MEDICAL POLICY

POLICY TITLE	DIAGNOSIS AND TREATMENT OF SACROILIAC JOINT PAIN
POLICY NUMBER	MP 5.048

CLINICAL BENEFIT	☒ MINIMIZE SAFETY RISK OR CONCERN. ☒ MINIMIZE HARMFUL OR INEFFECTIVE INTERVENTIONS. ☐ ASSURE APPROPRIATE LEVEL OF CARE. ☐ ASSURE APPROPRIATE DURATION OF SERVICE FOR INTERVENTIONS. ☒ ASSURE THAT RECOMMENDED MEDICAL PREREQUISITES HAVE BEEN MET. ☐ ASSURE APPROPRIATE SITE OF TREATMENT OR SERVICE.
Effective Date:	**4/1/2026**

I. POLICY

Sacroiliac Joint Arthrography
Arthrography of the sacroiliac joint (SIJ) is considered **investigational.** There is insufficient evidence to support a conclusion concerning the general health outcomes or benefits associated with this procedure.

Sacroiliac Joint Injections
Injection of anesthetic for **diagnosing** SIJ pain may be considered **medically necessary** when the following criteria have been met:

- Pain has failed to respond to 3 months of conservative management, which may consist of therapies such as nonsteroidal anti-inflammatory medications, acetaminophen, manipulation, physical therapy, and a home exercise program; 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 may be considered **medically necessary** for the **treatment** of SIJ pain when the following criteria have been met:

- Pain has failed to respond to 3 months of conservative management, which may consist of therapies such as nonsteroidal anti-inflammatory medications, acetaminophen, manipulation, physical therapy, and a home exercise program; and
- The injection is performed under imaging guidance; and
- No more than three injections are given per twelve-month period.

Sacroiliac injections are considered **investigational** for indications other than those listed above. There is insufficient evidence to support a conclusion concerning the general health outcomes or benefits associated with this procedure.

Radiofrequency Ablation

MEDICAL POLICY

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Radiofrequency ablation (RFA) of the sacroiliac joint is considered **investigational**. There is insufficient evidence to support a conclusion concerning the general health outcomes or benefits associated with this procedure.

Policy Guidelines

This policy does not address the treatment of sacroiliac joint pain due to infection, trauma, or neoplasm.

Conservative nonsurgical therapy for the duration specified should include the following:

- Use of prescription strength analgesics for several weeks at a dose sufficient to induce a therapeutic response
  - Analgesics should include anti-inflammatory medications with or without adjunctive medications such as nerve membrane stabilizers or muscle relaxants AND
- Participation in at least 6 weeks of physical therapy (including active exercise) or documentation of why the patient could not tolerate physical therapy, AND
- Evaluation and appropriate management of associated cognitive, behavioral, or addiction issues
- Documentation of patient compliance with the preceding criteria.

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., 3 hours longer with bupivacaine than lidocaine). There is no consensus on whether a minimum of 50% or 75% reduction in pain would be required to be considered a successful diagnostic block, although evidence that supported a criterion standard of 75% to 100% reduction in pain with dual blocks. No therapeutic intra-articular injections (i.e., steroids, saline, other substances) should be administered for a period of at least 4 weeks before the diagnostic 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).

Cross-References:

MP 5.049 Facet Joint Denervation
MP 2.061 Prolotherapy

PRODUCT VARIATIONS

This policy is only applicable to certain programs and products administered by Capital Blue Cross and subject to benefit variations. Please see additional information below.

FEP PPO - Refer to FEP Medical Policy Manual. The FEP Medical Policy manual can be found at: https://www.fepblue.org/benefit-plans/medical-policies-and-utilization-management-guidelines/medical-policies

DESCRIPTION/BACKGROUND

SACROILIAC JOINT PAIN

Similar to other structures in the spine, it is assumed that the sacroiliac joint (SIJ) may be a source of low back pain. In fact, before 1928, the SIJ 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 SIJ received less research attention.

Diagnosis

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

Because of inconsistent information obtained from history and physical examination, some have proposed the use of image-guided anesthetic injection into the SIJ for the diagnosis of SIJ pain. Treatments being investigated for SIJ pain include prolotherapy (see Medical Policy 2.061), corticosteroid injection, radiofrequency ablation, stabilization, and arthrodesis. Some procedures have been referred to as SIJ fusion but may be more appropriately called fixation due to little to no bridging bone on radiographs. Devices for SIJ fixation/fusion that promote bone ingrowth to fixate the implants include a triangular implant (iFuse Implant System) and cylindrical threaded devices (Rialto, SImmetry, Silex, SambaScrew, SI-LOK). Some devices also have a slot in the middle where autologous or allogeneic bone can be inserted. This added bone is intended to promote fusion of the SIJ.

REGULATORY STATUS

A number of radiofrequency generators and probes have been cleared for marketing by the U.S. Food and Drug Administration (FDA) through the 510(k) process. In 2005, the SInergy® (Halyard; formerly Kimberly-Clark), a water-cooled single-use probe, was cleared by the FDA, 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. FDA product code: GXD, GXI.

RATIONALE

Summary of Evidence

For individuals who have suspected SIJ pain who receive a diagnostic sacroiliac block, the evidence includes systematic reviews. Relevant outcomes are test validity, symptoms, functional outcomes, quality of life, medication use, and treatment-related morbidity. Current evidence is conflicting on the diagnostic utility of SIJ blocks. The evidence is insufficient to determine the effects of the technology on health outcomes.

