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Subject: Sacroiliac Joint Injections

THIS MEDICAL COVERAGE GUIDELINE IS NOT AN AUTHORIZATION, CERTIFICATION, EXPLANATION OF BENEFITS, OR A GUARANTEE OF PAYMENT, NOR DOES IT SUBSTITUTE FOR OR CONSTITUTE MEDICAL ADVICE. ALL MEDICAL DECISIONS ARE SOLELY THE RESPONSIBILITY OF THE PATIENT AND PHYSICIAN. BENEFITS ARE DETERMINED BY THE GROUP CONTRACT, MEMBER BENEFIT BOOKLET, AND/OR INDIVIDUAL SUBSCRIBER CERTIFICATE IN EFFECT AT THE TIME SERVICES WERE RENDERED. THIS MEDICAL COVERAGE GUIDELINE APPLIES TO ALL LINES OF BUSINESS UNLESS OTHERWISE NOTED IN THE PROGRAM EXCEPTIONS SECTION.

DESCRIPTION:

The sacroiliac (SI) joint is a synovial joint formed at the juncture of the sacrum and ilium. The SI joint and its supporting ligaments may be a source of low back pain resulting from injury, disease, or previous surgery. Diagnostic injection into the SI joint with a local anesthetic and/or steroid medication may be performed to determine if the SI joint is the source of the low back pain. Following positive identification of the SI joint as the pain generator, therapeutic injection into the SI joint with a local anesthetic and/or steroid medication may be performed to relieve pain for longer periods of time.

Summary and Analysis of Evidence: Newman et al (2022) stated (s)acroiliac (SI) joint dysfunction is a common cause of low back pain and accurate diagnosis can be challenging. A complete history and physical examination are critical in differentiating other diagnoses that may have similar signs and symptoms. Positive responses to at least three physical provocation tests suggest SI joint dysfunction, and local anesthetic SI joint blocks can also be useful for confirming the SI joint as the source of pain. Conservative treatment consists of a multimodal program combining patient education, pelvic girdle stabilization with focused stretching, and manipulative therapy. These programs can be performed by physical therapists or clinicians trained in manipulative therapy. Pelvic belts may be beneficial in affected postpartum patients. Patients with symptoms that do not improve with conservative management may benefit from interventional treatment options including intra-articular corticosteroid injections … If sacroiliitis or other spondyloarthropathies are suspected, referral to an orthopedist, interventional radiologist, or pain physician to provide an intra-articular corticosteroid injection may be appropriate. Physicians who specialize in the treatment of chronic pain can also provide other interventional treatments." Patel et al (2022) randomized 72 patients with SIJ pain and sacroiliac joint dysfunction to fluoroscopy-guided intra-articular injection of corticosteroid and local anesthesia or a sham group consisting of fluoroscopy-guided anesthetic injection and distilled water injection. Diagnosis of sacroiliac joint dysfunction was based on the International Association for the Study of Pain criteria. All patients reported pain located over the SIJ. In a single-blinded assessment, pain (Numeric Rating

