Cohere Medicare Advantage Policy - Sacroiliac Joint Injections and Radiofrequency Ablation

Clinical Policy for Medical Necessity Review

Version: 2
Revision Date: June 26, 2025

Important Notices

Notices & Disclaimers:

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Other Notices:

Guideline Information:

Specialty Area: Musculoskeletal Care
Policy Name: Cohere Medicare Advantage Policy - Sacroiliac Joint Injections
Type: [**X**] Adult (18+ yo) | [**X**] Pediatric (0-17 yo)

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Medical Necessity Criteria

Service: Sacroiliac Joint Injections and Radiofrequency Ablation

Related CMS Documents

Please refer to the CMS Medicare Coverage Database for the most current applicable CMS National Coverage.[1-6]

- Local Coverage Determination. Sacroiliac Joint Injections and Procedures. (L39383)
  - Billing and Coding: Sacroiliac Joint Injections and Procedures. (A59154)
- Local Coverage Determination. Sacroiliac Joint Injections and Procedures. (L39455)
  - Billing and Coding: Sacroiliac Joint Injections and Procedures. (A59233)
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Description

Injections for sacroiliac (SI) joint disorders (e.g., chronic SI joint pain, trauma, arthritis) are given for diagnostic or therapeutic purposes. The standard of care for chronic SI joint pain begins with non-surgical management, such as physical therapy, analgesic medication (e.g., non-steroidal anti-inflammatory drugs), home exercise programs, or cognitive behavioral therapy.[1–6] When conservative treatments are ineffective, invasive procedures are considered, including local anesthetic injections (with or without steroids) into the SI joint between the spine and the pelvis.[1–6] SI joint injections are used to diagnose SI joint disorders, treat pain and inflammation, and improve mobility.[7]

Radiofrequency ablation (RFA) removes unwanted tissue using radio waves traveling through electrodes.[1–6] For SI joint pain, RFA has been studied to target sensory nerve fibers and interrupt pain signals.[1–6] Evidence of RFA for the treatment of SI joint pain is limited; therefore, it is considered clinically unproven and not medically reasonable and necessary.[1–6]

Medical Necessity Criteria

Indications

A **sacroiliac (SI) joint injection** is considered appropriate if **ALL** of the following are **TRUE**[1–7,11–25]:

- Clinical evaluation (including history and physical examination) shows **ALL** of the following:
  - Low back pain for at least 3 months; **AND**
  - Moderate to severe low back pain, as measured on a pain scale (e.g., NRS or VAS); **AND**
  - Low back pain, primarily over the SI joints; **AND**
  - Clinical findings and/or imaging studies do not suggest any other diagnoses or obvious cause of lumbosacral pain; **AND**
  - Positive response to **AT LEAST THREE** SI joint provocative tests[20-21]:
    - Distraction test; **OR**
    - Compression test; **OR**
    - Thigh thrust; **OR**
    - Posterior shear test; **OR**
    - Gaenslen's test; **OR**
    - Yeoman's test; **OR**
    - FABER maneuver/Patrick's sign; **OR**
    - Posterior provocation test; **AND**

    - Failure of conservative management (e.g., rest, analgesics, physical therapy, oral or injectable corticosteroids) must be documented for a period of greater than 4 weeks. Documentation should include detailed evidence of the measures taken rather than solely a physician's statement[22]; **AND**
- **ANY** of the following:
    - The injection is a **diagnostic SI joint injection**, and **ALL** of the following are **TRUE**:
        - No other injections in the lumbosacral spine are performed at the same time as the SI joint injection; **AND**
        - No more than 2 diagnostic injections, unilateral or bilateral, for diagnostic purposes*; **OR**
    - The injection is a **therapeutic SI joint injection**, and **ALL** of the following are **TRUE**:
        - No other injections in the lumbosacral spine are performed at the same time as the SI joint injection; **AND**
        - No more than 4 therapeutic SI joint injections, unilateral or bilateral, in a rolling 12 months*; **AND**
        - **ANY** of the following:
            - For an initial therapeutic injection, the patient has SI joint pain confirmed by at least 1 diagnostic injection at the same site, with greater than or equal to 75% pain relief; **OR**
            - For a subsequent therapeutic injection, the patient has **ALL** of the following:
                - The most recent therapeutic SI joint injection at the same site provided **ANY** of the following:
                    - Greater than or equal to 50% pain relief for 3 months; **OR**
                    - Greater than or equal to 50% consistent improvement in ability to perform previously painful movements and activities of daily living for 3 months; **AND**
                - The patient should be continuing conservative care and be part of an ongoing and be actively participating in a rehabilitation program, home exercise program, or functional restoration program[1–6, 18-19]; **AND**
        - **ANY** of the following:
            - Treatment has not exceeded 12 months; **OR**
            - Treatment has exceeded 12 months, and **ALL** of the following:

