Sacroiliac Joint Injections

Policy Number: OCA 3.9642
Version Number: 14
Version Effective Date: 06/01/16

Product Applicability

- All Plan+ Products

Well Sense Health Plan
- New Hampshire Medicaid
- NH Health Protection Program

Boston Medical Center HealthNet Plan
- MassHealth
- Qualified Health Plans/ConnectorCare/Employer Choice Direct
- Senior Care Options ◊

Notes:
+ Disclaimer and audit information is located at the end of this document.
◊ The guidelines included in this Plan policy are applicable to members enrolled in Senior Care Options only if there are no criteria established for the specified service in a Centers for Medicare & Medicaid Services (CMS) national coverage determination (NCD) or local coverage determination (LCD) on the date of the prior authorization request. Review the member’s product-specific benefit documents at www.SeniorsGetMore.org to determine coverage guidelines for Senior Care Options.

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. It will be determined during the Plan’s prior authorization process if the service is considered medically necessary for the requested indication. See the Plan policy, Medically Necessary (policy number OCA 3.9642).
Sacroiliac Joint Injections

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**Description of Item or Service**

**Sacroiliac Joint Injection:** A diagnostic or therapeutic injection using a local anesthetic agent and/or steroid injected into the sacroiliac joint (i.e., the junction between the sacrum and the ilium that connects the spine to the pelvis) for the treatment of chronic low back pain associated with the sacroiliac joint.

**Medical Policy Statement**

Diagnostic or therapeutic sacroiliac joint (SIJ) injections are considered medically necessary when ALL of the following applicable medical criteria and injection frequency guidelines are met. See item A1 (Criteria for Diagnostic SIJ Injections) and item B1 (Guidelines for Frequency and Number of Injections/Diagnostic Phase) for applicable criteria for diagnostic SIJ injections. Review item A2 (Criteria for Therapeutic SIJ Injections) and item B2 (Guidelines for Frequency and Number of Injections/Treatment or Therapeutic Phase) for applicable criteria for therapeutic SIJ injections.

**A. Medical Criteria:**

See applicable criteria below, EITHER item 1 for criteria for diagnostic SIJ injections or item 2 for criteria for therapeutic SIJ injections.

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

Diagnostic SIJ injections are considered medically necessary when ALL of the following applicable medical criteria are met for diagnostic injections (as specified below in items a through f), and the guidelines for the frequency and number of injections are met for the diagnostic phase (as specified in item B1 of this section):

a. The member has experienced severe and disabling non-radicular low back pain with BOTH of the following pain characteristics, as specified below in items (1) and (2):

   (1) Pain has occurred for at least three (3) months (i.e., chronic pain); AND

   (2) Pain is at least intermittent or continuous and is causing functional disability; AND

b. The 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 one** Sacroiliac Joint Injection

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**least THREE (3)** of the following clinical tests documented in the medical record, as specified below 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. The member’s symptoms have failed to respond to conservative treatment (including physical therapy), as defined below in BOTH item (1) and item (2):

(1) **Conservative Treatment (Except Physical Therapy):**

The member’s symptoms have failed to respond to at least a three (3)-month course of documented conservative measures, including at least ONE (1) of the following, as specified below in items (a) through (d):

*Sacroiliac Join Injections*
(a) Activity modification; OR

(b) Correction of postural abnormalities; OR

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

(d) The treating physician, and/or treating licensed independent practitioner practicing within the scope of his/her 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 for physical therapy, as specified below in item (a) for failed clinical response to physical therapy or item (b) when the member is unable to tolerate physical therapy:

(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 of the following conditions in the member’s medical record, as specified below in item i and item ii:

i. The member’s symptoms have failed to respond to six (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 six (6) weeks of physical therapy may also be included as a component of the three (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 his/her license (i.e., nurse practitioner or physician assistant) has documented in the member’s medical record.
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 injections does not exceed the Plan’s frequency guidelines specified in item B1 of this section (Guidelines for Frequency and Number of Injections/Diagnostic Phase); OR

2. Criteria for Therapeutic SIJ Injections:

Therapeutic SIJ injections are considered medically necessary when ALL of the following medical criteria are met for therapeutic injections (as specified below in items a through d), and the guidelines for the frequency and number of injections are met for the therapeutic phase (as specified in item B2 of this section):

a. ALL criteria are met for diagnostic SIJ injection (as specified in item A1 above); AND

b. A previous diagnostic 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) Ability to perform previously painful movement without deterioration of pain relief; AND

c. Therapeutic injection is provided as part of a comprehensive pain management program, and the pain management program includes ALL of the following components, as specified below 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

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activities, including at least ONE (1) of the following, as specified below 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); OR