Scale [NRS]) and disability (Oswestry Disability Index [ODI]) were significantly reduced at 4 weeks follow-up within each group, but the corticosteroid injection group had a significantly greater magnitude for both outcomes. The authors concluded "(f)luoroscopy-guided corticosteroid injection is an effective measure for reducing pain and disability in patients with sacroiliac joint dysfunction." Visser et al (2013) randomized 51 patients with SIJ and leg pain to physical therapy, manual therapy, or intra-articular injection of corticosteroid. Diagnosis of SIJ pain was based on provocation tests and not SIJ injections. In a blinded assessment, 25 (56%) patients 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 scale (VAS) score for pain. UpToDate review "Subacute and chronic low back pain: Nonsurgical interventional treatment" (Chou, 2024) states, "(t)he sacroiliac joints are thought to be the source of low back pain in some patients. Effective methods for diagnosing and treating sacroiliac joint pain in patients without spondyloarthropathy remain controversial. Periarticular steroid injection does not require radiographic guidance. One small (n = 24), randomized trial found periarticular sacroiliac joint glucocorticoid injection more effective than local anesthetic injection for pain relief (change in pain of -40 versus -13 mm on a 100 mm visual analogue scale one month after injection) in patients with chronic pain in the sacroiliac joint area and at least one physical exam finding for sacroiliac pain. These results should be considered preliminary, due to the small sample size and relatively short-term follow-up. There are no randomized trials of intraarticular sacroiliac joint steroid injection versus a sham procedure in patients without spondyloarthropathy." Another UpToDate review, "Musculoskeletal ultrasonography: Guided injection, aspiration, and biopsy of joints and related structures" (Bruyn, 2024) states "US-guidance is under evaluation as an aid for localizing the deep-seated sacroiliac joint for injection as an alternative to computed tomography (CT), but it is not widely used. In limited studies, the joints in patients or cadavers have been successfully entered approximately 77 to 90 percent of the time, but direct comparison with CT has not been performed. One study has shown that image fusion of real-time US with previously obtained CT imaging is also a feasible approach but is not generally available." Perry et al (2016) studied the accuracy of ultrasound-guided SI joint injections using a cadaveric model in a controlled laboratory study at the Skills Laboratory of the American Sports Medicine Institute in St. Vincent's Hospital, Birmingham, AL. Seventeen cadaveric SI joints were injected under ultrasound guidance and dissected to determine the accuracy of intra-articular injections. Of 17 SI joints, 15 (88.2%) were accurately injected intra-articularly. One of the joints with no intra-articular spread was found to be partially frozen at the time of dissection, and the second joint was considered an unsuccessful injection before dissection due to difficulty entering the joint under ultrasound guidance because of marginal osteophytes at the joint line. Of the 15 joints with intra-articular placement, 5 joints (33.3%) showed partial extra-articular spread at the time of initial injection and required redirection of the needle under ultrasound guidance, and 3 joints (20%) had extra-articular spread that was not seen during ultrasound. The authors concluded "(u)ltrasound allowed intra-articular injection in 88.2% of joints in this cadaveric study. Ultrasound does not expose the patient to radiation, as seen with fluoroscopic guidance, which is currently the gold standard for this injection. In addition, ultrasound may allow visualization of extra-articular spread when caused by extra-articular needle placement, which can allow for redirection of the needle to achieve intra-articular injection." Soneji et al (2015) conducted a small study to compare both accuracy and efficacy of US and FL guidance for sacroiliac joint injections. Forty patients with chronic moderate-to-severe LBP secondary to SIJ arthritis were randomized to receive US- or FL-guided unilateral SIJ injections. There was no control group of injections without imaging. Primary outcomes included pain at 1 month measured by numerical rating scale (NRS) scores.

Secondary outcomes included NRS scores at 24 hours, 72 hours, 1 week, and 3 months after injection, physical functioning at 1 month after the procedure, procedure time, incidence of intra-articular and peri-articular needle placement, patient discomfort, overall patient satisfaction, and daily opioid consumption. The authors found no significant difference in NRS pain scores between the 2 groups at 1 month or at any other follow-up points. A significant reduction from baseline mean NRS scores was observed in both groups at 1 month after injection (US 22.7%; FL 37.3%). There was no significant difference in procedure-related variables, physical functioning, discomfort, opioid utilization, and patient satisfaction between the 2 groups. The authors concluded "(u)ltrasound-guided SIJ injection with fluoroscopic confirmation has similar accuracy and efficacy to fluoroscopy alone for SIJ injections in patients with chronic low back pain secondary to SIJ arthritis."

