REIMBURSEMENT POLICY STATEMENT
GEORGIA MEDICAID

Policy Name		Policy Number	Effective Date
Sacroiliac Joint Fusion		PY-1216	09/01/2020-05/31/2021
Policy Type			
Medical	Administrative	Pharmacy	**REIMBURSEMENT**

Reimbursement Policy Statement: Reimbursement Policies prepared by CSMG Co. and its affiliates (including CareSource) are intended to provide a general reference regarding billing, coding and documentation guidelines. Coding methodology, regulatory requirements, industry-standard claims editing logic, benefits design and other factors are considered in developing Reimbursement Policies.

In addition to this Policy, Reimbursement of services is subject to member benefits and eligibility on the date of service, medical necessity, adherence to plan policies and procedures, claims editing logic, provider contractual agreement, and applicable referral, authorization, notification and utilization management 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 federal or state coverage mandate, Evidence of Coverage documents, Medical Policy Statements, Provider Manuals, Member Handbooks, and/or other policies and procedures.

This Policy does not ensure an authorization or Reimbursement of services. Please refer to the plan contract (often referred to as the Evidence of Coverage) for the service(s) referenced herein. If there is a conflict between this Policy 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.

CSMG Co. and its affiliates may use reasonable discretion in interpreting and applying this Policy to services provided in a particular case and may modify this Policy at any time.

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A. Subject

Sacroiliac Joint Fusion

B. Background

Reimbursement policies are designed to assist you when submitting claims to CareSource. They are routinely updated to promote accurate coding and policy clarification. These proprietary policies are not a guarantee of payment. Reimbursement for claims may be subject to limitations and/or qualifications. Reimbursement will be established based upon a review of the actual services provided to a member and will be determined when the claim is received for processing. Health care providers and their office staff are encouraged to use self-service channels to verify member's eligibility.

It is the responsibility of the submitting provider to submit the most accurate and appropriate CPT/HCPCS code(s) for the product or service that is being provided. The inclusion of a code in this policy does not imply any right to reimbursement or guarantee claims payment.

The sacroiliac (SI) joints 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 bones (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. There are normally less than 4 degrees of rotation and 2 mm of translation at these joints.

Sacroiliac Joint (SIJ) dysfunction is indicated by the 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. SI joint pain can often appear to be disogenic or radicular back pain. This can lead to the potential for inaccurate diagnosis and treatment, reviews caution difficult diagnosis and evidence for efficacy. 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 2 bones fuse.

C. Definitions

- **Conservative Therapy -** is a multimodality plan of care. Multimodality care plans include ALL of the following:
  - **Active Conservative Therapies -** such as physical therapy, occupational therapy or a physician supervised home exercise program (HEP)
    - **Home Exercise Program (HEP) -** includes two components that are both required to meet CareSource policy for completion of conservative therapy:

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- An exercise prescription and/or plan documented in the medical record.
- A follow up documented in the medical record regarding completion of a HEP (after suitable six (6) week period), or inability to complete a HEP due to a stated physical reason- i.e. increased pain, inability to physically perform exercises. (Patient inconvenience or noncompliance without explanation does not constitute "inability to complete").

- **Passive Conservative Therapies -** such as rest, ice, heat, medical devices, TENS unit and prescription medications

D. Policy

I. Sacroiliac Joint Fusion

A. Prior authorization is required for minimally invasive fusion/stabilization of the sacroiliac joint (SIJ) for the treatment of back pain when the medically necessary criteria in the Sacroiliac Joint Fusion Medical policy, MM-0838, has been met.

II. Exclusions

A. 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 (e.g. somatoform disorder) or generalized pain disorder (e.g. fibromyalgia);
3. Infection, tumor, or fracture;
4. Acute, traumatic instability of the SIJ;
5. 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

Reimbursement is dependent on, but not limited to, submitting approved HCPCS and CPT codes along with appropriate modifiers, if applicable. Please refer to the individual fee schedule for appropriate codes.

- **The following list(s) of codes is provided as a reference. This list may not be all inclusive and is subject to updates.**

CPT Code	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

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F. Related Policies/Rules

Sacroiliac Joint Fusion MM-0838

G. Review/Revision History

	DATE	ACTION
Date Issued	05/13/2020	New Policy
Date Revised		
Date Effective	09/01/2020	
Date Archived	05/31/2021	No longer effective as of 05/31/2021. 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

1. Georgia Department of Community Health Fee Schedules. Retrieved on April 15, 2020 from gammis.georgia.gov

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

GA-MED-P-131362 Date Issued 05/13/2020 DCH Approved 06/09/2020

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