BlueCross BlueShield of Alabama

Name of Policy:
Diagnosis and Treatment of Sacroiliac Joint Pain

Policy #: 558
Category: Surgery

Latest Review Date: December 2017
Policy Grade: A

Background/Definitions:

As a general rule, benefits are payable under Blue Cross and Blue Shield of Alabama health plans only in cases of medical necessity and only if services or supplies are not investigational, provided the customer group contracts have such coverage.

The following Association Technology Evaluation Criteria must be met for a service/supply to be considered for coverage:

1. *The technology must have final approval from the appropriate government regulatory bodies;*
2. *The scientific evidence must permit conclusions concerning the effect of the technology on health outcomes;*
3. *The technology must improve the net health outcome;*
4. *The technology must be as beneficial as any established alternatives;*
5. *The improvement must be attainable outside the investigational setting.*

Medical Necessity means that health care services (e.g., procedures, treatments, supplies, devices, equipment, facilities or drugs) that a physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury or disease or its symptoms, and that are:

1. *In accordance with generally accepted standards of medical practice; and*
2. *Clinically appropriate in terms of type, frequency, extent, site and duration and considered effective for the patient's illness, injury or disease; and*
3. *Not primarily for the convenience of the patient, physician or other health care provider; and*
4. *Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.*

Description of Procedure or Service:

Sacroiliac joint arthrography using fluoroscopic guidance with injection of an anesthetic has been explored as a diagnostic test for sacroiliac joint pain. Duplication of the patient's pain pattern with the injection of contrast medium suggests a sacroiliac etiology, as does relief of chronic back pain with injection of local anesthetic. Treatment of sacroiliac joint pain with corticosteroids, radiofrequency ablation (RFA), and stabilization has also been explored.

Similar to other structures in the spine, it is assumed that the sacroiliac joint may be a source of low back pain. In fact, before 1928, the sacroiliac joint was thought to be the most common cause of sciatica. In 1928, the role of the intervertebral disc was elucidated, and from that point forward, the sacroiliac joint received less research attention.

Research into sacroiliac joint pain has been thwarted by any criterion standard to measure its prevalence and against which various clinical examinations can be validated. For example, sacroiliac joint pain is typically without any consistent, demonstrable radiographic or laboratory features and most commonly exists in the setting of morphologically normal joints. Clinical tests for sacroiliac joint pain may include various movement tests, palpation to detect tenderness, and pain descriptions by the patient. Further confounding study of the sacroiliac joint is that multiple structures, such as posterior facet joints and lumbar discs, may refer pain to the area surrounding the sacroiliac joint.

Because of inconsistent information obtained from history and physical examination, some have proposed the use of image-guided anesthetic injection into the sacroiliac joint for the diagnosis of sacroiliac joint pain. Cryoablation is a minimally invasive procedure that involves the use of extreme cold to destroy abnormal tissue. Treatments being investigated for sacroiliac joint pain include prolotherapy (refer to policy # *235 Prolotherapy*), corticosteroid injection, RFA, stabilization, and arthrodesis. For indications and coverage criteria related to sacroiliac arthrodesis and minimally invasive procedures related to the SI joint please refer to policy #555 *Sacroiliac Joint Fusion*. Also this policy does not address treatment of pain in the sacroiliac joint due to infection, trauma, or neoplasm.

Policy:

Effective for dates of services on or after May 14, 2017:

Injection of anesthetic for diagnosing sacroiliac joint pain meets Blue Cross and Blue Shield of Alabama's medical criteria for coverage when **ALL** of the following criteria have been met:

- Pain has failed to respond to 3 months of conservative therapy*; **AND**
- Dual (controlled) diagnostic blocks** with 2 anesthetic agents with differing duration of action are used; **AND**
- The injections are performed under imaging guidance.

