blue of california

Medical Policy

Sacroiliac Joint Injections	
Type: Medical Necessity/Not Medical Necessity	**Policy Specific Section:** Surgery
Original Policy Date: October 15, 2007	**Effective Date:** June 28, 2013

Definitions of Decision Determinations

Medically Necessary: A treatment, procedure or drug is medically necessary only when it has been established as safe and effective for the particular symptoms or diagnosis, is not investigational or experimental, is not being provided primarily for the convenience of the patient or the provider, and is provided at the most appropriate level to treat the condition.

Investigational/Experimental: A treatment, procedure or drug is investigational when it has not been recognized as safe and effective for use in treating the particular condition in accordance with generally accepted professional medical standards. This includes services where approval by the federal or state governmental is required prior to use, but has not yet been granted.

Split Evaluation: Blue Shield of California / Blue Shield of California Life & Health Insurance Company (Blue Shield) policy review can result in a Split Evaluation, where a treatment, procedure or drug will be considered to be investigational for certain indications or conditions, but will be deemed safe and effective for other indications or conditions, and therefore potentially medically necessary in those instances.

Description

Sacroiliac joint arthrography using imaging guidance with an 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.

Policy

Sacroiliac joint injections may be considered **medically necessary** when **all** of the following criteria are met:

- Patient has been diagnosed with sacroiliac joint pain which has resulted from disease, injury or surgery, based on clinical history and physical examination
- Patient has not responded sufficiently to at least a four-week course of conservative measures (exercise, physical methods including physical therapy, chiropractic care, NSAIDs and analgesics)
- Procedure is to be performed under imaging guidance
- Performed in conjunction with active rehabilitative program/therapeutic exercise/home exercise program/functional restoration program

A repeat sacroiliac joint injection (corticosteroid with or without anesthetic) may be considered **medically necessary** when **all** of the following criteria are met:

- At least a 50% reduction in the reported pain for the duration of the anesthetic, or if a steroid was injected, lasting at least six weeks
- Performed at a frequency of no greater than once every two months for therapeutic injections
- Performed at a maximum of four times per year

Injections performed in isolation without the patient participating in an active rehabilitation program/home exercise program/functional restoration program may be considered **not medically necessary**.

Note: If another spinal procedure (e.g., epidural steroid injection, facet joint injection or nerve block, regional sympathetic block) is performed on the same day of service as an SJI injection, both procedures will be reviewed for medical necessity based on applicable Blue Shield Medical Policy criteria. (See Index/Cross Reference Section of Related BSC Medical Policies in the Appendix).

Policy Guideline

- Code 27096: Used only if the CT [computed tomography] or fluoroscopic imaging is used to confirm the intra-articular needle positioning (used for physician billing)
- Code G0259: Used for SJI procedure for sacroiliac joint; arthrography (used for ASC billing)
- Code G0260: Describes the difference of injection procedure for sacroiliac joint: provision of anesthetic, steroid and/or other therapeutic agent, with or without arthrography (used for ASC billing)

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Internal Information

There is an MD Determination Form for this Medical Policy. It can be found on the following Web page:
http://myworkpath.com/healthcareservices/MedicalOperations/PSR_Determination_Pages.htm

Documentation Required for Clinical Review
• History and physical including: previous treatment and response • Pertinent progress notes (i.e., physician, physical therapy) • Prior procedure report(s) (if applicable) • Radiology report(s) (if applicable) Post Service • Procedure report(s)

The materials provided to you are guidelines used by this plan to authorize, modify, or deny care for persons with similar illness or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under your contract. These Policies are subject to change as new information becomes available.

Click here to view the appendix for this policy

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