see Plan policy, *Facet Joint Nerve Injections for Chronic Back Pain and Chronic Neck Pain* (policy number OCA 3.9641) effective 06/01/13.

Policy Revisions History			
Review Date	**Summary of Revisions**	**Revision Effective Date and Version Number**	**Approved by**
06/23/09	Changed name of the policy, added additional criteria for SIJ injections and replaced the criteria for radiological findings negative for disc herniation and nerve root compression with: negative physical signs of radiculopathy or radicular pain, including negative straight leg raising or root tension signs, normal neurological examination, absence of signs of radiculopathy on any electrodiagnostic examinations. Updated the diagnostic clinical criteria to allow no more than 2 joint levels bilaterally or 3 joint levels unilaterally in a 7 to 14 day period to determine the origin of the patient's pain. For SIJ injections, no more than 2 procedures may be allowed in a 7 to 14 day period to determine the origin of the patient's	10/01/09 Version 2	06/23/09: MPCTAC 06/23/09: UMC 07/22/09: QIC

Policy Revisions History			
	pain. Updated references and coding sections. Effective date of changes is 10/01/09.		
06/01/10	No changes to criteria. Updated references and coding.	Version 3	06/30/10: MPCTAC 07/28/10: QIC
06/01/11	Updated clinical criteria to clarify that the absence of prior spinal fusion must be at the clinically suspect levels. Updated references.	Version 4	06/29/11: MPCTAC 07/27/11: QIC
07/01/12	Updated references and revised the introductory paragraph in Applicable Coding section. Code descriptions updated but no change to list of applicable codes. Revised policy title and text to specify the policy relates to chronic neck pain and chronic back pain. Added the following additional contraindication for procedures: 'Patient with a malignancy at the injection site.' Clinical criteria updated for facet joint nerve injections and sacroiliac joint injections. Definitions added for radiculopathy and straight leg raise test. For facet joint injections, added symptoms of axial pain and signs of facet disease. For sacroiliac joint injections, added types of tests used for a sacroiliac exam. Added definition of a comprehensive pain management program and referenced the Plan's *Medically Necessary* policy.	Version 5	06/20/12: MPCTAC 07/18/12: MPCTAC 08/22/12: QIC
08/01/12	Off cycle review for WellSense New Hampshire. No changes.	Version 6	08/13/12: MPCTAC 09/06/12: QIC
12/01/12	Revised sacroiliac joint injection frequency guidelines in Medical Policy Statement section.	Version 7	12/19/12: MPCTAC 12/20/12: QIC
02/01/13	Review for effective date 06/01/13. Separated facet joint nerve injections and sacroiliac joint injections into two separate policies; policy formerly titled *Facet Joint Nerve Injections and Sacroiliac Joint Injections for Chronic Neck Pain and Chronic Back Pain* (formerly policy number OCA 3.964). Revised title and re-numbered policy. Updated language in Summary, Description of Item or Service, and Clinical Background Information sections. Revised applicable code list, and updated references. Deleted definitions for radiculopathy and straight leg raise test in Definition section because not referenced in policy. Added the following definitions: Compression test, Fortin finger test, Gaenslen test, Gillet's test, Patrick test (or Faber maneuver), Piedallu seated flexion test, and Van Durson standing flexion test.	06/01/13 Version 8	02/20/13: MPCTAC 03/21/13: QIC

[+] *Plan* refers to Boston Medical Center Health Plan, Inc. and its affiliates and subsidiaries offering health coverage plans to enrolled members. The Plan operates in Massachusetts under the trade name Boston Medical Center HealthNet Plan and in other states under the trade name WellSense New Health Plan.