Injection of corticosteroid for the treatment of sacroiliac joint pain meets Blue Cross and Blue Shield of Alabama's medical criteria for coverage when **ALL** of the following criteria have been met:

- Pain has failed to respond to 3 months of conservative therapy*; **AND**
- The injection is performed under imaging guidance; **AND**

- No more than 3 injections are given in one year.

Arthrography of the sacroiliac joint does not meet Blue Cross and Blue Shield of Alabama's criteria for coverage and will be considered **investigational**.

Radiofrequency denervation of the sacroiliac joint does not meet Blue Cross and Blue Shield of Alabama's criteria for coverage and will be considered **investigational**.

Cryoablation (cryodenervation, cryoneurolysis, cryosurgery, or cryoanesthesia) of the sacroiliac joint does not meet Blue Cross and Blue Shield of Alabama's criteria for coverage and will be considered **investigational**.

Effective for dates of service prior to May 14, 2017:

Injection of anesthetic for diagnosing sacroiliac joint pain meets Blue Cross and Blue Shield of Alabama's medical criteria for coverage when **ALL** of the following criteria have been met:

- Pain has failed to respond to 3 months of conservative therapy*; **AND**
- Dual (controlled) diagnostic blocks** with 2 anesthetic agents with differing duration of action are used; **AND**
- The injections are performed under imaging guidance.

Injection of corticosteroid for the treatment of sacroiliac joint pain meets Blue Cross and Blue Shield of Alabama's medical criteria for coverage when **ALL** of the following criteria have been met:

- Pain has failed to respond to 3 months of conservative therapy*; **AND**
- The injection is performed under imaging guidance; **AND**
- No more than 3 injections are given in one year.

Arthrography of the sacroiliac joint does not meet Blue Cross and Blue Shield of Alabama's criteria for coverage and will be considered **investigational**.

Radiofrequency denervation of the sacroiliac joint does not meet Blue Cross and Blue Shield of Alabama's criteria for coverage and will be considered **investigational**.

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*__Conservative therapy__ is the use of structured physician-directed modalities which may include: prescription strength analgesics/anti-inflammatory medications if not contraindicated; participation in therapeutic physical medicine modality(ies) and/or manipulations when rendered by an eligible provider (including active exercise).

****** A successful trial of controlled diagnostic lateral branch blocks consists of two separate positive blocks on different days with local anesthetic only (no steroids or other drugs), or a placebo-controlled series of blocks, under fluoroscopic guidance, that has resulted in a reduction in pain for the duration of the local anesthetic used (e.g., three hours longer with bupivacaine than lidocaine). There is not a consensus on whether a minimum of 50% or 75% reduction in pain would be required to be considered a successful diagnostic block, although evidence supports a criterion standard of 75% to 100% reduction in pain with dual blocks. No

therapeutic intra-articular injections (i.e., steroids, saline, and other substances) should be administered for a period of at least four weeks before the diagnostic lateral branch block. The diagnostic blocks should not be conducted under intravenous sedation unless specifically indicated (e.g., the patient is unable to cooperate with the procedure).

Blue Cross and Blue Shield of Alabama does not approve or deny procedures, services, testing, or equipment for our members. Our decisions concern coverage only. The decision of whether or not to have a certain test, treatment or procedure is one made between the physician and his/her patient. Blue Cross and Blue Shield of Alabama administers benefits based on the member's contract and corporate medical policies. Physicians should always exercise their best medical judgment in providing the care they feel is most appropriate for their patients. Needed care should not be delayed or refused because of a coverage determination.

Key Points:

The most recent literature review was performed through September 11, 2017. Following is a summary of key references to date.

