CHECKLIST FOR SACROILIAC JOINT INJECTIONS

Patient Name: ________________________________ DOB: ______________

Provider Name: ________________________________ DOS: ______________

DOCUMENTATION
☐ The assessment as it relates to the complaint for that visit
☐ Relevant medical history and physical examination
☐ Results of pertinent tests/procedures
☐ Signed and dated office visit record/operative report
☐ Documentation to support the medical necessity of the procedure(s)

CRITERIA FOR DIAGNOSTIC BLOCKS (5 COMPONENTS)
☐ Moderate to severe axial low back pain over anatomic location of the SI joints below L5
☐ 3 months duration of pain
☐ At least 3 positive findings with provocative maneuvers:
  ☐ FABER
  ☐ Gaenslen
  ☐ Thigh Thrust
  ☐ Yeoman Tests
  ☐ Posterior Shear
☐ Inadequate response to conservative methods at least for 4 weeks (chiropractic, physical therapy, structured exercise program, NSAIDs, and other drugs) with duration and effects
☐ No untreated radiculopathy (current imaging)

FIRST BLOCK Date: ___________________________  ____ Positive ____ Negative
☐ First diagnostic block is performed with lidocaine 1% or 2%, 1.5 mL, producing ≥ 80% pain relief with movements (policy says 75%, to make it easier to remember with facet joint interventions, 80% may make some sense, but 75% is fine)

SECOND BLOCK Date: ___________________________  ____ Positive ____ Negative
☐ The second block, if the first block was positive, is performed with 0.25% or 0.5% bupivacaine, 1.5 mL, producing ≥ 80% pain relief with movements (policy says 75%, to make it easier to remember with facet joint interventions, 80% may make some sense, but 75% is fine)

THERAPEUTIC SACROILIAC JOINT INJECTIONS
☐ Therapeutic sacroiliac joint injections (2 mL) per joint, including steroids, with proper indications should provide 3 months of ≥ 50% relief
☐ Indications documented

LIMITATIONS
☐ No more one level bilateral or unilateral are billed
☐ Only mild sedation of joint injections and nerve blocks; moderate sedation or MAC allowed for RF
☐ CT or fluoro – save images
☐ No multiple procedures on same date of service

LETTER
☐ Letter to family physician if treatment is provided beyond 12 months, similar to epidural injections