

This guideline may contain custom content that has been modified from the MCG care guidelines and has not been reviewed or approved by MCG Health.

RMHP Sacroiliac Joint (SIJ) Injection

AUTH: RMHP-A-069525SI (AC)

MCG Health
Ambulatory
Care
27th Edition

[Link to Codes](#)

- [Clinical Indications for Procedure](#)
- [Alternatives to Procedure](#)
- [Evidence Summary](#)
 - [Background](#)
 - [Criteria](#)
 - [Inconclusive or Non-Supportive Evidence](#)
- [Reviewer Guidance](#)
- [Policy History](#)
- [References](#)
- [Limitations](#)
- [References](#)
- [Footnotes](#)
- [Codes](#)

Clinical Indications for Procedure

[Return to top of RMHP Sacroiliac Joint \(SIJ\) Injection - AC](#)

NOTE: Ablation for treating sacroiliac pain is unproven and not medically necessary due to insufficient evidence of efficacy. Therefore, **radiofrequency ablation (RFA) of nerves innervating SI Joint, CPT 64625 is non-covered for ALL Plans**. See Reviewer Guidance and References.

- The Member has **RMHP Medicare (CareAdvantage and DSNP), Individual and Family Plan (IFP) Commercial, PRIME (Medicaid) or CHP Plus** health plan coverage. Sacroiliac (SI) joint injection may be indicated when **ALL** of the following are present(1) :
 - Diagnostic block needed to confirm SI joint as source of spinal pain, as indicated by **1 or more** of the following(2)(3)(4)(5)(6) :
 - Initial diagnostic block to diagnose SI joint pain (dual diagnostic blocks are necessary to diagnose SI joint pain)
 - Second confirmatory diagnostic block (dual diagnostic blocks are necessary to diagnose SI joint) if documentation indicates first diagnostic block produced 80% or greater relief of primary (index) pain, and duration of relief is consistent with agent employed
 - Patient is candidate for SI joint injection as indicated by **ALL** of the following(7) :
 - Chronic pain (at least 3 months' duration) originating from the SI joint
 - Failure of nonoperative management, as indicated by **ALL** of the following
 - Exercise program
 - Pharmacotherapy [A]

- Documented physical therapy or spinal manipulation therapy completed in the last 24 months
 - Imaging studies and physical examination have ruled out other causes of SI joint pain (eg, fracture, tumor).(9)(10)
- No coagulopathy(11)
- No current infection(11)
- The procedure will NOT be done using general anesthesia, conscious sedation or monitored anesthesia care (MAC). See item 2 under Limitations section.

Alternatives to Procedure

[Return to top of RMHP Sacroiliac Joint \(SIJ\) Injection - AC](#)

- Nonoperative management may include(12)(13)(14):
 - Cognitive behavioral therapy
 - Exercise program
 - Pharmacotherapy(15)
 - Physical therapy. See [Spine Soft Tissue Dysfunction Rehabilitation](#) ^{AC} for further information.
 - Spinal manipulation therapy. See [Spinal Manipulation Therapy \(SMT\), Chiropractic and Other](#)

^{AC} for further information.

Evidence Summary

[Return to top of RMHP Sacroiliac Joint \(SIJ\) Injection - AC](#)

Background

[Return to top of RMHP Sacroiliac Joint \(SIJ\) Injection - AC](#)

Sacroiliac (SI) joint injections are similar in scope and nature to facet joint injections. This clinical policy is a customized version of the MCG policy for facet joint injections. It has been modified with permission via contract to address clinical indications for coverage of SI joint injections.

A potential source of spinal pain is the posterior zygapophysial joint (facet, Z joint), which adjoins adjacent vertebrae and is innervated by medial branches of the dorsal spinal nerves at 2 levels; however, there is no single history or physical examination finding considered pathognomonic for Z joint syndrome.(16) (EG 2)

Fluoroscopic-guided diagnostic medial branch block or intra-articular injection is utilized to identify patients with facet joint pain who are potential candidates for radiofrequency neurotomy. Intra-articular injection is more difficult to perform, and it may have lower prognostic power to determine which patients will respond to neurotomy.(17)(18)(12) (EG 2)