Diagnosis of Sacroiliac Joint Pain

The use of diagnostic blocks to evaluate sacroiliac joint pain builds on the experience of use of diagnostic blocks in other joints to evaluate pain. Blinded studies with placebo controls (although difficult to conduct when dealing with invasive procedures) are ideally required for scientific validation of sacroiliac joint blocks, particularly when dealing with pain relief well-known to respond to placebo controls. In the typical evaluation of a diagnostic test, the results of sacroiliac diagnostic block would then be compared with a criterion standard. However, there is no current criterion standard for sacroiliac joint injection. In fact, some authors have positioned sacroiliac joint injection as the criterion standard against which other diagnostic tests and physical exam may be measured. Ultimately, the point of diagnosis is to select patients appropriately for treatment that improves outcomes. Diagnostic tests that differentiate patients who do or do not benefit from a particular treatment are clinically useful.

The 2009 practice guidelines from the American Pain Society (APS) were based on a systematic review that was commissioned by the APS and conducted at the Oregon Evidence-based Practice Center. The systematic review concluded that no reliable evidence existed to evaluate validity or utility of diagnostic sacroiliac joint block as a diagnostic procedure for low back pain with or without radiculopathy, with a resulting guideline recommendation of insufficient evidence. Data on sacroiliac joint steroid injection were limited to one small controlled trial, resulting in a recommendation of insufficient evidence for therapeutic injection of this joint. In 2010, Manchikanti et al published critical reviews of the APS guidelines for interventional techniques, including sacroiliac injections. Evidence for diagnostic sacroiliac injections was considered to be fair to poor, and no additional literature was identified since the 2009 systematic review by Rupert et al.

In 2013, the American Society of Interventional Pain Physicians (ASIPP) published an updated evidence review and guidelines regarding diagnosis of sacroiliac joint pain. Various studies evaluating diagnostic blocks were reviewed in which the criteria for a positive test varied from

50% to 100% relief from either single or dual blocks. The most stringent criteria, 75% to 100% relief with dual blocks, were evaluated in 7 studies. The prevalence of a positive test in the 7 studies ranged from 10% to 44.4% in patients with suspected sacroiliac disease. The evidence for diagnostic sacroiliac intra-articular injections was considered to be good using 75% to 100% pain relief with single or dual blocks as the criterion standard.

Section Summary: Diagnosis of Sacroiliac Joint Pain
Although there is no independent reference standard for the diagnosis of sacroiliac joint pain, sacroiliac joint blocks are considered the reference standard for the condition. The utility of this test ultimately depends on its ability to identify patients who benefit from treatment.

Treatment of Sacroiliac Joint Pain
Evidence reviews assess the clinical evidence to determine whether the use of a technology improves the net health outcome. Broadly defined, health outcomes are length of life, quality of life, and ability to function- including benefits and harms. Every clinical condition has specific outcomes that are important to patients and to managing the course of that condition. Validated outcome measures are necessary to ascertain whether a condition improves or worsens; and whether the magnitude of that change is clinically significant. The net health outcome is balance of benefits and harms.

To assess whether the evidence is sufficient to draw conclusions about the net health outcome of a technology, 2 domains are examined: the relevance and the quality and credibility. To be relevant, studies must represent one or more intended clinical use of the technology in the intended population and compare an effective and appropriate alternative at a comparable intensity. For some conditions the alternative will be supportive care or surveillance. The quality and credibility of the evidence depend on study design and conduct, minimizing bias and confounding that can generate incorrect findings. The randomized controlled trial (RCT) is preferred to assess efficacy; however, in some circumstances, nonrandomized studies may be adequate. RCTs are rarely large enough or long enough to capture less common adverse events and long-term effects. Other types of studies can be used for these purposes and to assess generalizability to broader clinical populations and settings of clinical practice.

Systematic Reviews
Hansen et al published an updated systematic review of sacroiliac joint interventions in 2012. The primary outcome was short-term (≤6 months) or long-term (>6 months) pain relief. Evidence was classified as good, fair, or limited/poor based on the quality of evidence. A total of 11 studies (6 randomized, 5 nonrandomized trials) met inclusion criteria. Review found that evidence for intra-articular steroid injections is limited/poor, as is the evidence for periarticular injections (local anesthetic and steroid or botulinum toxin). For radiofrequency neurotomy, the evidence for cooled radiofrequency was found to be fair (2 randomized controlled trials [RCTs]), while evidence for conventional radiofrequency or pulsed radiofrequency was limited/poor. The 2013 ASIPP evidence review found no additional studies on intra-articular or periarticular injections besides those identified by Hansen.