For individuals who have SIJ pain who receive therapeutic corticosteroid injections, the evidence includes systematic reviews, randomized controlled trials (RCTs), and case series. Relevant outcomes are symptoms, functional outcomes, quality of life, medication use, and treatment-related morbidity. In general, the literature on injection therapy of joints in the back is of poor quality. Results from one RCT showed superiority over a sham control group, but two RCTs showed that therapeutic SIJ steroid injections were not as effective as other active treatments. Larger trials with rigorous designs and sufficient follow-up, preferably using sham injections, are needed to determine that the technology improves the net health outcome. The evidence is insufficient to determine the effects of the technology on health outcomes.

For individuals who have SIJ pain who receive radiofrequency ablation (RFA), the evidence includes 6 RCTs using different radiofrequency applications and case series. Relevant outcomes are symptoms, functional outcomes, quality of life, medication use, and treatment-related morbidity. Meta-analysis of available sham controlled RCTs suggests that there may be a small effect of RFA on SIJ pain at short-term (1-6 months) follow-up. However, the RCTs of RFA have methodologic limitations, and there is limited data on the duration of the treatment effect. The single RCT with 6- and 12-month follow-up showed no significant benefit of RFA compared to an exercise control group at these time points. In addition, heterogeneity of RFA treatment techniques precludes generalizing results across different studies. For RFA with a cooled probe, three RCTs reported short-term benefits, but these are insufficient to determine the overall effect on health outcomes. An RCT on palisade RFA of the SIJ did not include a sham control. Another sham-controlled RCT showed no benefit from RFA. Further high-quality controlled trials are needed to compare this procedure in defined populations with sham control and alternative treatments. The evidence is insufficient to determine the effects of the technology on health outcomes.

DEFINITIONS

ARTHROGRAPHY is a diagnostic study that involves the injection of contrast media into a joint.

DISCLAIMER

Capital Blue Cross' medical policies are used to determine coverage for specific medical technologies, procedures, equipment, and services. These medical policies do not constitute medical advice and are subject to change as permitted by law or applicable clinical evidence from independent treatment guidelines. Treating providers are solely responsible for medical advice and treatment of members. These polices are not a guarantee of coverage or payment. Payment of claims is subject to a determination regarding the member's benefit program and eligibility on the date of service, and a determination that the services are medically necessary and appropriate. Final processing of a claim is based upon the terms of contract that applies to the members' benefit program, including benefit limitations and exclusions. If a provider or a member has a question concerning this medical policy, please contact Capital Blue Cross' Provider Services or Member Services.

CODING INFORMATION

Note: This list of codes may not be all-inclusive, and codes are subject to change at any time. The identification of a code in this section does not denote coverage as coverage is determined by the terms of member benefit information. In addition, not all covered services are eligible for separate reimbursement.

Investigational when used to bill for sacroiliac joint arthrography; therefore, not covered:

Procedure Codes								
27096	G0259							

Investigational when billed for radiofrequency ablation of the sacroiliac joint; therefore, not covered:

Procedure Codes								
64625	64640							

Covered when medically necessary:

Procedure Codes								
27096	64451	G0260						

ICD-10-CM Diagnosis Codes	Description
M46.1	Sacroiliitis, not elsewhere classified
M47.898	Other spondylosis, sacral and sacrococcygeal region
M47.899	Other spondylosis, site unspecified
M48.08	Spinal stenosis, sacral and sacrococcygeal region
M53.2X8	Spinal instabilities, sacral and sacrococcygeal region
M53.3	Sacrococcygeal disorders, not elsewhere classified
M54.18	Radiculopathy, sacral and sacrococcygeal region
M54.30	Sciatica, unspecified side
M54.31	Sciatica, right side
M54.32	Sciatica, left side
M54.40	Lumbago with sciatic, unspecified side
M54.41	Lumbago with sciatica, right side
M54.42	Lumbago with sciatica, left side
M54.50	Low back pain, unspecified
M54.51	Vertebrogenic low back pain
M54.59	Other low back pain

***Note:** For codes 27278, 27279, 27280, and C1737 related to arthrodesis and spinal devices, refer to TurningPoint Healthcare policies.*

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POLICY HISTORY

MP 5.048	**01/01/2020 Administrative Update.** New code added, 64625.
	06/16/2020 Consensus Review. No change to policy statement. References reviewed. Two ICD codes added to include unspecified codes.
	08/09/2021 Consensus Review. Policy statement unchanged. Background, Rationale and References updated.
	09/07/2021 Administrative Update. Added new ICD-10 codes. Effective date 10/01/2021.
	12/01/2022 Consensus Review. No change to policy statements. References updated. Background and summary of evidence reviewed.
	11/09/2023 Consensus Review. No change to policy statements. References updated. Coding reviewed and updated.
	11/19/2024 Minor Review. Changed all policy statements that were Not Medically Necessary to Investigational. Sacroiliac injections are now divided into therapeutic and diagnostic sections. References reviewed and updated. No coding changes.

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	09/30/2025 Minor Review. Criteria changed in policy statement from 4 to 3 injections per 12-month period. References, notes, summary of evidence, description/background, coding table, and clinical benefit reviewed and updated.