Diagnosis of facet joint pain can be made when controlled local anesthetic blockade of the medial branches of the posterior rami of the spinal nerves that supply the putative painful joint(s) provides relief of the target pain. In controlled diagnostic testing, the patient receives an injection of a short-acting anesthetic agent (lidocaine), and those patients who have at least 75% to 80% short-term pain reduction from baseline pain scores are then injected with a longer-acting agent (bupivacaine). Patients with at least 75% to 80% pain reduction from baseline pain scores after injection of the longer-acting anesthetic agent are considered to be candidates for facet neurotomy.(17)(12)(19)(13) (EG 2)

Criteria

[Return to top of RMHP Sacroiliac Joint \(SIJ\) Injection - AC](#)

For diagnostic block, The goal of facet joint injection is to make a diagnosis of facet joint pain to determine if a patient is a candidate for facet neurotomy. In controlled diagnostic testing, the patient receives an injection of a short-acting anesthetic agent (eg,

lidocaine); those patients who have at least 75% to 80% short-term pain reduction from baseline pain scores are then injected with a longer-acting agent (bupivacaine). Patients with at least 75% to 80% pain reduction from baseline pain scores after injection of the longer-acting anesthetic agent are candidates for facet neurotomy. Diagnostic injection of the local anesthetic agent is either performed via blockade of the medial branches of the posterior rami of the spinal nerves that supply the putative painful joint(s), or alternatively via intra-articular injection; medial branch block is associated with a better prediction of success of neurotomy compared with intra-articular injection.(17)(18)(12)(13) **(EG 2)** Single diagnostic blocks carry a false-positive rate of between 25% and 41%.(12)(20) **(EG 2)** For diagnosis of cervical facet joint pain, a systematic review of 10 studies (1192 patients) evaluating the diagnostic accuracy of facet joint injections (using 75% or more pain relief as a criterion standard) found there was good evidence to support their use and that the false-positive rate was 27% to 63%.(21) **(EG 1)** For diagnosis of lumbar facet joint pain, a systematic review of 14 studies (2804 patients) evaluating the diagnostic accuracy of facet joint injections (using 75% or more pain relief as a criterion standard) found there was good evidence to support their use and that the false-positive rate was 17% to 49%.(21) **(EG 1)** An evidence-based guideline states that there is moderate evidence that the diagnosis of lumbar facet-mediated back pain can be established with the use of a medial nerve double-injection technique that results in a greater than 80% pain improvement threshold; the results are predictive of a good response to facet neurotomy.(22) **(EG 2)** A multispecialty consensus practice guideline recommends that a 50% or more reduction in pain be used to define a positive diagnostic block, acknowledging that the exact amount of pain reduction for a positive block remains uncertain; further studies are needed to identify optimal response criteria.(23) **(EG 2)** For diagnosis of thoracic facet joint pain, a systematic review of 3 studies from the same research group (183 patients) evaluating the diagnostic accuracy of facet joint injections (using 80% or more pain relief as a criterion standard) found there was good evidence for their use and that the false-positive rate was 42% to 58%.(21) **(EG 1)**

Inconclusive or Non-Supportive Evidence

[Return to top of RMHP Sacroiliac Joint \(SIJ\) Injection - AC](#)

For therapeutic intra-articular facet joint injection, An evidence-based technology assessment found limited evidence to suggest that facet joint corticosteroid injections are not effective for presumed facet joint pain.(24) **(EG 1)** A systematic review of cervical intra-articular facet joint injection identified only 2 randomized trials that reported conflicting outcomes (one reported negative outcomes, and the other reported indeterminate results); these studies had significant structural problems, which included lack of placebo controls, confounding variables of trigger point and botulinum toxin injection, and a withdrawal rate of greater than 20%. The authors concluded that the evidence supporting cervical intra-articular facet joint injection was of moderate or low quality.(25) **(EG 1)** A randomized double-blind controlled study of 28 patients with lumbar Z joint pain confirmed by medial branch block comparing intra-articular fluoroscopic-guided corticosteroid injection with saline injection found no significant difference in the average time to, or percentage of patients receiving, subsequent radiofrequency ablation. The study was terminated early because more than 75% of patients in both groups underwent radiofrequency ablation by the first study follow-up visit at 6 weeks. The authors advise larger, adequately powered analyses.(26) **(EG 1)** For lumbar intra-articular facet joint injection, a systematic review of 5 randomized controlled trials found that the evidence supporting its use was of moderate or low quality.(25) **(EG 1)** Another systematic review of 6 randomized controlled trials (434 patients) evaluating the efficacy of therapeutic lumbar intra-articular facet joint injections with active drug found that there is insufficient high-quality evidence to support their use over sham procedure, placebo injection, or conservative therapy.(27) **(EG 1)** An evidence-based guideline states that there is moderate evidence suggesting the lack of a role for intra-articular facet joint injections for treatment of facet-mediated chronic low back pain without radiculopathy in patients with degenerative disease of the lumbar spine.(22) **(EG 2)** For thoracic intra-articular facet joint injection, a systematic review revealed that there was no available literature investigating its efficacy.(25) **(EG 1)** A consensus practice guideline recommends against the routine use of therapeutic medial branch blocks and intra-articular injections but offers there may be a role for these interventions for certain populations, such as patients with contraindications to radiofrequency ablation.(23) **(EG 2)**