Therapeutic Corticosteroid Injections

Randomized Controlled Trials

The available literature on therapeutic corticosteroid injections is limited, consisting of small RCTs and case series. Case series studies evaluating corticosteroid injections are described in systematic reviews and show variable findings at generally short-term follow-up.

A 2013 study randomized 51 patients with sacroiliac joint and leg pain to physiotherapy, manual therapy, or intra-articular injection of corticosteroid. Diagnosis of sacroiliac joint pain was based on provocation tests and not sacroiliac joint injections. In a blinded assessment, 25 patients (56%) were considered to be successfully treated at the 12-week follow-up visit based on complete relief of pain and improvement in the visual analog score (VAS) for pain. Physical therapy was successful in 20%, manual therapy in 72%, and intra-articular injection in 50%.

Kim et al reported a randomized double-blind, controlled trial of intra-articular prolotherapy compared with steroid injection for sacroiliac joint pain in 2010. The study included 48 patients with sacroiliac joint pain, confirmed by 50% or greater improvement in response to a single local anesthetic block, who had failed medical treatment. Intra-articular dextrose water prolotherapy or steroid injections were administered under fluoroscopic guidance on a biweekly schedule, with a maximum of 3 injections. Injections were stopped when pain relief was 90% or greater, which required a mean of 2.7 prolotherapy injections and 1.5 steroid injections. Pain (numerical rating scale) and disability scores (Oswestry Disability Index) were assessed at baseline, 2 weeks, and monthly after completion of treatment. At 2-week follow-up, pain and disability scores were significantly improved in both groups, with no significant difference between the groups. Pain on the numerical rating scale improved from 6.3 to 1.4 in the prolotherapy group and from 6.7 to 1.9 in the steroid group. At 6 months after treatment, 63.6% of patients in the prolotherapy group remained improved from baseline (≥50%), compared with 27.2% in the steroid group. At 15-month follow-up, the cumulative incidence of sustained pain relief was 58.7% in the prolotherapy group compared with 10.2% in the steroid group. The median duration of survival (recurrence of severe sacroiliac joint pain) was three months for the steroid group.

Section Summary: Therapeutic Corticosteroid Injections

Results from these 2 small trials are insufficient to permit conclusions regarding the effect of this procedure on health outcomes. Steroid injections were not the most effective treatment in either trial, and the degree of pain relief was limited. Larger trials with rigorous designs, preferably using sham injections, are needed to determine whether the treatment is effective.

Radiofrequency Denervation

Evidence comparing radiofrequency denervation of the sacroiliac joint to other treatments is limited. Two small RCTs using a cooled radiofrequency probe were identified. A third RCT used palisade sacroiliac joint radiofrequency neurotomy. Another RCT used a multi-electrode radiofrequency probe to perform the procedure.

Systematic Reviews

Aydin et al published a meta-analysis of radiofrequency ablation (RFA) for sacroiliac pain in 2010. Nine studies were included that reported the primary outcome measure of a reduction of

pain of 50% or greater, including one randomized placebo controlled study, 3 prospective observational studies, and 5 retrospective studies. All of the studies used injection of local anesthetic to determine if RFA was indicated for the patient. Seven studies reported follow-up to 3 months, and 6 studies reported follow-up to 6 months. Meta-analysis indicated that half or greater of the patients who received RFA to the sacroiliac joint showed a reduction in their pain of 50% or more at 3 and 6 months. Analysis found no evidence of publication bias, but heterogeneity in studies was observed for the 6-month follow-up. This meta-analysis showed low quality studies and lacked RCTs. In addition, as noted by the authors, no standards have been established for the specific nerves to ablate or type of technique.

