

Sacroiliac Fusion, Open and Percutaneous, Surgical 116

Table of Content

[Description & Definitions](#)
[Criteria](#)
[Document History](#)
[Coding](#)
[Special Notes](#)
[References](#)
[Keywords](#)

[Effective Date](#) 10/1/2025
[Next Review Date](#) 7/2026
[Coverage Policy](#) Surgical 116
[Version](#) 6

Member-specific benefits take precedence over medical policy and benefits may vary across plans. Refer to the individual's benefit plan for details ^{*}.

Description & Definitions:

Sacroiliac Joint Fusion (Arthrodesis) creates an immobile unit between the ilium and sacrum. This can be completed by bone graft or instrumentation as well as open or minimally invasive techniques.

Other Names: (SIJF), Spinal fusion

Criteria:

Sacroiliac Joint Fusion (Arthrodesis) stabilization is considered medically necessary for individuals with **ALL** of the following:

- Individual has physical examination maneuvers specific for SI joint pain of at least **3 or more** of the following:
 - o Compression test
 - o Posterior Pelvic Pain Provocation test - P4 (Thigh Thrust)
 - o Patrick's test (Fabere)
 - o Sacroiliac distraction test
 - o Geanslens test
- Absence of generalized pain behavior (e.g., somatoform disorder), generalized pain disorder (e.g., fibromyalgia) or untreated, underlying mental health conditions/issues (e.g., depression, drug, alcohol abuse) as a major contributor to chronic back pain
- Sacroiliac joint diagnostic imaging (Plain X-rays, CT scan, MRI) documentation within the last six months which indicates evidence of injury and/or degeneration
- Impacts quality of life and/or significantly limits activities of daily living (ADL's)
- Two separate fluoroscopic or CT controlled injection of local anesthetic into affected SI joint with documentation of at least 70% improvement of the pre injection NRS score
- Individual has failed at least six months conservative treatment including pharmacotherapy (e.g., NSAIDS, activity modification, bracing and active physical therapy targeting the lumbar spine, pelvis, sacroiliac joint, and hip, including a home exercise program)

- Choice of **1 or more** of the following procedures:
 - **Percutaneous or Minimally Invasive Sacroiliac joint** for individuals with low back/buttock pain from definitive involvement of the SI joint(due to degenerative sacroiliitis or sacroiliac joint disruption) and **ALL** of the following:
 - Individual is 18 years of age or older
 - Pain has been present for at least six months below the lumbar spine at or close to the posterior SI joint with possible radiation into buttocks, posterior thigh/groin and the individual can point to the location of pain at the sacral sulcus (Fortin Finger Test)
 - Diagnostic imaging studies (Plain X-rays, CT scan, MRI) within the last six months which documents **ALL** of the following exclusions:
 - Acute fracture, tumor, infection, inflammatory arthropathy (e.g., ankylosing spondylitis, rheumatoid arthritis), osteoporosis of the SI joint
 - Concomitant hip disease (such as fracture, osteoarthritis)
 - Concomitant lumbar spine disease (such as fracture, neural compression, degenerative conditions) as possible sources of low back/buttock pain
 - **Open Sacroiliac Joint Fusion** for individuals with **1 or more** of the following indications:
 - Sacroiliac joint infection
 - Tumor involving the sacrum
 - Sacroiliac pain from severe traumatic injury associated with pelvic ring fracture
 - Adjunct to sacrectomy or partial sacrectomy due to tumors involving the sacrum
 - During multisegment spinal constructs extending to the ilium (e.g. correction of deformity in scoliosis or kyphosis surgery)

Sacroiliac Joint Fusion (Arthrodesis) is considered **not medically necessary** and There is insufficient scientific evidence to support for any use other than those indicated in clinical criteria, to include but not limited to:

- sacroiliac fusion or pinning for the treatment of lower back pain due to sacroiliac joint syndrome.

Document History:

Revised Dates:

- 2025: July – Implementation date of October 1, 2025. Annual review completed. New format and housekeeping.
- 2020: August
- 2016: April
- 2015: February, May, September
- 2014: January, June, August, November
- 2013: May, June
- 2012: February, May
- 2011: May, June, November
- 2010: May
- 2009: May
- 2008: May
- 2006: October
- 2004: September
- 2002: August

Reviewed Dates:

- 2024: July - Annual review completed. New code 27278 added to coverage section. References updated.
- 2023: July
- 2022: July

- 2021: September
- 2019: April
- 2018: November
- 2017: December
- 2016: May
- 2014: May
- 2010: April
- 2007: December
- 2005: February, October
- 2004: July
- 2003: July

Origination Date: May 2002

Coding:

Medically necessary with criteria:

| Coding | Description |
|--------|---|
| 27278 | Arthrodesis, sacroiliac joint, percutaneous, with image guidance, including placement of intra-articular implant(s) (eg, bone allograft[s], synthetic device[s]), without placement of transfixation device |
| 27279 | Arthrodesis, sacroiliac joint, percutaneous or minimally invasive (indirect visualization), with image guidance, includes obtaining bone graft when performed, and placement of transfixing device |
| 27280 | Arthrodesis, open, sacroiliac joint, including obtaining bone graft, including instrumentation, when performed |

Considered Not Medically Necessary:

| Coding | Description |
|--------|-------------|
| | None |

U.S. Food and Drug Administration (FDA) - approved only products only.