For therapeutic medial branch nerve block, For cervical facet joint pain, a systematic review identified only one randomized controlled trial and one observational study (from the same research group) supporting the short-term and long-term effectiveness of medial branch block; limitations of the studies included lack of a placebo group in the randomized controlled trial and lack of randomization in the observational study.(25) **(EG 1)** A randomized double-blind controlled trial of 120 patients with cervical facet

joint pain who received medial branch nerve block with local anesthetic with or without steroids found, at 2-year follow-up, that although both groups had significant improvement in pain scores and functional assessment, there was no significant difference between the groups. In addition, although both groups showed a decrease in opioid intake, the difference was not significant. The authors noted that the study lacked a placebo group and recommended larger, placebo-controlled studies to validate the findings.(28) (EG 1) For lumbar facet joint pain, a systematic review identified only 2 randomized controlled studies of moderate to good-quality evidence supporting the use of lumbar facet nerve block.(29) (EG 1) A randomized double-blind controlled trial of 120 patients with lumbar facet joint pain who received medial branch nerve block with local anesthetic with or without steroids found, at 2-year follow-up, that although both groups had significant improvement in pain scores and functional assessment, there was no significant difference between the groups. In addition, although both groups showed a decrease in opioid intake, the difference was not significant. The authors noted that the study lacked a placebo group and recommended larger, placebo-controlled studies to validate the findings.(30) (EG 1) For osteoporotic compression fracture, a retrospective study of 53 patients who underwent therapeutic medial branch block found that there was significant improvement in pain and disability scores at 12-month follow-up. The study was structurally limited by performance of a single diagnostic block and lack of a placebo control group. Additional double-blind randomized controlled studies were recommended.(31) (EG 2) For thoracic facet joint pain, a systematic review identified only one randomized trial and one observational study (from the same research group) supporting the use of thoracic facet joint nerve block.(25) (EG 1) A randomized double-blind controlled trial of 100 patients with thoracic facet joint pain who received medial branch nerve block with local anesthetic with or without steroids found, at 2-year follow-up, that although both groups had significant improvement in pain scores and functional assessment, there was no significant difference between the groups. In addition, although both groups showed a decrease in opioid intake, the difference was not significant. The authors noted that the study lacked a placebo group and recommended larger, placebo-controlled studies to validate the findings.(32) (EG 1)

Reviewer Guidance

[Return to top of RMHP Sacroiliac Joint \(SIJ\) Injection - AC](#)

For all RMHP plans, ablation for treating sacroiliac pain is unproven and not medically necessary due to insufficient evidence of efficacy. See References.

Policy History

[Return to top of RMHP Sacroiliac Joint \(SIJ\) Injection - AC](#)

History Summary: Policy created 12/23/2019 for new CPT codes 64451 (and 64625 indirectly) effective 1/1/2020 per RP MD with annual review, updates and approvals thereafter through 12/29/2022. See archived versions for details. Annual review and updated references 10/11/2023.

References

[Return to top of RMHP Sacroiliac Joint \(SIJ\) Injection - AC](#)

King W, et al. Diagnosis and treatment of posterior sacroiliac complex pain: a systematic review with comprehensive analysis of the published data. *Pain Medicine* 2015;16(2):257-65. DOI: 10.1111/pme.12630.