No additional studies were identified in the 2013 ASIPP evidence review, which concluded that evidence is limited for conventional radiofrequency neurotomy, limited for pulsed radiofrequency neurotomy, and fair for cooled radiofrequency neurotomy.

Randomized Controlled Trials
The single RCT included in the systematic review was published in 2008. This trial by Cohen et al examined the effect of lateral branch radiofrequency denervation with a cooled probe in 28 patients with injection-diagnosed sacroiliac joint pain. Two (14%) of 14 patients in the placebo-control group reported pain relief at 1-month follow-up. None reported benefit at 3-month follow-up. Of 14 patients treated with radiofrequency denervation, 11 (79%) reported pain relief at 1 month, 9 (64%) at 3 months, and 8 (57%) at 6 months.

In 2012, Patel et al reported a randomized double-blind placebo-controlled trial of lateral branch neurotomy with a cooled radiofrequency probe. Twelve month follow-up was reported in 2016. Fifty-one patients who had a positive response to 2 lateral branch blocks were randomized in a 2:1 ratio to lateral branch radiofrequency or to sham. At 3-month follow-up, significant improvements in pain (-2.4 vs -0.8), physical function (14 vs 3), disability (-11 vs 2), and quality of life (0.09 vs 0.02) were observed for radiofrequency treatment compared with controls (all respectively). With treatment success defined as a 50% or greater reduction in the numerical rating scale (NRS), 47% of radiofrequency-treated patients and 12% of sham-treated patients achieved treatment success. The treatment response was durable to 12 months in the 25 of 34 patients who completed all follow-up visits. Of the 9 patients who terminated study participation, 4 (12%) of 34 were considered treatment failures.

In 2014, Zheng et al reported an RCT of palisade sacroiliac RFA in 155 patients with ankylosing spondylitis (AS). Palisade RFA uses a row of radiofrequency cannulae perpendicular to the dorsal sacrum. Inclusion criteria were age 18 to 75 years; diagnosis of AS; chronic low back pain for at least 3 months; axial pain below L5; no peripheral involvement; pain aggravation on manual pressing of the sacroiliac joint area; and at least 50% pain relief following fluoroscopically guided anesthetic injection into the joint. Patients who met the inclusion criteria were randomized to palisade RFA or celecoxib. Blinded evaluation to 24 weeks found that RFA (2.8) resulted in lower global VAS scores compared with celecoxib (5.0; $p<0.001$), as well improved scores for secondary outcome measures. This study lacked sham control.

In 2016, van Tilburg et al reported a sham-controlled RCT of percutaneous RFA in 60 patients with sacroiliac joint pain. Patients selected had clinically suspected SI joint pain of 2 or more points on a 10-point pain scale with a diagnostic SI block. At 3-month follow-up, there was no statistically significant difference in pain level over time between the groups (group by period interaction, p=0.56). Both groups improved over time (≈2 points out of 10; p value for time p<0.001). In their discussion, the authors mention that the criteria and method used for diagnosing SI joint pain may have resulted in selection some patients who did not have SI joint pain.

In 2017, Kuch et al reported a nonblinded multicenter RCT of radiofrequency denervation in 228 of 2498 patients with suspected sacroiliac pain who were asked to participate in the trial. Patient selection criteria included BMI (<35 kg/m^2), age (<70 years old), and pain reduction of at least 50% within 30 to 90 minutes of receiving a diagnostic sacroiliac block (n=228). An additional 202 patients who had negative diagnostic sacroiliac block; 1666 patients declined to participate in the trial. Patients meeting criteria were randomized to exercise plus radiofrequency denervation (n=116) or an exercise program alone (n=112), and were followed for a year. The RFA group had a modest improvement for the primary outcome at 3 months (-0.71; 95% confidence interval [CI], -1.35 to -0.06), but the control group improved over time and there were no statistically significant differences between the groups for pain intensity score (p=0.09) or in the number of patients who had more than 30% reduction in pain intensity (p=0.48) at 12 months. Limitations included the use of several techniques to achieve radiofrequency denervation, self-selection, lack of blinding, and high dropout rate (31%) in the control group.

