



MEDICAL POLICY STATEMENT

Georgia Medicaid

Policy Name & Number	Date Effective
Sacroiliac Joint Fusion-GA MCD-MM-1040	01/01/2024-04/30/2024
Policy Type	
MEDICAL	

Medical Policy Statement prepared by CareSource and its affiliates are derived from literature based on and supported by clinical guidelines, nationally recognized utilization and technology assessment guidelines, other medical management industry standards, and published MCO clinical policy guidelines. Medically necessary services include, but are not limited to, those health care services or supplies that are proper and necessary for the diagnosis or treatment of disease, illness, or injury and without which the patient can be expected to suffer prolonged, increased or new morbidity, impairment of function, dysfunction of a body organ or part, or significant pain and discomfort. These services meet the standards of good medical practice in the local area, are the lowest cost alternative, and are not provided mainly for the convenience of the member or provider. Medically necessary services also include those services defined in any Evidence of Coverage documents, Medical Policy Statements, Provider Manuals, Member Handbooks, and/or other policies and procedures.

Medical Policy Statements prepared by CareSource and its affiliates do not ensure an authorization or payment of services. Please refer to the plan contract (often referred to as the Evidence of Coverage) for the service(s) referenced in the Medical Policy Statement. If there is a conflict between the Medical Policy Statement and the plan contract (i.e., Evidence of Coverage), then the plan contract (i.e., Evidence of Coverage) will be the controlling document used to make the determination. According to the rules of Mental Health Parity Addiction Equity Act (MHPAEA), coverage for the diagnosis and treatment of a behavioral health disorder will not be subject to any limitations that are less favorable than the limitations that apply to medical conditions as covered under this policy.

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A. Subject

Sacroiliac Joint Fusion

B. Background

The sacroiliac joints (SIJ) are formed by the connection of the sacrum and the right and left iliac bones. The sacrum is the triangular-shaped bone in the lower portion of the spine below the lumbar spine. While most of the vertebrae of the spine are mobile, the sacrum is made up of five vertebrae that are fused together and do not move. The iliac bones are the two large bones that make up the pelvis. As a result, the SI joints connect the spine to the pelvis. The sacrum and the iliac bones (ileum) are held together by a collection of strong ligaments. There is relatively little motion at the SI joints, normally less than 4° of rotation and 2 mm of translation.

SIJ dysfunction occurs when there is abnormal movement or malalignment of the sacroiliac joint and is the main source of lower back pain in 15% to 30% of patients. The condition causes disability and pain, and may be caused by prior lumbar sacral fusion, trauma, inflammatory arthritis, sacral tumors, osteoarthritis, or pregnancy. Patients may present with low back, groin, and/or gluteal pain. SIJ pain is often similar to discogenic pain or radicular back pain. This can lead to misdiagnosis and treatment; imaging studies and physical exam are usually necessary to determine if pain is caused by SIJ dysfunction. For many individuals, conservative management and/or minimally invasive procedures can improve pain management. However, joint fusion may be warranted following trauma or failure of conservative management and less invasive procedures (eg, SIJ injections).

Open SIJ fusion is typically performed when a large visual field is required (e.g., post-traumatic injury, tumor resection), while percutaneous SIJ fusion may be used for treatment of refractory chronic low back pain. Open SIJ fusion typically involves opening the SIJ, denuding of cartilage, and bone grafting. To stabilize the SIJ, the iliac crest bone and the sacrum are typically held together by plates or screws or an interbody fusion cage until the bones fuse. The minimally invasive procedure for SIJ fusion is performed by an orthopedic or neurologic surgeon in an inpatient or outpatient setting. The procedure typically ranges from 45 to 70 minutes and requires general endotracheal anesthesia, fluoroscopic guidance, and a small (approximately 3 mm) incision in the buttock region. Postoperatively, patients ambulate with a walker or crutches and follow a progressive regimen to develop flexibility and strength until they are fully ambulatory.

C. Definitions

- **Conservative Therapy** - A multimodality plan of care including both active and inactive conservative therapies.
 - **Active Conservative Therapies** - Actions or activities that strengthen muscle groups and target key spinal structures, including physical therapy, occupational therapy, and/or a physician supervised home exercise program (HEP).

- **HEP** - A 6-week program requiring an exercise prescription and/or plan and a follow-up documented in the medical record after completion, or documentation of the inability to complete the HEP due to a stated physical reason (ie, increased pain, inability to physically perform exercises). Patient inconvenience or noncompliance without explanation does not constitute an inability to complete.
- **Inactive Conservative Therapies** - Passive activities by the patient that aid in treating symptoms associated with pain, including rest, ice, heat, medical devices, transcutaneous electrical nerve stimulation (TENS), and/or pharmacotherapy (prescription or over the counter [eg, non-steroidal anti-inflammatory drugs, acetaminophen]).
- **Transcutaneous Electrical Nerve Stimulator (TENS)** - A device that utilizes electrical current delivered through electrodes placed on the surface of the skin to decrease the patient's perception of pain by inhibiting the transmission of afferent pain nerve impulses and/or stimulating the release of endorphins. Its use, frequency, duration, and start dates must be documented in the medical record to be considered part of conservative therapy during the period of prior authorization request.