The Centers for Medicare and Medicaid Services (CMS) Medicare Physician's Fee Schedule Code Search - Procedure code 64625 and 64451, both status indicator A, includes " The presence of an "A" indicator does not mean that Medicare has made a national coverage determination regarding the service; **carriers remain responsible for coverage decisions in the absence of a national Medicare policy** . RMHP Coverage decision to follow UHC in the absence of CMS NCD or Novitas MAC guidance. No MCG exists in 27th edition as of 10/11/2023 review.

Note: The associated Centers for Medicare and Medicaid Services (CMS) current Local Coverage Determinations (LCDs) and Articles (LDAs) on Medicare Coverage Database reviewed 10/11/2023 do not apply to Colorado; RMHP Medicare plans follow MCG

then UHC in the absence of CMS national coverage guidance. See status indicator A guidance on CMS MPFS above. No MCG exists, therefore follow UHC for non-coverage of ablative treatment for sacroiliac pain.

UnitedHealthcare® Community Plan Medical Policy Ablative Treatment for Spinal Pain Policy Number: CS001.Q Effective Date: August 1, 2023, review date 10/11/2023.

United Healthcare Commercial and Individual Exchange Medical Policy, Ablative Treatment for Spinal Pain, Policy Number 2023T0107CC, Effective Date: October 1, 2023, Review Date 10/11/2023.

UnitedHealthcare® Medicare Advantage Coverage Summary Pain Management and Rehabilitation Policy Number: MCS070.04 Approval Date: August 9, 2023, Review Date 10/11/2023.

Limitations

[Return to top of RMHP Sacroiliac Joint \(SIJ\) Injection - AC](#)

1. SI joint interventions done without CT or fluoroscopic guidance are considered not medically reasonable and necessary. This includes SI joint interventions done without any guidance, performed under ultrasound guidance, or with Magnetic Resonance Imaging (MRI).
2. General anesthesia is considered not medically reasonable and necessary for SI joint interventions. Neither conscious sedation nor Monitored Anesthesia Care (MAC) is routinely necessary for SI joint injections and are not routinely considered medically reasonable and necessary. Individual consideration may be given on redetermination (appeal) for payment in rare, unique circumstances if the medical necessity of sedation is unequivocal and clearly documented in the medical record. Frequent reporting of these services together may trigger focused medical review.
3. It is not routinely necessary for multiple blocks (e.g., epidural injections, sympathetic blocks, trigger point injections, etc.) to be provided to a patient on the same day as SI joint procedures. Multiple blocks on the same day could lead to improper or lack of diagnosis. If performed, the medical necessity of each injection must be clearly documented in the medical record. For example, the performance of both an SI joint procedure and an epidural steroid injection (ESI) at the same location or at a close spinal level at the same encounter would not be typically expected. Frequent reporting of multiple blocks on the same day may trigger a focused medical review.
4. SI joint injections may involve the use of anesthetic, corticosteroids, anti-inflammatories and/or contrast agents and do not include injections of biologicals or other substances not FDA designated for this use.
5. SI joint procedures in patients for the indication of generalized pain conditions (such as fibromyalgia) or chronic centralized pain syndromes are considered not medically reasonable and necessary. Individual consideration may be considered under unique circumstances and with sufficient documentation of medical necessity on appeal.
6. In patients with implanted electrical devices, providers must follow manufacturer instructions and extra planning as indicated to ensure safety of procedure.
7. SI joint prolotherapy is considered not medically reasonable and necessary.

References

[Return to top of RMHP Sacroiliac Joint \(SIJ\) Injection - AC](#)