B. Guidelines for Frequency and Number of Injections:

See applicable criteria below for frequency and number of injections, EITHER item 1 for the diagnostic phase or item 2 for the treatment or therapeutic phase. When the Plan’s applicable medical criteria are met (as stated above for either the diagnostic or therapeutic phase of treatment), the frequency and number of SIJ injections that are considered medically necessary are as follows:

1. Diagnostic Phase:

   ALL of the following criteria must be met for the diagnostic phase, as specified below 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 one (1) week apart with no more than two (2) injections allowed in a 14-day period (i.e., each series of injections within this guideline counts as one [1] session of treatment for the member); AND
c. No more than one (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

d. The member has received no more than four (4) sessions of injections 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 of the following criteria must be met for the therapeutic phase, as specified below in items a through e:

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

   b. The diagnostic phase has been completed; AND

   c. A previous diagnostic SIJ injection identifies sacroiliac joint 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 from the last diagnostic SIJ injection; AND

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

   d. A maximum of four (4) sessions for SIJ injections is allowed in a 12-month period and must also comply with ALL of the following parameters, as specified below in items (1), (2), and (3):

      (Note: Each series of injections within this guideline counts as one [1] session of treatment for the member.)

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

      (2) No more than one (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 injection, the injection has provided greater than 50% pain relief from baseline pain for at least six (6) weeks.

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Limitations

1. Sacroiliac joint injection for the treatment of acute back pain is not considered medically necessary.

2. Sacroiliac joint injection is considered experimental and investigational for any indication other than chronic low back pain or when Plan criteria are not met.

3. A request for a sacroiliac joint injection for member less than age 18 on the date of service requires Plan Medical Director review.

4. A request for a sacroiliac joint injection for a member with a malignancy at the injection site requires Plan Medical Director review; sacroiliac joint injections may or may not be considered medically necessary after individual consideration (based on clinical documentation provided to the Plan) for palliative pain relief when the member is actively being treated by an oncologist.

5. When the member has exceeded the maximum allowable number of injections specified in the Medical Policy Statement section of this Plan policy, the service is not considered medically necessary.

6. A sacroiliac joint injection conducted without fluoroscopic guided imaging (i.e., blinded) is considered experimental and investigational. A sacroiliac joint injection guided by CT, ultrasonography, or MRI (rather than fluoroscopic guidance) is considered experimental and investigational.

7. A sacroiliac joint injection is not considered medically necessary if a facet injection is performed at the same session.

8. Contraindications to sacroiliac joint injections include ANY of the following, as specified below in items a through d:

   a. Patient with local or systemic infection 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.

**Definitions**

**Compression Test:** In the compression test, the patient lies on one side. The examiner applies pressure on one pelvic brim in the direction of the other. A positive result is pain across the sacroiliac (SI) joint.

**Flamingo Test:** Patient stands on the test extremity lifting the unaffected leg off the ground. Test is positive if patient’s symptoms are reproduced on that side or at the pubic symphysis. An additional provocation may be to add gentle to moderate hopping.

**Fortin Finger Test:** In the Fortin finger test, the patient points to the area of pain with one finger. The result is positive if the site of pain is within 1 cm of the posterior superior iliac spine (PSIS), generally inferomedially.

**Gaenslen Test:** In the Gaenslen test, the patient is supine. The hip and knee are maximally flexed toward the trunk, and the opposite leg is extended. Pressure is applied to the flexed extremity. The finding is positive if pain is felt across the SI joint. Gaenslen's test is one of the five (5) provocation tests that can be used to detect musculoskeletal abnormalities and primary-chronic inflammation of the lumbar vertebrae and sacroiliac joint. The subsequent tests include the Distraction test, Thigh thrust test, Compression test and the Sacral thrust test.

**Gillet’s Test:** Gillet’s test is done with the patient in the standing position. The patient stands on one leg while flexing the opposite hip and knee into the chest. Motion of the sacroiliac joint is assessed by placing one thumb under the posterior superior iliac spine on the side of hip flexion, with the other thumb in the midline at the S2 level. Normally, the thumb under the posterior superior iliac spine drops inferiorly and laterally with hip flexion. Restriction is indicated by decreased motion compared to the normal side.

**Patrick Test (or Faber Maneuver):** The Patrick test or the Faber maneuver is flexion, abduction, and external rotation of the hip. The patient lies supine. The heel of the tested side is placed on the opposite knee. Pressure is put on the flexed knee and the opposite anterior superior iliac spine area. Result is positive for SI dysfunction if pain is elicited in the SI joint area.

**Pelvic Compression Test:** The patient lies on his side with the affected side up. The examiner places his forearm over the iliac crest and presses downward for approximately 30 seconds. This test is positive if pain occurs.
Pelvic Rock Test: Pressure is applied on the pelvis while the examiner’s palms are on the iliac tubercles and the thumbs on the anterosuperior iliac spines. Pain at the sacroiliac joint may indicate sacroiliac joint pathology.

