Sacroiliac joint pain treatment procedures

These services may or may not be covered by your HealthPartners plan. Please see your plan documents for your specific coverage information. If there is a difference between this general information and your plan documents, your plan documents will be used to determine your coverage.

Administrative Process

Prior authorization is required for each sacroiliac joint injection. A completed medical review form must be submitted with documentation as outlined for prior authorization.

Prior authorization is required for minimally invasive sacroiliac joint fusion surgery.

Prior authorization is not applicable for open sacroiliac joint fusion surgery.

Prior authorization is not applicable for radiofrequency ablation for sacroiliac joint pain.

Coverage

Sacroiliac joint injections are generally covered subject to the indications listed below and per your plan documents.

Minimally invasive sacroiliac joint fusion surgery is generally covered subject to the indications listed below and per your plan documents.

Open sacroiliac joint fusion surgery is considered investigational/experimental and is therefore not covered.

Radiofrequency ablation for sacroiliac joint pain is considered investigational/experimental and is therefore not covered.

Indications that are covered

Sacroiliac joint injections (unilateral or bilateral) are covered to diagnose or treat sacroiliac (SI) joint pain when the following criteria are met:

1. Pain limiting activities of daily living for at least three months despite conservative treatments (including physical therapy, activity modification, and pharmacological management), that is documented in the clinical records submitted for prior authorization.

   Conservative therapy must include physical therapy (PT) and may include activity modification, weight loss, and drug therapy. Documentation must correspond to the current episode of pain (within six months).

   Formal physical therapy, at least four visits over a six week course, including active muscle conditioning is required, or there must be an explicit statement in the clinical documents that explains why such physical therapy is contraindicated. The requirement for physical therapy will not be met if there is a failure to complete prescribed physical therapy for non-clinical reasons. Documentation of formal physical therapy would be the therapist’s notes. If a patient is unable to complete physical therapy (PT) due to progressively, worsening pain and disability, the case will be reviewed on an individual basis by an internal physician reviewer. Documentation in the physical therapist’s notes demonstrating this must be submitted; and

   2. Pain is below the L5 level – low back and buttock pain with or without groin pain.

   3. When fewer than twelve months have lapsed since the initial injection, repeat injection is covered when the two criteria below are met:

      A. The previous injection provided significant benefit
      B. Buttock and low back pain below L5 level has reoccurred

   4. A maximum of three injections per 12 month period will be authorized if coverage criteria are met

Minimally invasive or percutaneous sacroiliac joint fusion is covered when all of the following criteria are met:

1. There is a positive response to at least three provocative tests (e.g. thigh thrust test, compression test, Gaenslen’s test, distraction test, Patrick’s sign); and

2. Absence of generalized pain behavior (e.g. somatoform disorder) and generalized pain disorders (e.g. fibromyalgia); and

3. Member reports of non-radiating, unilateral pain that is caudal to the lumbar spine (L5 vertebrae), localized over the posterior SIJ, and consistent with SIJ pain; and

4. Physical examination demonstrates localized tenderness with palpation over the sacral sulcus.
(Fortin’s point) in the absence of tenderness of similar severity elsewhere (e.g. greater trochanter, lumbar spine, coccyx) and other obvious sources for their pain do not exist; and

5. Diagnostic imaging studies obtained in the last 12 months that include all of the following:
   A. Imaging (plain radiographs and a CT or MRI) of the SI joint that excludes the presence of destructive lesions (e.g. tumor, infection) fracture, traumatic SIJ instability or inflammatory arthropathy that would not be properly addressed by percutaneous SIJ fusion; and
   B. Imaging of the ipsilateral hip (plain radiographs) to rule out osteoarthritis; and
   C. Imaging of the lumbar spine (CT or MRI) to rule out neural compression or other degenerative condition that can be causing low back or buttock pain; and

6. Reported reduction in pain from SI joint injection on two separate occasions for the requested side; and

7. Six months of failed conservative treatment that includes all of the following: activity modification, pharmacological management with nonsteroidal anti-inflammatory drugs (NSAIDS) or other analgesic medications and physical therapy. Physical therapy, at least four visits over a six week course, including active muscle conditioning is required, or there must be an explicit statement in the clinical documents that explains why such physical therapy is contraindicated. The requirement for physical therapy will not be met if there is a failure to complete prescribed physical therapy for non-clinical reasons. Documentation of formal physical therapy would be the therapist’s notes. If a patient is unable to complete physical therapy (PT) due to progressively, worsening pain and disability, the case will be reviewed on an individual basis by an internal physician reviewer. Documentation in the physical therapist’s notes demonstrating this must be submitted.

Indications that are not covered

1. Sacroiliac joint injections are not covered when performed without guidance by real-time fluoroscopic imaging.
2. Open sacroiliac joint fusion surgery is considered experimental and investigational and not covered because there is not published peer reviewed scientific evidence to establish the safety and efficacy of this treatment or its effect on health care outcomes.
3. Sacroiliac joint radiofrequency ablation (RFA), conventional cooled, laser or other variations, is considered experimental and investigational and not covered because there is not published peer reviewed scientific evidence to establish the safety and efficacy of this treatment or its effect on health care outcomes.

Codes

If available, codes are listed below for informational purposes only, and do not guarantee member coverage or provider reimbursement. The list may not be all-inclusive.

Codes that may be covered after prior authorization

**Sacroiliac Joint Injections**

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<thead>
<tr>
<th>Codes</th>
<th>Description</th>
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<tbody>
<tr>
<td>27096</td>
<td>Injection procedure for sacroiliac joint, anesthetic/steroid, with image guidance (fluoroscopy or CT) including arthrography when performed</td>
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<tr>
<td>G0259</td>
<td>Injection procedure for sacroiliac joint, arthrography</td>
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<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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**Sacroiliac Joint Fusion**

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<th>Codes</th>
<th>Description</th>
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<tr>
<td>27279</td>
<td>Arthrodesis, sacroiliac joint, percutaneous or minimally invasive (indirect visualization), with image guidance, includes obtaining bone graft when performed, and placement of transfixing device</td>
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<tr>
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<tbody>
<tr>
<td>27280</td>
<td>Arthrodesis, sacroiliac joint (including obtaining graft)</td>
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**Radiofrequency Ablation for sacroiliac pain**

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<th>Codes</th>
<th>Description</th>
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<tr>
<td>64635</td>
<td>Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT): lumbar or sacral, single facet joint</td>
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<tr>
<td>64636</td>
<td>Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance</td>
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Products

This information is for most, but not all, HealthPartners plans. Please read your plan documents to see if your plan has limits or will not cover some items. If there is a difference between this general information and your plan documents, your plan documents will be used to determine your coverage. These coverage criteria may not apply to Medicare Products if Medicare requires different coverage. For more information regarding Medicare coverage criteria or for a copy of a Medicare coverage policy, contact Member Services at 952-983-7979 or 1-800-233-9645.


References