D. Policy

I. Sacroiliac Joint Fusion

- A. CareSource considers open sacroiliac joint (SIJ) fusion medically necessary when **ALL** the following criteria are met:
 1. **At least ONE** of the following applies:
 - a. Patient has post-traumatic injury of the SIJ (eg, following pelvic ring fracture).
 - b. The procedure will be performed as an adjunctive treatment for sacroiliac joint infection (eg, osteomyelitis, pyogenic sacroiliitis)/sepsis.
 - c. The procedure will be performed for management of sacral tumor (eg, partial sacrectomy).
 - d. The procedure will be performed as part of a multisegmental long fusion construct for the correction of spinal deformity (eg, idiopathic scoliosis, neuromuscular scoliosis).
 - e. Prior percutaneous SIJ fusion has failed.
 2. Recent (within 6 months) plain x-rays and/or cross-sectional imaging (CT or MRI) demonstrate localized SIJ pathology.
- B. CareSource considers percutaneous SIJ fusion/stabilization for the treatment of back pain medically necessary when **ALL** the following criteria are met:
 1. Presence of non-radiating pain that is caudal to the lumbar spine (L5 vertebrae), localized over the posterior SIJ, and consistent with SIJ pain.
 2. SIJ pain registering at least a 5 on a 0 – 10 number scale.
 3. Localized tenderness with palpation of the posterior SIJ in the absence of tenderness of similar severity elsewhere (eg, greater trochanter, lumbar spine, coccyx) and other obvious sources for their pain do not exist.

4. The patient has undergone and failed conservative therapy, as evidenced by **ALL** the following:
 - a. Documentation in the medical record of at least 6 months of active conservative therapy (see definition above) within the past 12 months OR inability to complete active conservative therapy due to contraindication, increased pain, or intolerance.
 - b. Documentation in the medical record of at least 6 months of inactive conservative therapy (see definition above) within the past 12 months.
5. Positive response to the thigh thrust test OR compression test.
6. Positive response to two of the following provocative tests:
 - Gaenslen's test
 - distraction test
 - Patrick's sign
7. Diagnostic confirmation of the SIJ as the pain generator through at least a 50% reduction of pain for the expected duration of the anesthetic used following an image-guided, contrast-enhanced SIJ injection on two separate occasions.
8. Exclusion of generalized pain behavior or generalized pain disorders as the primary etiology of the patient's pain.
9. Diagnostic imaging studies that include **ALL** the following:
 - a. Imaging (plain radiographs and a CT or MRI) of the SIJ that excludes the presence of destructive lesions (eg, tumor, infection) or inflammatory arthropathy that would not be properly addressed by percutaneous SIJ fusion.
 - b. Imaging of the ipsilateral hip (plain radiographs) to rule out osteoarthritis.
 - c. Imaging of the lumbar spine (CT or MRI) to rule out neural compression or other degenerative condition that can be causing low back or buttock pain.

II. Exclusions

- A. Open SIJ fusion is considered not medically necessary for any other indication not outlined above, including (but not limited to) the following:
 1. mechanical low back syndrome
 2. sacroiliac joint syndrome
 3. degenerative sacroiliac joint
 4. presence of neural compression as seen on an MRI or CT that correlates with the patient's symptoms or other more likely source for their pain (eg, radicular pain)
- B. Percutaneous SIJ fusion for SIJ pain is NOT indicated in the presence of
 1. systemic arthropathy such as ankylosing spondylitis or rheumatoid arthritis
 2. generalized pain behavior (eg, somatoform disorder) or generalized pain disorder (eg, fibromyalgia)
 3. infection, tumor, or fracture
 4. acute, traumatic instability of the SIJ

The MEDICAL Policy Statement detailed above has received due consideration as defined in the MEDICAL Policy Statement Policy and is approved.

5. presence of neural compression as seen on an MRI or CT that correlates with the patient's symptoms or other more likely source for their pain

E. Conditions of Coverage
NA

F. Related Policies/Rules
NA

G. Review/Revision History

	DATE	ACTION
Date Issued	05/13/2020	New Policy
Date Revised	04/28/2021 04/12/2022 12/14/2022 08/30/2023	Annual Update: Removed PA language Annual Review: added open SIJ fusion indications, re-organized percutaneous criteria, added references Out of Cycle: adjusted pain scale and pain relief to match MCG, adjusted conservative therapy time frame to 6w in 6m Annual review: adjusted conservative therapy to match MCG, simplified criteria, expanded definitions, updated references. Approved at Committee.
Date Effective	01/01/2024	
Date Archived	04/30/2024	This Policy is no longer active and has been archived. Please note that there could be other Policies that may have some of the same rules incorporated and CareSource reserves the right to follow CMS/State/NCCI guidelines without a formal documented Policy

H. References

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