Piedallu Seated Flexion Test: In the Piedallu seated flexion test, the patient is seated with the examiner behind him. The examiner’s thumbs are placed just below the posterior superior iliac spine. The patient flexes the trunk forward. A positive result is asymmetry of motion.

Sacroiliac Resisted Abduction Test (REAB): This test is done with the patient lying on the side with the upper leg straight out and slightly abducted while the lower leg is flexed at the hip and knee for stability. With the patient resisting, the examiner applies downward pressure on the upper limb. The test is then repeated on the opposite side. If this action causes pelvic pain around the posterior superior iliac spine, the test is considered positive, indicating a Sacroiliac lesion, and more specifically, a sacroiliac sprain or subluxation.

Van Durson Standing Flexion Test: In the Van Durson standing flexion test, the patient is standing with the examiner behind him. The examiner’s thumbs are placed just below each posterior iliac spine. The patient flexes the trunk forward without bending the knees. A positive sign is asymmetric motion.

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). Because 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 Medical Policy Statement section and Limitation section of this Plan policy, 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. Coverage for services is subject to benefit eligibility under the member’s benefit plan. Please refer to the member’s benefits document in effect at the time of the service to determine coverage or non-coverage as it applies to an individual member. See Plan reimbursement policies for Plan billing guidelines.
### CPT Codes

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<thead>
<tr>
<th>CPT Codes</th>
<th>Description: Codes Covered When Medically Necessary (Using Fluoroscopy or CT)</th>
</tr>
</thead>
<tbody>
<tr>
<td>27096</td>
<td>Injection procedure for sacroiliac joint, anesthetic/steroid, with image guidance (fluoroscopy or CT) including arthrography when performed</td>
</tr>
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<td></td>
<td>Plan note: This code should only be used for the professional component of the service.</td>
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<tr>
<th>HCPCS Code</th>
<th>Description: Codes Covered When Medically Necessary</th>
</tr>
</thead>
<tbody>
<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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<tr>
<td></td>
<td>Plan note: This code should only be used for the technical component of the service.</td>
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</table>

### Clinical Background Information

Lumbar intervertebral discs, facet joints, sacroiliac joint, ligaments, fascia, muscles, and nerve root dura have been shown to be capable of transmitting pain in the lumbar spine with resulting symptoms of low back pain and lower extremity pain. The diagnostic blocks applied in the precision diagnosis of chronic low back pain include lumbar facet joint nerve blocks, lumbar provocation discography, and sacroiliac joint blocks.

Disorders of the sacroiliac joints (SIJ) often contribute to chronic low back pain. By blocking the nerve to the SIJ, the pain impulses can be interrupted. Generally, SIJ injections are performed as part of a work-up for chronic back pain and are considered diagnostic or therapeutic. Diagnostic SIJ injections use short-acting local anesthetics to diagnose SIJ dysfunction as the cause of chronic low back pain. Confirmation that the SIJ is the source of pain is obtained if the block is successful in pain relief. Therapeutic SIJ blocks use long-acting local anesthetics and/or anti-inflammatory agents such as corticosteroids as a treatment for chronic low back pain. If successful, a series of SIJ blocks may be medically necessary for relapse in pain, however, it is generally not reasonable to perform more than 4 series of injections in a 12-month period.

SIJ procedures involve placing a needle into the SIJ, generally under fluoroscopic guidance. Typically, the procedure is done in the outpatient setting and is usually performed by an orthopedic surgeon, physiatrist, interventional radiologist, neurosurgeon, pain management physician, or other qualified physician. Serious side effects are rare, but reported complications include local anesthetic reactions, superficial infections, and/or degenerative changes in the joints.

At the time of the Plan’s most recent policy review, no clinical guidelines were found from the Centers for Medicare & Medicaid Services (CMS) for sacroiliac joint injections. Determine if applicable CMS criteria are in effect for this service in a national coverage determination (NCD) or local coverage determination (LCD) on the date of the prior authorization request for a Senior Care Options member.
References


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Cimolin V. Effects of obesity and chronic low back pain on gait. J Neuroeng Rehabil. 01 Jan 2011; 8: 55.