Section Summary: Radiofrequency Ablation
The randomized trials of RFA have methodologic limitations and there is limited data on duration of treatment effect. Heterogeneity of RFA treatment techniques precludes generalizing the results across different studies.

Cryoablation
Cryoablation, also known as cryoneurolysis or cryodenervation is a minimally invasive method used to treat pain associated with sacroiliac joint disease. Under local anesthesia a slim, luminated, double-walled cryodenervation probe, which is cooled by carbon dioxide, is brought to the location of pain to freeze the nerves and achieve a prolonged but reversible nerve conduction block. The published scientific evidence is insufficient to support the efficacy and safety of this procedure for the treatment of chronic pain associated with sacroiliac joint disease.

Summary of Evidence
For individuals who have sacroiliac joint pain who receive therapeutic corticosteroid injections, the evidence includes small randomized controlled trials (RCTs) and case series studies. Relevant outcomes are symptoms, functional outcomes, quality of life, medication use, and treatment-related morbidity. In general, the literature regarding injection therapy on joints in the back is of poor quality. Results from 2 small RCTs of therapeutic sacroiliac joint injections are insufficient to permit conclusions on the effect of this procedure. Steroid injections were not as effective as the other active treatments used in these trials. Larger trials, preferably using sham

injections, are needed to determine the degree of benefit over placebo. The evidence is insufficient to determine the effects of the technology on health outcomes.

Clinical input supports the use of controlled diagnostic blocks with at least 75% pain relief for diagnosis of sacroiliac pain. Clinical input supported the use of corticosteroids for the treatment of sacroiliac joint pain. Based on clinical input and the established use of injections to diagnose and treat pain in other joints, controlled diagnostic (2 blocks with anesthetics of different duration) and therapeutic (corticosteroid) injections may be considered medically necessary for the diagnosis and treatment of sacroiliac joint pain.

For individuals who have sacroiliac joint pain who receive RFA, the evidence includes 4 small RCTs using different techniques of applying RF and case series studies. Relevant outcomes are symptoms, functional outcomes, quality of life, medication use, and treatment-related morbidity. For RFA with a cooled probe, the 2 small RCTs report short-term benefit, but these are insufficient to determine the overall effect on health outcomes. The RCT on palisade RFA of the sacroiliac joint did not include a sham control. Another sham-controlled RCT showed no benefit of RFA. Further high-quality controlled trials are needed that compare this procedure in defined populations with sham control and with alternative treatments. The evidence is insufficient to determine the effects of the technology on health outcomes.

Practice Guidelines and Position Statements

American Society of Interventional Pain Physicians Interventional Pain Management

American Society of Interventional Pain Physicians Interventional Pain Management guidelines were updated in 2013. The updated guidelines recommend the use of controlled sacroiliac joint blocks with placebo or controlled comparative local anesthetic block when indications are satisfied with suspicion of sacroiliac joint pain. A positive response to a joint block is considered to be at least a 75% improvement in pain or in the ability to perform previously painful movements. For therapeutic interventions, the only effective modality with fair evidence was cooled radiofrequency neurotomy, when used after the appropriate diagnosis was confirmed by diagnostic sacroiliac joint injections.

American Society of Anesthesiologists et al

In 2010, the American Society of Anesthesiologists Task Force on Chronic Pain Management and the American Society of Regional Anesthesia and Pain Medicine Practice updated their guidelines for chronic pain management. The guidelines recommend that diagnostic sacroiliac joint injections or lateral branch blocks may be considered for the evaluation of patients with suspected sacroiliac joint pain. Based on opinions of consultants and society members, the guidelines recommend that water-cooled RFA or sacroiliac joint injections may be used for chronic sacroiliac joint pain.