Policy Revisions History			
	Revised medical criteria in the Medical Policy Statement section (formerly named the Clinical Guideline Statement section).		
08/14/13	Off cycle review for WellSense New Hampshire and merged policy format. Incorporate policy revisions dated 12/01/12 and 02/01/13 (as specified above) for the WellSense New Hampshire Product; these policy revisions were approved by MPCTAC (on 12/19/12 and 02/20/13) and QIC (on 12/20/12 and 03/21/13) for applicable Plan products.	Version 9	08/14/13: MPCTAC (electronic vote) 08/15/13: QIC
03/01/14	Review for effective date 07/01/14. Changed policy title from *Sacroiliac Joint Injections for Chronic Low Back Pain* to *Sacroiliac Joint Injections.* Revised Summary and References sections. Revised criteria in the Medical Policy Statement section and the Limitations section. Removed HCPCS code G0259 as an applicable code.	07/01/14 Version 10	03/19/14: MPCTAC 04/16/14: QIC
09/01/14	Review for effective date 11/01/14. Clarified in the Medical Policy Statement section that bilateral injections may be medically necessary for both the diagnostic phase and therapeutic phase when all Plan applicable criteria are met. Updated references.	11/01/14 Version 11	09/17/14: MPCTAC 10/08/14: QIC
02/01/15	Review for effective 06/01/15. Updated Definitions and References sections. Revised criteria in the Medical Policy Statement and Limitations sections. Removed Commonwealth Care, Commonwealth Choice, and Employer Choice from the list of applicable products because the products are no longer available.	06/01/15 Version 12	02/27/15: MPCTAC (electronic vote) 03/11/15: QIC
11/25/15	Review for effective date 01/01/16. Updated template with list of applicable products and notes. Revised language in the Applicable Coding section.	01/01/16 Version 13	11/18/15: MPCTAC 11/25/15: MPCTAC (electronic vote) 12/09/15: QIC
02/01/16	Review for effective date 06/01/16. Updated criteria in the Medical Policy Statement section. Administrative changes made to the Applicable Coding section without changing the list of codes. Revised the Clinical Background Information, References, and Reference to Applicable Laws and Regulations sections.	06/01/16 Version 14	02/17/16: MPCTAC 03/09/16: QIC
01/01/17	Review for effective date 05/01/17. Updated criteria in the Medical Policy Statement and Limitations sections. Updated Summary, Clinical Background	05/01/17 Version 15	01/18/17: MPCTAC 02/08/17: QIC

[+] *Plan* refers to Boston Medical Center Health Plan, Inc. and its affiliates and subsidiaries offering health coverage plans to enrolled members. The Plan operates in Massachusetts under the trade name Boston Medical Center HealthNet Plan and in other states under the trade name WellSense New Health Plan.

Policy Revisions History			
	Information, and References sections. Plan note added to Applicable Coding section (with no change to the applicable code list).		
02/01/18	Review for effective date 05/01/18. Administrative changes made to the Policy Summary, Limitations References, and Other Applicable Policies sections. Criteria revised in the Medical Policy Statement section.	05/01/18 Version 16	02/21/18: MPCTAC
02/01/19	Review for effective date 03/01/19. Administrative changes made to the Policy Summary, References, Other Applicable Policies, and Reference to Applicable Laws and Regulations sections.	03/01/19 Version 17	02/20/19: MPCTAC
02/01/20	Review for effective date 03/01/20. Administrative changes made to the Limitations, Applicable Coding, References, and Reference to Applicable Laws and Regulations sections.	03/01/20 Version 18	02/19/20: MPCTAC
02/01/21	Review for effective date 03/01/21. Administrative changes made to the References section.	03/01/21 Version 19	02/17/21: MPCTAC
11/01/21	Review for effective date 12/01/21. Adopted new medical policy template; removed administrative sections, Medical Policy Statement section renamed Clinical Criteria section, and Limitations section renamed Limitation and Exclusions section. Added WellSense Medicare Advantage HMO as an applicable product effective 01/01/22. Administrative changes made to the Policy Summary, Clinical Criteria, Limitations and Exclusions, Applicable Coding, and References sections.	12/01/21 Version 20	11/17/21: MPCTAC

Next Review Date

02/01/22

Authorizing Entity

MPCTAC

Disclaimer Information: +

Medical Policies are the Plan's guidelines for determining the medical necessity of certain services or supplies for purposes of determining coverage. These Policies may also describe when a service or supply is considered experimental or investigational, or cosmetic. In making coverage decisions, the Plan uses these guidelines and other Plan Policies, as well as

the Member's benefit document, and when appropriate, coordinates with the Member's health care Providers to consider the individual Member's health care needs.

Plan Policies are developed in accordance with applicable state and federal laws and regulations, and accrediting organization standards (including NCQA). Medical Policies are also developed, as appropriate, with consideration of the medical necessity definitions in various Plan products, review of current literature, consultation with practicing Providers in the Plan's service area who are medical experts in the particular field, and adherence to FDA and other government agency policies. Applicable state or federal mandates, as well as the Member's benefit document, take precedence over these guidelines. Policies are reviewed and updated on an annual basis, or more frequently as needed. Treating providers are solely responsible for the medical advice and treatment of Members.

The use of this Policy is neither a guarantee of payment nor a final prediction of how a specific claim(s) will be adjudicated. Reimbursement is based on many factors, including member eligibility and benefits on the date of service; medical necessity; utilization management guidelines (when applicable); coordination of benefits; adherence with applicable Plan policies and procedures; clinical coding criteria; claim editing logic; and the applicable Plan – Provider agreement.