Sacroiliac Joint Injections


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**Sacroiliac Joint Injections**

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### Regulatory Approval:
- N/A

### Internal Approval:
- 06/10/08: MPCTAC
- 06/24/08: UMC
- 08/13/08: QIC

### Original Approval Date*

<table>
<thead>
<tr>
<th>Regulatory Approval: N/A</th>
<th>Original Effective Date and Version Number</th>
<th>Policy Owner</th>
<th>Approved by</th>
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<tbody>
<tr>
<td></td>
<td>11/01/08 Version 1</td>
<td>Medical Policy Manager as Chair of Medical Policy, Criteria, and Technology Assessment Committee (MPCTAC) and member of Quality Improvement Committee (QIC)</td>
<td>MPCTAC, Utilization Management Committee (UMC), and QIC</td>
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*Effective Date for the BMC HealthNet Plan Commercial Product(s): 01/01/12
*Effective Date for the Well Sense Health Plan New Hampshire Medicaid Product(s): 01/01/13
*Effective Date for Senior Care Options Product(s): 01/01/16

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

<table>
<thead>
<tr>
<th>Review Date</th>
<th>Summary of Revisions</th>
<th>Revision Effective Date and Version Number</th>
<th>Approved by</th>
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<tbody>
<tr>
<td>06/23/09</td>
<td>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 pain. Updated references and coding sections. Effective date of changes is 10/01/09.</td>
<td>10/01/09 Version 2</td>
<td>06/23/09: MPCTAC 06/23/09: UMC 07/22/09: QIC</td>
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<tr>
<td>06/01/10</td>
<td>No changes to criteria. Updated references and coding.</td>
<td>Version 3</td>
<td>06/30/10: MPCTAC 07/28/10: QIC</td>
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<tr>
<td>06/01/11</td>
<td>Updated clinical criteria to clarify that the absence of</td>
<td>Version 4</td>
<td>06/29/11: MPCTAC</td>
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<tbody>
<tr>
<td>07/01/12</td>
<td>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 <em>Medically Necessary</em> policy.</td>
<td>Version 5</td>
<td>06/20/12: MPCTAC 07/18/12: MPCTAC 08/22/12: QIC</td>
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<tr>
<td>08/01/12</td>
<td>Off cycle review for Well Sense Health Plan. No changes.</td>
<td>Version 6</td>
<td>08/13/12: MPCTAC 09/06/12: QIC</td>
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<tr>
<td>12/01/12</td>
<td>Revised sacroiliac joint injection frequency guidelines in Medical Policy Statement section.</td>
<td>Version 7</td>
<td>12/19/12: MPCTAC 12/20/12: QIC</td>
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<tr>
<td>02/01/13</td>
<td>Review for effective date 06/01/13. Separated facet joint nerve injections and sacroiliac joint injections into two separate policies; policy formerly titled <em>Facet Joint Nerve Injections and Sacroiliac Joint Injections for Chronic Neck Pain and Chronic Back Pain</em> (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. Revised medical criteria in the Medical Policy Statement section (formerly named the Clinical Guideline Statement section).</td>
<td>06/01/13</td>
<td>02/20/13: MPCTAC 03/21/13: QIC</td>
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<td>08/14/13</td>
<td>Off cycle review for Well Sense Health Plan and merged policy format. Incorporate policy revisions dated 12/01/12 and 02/01/13 (as specified above) for Sacroiliac Join Injections.</td>
<td>Version 9</td>
<td>08/14/13: MPCTAC (electronic vote) 08/15/13: QIC</td>
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<thead>
<tr>
<th>Date</th>
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<th>Revisions History</th>
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<tbody>
<tr>
<td>03/01/14</td>
<td>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.</td>
<td>07/01/14</td>
<td>03/19/14: MPCTAC 04/16/14: QIC</td>
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<td>09/01/14</td>
<td>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.</td>
<td>11/01/14</td>
<td>09/17/14: MPCTAC 10/08/14: QIC</td>
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<tr>
<td>02/01/15</td>
<td>Review for effective date 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.</td>
<td>06/01/15</td>
<td>02/27/15: MPCTAC (electronic vote) 03/11/15: QIC</td>
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<tr>
<td>11/25/15</td>
<td>Review for effective date 01/01/16. Updated template with list of applicable products and notes. Revised language in the Applicable Coding section.</td>
<td>01/01/16</td>
<td>11/18/15: MPCTAC 11/25/15: MPCTAC (electronic vote) 12/09/15: QIC</td>
<td></td>
</tr>
<tr>
<td>02/01/16</td>
<td>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.</td>
<td>06/01/16</td>
<td>02/17/16: MPCTAC 03/09/16: QIC</td>
<td></td>
</tr>
</tbody>
</table>

### Last Review Date
02/01/16

### Next Review Date
02/01/17

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Sacroiliac Join Injections

*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 Well Sense Health Plan.*
**Authorizing Entity**

QIC

**Other Applicable Policies**

Medical Policy - *Experimental and Investigational Treatment*, policy number OCA 3.12
Medical Policy - *Facet Denervation Treatments (Including Percutaneous, Non-Pulsed Radiofrequency)*, policy number OCA 3.70
Medical Policy - *Facet Joint Nerve Injections*, policy number OCA 3.9641
Medical Policy - *Medically Necessary*, policy number OCA 3.14

**Reference to Applicable Laws and Regulations**


**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.

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