American Pain Society

The 2009 practice guidelines from the American Pain Society (APS) were based on a systematic review that was commissioned by the APS and conducted at the Oregon Evidence-based Practice Center. The APS guideline states that there is insufficient evidence to evaluate validity or utility of diagnostic sacroiliac joint block as a diagnostic procedure for low back pain

with or without radiculopathy and that there is insufficient evidence to adequately evaluate benefits of sacroiliac joint steroid injection for non-radicular low back pain.

U.S. Preventive Services Task Force Recommendations
Not Applicable.

Key Words:
Arthrography, Sacroiliac Joint Arthrography, Sacroiliac Joint Radiofrequency Ablation or Denervation, SI joint Injections, Diagnostic Blocks, Cryodenervation, Cryoneurolysis, Cryosurgery, Cryoanesthesia, Cryoablation

Approved by Governing Bodies:
A number of radiofrequency generators and probes have been cleared for marketing through the U.S. Food and Drug Administration's (FDA) 510(k) process. One device, the SInergy® by Halyard; formerly Kimberly Clark/Baylis, is a water-cooled single-use probe that received FDA clearance in 2005, listing the Baylis Pain Management Probe as a predicate device. The intended use is in conjunction with a radiofrequency generator to create radiofrequency lesions in nervous tissue.

Benefit Application:
Coverage is subject to member's specific benefits. Group specific policy will supersede this policy when applicable.
ITS: Home Policy provisions apply.
FEP: Special benefit consideration may apply. Refer to member's benefit plan. FEP does not consider investigational if FDA approved and will be reviewed for medical necessity.

Current Coding:

CPT Codes	**27096**	Injection procedure for sacroiliac joint, anesthetic/steroid, with image guidance (fluoroscopy or CT) including arthrography when performed
	20552	Injection(s); single or multiple trigger points(s), 1 or 2 muscle(s)
	27299	unlisted procedure, pelvis or hip joint
	64999	unlisted procedure, nervous system
HCPCS		
	G0259	Injection procedure for sacroiliac joint; arthrography
	G0260	Injection procedure for sacroiliac joint; provision of anesthetic, steroid and/or other therapeutic agent, with or without arthrography

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Policy History:

Medical Policy Panel, May 2014
Medical Policy Group, July 2014 **(3):** New Policy removed section from policy 303 related to SI joint injections as well as section from 141 related to SI joint denervation
Medical Policy Administration Committee, August 2014

Available for comment September 8 through October 22, 2014
Medical Policy Group, September 2014 **(3)**: added word "modality(ies)" to description of physical therapy in conservative therapy definition per Medical Director
Medical Policy Panel, April 2015
Medical Policy Group, May 2015 (**2**): 2015 Updates to Description, Key Points, Current Coding- added CPT code 20552, and References; no change to Policy statement.
Medical Policy Group, May 2015 (**2**): HCPCS codes G0259 and G0260 added to policy.
Medical Policy Panel, November 2015
Medical Policy Group, November 2015 (**2**): Updates to Key Points, Approved by Governing Bodies, and References; no change in policy statement.
Medical Policy Panel, August 2016
Medical Policy Group, August 2016 (**7**): Updates to Key Points and References. Policy Statement intent remains unchanged. Clarification to wording – removed "for the purpose" and added "anesthetic for."
Medical Policy Panel, October 2016
Medical Policy Group, October 2016 **(7)**: Updates to Key Points. No change in Policy Statement.
Medical Policy Group, March 2017 (7): Updates to Description, Key Points, Key Words, Current Coding- added CPT code 64999, and References. Also, added cryoablation as investigational to Policy Statement.
Available for comment March 30 through May 13, 2017
Medical Policy Group, April 2017 (7): Clarification to "conservative therapy" definition.
Medical Policy Panel, December 2017
Medical Policy Group, December 2017 **(7)**: 2017 Updates to Key Points and References. No change in Policy Statement.