POSITION STATEMENT:

Sacroiliac joint injection performed under fluoroscopy or with arthrography **meets the definition of medical necessity** when **ALL** the following criteria are met:

- Sacroiliac joint pain for more than 3 months, **AND**
- Sacroiliac joint injections are part of a comprehensive pain treatment plan, **AND**
- Continued pain after 6 weeks with **ALL** of the following treatments:
    - NSAIDS ≥ 4 weeks (if not contraindicated), **AND**
    - Activity modification ≥ 6 weeks, **AND**
    - Physical therapy, chiropractic therapy or home exercise program ≥ 6 weeks, **OR**
- Worsening pain after 2 weeks with **ALL** of the following treatments:
    - NSAIDS (if not contraindicated), **AND**
    - Activity modification, **AND**
    - Physical therapy, chiropractic therapy or home exercise program
- In the diagnostic phase, up to two (2) injections may be administered, at intervals of no sooner than one (1) week
- In the therapeutic phase, each subsequent injection requires that prior injection provided ≥ 50% pain reduction for at least six (6) weeks

Sacroiliac joint injections **do not meet the definition of medical necessity** if medical documentation indicates the injection procedures are not effective.

Sacroiliac joint injection performed with ultrasound guidance is considered **experimental or investigational**. There is insufficient evidence to support conclusions regarding effects on net health outcomes.

NOTE: It is not expected that epidural blocks, multiple facet joint injections, sacroiliac joint injections, and sympathetic nerve blocks in any and all combinations would be administered to the same individual on the same day. If the first procedure used to treat the presumptive diagnosis fails to produce improvement and rules out that possibility, then it may be appropriate to proceed to the next logical treatment.

BILLING/CODING INFORMATION:

CPT Coding:

27096	Injection procedure for sacroiliac joint, anesthetic/ steroid, with image guidance (fluoroscopy or CT) including arthrography when performed

HCPCS Coding:

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

ICD-10 Diagnosis Codes That Support Medical Necessity:

M46.1	Sacroiliitis, not elsewhere classified
M47.898	Other spondylosis, sacral and sacrococcygeal region
M48.08	Spinal stenosis, sacral and sacrococcygeal region
M53.2X8	Spinal instabilities, sacral and sacrococcygeal region
M54.18	Radiculopathy, sacral and sacrococcygeal region
M54.30 – M54.32	Sciatica
M54.40 – M54.42	Lumbago with sciatica
M54.50, M54.51, M54.59	Low back pain, including vertebrogenic low back pain
M54.6	Pain in thoracic spine
S33.2XXA, D, S	Dislocation of sacroiliac and sacrococcygeal joint
S33.6XXA, D, S	Sprain of sacroiliac joint

REIMBURSEMENT INFORMATION:

Total number of sacroiliac joint injections is limited to three (3) injections per sacroiliac joint in six (6) months.

NOTE: Services in excess of the limitations shown above are subject to medical review of documentation for determination of medical necessity. The following information may be required documentation to support medical necessity: physician history and physical, radiology study reports, physician progress notes, with documentation of conservative treatment, treatment plan including narrative, and physician operative report.

LOINC Codes:

Documentation Table	LOINC Codes	LOINC Time Frame Modifier Code	LOINC Time Frame Modifier Codes Narrative
Physician history and physical	28626-0	18805-2	Include all data of the selected type that represents observations made six months or fewer before starting date of service for the claim.

Attending physician progress notes	18741-9	18805-2	Include all data of the selected type that represents observations made six months or fewer before starting date of service for the claim.
Radiology report	18726-0	18805-2	Include all data of the selected type that represents observations made six months or fewer before starting date of service for the claim.
Physician operative report	28573-4	18805-2	Include all data of the selected type that represents observations made six months or fewer before starting date of service for the claim.
Treatment plan, plan of treatment	18776-5	18805-2	Include all data of the selected type that represents observations made six months or fewer before starting date of service for the claim.
Physical therapy initial assessment	18735-1	18805-2	Include all data of the selected type that represents observations made six months or fewer before starting date of service for the claim.
Physical therapy progress note	11508-9	18805-2	Include all data of the selected type that represents observations made six months or fewer before starting date of service for the claim.
Current, discharge, or administered medications	34483-8	18805-2	Include all data of the selected type that represents observations made six months or fewer before starting date of service for the claim.

PROGRAM EXCEPTIONS:

Federal Employee Program (FEP): Follow FEP guidelines.

State Account Organization (SAO): Follow SAO guidelines.

Medicare Advantage Products: No National Coverage Determination (NCD) and/or Local Coverage Determination (LCD) were found at the time of the last guideline review date.