- Pain is severe enough to cause a significant degree of functional disability or vocational disability and providers use established and measurable goals and objective scales to assess functionality and activities of daily living measures; **AND**
- Injections provide greater than or equal to 50% sustained and consistent improvement of pain and/or 50% sustained and consistent objective improvement in function (using the same scale as baseline) for at least 3 months; **AND**
- Rationale for the continuation of injections includes but is not limited to the patient being a high-risk surgical candidate, the patient does not desire surgery, and/or the recurrence of pain in the same location was sustained and consistently relieved with the injections for at least 3 months; **AND**
- The primary care provider is notified regarding the continuation of procedures and prolonged repeat steroid use to allow for systematic care delivery, treatment surveillance, and multidisciplinary biopsychosocial rehabilitation.

*NOTE: To clarify, an SI joint injection session if performed on one side first and then on the opposite side at a different session would qualify as two (2) sessions.

Non-Indications

A **sacroiliac (SI) joint injection** is not appropriate if **ANY** of the following is **TRUE**[1–6]:

- SI joint injection is performed without fluoroscopy or computed tomography (CT) guidance; except when ultrasound guidance is reasonable and necessary where there is a documented contrast allergy or pregnancy[2,3]; **OR**
- Request for SI joint injection with biologics (e.g., platelet-rich plasma, stem cells, amniotic fluid, etc.); **OR**
- Request for SI joint injection to treat non-specific low back pain, axial spine pain primary above the level of L5, complex regional pain syndrome, widespread diffuse pain, chronic pain syndrome, or pain from neuropathy; **OR**

- Request for SI joint injection used as part of a series of lumbar spine and musculoskeletal injections to treat nonspecific or chronic low back pain; **OR**
- Request for diagnostic anesthetic blocks of the nerves innervating the SI joint to assess candidacy for radiofrequency ablation (RFA); **OR**
- Request for SI joint RFA or RFA of nerves innervating the SI joint.

Level of Care Criteria

Outpatient

Procedure Codes (CPT/HCPCS)

CPT/HCPCS Code	Code Description
27096	Injection procedure for sacroiliac joint, anesthetic/steroid, with image guidance (fluoroscopy or CT) including arthrography when performed
64625	Radiofrequency ablation, nerves innervating the sacroiliac joint, with image guidance (e.g., fluoroscopy or computed tomography)
64451	Injection(s), anesthetic agent(s) and/or steroid; nerves innervating the sacroiliac joint, with image guidance (ie, fluoroscopy or computed tomography)
76000	Fluoroscopy (separate procedure), up to 1 hour physician or other qualified healthcare professional time
G0260	Injection procedure for sacroiliac joint; provision of anesthetic, steroid and/or other therapeutic agent, with or without arthrography

Disclaimer: S Codes are non-covered per CMS guidelines due to their experimental or investigational nature.