The preceding codes are included above for informational purposes only and may not be all inclusive. Additionally, inclusion or exclusion of a treatment, procedure, or device code(s) does not constitute or imply member coverage or provider reimbursement. Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage of these services as it applies to an individual member.

Special Notes: *

- Coverage:
 - See the appropriate benefit document for specific coverage determination. Member specific benefits take precedence over medical policy.
- Application to products:
 - Policy is applicable to Sentara Health Plan Commercial products.
- Authorization requirements:
 - Pre-certification by the Plan is required.

- Special Notes:
 - Commercial
 - Medical policies can be highly technical and complex and are provided here for informational purposes. These medical policies are intended for use by health care professionals. The medical policies do not constitute medical advice or medical care. Treating health care professionals are solely responsible for diagnosis, treatment, and medical advice. Sentara Health Plan members should discuss the information in the medical policies with their treating health care professionals. Medical technology is constantly evolving, and these medical policies are subject to change without notice, although Sentara Health Plan will notify providers as required in advance of changes that could have a negative impact on benefits.
 - Services mean both medical and behavioral health (mental health) services and supplies unless We specifically tell You otherwise. We do not cover any services that are not listed in the Covered Services section unless required to be covered under state or federal laws and regulations. We do not cover any services that are not Medically Necessary. We sometimes give examples of specific services that are not covered but that does not mean that other similar services are covered. Some services are covered only if We authorize them. When We say You or Your We mean You and any of Your family members covered under the Plan. Call Member Services if You have questions.

References:

Specialty Association Guidelines; Government Regulations; Winifred S. Hayes, Inc; UpToDate; Literature Review; Specialty Advisors; National Coverage Determination (NCD); Local Coverage Determination (LCD).

28th Edition. (2025). Retrieved 6 2025, from MCG: <https://careweb.careguidelines.com/ed28/>

(2025). Retrieved 6 2025, from Hayes:

<https://evidence.hayesinc.com/search?q=%257B%2522text%2522:%2522%2520Sacroiliac%2520joint%2520fusion%2522,%2522title%2522:null,%2522termsource%2522:%2522searchbar%2522,%2522page%2522:%257B%2522page%2522:0,%2522size%2522:50%257D,%2522type%2522:%2522all%2522>

(2025). Retrieved 6 2025, from UpToDate:

https://www.uptodate.com/contents/search?search=Sacroiliac%20joint%20fusion%20surgery&sp=0&searchType=PLAIN_TEXT&source=USER_INPUT&searchControl=TOP_PULLDOWN&autoComplete=false

Carelon - Sacroiliac Joint Fusion - updated 2025-01-01. (2025). Retrieved 6 2025, from Anthem:

<https://guidelines.carelonmedicalbenefitsmanagement.com/sacroiliac-joint-fusion-2024-10-20-updated-2025-01-01/>

LCD: Minimally Invasive Arthrodesis of the Sacroiliac Joint (SIJ) L39797 Palmetto. (2025, 4). Retrieved 6 2025, from CMS Local Coverage Determination: <https://www.cms.gov/medicare-coverage-database/view/lcd.aspx?lcdId=39797&ver=11>

Minimally Invasive Sacroiliac Joint Fusion. (2021). Retrieved 6 2025, from North American Spine Society (NASS): <https://www.spine.org/Research/Clinical-Guidelines>

Sacroiliac joint fusion Clinic. (2025). Retrieved 6 2025, from Mayo Clinic: <https://www.mayoclinic.org/departments-centers/sacroiliac-joint-clinic/overview/ovc-20472398>

Provider Manuals. (2025). Retrieved 6 2025, from DMAS: <https://www.dmas.virginia.gov/for-providers/>

Keywords:

Sacroiliac Fusion, Open and Percutaneous, SHP Surgical 116, Sacroiliac joint infection, Tumor, sacrum, sacroiliac pain, pelvic ring fracture, sacrectomy, Percutaneous Invasive Sacroiliac joint stabilization, arthrodesis, Minimally Invasive

Sacroiliac joint stabilization, low back pain, buttock pain, SI joint, Compression test, Posterior Pelvic Pain Provocation test, Thigh Thrust, Patrick's test, Fabere, Sacroiliac distraction test, Geanslens test, iFuse