If this Medical Coverage Guideline contains a step therapy requirement, in compliance with Florida law 627.42393, members or providers may request a step therapy protocol exemption to this requirement if based on medical necessity. The process for requesting a protocol exemption can be found at Coverage Protocol Exemption Request

DEFINITIONS:

Arthrography: a diagnostic study of the joint structures. X-ray contrast is injected, as the dye disperses, the radiologist documents whether the dye is contained or is leaking (indicates the stability and integrity of the joint and reveals cartilage tears and other injuries).

RELATED GUIDELINES:

None applicable

OTHER:

None applicable

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2. AHRQ National Guideline Clearinghouse. Guideline Summary NGC-9327: Low back disorders. 3rd ed. Elk Grove Village (IL): American College of Occupational and Environmental Medicine (ACOEM); 2011. p. 333-796.
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COMMITTEE APPROVAL:

This Medical Coverage Guideline (MCG) was approved by the Florida Blue Medical Policy and Coverage Committee on 10/23/25.

GUIDELINE UPDATE INFORMATION:

11/15/02	New Medical Coverage Guideline.
02/15/03	Program Exception added for Medicare & More due to previously being omitted.
05/15/03	Revised Billing & Coding section to include clarification for sacroiliac joint injections; 27096 are considered investigational.
08/15/03	Revised When Services Are Covered and Billing/Coding sections.
07/15/04	Review and revision to guideline consisting of updated references and various changes.

11/15/04	MCG archived per MPCC recommendation.
11/15/07	Review and revision of guideline consisting of updated references and addition of diagnosis codes.
05/15/09	Scheduled review; revise description section to include medical necessity management statement, update position statement to include coverage criteria, update ICD 9 coding by adding 846.0, remove CPT code 73542, remove HCPCS code G0259, and updated reimbursement information. Update references.
01/01/10	Annual HCPCS coding update: revise descriptor for CPT code 77003.
05/15/10	Review with revision to position statement and reimbursement statement consisting of the addition of CPT code 73542 for arthrography.
10/01/10	4th Quarter HCPCS coding update: ICD-9 diagnosis code 724.02 revised; ICD-9 diagnosis code 724.03 added.
10/15/10	Revision; related ICD-10 codes added.
01/01/11	Annual HCPCS coding update. Revised descriptor for code 77003.
04/15/11	Scheduled review; revised description, position statement and reimbursement sections; added Medicare program exception; updated references; reformatted guideline.
07/01/11	Revision; formatting changes.
01/01/12	Annual HCPCS coding update. Revised 27096 and 77003 descriptors. Deleted 73542.
07/15/12	Scheduled review; position statement maintained. Revised description section, CPT coding, ICD9 coding and Medicare Advantage program exception. Updated references. Reformatted guideline.
07/15/13	Scheduled review; position statement maintained. Revised Medicare Advantage program exception.
07/15/14	Scheduled review. Revised position statement and HCPCS coding, Updated references. Reformatted guideline.
06/15/15	Scheduled review. Position Statement maintained. Updated references and reformatted guideline.
10/01/15	Revision; updated ICD9 and ICD10 coding sections.
11/01/15	Revision: ICD-9 Codes deleted.
10/01/17	Quarterly CPT/HCPCS coding update: deleted M48.06; added M48.061, M48.062.
10/01/18	Revision: updated ICD10 coding section.
01/01/20	Annual CPT/HCPCS coding update. Added 64451.
02/15/20	Scheduled review. Revised description, maintained position statement, and updated references.
10/01/21	ICD10 coding update: added codes M54.50, M54.51, M54.59; deleted code M54.5.
02/15/22	Scheduled review. Revised description, maintained position statement, and updated references.
09/15/22	Deleted code 64451 (refer to MCG 02-61000-29 Nerve Block Injections).
05/23/23	Update to Program Exceptions section.
01/01/24	Position statements maintained.
11/15/24	Scheduled review. Revised description, maintained position statement and updated references.
11/15/25	Scheduled review. Maintained position statement and updated references.