MEDICAL POLICY STATEMENT
Arkansas PASSE

Policy Name & Number	Date Effective
Sacroiliac Joint Fusion-AR PASSE-MM-1508	06/01/2026
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.

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Table of Contents

A. Subject 2
B. Background 2
C. Definitions 2
D. Policy 3
E. Conditions of Coverage 4
F. Related Policies/Rules 4
G. Review/Revision History 4
H. References 5

A. Subject
Sacroiliac Joint Fusion

B. Background
The sacroiliac joints (SIJ) connect the sacrum, a triangular bone at the base of the spine, to the right and left iliac bones of the pelvis. These joints have very little movement and are held together by strong ligaments.

When the SIJ is misaligned or does not move properly, it can cause lower back pain in up to 30% of patients. Common causes include 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. Many patients improve with non-surgical, conservative treatments, but joint fusion may be needed if these do not help or following trauma.

SIJ fusion is typically performed using a minimally invasive technique but may also be an open surgical procedure. Open SIJ fusion is done when a large visual field is required (eg, post-traumatic injury, tumor resection), while percutaneous SIJ fusion may be used for treatment of refractory chronic low back pain. 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 conservative therapies.
  - **Active Conservative Therapies** – Actions or activities that strengthen supporting muscle groups and target key spinal structures, including physical therapy, occupational therapy, physician supervised home exercise program (HEP), and/or chiropractic care.
    - **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, 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. Member 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 [computed tomography (CT) or magnetic resonance imaging (MRI)] demonstrate localized SIJ pathology.
      B. CareSource considers **percutaneous SIJ fusion/stabilization** for the treatment of chronic 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 the pain do not exist.
         4. Failure of 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 either the thigh thrust test OR compression test.
         6. Positive response to two of the following provocative tests:
            a. Gaenslen’s test
            b. distraction test
            c. Patrick’s test
         7. Diagnostic confirmation of the SIJ as the pain generator through at least a 50% reduction in pain for the expected duration of the anesthetic used following image-guided, contrast-enhanced intra-articular SIJ block using a local anesthetic performed on two separate occasions.

8. Exclusion of generalized pain behavior (eg, somatoform disorder) or generalized pain disorders as the primary etiology of the member's pain (eg, fibromyalgia).
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 cause low back or buttock pain
10. Failure of a trial of at least two therapeutic intra-articular SIJ injections (ie, corticosteroid injection).

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 member's symptoms or other more likely source of pain (eg, radicular pain)

B. **Percutaneous SIJ fusion for SIJ pain** is considered not medically necessary for any other indication not outlined above, including (but not limited to) the following:
   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
   5. neural compression as seen on an MRI or CT that correlates with the member's symptoms or other more likely source for their pain

E. Conditions of Coverage

NA

F. Related Policies/Rules

Sacroiliac Joint Procedures

G. Review/Revision History

	DATE	ACTION
Date Issued	08/30/2023	New policy. Approved at Committee.
Date Revised	07/17/2024 04/23/2025	Review: updated references, approved at Committee Review: updated references, approved at Committee

	03/11/2026	Review: simplified background and added SIJ procedure policy. Approved at Committee
Date Effective	06/01/2026	
Date Archived		

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