1. Manchikanti L, et al. Comprehensive evidence-based guidelines for facet joint interventions in the management of chronic spinal pain: American Society of Interventional Pain Physicians (ASIPP) guidelines facet joint interventions 2020 guidelines. *Pain Physician* 2020;23(3S):S1-S127. [Context Link [1](#)]
2. Datta S, Lee M, Falco FJ, Bryce DA, Hayek SM. Systematic assessment of diagnostic accuracy and therapeutic utility of lumbar facet joint interventions. *Pain Physician* 2009;12(2):437-460. [Context Link [1](#)]
3. Sehgal N, Dunbar EE, Shah RV, Colson J. Systematic review of diagnostic utility of facet (zygapophysial) joint injections in chronic spinal pain: an update. *Pain Physician* 2007;10(1):213-228. [Context Link [1](#)]
4. Atluri S, Singh V, Datta S, Geffert S, Sehgal N, Falco FJ. Diagnostic accuracy of thoracic facet joint nerve blocks: an update of the assessment of evidence. *Pain Physician* 2012;15(4):E483-E496. [Context Link [1](#)]
5. Cohen SP, et al. Effectiveness of lumbar facet joint blocks and predictive value before radiofrequency denervation: the Facet Treatment Study (FACTS), a randomized, controlled clinical trial. *Anesthesiology* 2018;129(3):517-535. DOI: 10.1097/ALN.0000000000002274. [Context Link [1](#)]
6. Cohen SP, Hooten WM. Advances in the diagnosis and management of neck pain. *British Medical Journal* 2017;358:j3221. [Context Link [1](#)]
7. Manchikanti L, et al. An update of comprehensive evidence-based guidelines for interventional techniques in chronic spinal pain. Part II: guidance and recommendations. *Pain Physician* 2013;16(2 Suppl):S49-S283. (Reaffirmed 2020 May) [Context Link [1](#)]
8. Dowell D, Haegerich TM, Chou R. CDC guideline for prescribing opioids for chronic pain - United States, 2016. *MMWR - Recommendations and Reports* 2016;65(1):1-49. DOI: 10.15585/mmwr.rr6501e1. (Reaffirmed 2020 Jun) [Context Link [1](#)]
9. Gofeld M, Jitendra J, Faclier G. Radiofrequency denervation of the lumbar zygapophysial joints: 10-year prospective clinical audit. *Pain Physician* 2007;10(2):291-300. [Context Link [1](#)]
10. Tome-Bermejo F, Barriga-Martin A, Martin JL. Identifying patients with chronic low back pain likely to benefit from lumbar facet radiofrequency denervation: a prospective study. *Journal of Spinal Disorders and Techniques* 2011;24(2):69-75. DOI: 10.1097/BSD.0b013e3181dc9969. [Context Link [1](#)]
11. Mazin DA, Sullivan JP. Lumbar and sacral radiofrequency neurotomy. *Physical Medicine and Rehabilitation Clinics of North America* 2010;21(4):843-850. DOI: 10.1016/j.pmr.2010.06.010. [Context Link [1](#), [2](#)]
12. Cohen SP, Huang JH, Brummett C. Facet joint pain--advances in patient selection and treatment. *Nature Reviews. Rheumatology* 2013;9(2):101-116. DOI: 10.1038/nrrheum.2012.198. [Context Link [1](#), [2](#), [3](#), [4](#), [5](#)]
13. Teasell RW, et al. A research synthesis of therapeutic interventions for whiplash-associated disorder (WAD): part 4 - noninvasive interventions for chronic WAD. *Pain Research and Management* 2010 Sep-Oct;15(5):313-322. [Context Link [1](#)]
14. Nonopioid drugs for pain. *Medical Letter on Drugs and Therapeutics* 2018;60(1540):25-32. [Context Link [1](#)]
15. Cohen SP, Raja SN. Pathogenesis, diagnosis, and treatment of lumbar zygapophysial (facet) joint pain. *Anesthesiology* 2007;106(3):591-614. [Context Link [1](#)]
16. Perolat R, et al. Facet joint syndrome: from diagnosis to interventional management. *Insights Into Imaging* 2018;9(5):773-789. DOI: 10.1007/s13244-018-0638-x. [Context Link [1](#), [2](#)]
17. Nath S, Nath CA, Pettersson K. Percutaneous lumbar zygapophysial (Facet) joint neurotomy using radiofrequency current, in the management of chronic low back pain: a randomized double-blind trial. *Spine* 2008;33(12):1291-1298. DOI: 10.1097/BRS.0b013e31817329f0. [Context Link [1](#)]
18. Bogduk N. Evidence-informed management of chronic low back pain with facet injections and radiofrequency neurotomy. *Spine Journal* 2008;8(1):56-64. DOI: 10.1016/j.spinee.2007.10.010. [Context Link [1](#)]

