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

Sacroiliac (SI) joint pain treatments that require prior authorization:
1. Sacroiliac joint fusion surgery, including minimally invasive surgery for sacroiliac joint fusion including but not limited to use of iFuse implant system
2. Radiofrequency ablation for sacroiliac joint pain.
3. Sacroiliac joint injections for sacroiliac joint pain. A completed medical review form must be submitted with documentation as outlined for prior authorization.

Coverage

Sacroiliac joint pain treatment procedures are generally covered subject to the indications listed below.

Indications that are covered

Sacroiliac joint injections (unilateral or bilateral) are covered to diagnose or treat sacroiliac (SI) joint pain if ALL of the following criteria are met:
1. Severe pain limiting activities of daily living for at least 3 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 6 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. Repeat injections are covered if the patient has achieved significant benefit after the first injection and symptoms have reoccurred.
4. Prior authorization is required for each injection.
5. A maximum of 3 injections per 12 month period will be authorized if coverage criteria are met.

Indications that are not covered

1. Sacroiliac joint injections are not covered when performed without guidance by real-time fluoroscopic imaging
2. Sacroiliac joint fusion including minimally invasive surgery for sacroiliac joint fusion, including but not limited to use of iFuse implant system, is considered experimental and investigational and not covered because there is not published peer reviewed scientific evidence to prove effectiveness.
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 prove effectiveness.

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

<table>
<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</td>
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CT) including arthrography when performed

G0260 Injection procedure for sacroiliac joint; provision of anesthetic, steroid and/or other therapeutic agent, with or without arthrography

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<th>Codes</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>
<td>27280</td>
<td>Arthrodesis, sacroiliac joint (including obtaining graft)</td>
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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 (fluoroscopy or CT); lumbar or sacral, each additional facet joint (List separately in addition to code for primary procedure)</td>
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<tr>
<td>64999</td>
<td>Unlisted procedure, nervous system</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 952-883-7979 or 1-800-233-9645.


References