Priority Health	BILLING POLICY No. 114
SACROILIAC JOINT INJECTIONS & PROCEDURES	
Date of origin: July 11, 2025	**Review dates: None yet recorded**

APPLIES TO

- Commercial
- Medicare follows CMS unless otherwise specified
- Medicaid follows MDHHS unless otherwise specified

DEFINITION

A sacroiliac joint injection is a medical procedure where a needle is used to inject a combination of the anesthetic and steroid medication into the sacroiliac joint, which is connects the spine to the pelvis.

MEDICAL POLICY

- Spine Procedures (#91581)

FOR MEDICARE

For indications that don't meet criteria of NCD, local LCD or specific medical policy a Pre-Service Organization Determination (PSOD) will need to be completed. Get more information on PSOD in our Provider Manual.

POLICY SPECIFIC INFORMATION

Reimbursement rates

Find reimbursement rates for the codes listed on this page in our standard fee schedules for your contract. See our fee schedules (login required).

Reimbursement specifics

Maximum of 2 diagnostic joint sessions (CPT code 27096 and/or 64457) will be considered reasonable and necessary, regardless of the code that is billed

Maximum of 4 therapeutic SIJI sessions (CPT codes 27096 and/or 64457) will be reimbursed per a rolling 12 months regardless of the code that is billed

Billing details

This policy applies only to the sacroiliac joint injections (SIJI) and procedures and does not apply to other joint procedures (i.e. facet, sacroiliitis, epidural or other spinal procedures).

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

Includes:

- Confirmation intra-articular needle placement with CT or fluoroscopy
- Fluoroscopic guidance (77002-77003)

64451
Injection(s), anesthetic agent(s) and/or steroid; nerves innervating the sacroiliac joint, with image guidance (ie, fluoroscopy or computed tomography)

Includes:

- Imaging guidance and any contrast injection

G0260
Injection procedure for sacroiliac joint; provision of anesthetic, steroid and/or other therapeutic agent, with or without arthrography

Coding and billing specifics for diagnostic and therapeutic procedures

Sacroiliac joint injections may be performed as unilateral or bilateral in the same session.

- Bilateral SIJIs procedures reported with the CPT 27096 or 64451 should be reported with modifier 50.
- Unilateral joint injection (CPT 27096) is performed, and a unilateral sacral nerve block (CPT 64451) is performed on the contralateral side do not report modifier 50 with either code. Do not report a sacroiliac joint injection (CPT 27096) and a sacral nerve block (CPT 64451) for the same side.

For services that are performed in the Hospital Outpatient Department (TOB 13X) or an Ambulatory Surgical Center:

- ASC facility claims (specialty 49) report bilateral procedures on two separate lines, with one unit each.
- Modifiers -LT and -RT are appended to each line. ASC facilities should not report modifier 50.
- CPT 27096 is not a covered service for ASC facility (specialty 49) claims and is not recognized under OPPS. ASC facilities and OPPS hospital outpatient departments should report HCPCS code G0260 for sacroiliac joint injections. The medical record must contain documentation that fluoroscopic guidance or CT guidance was used with HCPC code G0260. Image guidance is packaged into G0260, and no separate payment is made to the ASC or the OPPS hospital outpatient department for CPT codes 77002 and 77012.

Injections of the nerves innervating the sacroiliac joint should be reported with CPT 64451. CPT 64451 includes the imaging guidance.

- Imaging codes should not be reported with CPT 64451.

Critical Access Hospitals (TOB 85X) should report sacroiliac joint injection with CPT 27096 and a sacral nerve block with CPT 64451.

- Bilateral injections should be reported using modifier 50.
- If a unilateral sacroiliac joint injection (CPT 27096) is performed and a unilateral sacral nerve block (CPT 64451) is performed on the contralateral side do not report modifier 50 with either code.
- Do not report a sacroiliac joint injection (CPT 27096) and a sacral nerve block (CPT 64451) for the same side.

Physician services in an ASC setting should report codes as noted above in the section on Professional services performed by the physician.

Documentation requirements

Complete and thorough documentation to substantiate the procedure performed is the responsibility of the provider. In addition, the provider should consult any specific documentation requirements that are necessary of any applicable defined guidelines.

1. The procedural report should clearly document the indications and also the medical necessity for the blocks along with the pre and post percent (%) pain relief achieved immediately post-injection.
2. Films that adequately document (minimum of 2 views) final needle position and the contrast flow should be retained and made available upon request.

Modifiers
Priority Health follows standard billing and coding guidelines which include CMS NCCI. Modifiers should be applied when applicable based on this guidance and only when supported by documentation.

Incorrect application of modifiers will result in denials. The modifier list below may not be an all-inclusive list. Get more information on modifier use in our Provider Manual.

- **KX**: Requirements specified in the medical policy have been met
    - KX modifier is only to be used for the initial diagnostic injection.
- **RT**: Right side (Used to identify procedures performed on the right side of the body)
- **LT**: Left side (Used to identify procedures performed on the left side of the body)
- **50**: Bilateral Procedure. Unless otherwise identified in the listings, bilateral procedures that are performed at the same session should be identified by adding modifier 50 to the appropriate 5-digit code. Note: This modifier should not be appended to designated "add-on" codes.

Place of service
Coverage will be considered for services furnished in the appropriate setting to the patient's medical needs and condition. Authorization may be required. Get more information in our Provider Manual.

REFERENCES

- Billing and Coding: Sacroiliac Joint Injections and Procedures (A59257) (CMS)

DISCLAIMER
Priority Health's billing policies outline our guidelines to assist providers in accurate claim submissions and define reimbursement or coding requirements if the service is covered by a Priority Health member's benefit plan. The determination of visits, procedures, DME, supplies and other services or items for coverage under a member's benefit plan or authorization isn't being determined for reimbursement. Authorization requirements and medical necessity requirements appropriate to procedure, diagnosis and frequency are still required. We use Current Procedural Terminology (CPT), Centers for Medicare and Medicaid Services (CMS), Michigan Department of Health and Human Services (MDHHS) and other defined medical coding guidelines for coding accuracy.

An authorization isn't a guarantee of payment when proper billing and coding requirements or adherence to our policies aren't followed. Proper billing and submission guidelines must be followed. We require industry standard, compliant codes defined by CPT, HCPCS and revenue codes for all claim submissions. CPT, HCPCPS, revenue codes, etc., can be reported only when the service has been performed and fully documented in the medical record to the highest level of specificity. Failure to document for services rendered or items supplied will result in a denial. To validate billing and coding accuracy, payment integrity pre- or post-claim reviews may be performed to prevent fraud, waste and abuse. Unless otherwise detailed in the policy, our billing policies apply to both participating and non-participating providers and facilities.

If guidelines detailed in government program regulations, defined in policies and contractual requirements aren't followed, Priority Health may:

- Reject or deny the claim
- Recover or recoup claim payment

An authorization on file for an item or services doesn't supersede coding, billing or reimbursement requirements.

These policies may be superseded by mandates defined in provider contracts or state, federal or CMS contracts or requirements. We make every effort to update our policies in a timely manner to align to these requirements or contracts. If there's a delay in implementation of a policy or requirement defined by state or federal law, as well as contract language, we reserve the right to recoup and/or recover claim payments to the effective dates per our policy. We reserve the right to update policies when necessary. Our most current policy will be made available in our Provider Manual.

CHANGE / REVIEW HISTORY

Date	Revisions made