REIMBURSEMENT POLICY STATEMENT
GEORGIA MEDICAID

Policy Name		Policy Number	Effective Date
Sacroiliac Joint Procedures		PY-1091	09/01/2020-05/31/2021
Policy Type			
Medical	Administrative	Pharmacy	**REIMBURSEMENT**

Reimbursement Policy Statement: Reimbursement Policies prepared by CSMG Co. and its affiliates (including CareSource) are intended to provide a general reference regarding billing, coding and documentation guidelines. Coding methodology, regulatory requirements, industry-standard claims editing logic, benefits design and other factors are considered in developing Reimbursement Policies.

In addition to this Policy, Reimbursement of services is subject to member benefits and eligibility on the date of service, medical necessity, adherence to plan policies and procedures, claims editing logic, provider contractual agreement, and applicable referral, authorization, notification and utilization management guidelines. Medically necessary services include, but are not limited to, those health care services or supplies that are proper and necessary for the diagnosis or treatment of disease, illness, or injury and without which the patient can be expected to suffer prolonged, increased or new morbidity, impairment of function, dysfunction of a body organ or part, or significant pain and discomfort. These services meet the standards of good medical practice in the local area, are the lowest cost alternative, and are not provided mainly for the convenience of the member or provider. Medically necessary services also include those services defined in any federal or state coverage mandate, Evidence of Coverage documents, Medical Policy Statements, Provider Manuals, Member Handbooks, and/or other policies and procedures.

This Policy does not ensure an authorization or Reimbursement of services. Please refer to the plan contract (often referred to as the Evidence of Coverage) for the service(s) referenced herein. If there is a conflict between this Policy and the plan contract (i.e., Evidence of Coverage), then the plan contract (i.e., Evidence of Coverage) will be the controlling document used to make the determination.

CSMG Co. and its affiliates may use reasonable discretion in interpreting and applying this Policy to services provided in a particular case and may modify this Policy at any time.

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A. Subject

Sacroiliac Joint Procedures

B. Background

Reimbursement policies are designed to assist you when submitting claims to CareSource. They are routinely updated to promote accurate coding and policy clarification. These proprietary policies are not a guarantee of payment. Reimbursement for claims may be subject to limitations and/or qualifications. Reimbursement will be established based upon a review of the actual services provided to a member and will be determined when the claim is received for processing. Health care providers and their office staff are encouraged to use self-service channels to verify member's eligibility.

It is the responsibility of the submitting provider to submit the most accurate and appropriate CPT/HCPCS code(s) for the product or service that is being provided. The inclusion of a code in this policy does not imply any right to reimbursement or guarantee claims payment.

Sacroiliac joint injections using local anesthetic and/or corticosteroid medication have been shown to be effective for diagnostic purposes, but provide limited short-term relief from pain resulting from SI joint dysfunction.

C. Definitions

- **Sacroiliac Joint Injections** - corticosteroid and local anesthetic therapeutic injections into the sacroiliac joint to treat pain that hasn't responded to conservative therapies.
- **Radiofrequency Facet Ablation (RFA)** - is performed using percutaneous introduction of an electrode under fluoroscopic guidance to thermocoagulate medial branches of the dorsal spinal nerves.

D. Policy

I. Sacroiliac Joint Procedures
   A. A prior authorization (PA) is required for each sacroiliac joint procedure for pain management.
   B. Sacroiliac Joint Injection Codes
      1. Codes 64451 and 27096 are considered the same procedure and may not be billed together.
   C. Sacroiliac Joint Injections
      1. Two (2) diagnostic injections per joint to evaluate pain and attain therapeutic effect, repeating no more than once every seven (7) days and with at least a 75% or greater reduction in pain after the first injection.
      2. Once the diagnostic injections are performed and the diagnosis is established, two (2) therapeutic injections per joint may be performed over a 12 month period.
      3. Injections should not be repeated more frequently than every two (2) months with no more than a total of four (4) injections (including both diagnostic and therapeutic) per joint in 12 months.

D. Image guidance and/or injection of contrast is included in sacroiliac injection procedures and may not be billed separately

F. Initial Radiofrequency Ablation of the SI Joint

1. A maximum of one (1) radiofrequency ablation for SI Joint pain per side per rolling twelve (12) months when CareSource medical policy MM-0010 clinical criteria has been met.

G. Repeat Radiofrequency Ablation of the SI Joint

1. Conservative therapy and diagnostic injections are not required if there has been a reduction in pain for at least twelve (12) months or more from the initial RFA within the last thirty-six (36) months.
2. When there has not been a repeat RFA in the last thirty-six (36) months, a diagnostic injection is required.

E. Conditions of Coverage

Reimbursement is dependent on, but not limited to, submitting approved HCPCS and CPT codes along with appropriate modifiers, if applicable. Please refer to the individual fee schedule for appropriate codes.

- **The following list(s) of codes is provided as a reference. This list may not be all inclusive and is subject to updates.**

Sacroiliac Joint Procedures	Description
27096	Injection procedure for sacroiliac joint, anesthetic/steroid, with image guidance (fluoroscopy or CT) including arthrography when performed
64451	Injection(s), anesthetic agent(s) and/or steroid; nerves innervating the sacroiliac joint, with image guidance (ie, fluoroscopy or computed tomography
64625	Radiofrequency ablation, nerves innervating the sacroiliac joint, with image guidance (ie, fluoroscopy or computed tomography)

F. Related Policies/Rules

Sacroiliac Joint Procedures MM-0215

G. Review/Revision History

	DATE	ACTION
Date Issued	12/11/2019	
Date Revised	05/13/2020	Revised to add coverage for ablation of the SI Joint; added codes: 64451 64625.
Date Effective	09/01/2020	
Date Archived	05/31/2021	This Policy is no longer active and has been archived. Please note that there could be other Policies that may have some of the same rules incorporated and CareSource reserves the right to follow CMS/State/NCCI guidelines without a formal documented Policy.

H. References

1. Georgia Department of Community Health Fee Schedules. Retrieved May 1, 2020 from www.mmis.georgia.gov

The Reimbursement Policy Statement detailed above has received due consideration as defined in the Reimbursement Policy Statement Policy and is approved.

GA-MED-P-131362 Date Issued 02/11/2019 DCH Approved 06/09/2020