MEDICAL POLICY STATEMENT
OHIO MEDICAID

Policy Name		Policy Number	Date Effective
Sacroiliac Joint Fusion		MM-0838	09/01/2021-07/31/2022
Policy Type			
MEDICAL	Administrative	Pharmacy	Reimbursement

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 (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.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 to complete 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 fully ambulatory. 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, a physician supervised home exercise program (HEP) or chiropractic care
  - **Inactive Conservative Therapies -** such as rest, ice, heat, medical devices, acupuncture, a transcutaneous electrical nerve stimulation (TENS) unit and prescription medications

D. Policy

I. Sacroiliac Joint Fusion

A. CareSource considers minimally invasive fusion/stabilization of the sacroiliac joint (SIJ) for the treatment of back pain medically necessary when ALL of the following criteria is met:

1. Have undergone and failed a minimum six months of conservative therapy, including:
   a. ACTIVE conservative therapy as part of a multimodality comprehensive approach and is addressed in the patient's care plan with documentation in the medical record that includes at least ONE of the following:
      01. The patient has received ACTIVE conservative therapy lasting for six (6) MONTHS or more within the past twelve (12) months including ONE of the following:
         (1) Physical therapy;
         (2) Occupational therapy;
         (3) A physician supervised home exercise program (HEP), including the following two requirements:
            i. An exercise prescription and/or plan documented in the medical record;
            ii. A follow up documented in the medical record regarding completion of an 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").
         (4) Chiropractic care.
      02. OR, the medical record documents at least ONE of the following exceptions to the 6 MONTHS ACTIVE conservative therapy requirement in the past twelve (12) months:
         (1) Moderate pain with significant functional loss at work or home;
         (2) Severe pain unresponsive to outpatient medical management;
         (3) Inability to tolerate non-surgical, non-injection care due to co-existing medical condition(s); or
         (4) Prior successful injections for same specific condition with relief of at least 3 months' duration.
   b. INACTIVE conservative therapy as part of a multimodality comprehensive approach is addressed in the patient's care plan with documentation in the medical record lasting for six (6) MONTHS or more within the past twelve (12) months including ONE of the following:
      01. Rest;
      02. Ice;
      03. Heat;
      04. Medical devices;
      05. Acupuncture;
      06. TENS unit

(1) If a TENS unit is part of the care plan, the frequency of use, and duration of use with dates must be documented in the medical record. General statements in the medical record such as "Patient has a TENS unit" do not document use, and will not suffice to meet this policy criterion.

07. Pain medications (prescription or over the counter) such as: non-steroidal anti-inflammatory drugs (NSAIDS), acetaminophen. Opioid narcotics are not required, necessary or recommended to meet pain medication criteria.

2. Patient's report of non-radiating; unilateral pain that is caudal to the lumbar spine (L5 vertebrae), localized over the posterior SIJ, and consistent with SIJ pain.
3. Localized tenderness with palpation of the posterior SIJ in the absence of tenderness of similar severity elsewhere (e.g. greater trochanter, lumbar spine, coccyx) and other obvious sources for their pain do not exist.
4. Positive response to the thigh thrust test OR compression test AND 2 of the following additional provocative tests: Gaenslen's test, Distraction test, Patrick's sign.
5. Exclusion of generalized pain behavior or generalized pain disorders as the primary etiology of the patient's pain.
6. Diagnostic imaging studies that include ALL of the following:
   a. Imaging (plain radiographs and a CT or MRI) of the SI joint that excludes the presence of destructive lesions (e.g. 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; and
   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.
7. At least 75 percent reduction of pain for the expected duration of the anesthetic used following an image-guided, contrast-enhanced SIJ injection on two separate occasions.

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; and
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

F. Related Polices/Rules

G. Review/Revision History

	DATE	ACTION
Date Issued	05/13/2020	New Policy
Date Revised	04/28/2021	Annual Update: Removed PA language.
Date Effective	09/01/2021	
Date Archived	07/31/2022	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. Centers for Medicare & Medicaid Services. Local Coverage Determination (LCD): Percutaneous minimally invasive fusion/stabilization of the sacroiliac joint for the treatment of back pain. (L36000). (11/01/2019). Retrieved April 6, 2021 from www.cms.gov
2. Chou, Roger, MD, (2019, January 2). Subacute and chronic low back pain: Nonsurgical interventional treatment. Retrieved April 7, 2021 from www.uptodate.com
3. DePhillipo, N. N., Corenman, D. S., Strauch, E. L., & Zalepa King, L. A. (2019, July). Sacroiliac Pain: Structural Causes of Pain Referring to the SI Joint Region. Retrieved April 7, 2021 from www.ncbi.nlm.nih.gov

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

Independent medical review – May 2020