Sentara® Health Plans

Commercial

Sacroiliac Fusion, Open and Percutaneous

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Effective Date	5/2002
Next Review Date	7/15/2024
Coverage Policy	Surgical 116
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Member-specific benefits take precedence over medical policy and benefits may vary across plans. Refer to the individual's benefit plan for details *.

Purpose:

This policy addresses the medical necessity of Sacroiliac Fusion, Open and Percutaneous surgeries.

Description & Definitions:

Sacroiliac fusion, Open and Percutaneous 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.

Criteria:

Sacroiliac fusion, Open and Percutaneous are considered medically necessary for individuals for **1 or more** of the following:

- **Open Sacroiliac Joint Fusion** is medically necessary for individuals with indications of **1 or more** of the following:
  - 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)
- **Percutaneous or Minimally Invasive Sacroiliac joint stabilization** for arthrodesis 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 or groin and the individual can point to the location of pain at the sacral sulcus (Fortin Finger Test)

- Individual has physical examination maneuvers specific for SI joint pain of at least **3 or more** of the following:
  - Compression test
  - Posterior Pelvic Pain Provocation test - P4 (Thigh Thrust)
  - Patrick's test (Fabere)
  - Sacroiliac distraction test
  - Geanslens test
- There is documentation of diagnostic imaging studies (Plain X-rays, CT scan, MRI) within the last six months which **excludes All** of the following:
  - 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
- Sacroiliac joint imaging indicates evidence of injury and/or degeneration
- Baseline lower back/buttock pain score of at least 5 on 0-10 point NRS (pain numeric rating scale) impacting quality of life and/or ADL's with at least 70% improvement of the pre injection NRS score after two separate fluoroscopic or CT controlled injection of local anesthetic into affected SI joint
- 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
- 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

Sacroiliac Fusion, Open and Percutaneous are considered **not medically necessary** for any use other than those indicated in clinical criteria, to include but not limited to:

- treatment of lower back pain due to sacroiliac joint syndrome

Coding:

Medically necessary with criteria:

Coding	Description
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.

Document History:

Revised Dates:

- 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:

- 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

Effective Date:

- May 2002

References:

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

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Sec. 888.3040 Smooth or threaded metallic bone fixation fastener. (2023, Jun 07). Retrieved Jul 11, 2023, from Code of Federal Regulations (National Archives): https://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfcfr/cfrsearch.cfm?fr=888.3040

Special Notes: *

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.

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