Evaluation of Clinical Harms and Benefits

Clinical determinations for Medicare Advantage beneficiaries are made in accordance with 42 CFR 422.101 guidance outlining CMS's required approach to decision hierarchy in the setting of NCDs/LCDs identified as being "not fully established". When clinical coverage criteria are "not fully established" Medicare Advantage organizations are instructed to create publicly accessible clinical coverage criteria based on widely-accepted clinical guidelines and/or scientific studies backed by a robust clinical evidence base. Clinical coverage criteria provided by Cohere Health in this manner include coverage rationale and risk/benefit analysis.

The potential clinical harms of using these criteria for sacroiliac joint injections and radiofrequency ablation may include:

- Adverse effects from delayed or denied treatment, such as increased pain or decreased mobility, can reduce the ability to perform activities of daily living.
- SI joint injection delay may result in increased healthcare utilization for emergency room visits or additional treatment, opioid dependence, and decreased quality of life.[7,8]
- Few adverse effects of SI joint injection have been reported; however, the risks that have been associated with SI joint injections include injection-site pain, vasovagal reactions, hematomas, sciatic nerve palsy, and septic arthritis.[1–6,9]

The clinical benefits of using these criteria for sacroiliac joint injections and radiofrequency ablation may include:

- Improved patient outcomes through timely and appropriate access to SI injections. Careful patient selection confers the best outcomes and can prevent adverse events.[9-10]
- Appropriate management of SI joint disorders such as chronic SI joint pain, trauma, and arthritis. For example, patients with chronic SI joint pain who receive SI joint injections report improvements in pain and functional outcomes.[11-12] Improvements in other outcomes, including disability and work status over time, were also found in patients who received SI joint injections.[13]

Medical Evidence

Janapala et al (2023) performed a systematic review and meta-analysis on the efficacy of sacroiliac joint (SI) joint injections for low back pain. The review included 11 randomized control trials (RCTs) and three observational studies that demonstrated positive pain relief outcomes (short- and long-term). The authors note the limitation of a lack of standardized patient selection and studies having a lack of uniform diagnostic blocks and dual blocks. This study found fair to moderate evidence for the effectiveness of therapeutic SI joint injections.[11]

Vu et al (2024) conducted a comprehensive literature review to evaluate the effectiveness of SI joint corticosteroid injection in axial spondyloarthritis, a chronic rheumatic, musculoskeletal, inflammatory disease that often includes sacroiliitis. From 7 studies reviewed, the authors concluded that SI joint corticosteroid injections can be appropriate and effective in treating refractory axial spondyloarthritis. All 7 studies reported a trend toward reduced pain severity after SI joint corticosteroid injections. The authors also recommended image guidance when performing SI joint injections for better outcomes due to the complexity and heterogeneity of the anatomy of the SI joint.[12]

Chen et al (2021) conducted a double-blind, randomized controlled trial to compare intra-articular platelet-rich plasma injections with intra-articular steroid injections for the treatment of SI joint pain. Improvements were seen in both groups; however, patients in the steroid injection group reported lower pain scores than those in the plasma injection group. At months 1, 3, and 6, the steroid injection group had more responders (defined as pain score improvements by 50% or more) and lower pain scores than patients receiving plasma. Functional outcomes were also better at months 1 and 3 in the steroid injection group. Although both groups showed improvements, more patients receiving steroid injections reported 50% or more pain reduction as well as faster improvements in functional outcomes for SI joint pain.[24]

Aranke et al (2022) reviewed recent literature regarding minimally invasive and conservative interventions for the treatment of SI joint pain. Treatment

options include physical therapy, intra-articular joint injections, radiofrequency ablation (RFA), platelet-rich plasma injections, and other injections with biologics. While positive outcomes are reported, evidence supports the use of minimally invasive procedures in combination with conservative management. The authors note a lack of high-quality evidence to support the use of RFA or SI injections with biologics.[25]

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Clinical Guideline Revision History/Information

Original Date: March 20, 2025		
Review History		
Version 2	06/26/2025	Added "unilateral or bilateral" to both the diagnostic and therapeutic indications for number of injections. Added a note: "*NOTE: To clarify, an SI joint injection session if performed on one side first and then on the opposite side at a different session would qualify as two (2) sessions."