19. Boswell MV, et al. A best-evidence systematic appraisal of the diagnostic accuracy and utility of Facet (Zygapophysial) joint injections in chronic spinal pain. *Pain Physician* 2015 Jul-Aug;18(4):E497-E533. [Context Link [1](#), [2](#), [3](#)]
20. Watters WC, et al. Guideline update for the performance of fusion procedures for degenerative disease of the lumbar spine. Part 13: injection therapies, low-back pain, and lumbar fusion. *Journal of Neurosurgery: Spine* 2014;21(1):79-90. DOI: 10.3171/2014.4.SPINE14281. [Context Link [1](#), [2](#)]
21. Cohen SP, et al. Consensus practice guidelines on interventions for lumbar facet joint pain from a multispecialty, international working group. *Regional Anesthesia and Pain Medicine* 2020;45(6):424-467. DOI: 10.1136/rapm-2019-101243. [Context Link [1](#), [2](#)]
22. Chou R, et al. Pain Management Injection Therapies for Low Back Pain. Technology Assessment Report ESIB0813 [Internet] Agency for Healthcare Research and Quality. 2015 July Accessed at: <https://www.ahrq.gov/>. [created 2015; accessed 2020 Oct 06] [Context Link [1](#)]
23. Manchikanti L, et al. A systematic review and best evidence synthesis of the effectiveness of therapeutic facet joint interventions in managing chronic spinal pain. *Pain Physician* 2015 Jul-Aug;18(4):E535-E582. [Context Link [1](#), [2](#), [3](#), [4](#), [5](#)]
24. Kennedy DJ, et al. Corticosteroid injections into lumbar facet joints: a prospective, randomized, double-blind placebo-controlled trial. *American Journal of Physical Medicine and Rehabilitation* 2018;97(10):741-746. DOI: 10.1097/PHM.0000000000000960. [Context Link [1](#)]
25. Vekaria R, Bhatt R, Ellard DR, Henschke N, Underwood M, Sandhu H. Intra-articular facet joint injections for low back pain: a systematic review. *European Spine Journal* 2016;25(4):1266-1281. DOI: 10.1007/s00586-016-4455-y. [Context Link [1](#)]
26. Manchikanti L, Singh V, Falco FJ, Cash KA, Fellows B. Comparative outcomes of a 2-year follow-up of cervical medial branch blocks in management of chronic neck pain: a randomized, double-blind controlled trial. *Pain Physician* 2010;13(5):437-450. [Context Link [1](#)]
27. Manchikanti L, Hirsch JA, Falco FJ, Boswell MV. Management of lumbar zygapophysial (facet) joint pain. *World Journal of Orthopedics* 2016;7(5):315-337. DOI: 10.5312/wjo.v7.i5.315. [Context Link [1](#)]
28. Manchikanti L, Singh V, Falco FJ, Cash KA, Pampati V. Evaluation of lumbar facet joint nerve blocks in managing chronic low back pain: a randomized, double-blind, controlled trial with a 2-year follow-up. *International Journal of Medical Sciences* 2010;7(3):124-135. [Context Link [1](#)]
29. Park KD, et al. Effect of medial branch block in chronic facet joint pain for osteoporotic compression fracture: one year retrospective study. *Annals of Rehabilitation Medicine* 2013;37(2):191-201. DOI: 10.5535/arm.2013.37.2.191. [Context Link [1](#)]
30. Manchikanti L, Singh V, Falco FJ, Cash KA, Pampati V, Fellows B. The role of thoracic medial branch blocks in managing chronic mid and upper back pain: a randomized, double-blind, active-control trial with a 2-year followup. *Anesthesiology Research and Practice* 2012;2012:585806. DOI: 10.1155/2012/585806. [Context Link [1](#)]

Footnotes

[Return to top of RMHP Sacroiliac Joint \(SIJ\) Injection - AC](#)

[A] There is some evidence to support the short-term benefit of opioids for mild to moderate pain, but the evidence for improvement in function is inconsistent. Given that chronic opioid therapy for noncancer pain often begins with acute opioid prescriptions, clinicians should provide the lowest effective dose necessary to alleviate pain when giving prescriptions for acute pain; in most instances, a maximum course of 3 days of medication should be sufficient, and a prescription for 7 or more days is only rarely justifiable.⁽⁸⁾ [A in Context Link [1](#)]

Codes

[Return to top of RMHP Sacroiliac Joint \(SIJ\) Injection - AC](#)

CPT® : 64451, 64625

CPT copyright 2022 American Medical Association. All rights reserved.

MCG Health
Ambulatory Care 27th Edition