Sacroiliac Fusion, Open and Percutaneous, Surgical 116

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Effective Date	10/1/2025
Next Review Date	7/2026
Coverage Policy	Surgical 116
Version	6

All requests for authorization for the services described by this medical policy will be reviewed per Early and Periodic Screening, Diagnostic and Treatment (EPSDT) guidelines. These services may be authorized under individual consideration for Medicaid members under the age of 21-years if the services are judged to by medically necessary to correct or ameliorate the member's condition. Department of Medical Assistance Services (DMAS), Supplement B - EPSDT (Early and Periodic Screening, Diagnosis and Treatment) Manual.*.

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:
  - Compression test
  - Posterior Pelvic Pain Provocation test - P4 (Thigh Thrust)
  - Patrick's test (Fabere)
  - Sacroiliac distraction test
  - Geanslens test
- Absence of generalized pain behavior (e.g., somatoform disorder), generalized pain disorder (e.g., fibromyalgia) or untreated, underlying mental healthconditions/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 physicaltherapy 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 sacroiliiitis 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 thighor 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

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.

Policy Approach and 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 Virginia Medicaid Products
- Authorization requirements
  - Precertification required by Plan
- Special Notes:
  - This medical policy express Sentara Health Plan's determination of medically necessity of services, and they are based upon a review of currently available clinical information. These policies are used when no specific guidelines for coverage are provided by the Department of Medical Assistance Services of Virginia (DMAS). Medical Policies may be superseded by state Medicaid Plan guidelines. Medical policies are not a substitute for clinical judgment or for any prior authorization requirements of the health plan. These policies are not an explanation of benefits.
  - 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.
  - The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) covers services, products, or procedures for children, if those items are determined to be medically necessary to "correct or

ameliorate" (make better) a defect, physical or mental illness, or condition (health problem) identified through routine medical screening or examination, regardless of whether coverage for the same service or support is an optional or limited service under the state plan. Children enrolled in the FAMIS Program are not eligible for all EPSDT treatment services. All requests for authorization for the services described by this medical policy will be reviewed per EPSDT guidelines. These services may be authorized under individual consideration for Medicaid members under the age of 21-years if the services are judged to by medically necessary to correct or ameliorate the member's condition. EPSDT Supplement B (updated 5.19.22) Final.pdf

- Service authorization requests must be accompanied by sufficient clinical records to support the request. Clinical records must be signed and dated by the requesting provider withing 60 days of the date of service requested.

References:

References used include but are not limited to the following: 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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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