Policy: MP301

Section: Medical Benefit Policy

Subject: Sacroiliac Joint Fusion

I. Policy: Sacroiliac Joint Fusion

II. Purpose/Objective:
To provide a policy of coverage regarding Sacroiliac Joint Fusion

III. Responsibility:
A. Medical Directors
B. Medical Management

IV. Required Definitions
1. Attachment – a supporting document that is developed and maintained by the policy writer or department requiring/authoring the policy.
2. Exhibit – a supporting document developed and maintained in a department other than the department requiring/authoring the policy.
3. Devised – the date the policy was implemented.
4. Revised – the date of every revision to the policy, including typographical and grammatical changes.
5. Reviewed – the date documenting the annual review if the policy has no revisions necessary.

V. Additional Definitions
Medical Necessity or Medically Necessary means Covered Services rendered by a Health Care Provider that the Plan determines are:

a. appropriate for the symptoms and diagnosis or treatment of the Member's condition, illness, disease or injury;
b. provided for the diagnosis, and the direct care and treatment of the Member's condition, illness disease or injury;
c. in accordance with current standards of good medical treatment practiced by the general medical community.
d. not primarily for the convenience of the Member, or the Member's Health Care Provider; and
e. the most appropriate source or level of service that can safely be provided to the Member. When applied to hospitalization, this further means that the Member requires acute care as an inpatient due to the nature of the services rendered or the Member's condition, and the Member cannot receive safe or adequate care as an outpatient.

Medicaid Business Segment
Medical Necessity shall mean a service or benefit that is compensable under the Medical Assistance Program and if it meets any one of the following standards:

(i) The service or benefit will, or is reasonably expected to, prevent the onset of an illness, condition or disability.
(ii) The service or benefit will, or is reasonably expected to, reduce or ameliorate the physical, mental or development effects of an illness, condition, injury or disability.
(iii) The service or benefit will assist the Member to achieve or maintain maximum functional
capacity in performing daily activities, taking into account both the functional capacity of the Member and those functional capacities that are appropriate for members of the same age.

DESCRIPTION: Sacroiliac joint fusion is a surgical procedure which fuses the pelvis to the sacrum to provide stabilization.

INDICATIONS: REQUIRES PRIOR MEDICAL DIRECTOR or DESIGNEE AUTHORIZATION (For lines of business in which coverage is not explicitly excluded).

Sacroiliac joint fusion is considered to be medically necessary for any for the following indications:
1. As an adjunct to sacrectomy or partial sacrectomy related to tumors involving the sacrum; OR
2. As an adjunct to the medical treatment of sacroiliac joint infection/sepsis; OR
3. Severe traumatic injuries associated with pelvic ring fracture; OR
4. During multisegment spinal constructs (for example, correction of deformity in scoliosis or kyphosis surgery) extending to the ilium.

Minimally invasive fusion of the SI joint utilizing the iFuse Implant System is considered to be medically necessary for the treatment of SI joint syndrome and SI joint mediated mechanical low back pain when all of the following criteria as recommended by the International Society for the Advancement of Spine Surgery (ISASS) are met:

- Significant SIJ pain (e.g., pain rating at least 5 on the 0-10 numeric rating scale where 0 represents no pain and 10 represents worst imaginable pain) or significant limitations in activities of daily living; and
- SIJ pain confirmed with at least 3 physical examination maneuvers that stress the SI joint (e.g., distraction test, compression test, thigh thrust, FABER (Patrick’s) test, Gaenslen’s maneuver, sacral sulcus tenderness) and cause the patient’s typical pain; and
- Confirmation of the SIJ as a pain generator with a 75% or greater acute decrease in pain upon fluoroscopically guided diagnostic intra-articular SI joint block using local anesthetic; and
- Failure to respond to at least 6 months of non-surgical treatment consisting of non-steroidal anti-inflammatory drugs and/or opioids (if not contraindicated) and one or more of the following: rest, physical therapy, SI joint steroid injection. Failure to respond means continued pain that interferes with activities of daily living and/or results in functional disability; and
- Additional or alternative diagnoses that could be responsible for the patient’s ongoing pain or disability have been ruled out (e.g., L5/S1 compression, hip osteoarthritis).

EXCLUSIONS:

Minimally invasive SIJ fusion is NOT indicated for patients with the following:
- Less than 6 months of back pain;
- Failure to pursue conservative treatment of the SI joint (unless contra-indicated);
- Pain not confirmed with a diagnostic SI joint block;
- Existence of other pathology that could explain the patient’s pain

The use of minimally invasive fusion products other than iFuse Implant System for sacroiliac joint fusion is considered experimental/investigational or unproven and therefore NOT COVERED.

Note: A complete description of the process by which a given technology or service is evaluated and determined to be experimental, investigational or unproven is outlined in MP 15 - Experimental Investigational or Unproven Services or Treatment.

CODING ASSOCIATED WITH: Sacroiliac Joint Fusion
The following codes are included below for informational purposes and may not be all inclusive. Inclusion of a procedure or device code(s) does not constitute or imply coverage nor does it imply or guarantee provider reimbursement. Coverage is determined by the member specific benefit plan document and any applicable laws regarding coverage of specific services.

27279 Arthrodesis, sacroiliac joint, percutaneous or minimally invasive (indirect visualization), with image guidance, includes obtaining bone graft when performed, and placement of transfixing device

Eligibility and contract specific benefit limitations and/or exclusions will apply. Coverage statements found in the line of business specific benefit document will supercede this policy.

REFERENCES:


Ashman, B, Norvell, DC, Hermsmeyer, JT. Chronic sacroiliac joint pain: fusion versus denervation as treatment options. Evid Based Spine Care J. 2010 Dec;1(3):35-44.


 Schroeder JE, Cunningham ME, Ross T, Boachie-Adjei O. Early results of sacro-iliac joint fixation following long fusion to the sacrum in adult spine deformity. HSS J. 2014 Feb;10(1):30-5.


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Cher DJ, Polly DW. Improvement in health state utility after sacroiliac joint fusion: comparison to normal populations. Global Spine Journal 2015

This policy will be revised as necessary and reviewed no less than annually.

Devised: 9/15
Revised: 4/16 (coverage criteria added)
Reviewed: