Sacroiliac Joint Fusion
Clinical Coverage Criteria

Description

Sacroiliac joint fusion (arthrodesis) is a surgical technique that is intended to achieve bony fusion of the sacroiliac joint and stabilize it, thus reducing pain and disability that hasn't responded to non-surgical treatments. Sacroiliac joint fusion may be performed as an open surgical procedure or as a minimally invasive (percutaneous) procedure. The open surgical procedure, whether from an anterior, a posterior, or a lateral approach, requires a large incision and extensive surgical dissection. Open procedures are associated with increased surgical time and correspondingly increased patient morbidity. Minimally invasive sacroiliac joint fusion can be performed using transfixing or non-transfixing procedures. Transfixing procedures involve placing a device that passes through the ilium, across the sacroiliac joint, and into the sacrum. Non-transfixing procedures, on the other hand, utilize distraction arthrodesis, where the joint is intentionally widened, and the space is filled with bone graft.

Policy

This Policy applies to the following Fallon Health products:

☒ Medicare Advantage (Fallon Medicare Plus, Fallon Medicare Plus Central)

☒ MassHealth ACO

☒ NaviCare (NaviCare HMO SNP, NaviCare SCO)

☒ PACE (Summit Eldercare PACE, Fallon Health Weinberg PACE)

☒ Community Care

Sacroiliac joint fusion requires prior authorization.

Fallon Health Clinical Coverage Criteria

Open Sacroiliac Joint Fusion

Fallon Health Clinical Coverage Criteria for open sacroiliac joint fusion applies to all products.

Effective June 1, 2025, Fallon Health will use InterQual® Criteria when making medical necessity determinations for open sacroiliac joint fusion (CPT 27280) for plan members 18 years of age and older.

For coverage criteria, refer to the InterQual® Criteria in effect on the date of service:

- InterQual® CP:Procedures, Sacroiliac (SI) Joint Fusion, Open Sacroiliac Joint Fusion (CPT 27280)

Minimally Invasive Sacroiliac Joint Fusion with Placement of a Transfixing Device

Fallon Health Clinical Coverage Criteria for minimally invasive sacroiliac joint fusion with placement of a transfixing device applies to MassHealth ACO and Community Care.

Effective June 1, 2025, Fallon Health will use InterQual® Criteria when making medical necessity determinations for minimally invasive sacroiliac joint fusion with placement of a transfixing device (CPT 27279) for plan members 18 years of age and older.

For coverage criteria, refer to the InterQual® Criteria in effect on the date of service:

- InterQual® CP:Procedures, Sacroiliac (SI) Joint Fusion, Minimally Invasive Sacroiliac Joint Fusion (CPT 27279)

Fallon Health makes InterQual® criteria available through the Transparency Tool on our website, effective January 1, 2024.

Minimally invasive sacroiliac joint fusion with placement of a transfixing device should be coded with CPT 27279. Numerous sacroiliac joint fixation devices have received FDA 510(k) clearance (510k Product Code OUR).

The non-transfixing minimally invasive sacroiliac joint fusion procedure is significantly distinct from the lateral procedure and is coded with CPT 27278.

Bilateral Procedures
In cases of bilateral sacroiliac pain, bilateral sacroiliac joint fusion may occasionally be indicated and is usually performed serially to minimize the impact on rehabilitation (i.e., patients who undergo simultaneous bilateral fusion procedures may be wheelchair or bedbound for several weeks, possible slowing overall recovery).

Medicare Variation

Medicare statutes and regulations do not have coverage criteria for open or minimally invasive sacroiliac joint fusion. Medicare does not have a National Coverage Determination (NCD) for open or minimally invasive sacroiliac joint fusion. National Government Services, Inc., the Part A and B Medicare Administrative Contractor (MAC) with jurisdiction in the Plan's service area has an LCD for Minimally-invasive Surgical (MIS) Fusion of the Sacroiliac (SI) Joint L36406 (Original Effective Date 04/01/2016; Revision Effective Date 10/10/2019) (MCD search 04/18/2025).

Coverage criteria for minimally invasive sacroiliac joint fusion with placement of a transfixing device are fully established by Medicare, therefore, the Plan's clinical coverage criteria for minimally invasive sacroiliac joint fusion are not applicable.

Link: Minimally-invasive Surgical (MIS) Fusion of the Sacroiliac (SI) Joint (L36406)

Coverage criteria for open sacroiliac joint fusion are not fully established by Medicare, therefore the Plan's clinical coverage criteria for open sacroiliac joint fusion are applicable.

Coverage criteria for minimally invasive sacroiliac joint fusion without placement of a transfixing device are not fully established by Medicare, therefore the Plan's coverage criteria are applicable.

MassHealth Variation

MassHealth does not have Medical Necessity Guidelines for open or minimally invasive sacroiliac joint fusion currently (MassHealth website search 04/18/2025), therefore, the Plan's clinical coverage criteria are applicable for open and minimally invasive sacroiliac joint fusion with placement of a transfixing device.

Note: CPT 27278 is not listed as nonpayable by MassHealth in Subchapter 6 of the Physician Manual (PHY-172), therefore is payable for MassHealth members.

Exclusions

- Fallon Health considers minimally invasive sacroiliac joint fusion without placement of a transfixing device, also referred to as posterior (dorsal) minimally invasive sacroiliac joint fusion, experimental/investigational and not medically necessary (CPT 27278). Note: CPT 27278 is not listed as nonpayable by MassHealth in Subchapter 6 of the Physician Manual (PHY-172), therefore is payable for MassHealth members.

Summary of Evidence

The sacroiliac joint may be a primary source of pain in patients complaining of low back and/or buttock pain. Sacroiliac joint pathology may include degenerative and inflammatory arthritis, post-traumatic arthritis, post-partum instability, post-infectious arthritis, joint degeneration related to previous lumbar spinal fusion, joint damage from previous posterior iliac crest bone graft harvesting, and neoplastic processes. Nonsurgical treatment of sacroiliac joint pain typically includes structured core and pelvic muscle flexibility and strengthening; pharmaceutical management through oral and injectable medication; and ablation procedures. For patients who do not improve with comprehensive, nonoperative treatment, surgical fusion of the sacroiliac joint is an option with overall good, reported outcomes.

Polly et al., 2016 conducted a multicenter randomized controlled trial (RCT) of minimally invasive sacroiliac joint fusion vs non-surgical management (NSM) for sacroiliac joint dysfunction (INSITE NCT01681004). The study was sponsored by the device's manufacturer (SI-BONE, Inc., San Jose, CA, USA), which included payment for the index and crossover surgical procedures and NSM treatments within the study. One hundred and forty-eight subjects with sacroiliac joint dysfunction were randomly assigned to minimally invasive SIJ fusion with triangular titanium implants (SIJF, n = 102) or non-surgical management (NSM, n = 46). The primary study endpoint, evaluated at 6 months after the most recent sacroiliac joint fusion (to accommodate subjects with planned staged bilateral surgery), was a binary success/failure composite measure. A subject was considered to be a success if all of the following criteria were met: reduction in VAS sacroiliac joint pain score by at least 20 points from baseline, absence of device-related serious adverse events, absence of neurological worsening related to the lumbosacral nerve roots, and absence of surgical re-intervention (i.e. removal, revision, reoperation, or supplemental fixation) for SIJ pain. The threshold of a 20-point decrease in VAS pain rating was selected because this has been shown to be the minimum clinically important difference for chronic lower back pain. An intent-to-treat approach was used for the 6-month primary endpoint such that any missing values were assumed to be failures. Sacroiliac joint pain (measured with a 100-point visual analog scale, VAS), disability (measured with Oswestry Disability Index, ODI) and quality of life scores were collected at baseline and at scheduled visits to 24 months. Crossover from non-surgical to surgical care was allowed after the 6-month study visit was complete. The proportions of subjects with clinical improvement (sacroiliac joint pain improvement ≥20 points, ODI ≥15 points) and substantial clinical benefit (sacroiliac joint pain improvement ≥25 points or sacroiliac joint pain rating ≤35, ODI ≥18.8 points) were compared. Of 148 randomized and treated subjects, 6-month follow-up (at which time the primary endpoint was determined) was obtained in 101/102 (99%) of subjects treated with sacroiliac joint fusion and 44/46 (95.7%) of subjects treated with NSM. 24-month follow-up was obtained in 89 (87.3%) sacroiliac joint fusion subjects. By months 6, 84 of 102 sacroiliac joint fusion subjects (82%, 95% posterior credible interval [CI] 74-89%) and 12 of 46 NSM subjects (26%, 14-41%) met the study's primary success endpoint. In the sacroiliac joint fusion group, one subject was a failure for the 6-month primary endpoint due to both inadequate pain relief and immediate revision required for symptomatic implant malposition. In the NSM group, all primary endpoint failures were as a result of inadequate pain relief. The intent-to-treat difference in success rates was 55% (95% CI 40-69%), representing a >3-fold difference in success rate, and the posterior probability that the success rate was higher in the sacroiliac joint fusion group was >0.9999. In the sacroiliac joint fusion group, sacroiliac joint pain improved rapidly and was sustained (mean improvement of 55.4 points) at month 24. The 6-month mean change in the NSM group (12.2 points) was substantially smaller than that in the sacroiliac joint fusion group (by 38.3 points, $p<0.0001$ for superiority). By month 24, 83.1% and 82.0% received either clinical improvement or substantial clinical benefit in VAS sacroiliac joint pain score. Similarly, 68.2% and 65.9% had received clinical improvement or substantial clinical benefit in ODI score at month 24. In the NSM group, these proportions were <10% with non-surgical treatment only.

Hermans et al., 2022, conducted a systematic review and meta-analysis to evaluate the literature on the effectiveness of minimally invasive sacroiliac joint fusion compared to conservative

management in patients with sacroiliac joint dysfunction. Two randomized controlled trials (RCTs) and one retrospective cohort study were included comparing minimally invasive sacroiliac joint fusion and conservative management with regard to pain and disability outcome, encompassing 388 patients (207 conservative and 181 surgical). The studies from Polly et al., 2016 and Dengler et al., 2019 were RCTs comparing outcomes after minimally invasive sacroiliac joint fusion vs conservative management for chronic SIJ dysfunction. Polly et al allowed crossover from conservative management to minimally invasive sacroiliac joint fusion after 6 months. Vanaclocha et al., 2018, performed a retrospective comparative cohort study to determine responses to conservative management, including sacroiliac joint denervation and minimally invasive sacroiliac joint fusion. All 3 studies used cannulated triangular, titanium implants with a porous surface for lateral transiliac SIJ fusion (iFuse Implant System, SI-BONE, Inc, San Jose, CA, USA). The studies by Polly et al. and Dengler et al. had a follow-up of 24 months for the MISJF groups and 6 months for the conservative management groups, with the notion that no further improvement in terms of pain and disability is to be expected after 6 months of conservative management.38 Vanaclocha et al.34 had a follow-up of up to 72 months for both minimally invasive sacroiliac joint fusion and conservative treated patients. Polly et al,, 2019, Dengler et al., 2019, and Vanaclocha et al., 2018, compared VAS-pain outcome in patients who underwent minimally invasive sacroiliac joint fusion compared with patients who were treated conservatively. All 3 found a statistically significant difference in favor of the minimally invasive sacroiliac joint fusion groups, respectively, 38.2 and 34.0 points on a 0 to 100 scale and 6.0 points on a 0 to 10 scale. Similarly, statistically significant Oswestry Disability Index (ODI) differences were reported in favor of the minimally invasive sacroiliac joint fusion groups, respectively, 23.8, 18.0, and 24.0 points. Only Polly et al. reported changes in SF-36. A statistically significant improvement in SF-36 was noted within the minimally invasive sacroiliac joint fusion group at 6, 12, and 24 months, respectively, 12.5, 12.8, and 11.2 points. While the mean SF-36 score of the conservative management group at 6 months remained low at 3.9 points. This difference between treatment groups was statistically significant. The crossover rate in Polly et al. from conservative management to minimally invasive sacroiliac joint fusion at 6 months was 89%. Data reported by Polly et al, Dengler et al3, and Vanaclocha et al., were used to perform a meta-analysis. For the meta-analysis of VAS-pain, only data from Polly et al. and Dengler et al. were analyzed, as Vanaclocha et al. reported VAS-pain on a 0 to 10 scale while Polly et al. and Dengler et al. used a 0 to 100 scale. Baseline scores for VAS-pain and ODI across minimally invasive sacroiliac joint fusion and conservative management groups were similar. An outcome timepoint of 6 months for both study groups was implemented. Study heterogeneity was low for VAS-pain and ODI with an I^2 of 0% for both fixed and random effects analysis. The overall effect for VAS-pain outcome was in favor of the MISJF group with a statistically significant mean difference of –37.03 points (95% CI [–43.91, –30.15], $P < 0.001$). The overall effect for ODI outcome was also in favor of the minimally invasive sacroiliac joint fusion group with a statistically significant mean difference of –21.14 points (95% CI [–24.93, –17.35], $P < 0.001$). Adverse events were low among the study groups and comparable across the included studies (Hermans et al., 2022).

Zaidi et al., 2015, systematically reviewed studies on sacroiliac joint fusion in the neurosurgical and orthopedic literature to investigate whether sufficient evidence exists to support its use. A total of 16 peer-reviewed journal articles met the inclusion criteria: 5 consecutive case series, 8 retrospective studies, and 3 prospective cohort studies. A total of 430 patients were included, of whom 131 underwent open surgery and 299 underwent minimally invasive surgery for sacroiliac joint fusion. The mean duration of follow-up was 60 months for open surgery and 21 months for minimally invasive surgery. Sacroiliac joint degeneration/arthrosis was the most common pathology among patients undergoing surgical intervention (present in 257 patients [59.8%]), followed by SIJ dysfunction (79 [18.4%]), postpartum instability (31 [7.2%]), posttraumatic (28 [6.5%]), idiopathic (25 [5.8%]), pathological fractures (6 [1.4%]), and HLA-B27+/rheumatoid arthritis (4 [0.9%]). Radiographically confirmed fusion rates were 20%–90% for open surgery and 13%–100% for minimally invasive surgery. Rates of excellent satisfaction, determined by pain reduction, function, and quality of life, ranged from 18% to 100% with a mean of 54% in open surgical cases. For minimally invasive surgery patients, excellent outcome, judged by patients' stated satisfaction with the surgery, ranged from 56% to 100% (mean 84%). The reoperation rate

after open surgery ranged from 0% to 65% (mean 15%). Reoperation rate after minimally invasive surgery ranged from 0% to 17% (mean 6%). Major complication rates ranged from 5% to 20%, with 1 study that addressed safety reporting a 56% adverse event rate. Zaidi et al., 2015, conclude that surgical intervention for sacroiliac joint pain is beneficial in a subset of patients. However, with the difficulty in accurate diagnosis and lack of evidence for the efficacy of the procedure itself, serious consideration of the cause of pain and treatment alternatives should be made before performing sacroiliac joint fusion. Prospective, randomized studies with a focus on long-term pain control and fusion rates after sacroiliac joint fusion are lacking in the neurosurgical and orthopedic literature. Further, well-designed studies are necessary to better understand the surgical and clinical efficacy of sacroiliac joint fusion.

Federico et al. 2023 reviewed the Medicare database to determine the trends in volume of open and minimally invasive sacroiliac joint fusion. CPT codes specific to open and MIS SI joint fusion (27279 and 27280) were identified and tracked for 2010 to 2020. A total of 33,963 sacroiliac joint fusions were conducted in the Medicare population between 2010 and 2020, with an overall increase in procedure volume of 2,350.9% from 318 cases in 2010 to 7,794 in 2020. Since the introduction of the 27279 CPT code in 2015, 8,806 cases (31.5%) have been open and 19,120 (68.5%) have been minimally invasive. Sacroiliac joint fusion volume in the Medicare population has increased substantially in the past 10 years, with minimally invasive sacroiliac joint fusion accounting for most of the procedures since the introduction of the 27279 CPT code in 2015.

The posterior sacroiliac joint fusion procedure is a recognized and well-described distinct surgical procedure. In the dorsal approach, allograft bone products or devices are placed into the ligamentous portion of the joint via dissection of the multifidus muscle and removal of a portion of the ligaments covering the dorsal, posterior aspect of the joint. A portion of the interosseous SIJ ligament is also typically removed. The posterior minimally invasive sacroiliac joint fusion procedure is distinct from lateral transiliac minimally invasive sacroiliac joint fusion using transfixing devices. Published outcomes data for minimally invasive sacroiliac joint fusion using a posterior approach are scarce (Lorio et al., 2020). Examples of posterior sacroiliac joint stabilization devices are CornerLoc (Foundation Fusion Solutions, LLC.), TransFasten (Captiva Spine®), and LinQ (PainTEQ).

Whang et al., 2023 conducted a systematic review and meta-analysis comparing outcomes for minimally invasive sacroiliac joint fusion procedures stratified by surgical technique: transiliac, including lateral transiliac (LTI) and posterolateral transiliac (PLTI), and posterior interpositional (PI) procedures. RCTs were only available for LTI. All studies with patient reported outcomes showed improvement from baseline after surgery. Meta-analytic improvements in pain scores were highest for LTI (4.8 points [0-10 scale]), slightly lower for PLTI (4.2 points), and lowest for PI procedures (3.8 points, P = 0.1533). Mean improvements in ODI scores were highest for LTI (25.9 points), lowest for PLTI procedures (6.8 points), and intermediate for PI (16.3 points, P = 0.0095). The authors concluded that literature support for sacroiliac joint fusion is growing. The LTI procedure contains the largest body of available evidence and shows the largest improvements in pain and ODI. Only LTI procedures have independent radiographic evidence of fusion and implant placement.

Calodney et al., 2024 conducted a non-comparative prospective study of 122 patients who underwent PI approach to SI joint fusion found this approach to be safe and effective for up to 12 months. Limitations to the study include lack of a comparator group and 20% of participants were not included in the final follow up.

Another retrospective study of 72 patients who underwent a posterior intra-articular approach showed improvement in disability at short-term follow up of 6 months and longer-term follow ups of 2 years and 3 years; however, limitations to the study included loss of participation of approximately 27% at 6 months and over 93% loss at 3 years (Kaye et al., 2024).

Analysis of Evidence (Rationale for Determination)

Studies of minimally invasive sacroiliac joint fusion with placement of a transfixing device consistently show improved pain scores with fewer complications than open fusion in patients with non-infectious, non-traumatic related sacroiliac pain. This improvement appears to be sustained in the long term. These results along with the 2016 ISASS guideline recommendation and 2020 Update are the basis for coverage of minimally invasive sacroiliac joint fusion in carefully selected patients.

Due to the lower efficacy found in the systematic review and meta-analysis along with the lack of high-quality studies with long-term follow up and participant retention, minimally invasive SI joint fusion without placement of a transfixing device is considered experimental/investigational and not mediclly necessary. Posterior minimally invasive sacroiliac joint fusion is not recommended in the ISASS 2020 Update. Clinical evidence supporting the safety and effectiveness of posterior minimally invasive surgical sacroiliac joint fusion are needed.

Coding

The following codes are included below for informational purposes only; inclusion of a code does not constitute or imply coverage or reimbursement.

CPT code 27279 describes percutaneous arthrodesis of the sacroiliac joint using a minimally invasive technique to place an internal fixation device that passes through the ilium, across the sacroiliac joint and into the sacrum, thus transfixing the sacroiliac joint.

Report CPT code 27278 for the percutaneous placement of an intra-articular stabilization device into the sacroiliac joint using a minimally invasive technique that does not transfix the sacroiliac joint.

CPT code, 27278, replaces deleted Category III code 0775T for percutaneous sacroiliac joint arthrodesis (fusion) when bone allograft is placed. CPT code 27278 clarifies that it does not describe placement of a transfixion device across the sacroiliac joint. Instead, report CPT code 27279.

CPT	Description
27278	Arthrodesis, sacroiliac joint, percutaneous, with image guidance, including placement of intra-articular implant(s) (eg, bone allograft(s), synthetic device(s)), without placement of transfixing device
27279	Arthrodesis, sacroiliac joint, percutaneous or minimally invasive (indirect visualization), with image guidance, includes obtaining bone graft when performed, and placement of transfixing device
27280	Arthrodesis, open, sacroiliac joint, including obtaining bone graft, including instrumentation, when performed

References

1. National Government Services, Inc. Local Coverage Determination (LCD) Minimally-invasive Surgical (MIS) Fusion of the Sacroiliac (SI) Joint (L36406). Original Effective Date 4/1/2016. Revision Effective Date 10/10/2019. Available at: https://www.cms.gov/medicare-coverage-database/view/lcd.aspx?lcdid=36406&ver=9&bc=0. Accessed 04/18/2025.
2. National Government Services, Inc. Local Coverage Article (LCA) Billing and Coding: Minimally-invasive Surgical (MIS) Fusion of the Sacroiliac (SI) Joint (A57431). Original Effective Date 10/10/2019. Revision Effective Date 01/01/2025. Available at: https://www.cms.gov/medicare-coverage-database/view/article.aspx?articleId=57431&ver=5. Accessed 04/18/2025.
3. Zaidi HA, Montoure AJ, Dickman CA. Surgical and clinical efficacy of sacroiliac joint fusion: a systematic review of the literature. *J Neurosurg Spine*. 2015 Jul;23(1):59-66.
4. Lorio M, Kube R, Araghi A. International Society for the Advancement of Spine Surgery Policy 2020 Update-Minimally Invasive Surgical Sacroiliac Joint Fusion (for Chronic

Sacroiliac Joint Pain): Coverage Indications, Limitations, and Medical Necessity. *Int J Spine Surg*. 2020 Dec;14(6):860-895.
5. Himstead AS, Brown NJ, Shahrestani S, Tran K, Davies JL, Oh M. Trends in Diagnosis and Treatment of Sacroiliac Joint Pathology Over the Past 10 Years: Review of Scientific Evidence for New Devices for Sacroiliac Joint Fusion. *Cureus*. 2021 Jun 3;13(6):e15415.
6. Polly DW, Swofford J, Whang PG, Frank CJ, Glaser JA, Limoni RP, Cher DJ, Wine KD, Sembrano JN; INSITE Study Group. Two-Year Outcomes from a Randomized Controlled Trial of Minimally Invasive Sacroiliac Joint Fusion vs. Non-Surgical Management for Sacroiliac Joint Dysfunction. *Int J Spine Surg*. 2016 Aug 23;10:28.
7. Dengler J, Kools D, Pflugmacher R, et al. Randomized trial of sacroiliac joint arthrodesis compared with conservative management for chronic low back pain attributed to the sacroiliac joint. *J Bone Joint Surg Am*. 2019;101(5):400–411.
8. Dengler J, Duhon B, Whang P, Frank C, Glaser J, Sturesson B, Garfin S, Cher D, Rendahl A, Polly D; INSITE, iMIA, SIFI study groups. Predictors of Outcome in Conservative and Minimally Invasive Surgical Management of Pain Originating from the Sacroiliac Joint: A Pooled Analysis. *Spine (Phila Pa 1976)*. 2017 Nov 1;42(21):1664-1673.
9. Ballatori AM, Shahrestani S, Chen XT, Ton A, Wang JC, Buser Z. Propensity-matched Analysis of 1062 Patients Following Minimally Invasive Versus Open Sacroiliac Joint Fusion. *Clin Spine Surg*. 2021 Oct 1;34(8):E477-E482.
10. Ledonio CG, Polly DW Jr, Swiontkowski MF, Cummings JT Jr. Comparative effectiveness of open versus minimally invasive sacroiliac joint fusion. *Med Devices (Auckl)*. 2014 Jun 5;7:187-93.
11. Smith AG, Capobianco R, Cher D, et al. Open versus minimally invasive sacroiliac joint fusion: a multi-center comparison of perioperative measures and clinical outcomes. *Ann Surg Innov Res*. 2013 Oct 30;7(1):14.
12. Federico VP, Zavras AG, Butler A, et al. Medicare Reimbursement Rates and Utilization Trends in Sacroiliac Joint Fusion. *J Am Acad Orthop Surg*. 2023 Sep 1;31(17):923-930.
13. International Society for the Advancement of Spine Surgery (ISASS). ISASS Policy Statement – Minimally Invasive Sacroiliac Joint Fusion (July 2016). Updated July 5, 2016. This supplements the ISASS Policy Statement – Minimally Invasive Sacroiliac Joint Fusion (2014). Available at: https://isass.org/isass-policy-statement-minimally-invasive-sacroiliac-joint-fusion-july-2016/. Accessed 09/21/2023.
14. Lorio MP. Editor's Introduction: Update on Current Sacroiliac Joint Fusion Procedures: Implications for Appropriate Current Procedural Terminology Medical Coding. Int J Spine Surg. 2020 Dec;14(6):853-859.
15. Polly DW, Cher DJ, Wine KD, et al. Randomized Controlled Trial of Minimally Invasive Sacroiliac Joint Fusion Using Triangular Titanium Implants vs Nonsurgical Management for Sacroiliac Joint Dysfunction: 12-Month Outcomes. Neurosurgery. 2015;77(5):674-691.
16. Polly DW, Cher DJ, Wine KD, et al. Randomized Controlled Trial of Minimally Invasive Sacroiliac Joint Fusion Using Triangular Titanium Implants vs Nonsurgical Management for Sacroiliac Joint Dysfunction: 12-Month Outcomes. Neurosurgery. 2015;77(5):674-691.
17. Vanaclocha V, Herrera JM, Sáiz-Sapena N, Rivera-Paz M, Verdú-López F. Minimally invasive sacroiliac joint fusion, radiofrequency denervation, and conservative management for sacroiliac joint pain: 6-year comparative case series. Neurosurgery. 2018;82(1):48–55.
18. Whang PG, Patel V, Duhon B, et al. Minimally Invasive SI Joint Fusion Procedures for Chronic SI Joint Pain: Systematic Review and Meta-Analysis of Safety and Efficacy. Int J Spine Surg. 2023 Dec 26;17(6):794-808.
19. Sturesson B, Kools D, Pflugmacher R, et al. Six-month outcomes from a randomized controlled trial of minimally invasive SI joint fusion with triangular titanium implants vs conservative management. *Eur Spine* J. 2017 Mar;26(3):708-719.
20. Chang E, Rains C, Ali R, et al. Minimally invasive sacroiliac joint fusion for chronic sacroiliac joint pain: a systematic review. Spine J 2022. 22(8):1240-53.
21. Hermans SMM, Droeghaag R, Schotanus MGM, et al. Minimally Invasive Sacroiliac Joint Fusion vs Conservative Management in Patients With Sacroiliac Joint Dysfunction: A Systematic Review and Meta-Analysis. *Int J Spine Surg*. 2022. 16(3):472-80.

22. Tran ZV, Ivashchenko A, Brooks L.. Sacroiliac Joint Fusion Methodology - Minimally Invasive Compared to Screw-Type Surgeries: A Systematic Review and Meta-Analysis. *Pain Physician*. 2019. 22(1):29-40.
23. Endres S, Ludwig E. Outcome of distraction interference arthrodesis of the sacroiliac joint for sacroiliac arthritis. Indian J Orthop. 2013;47(5):437-442.
24. North American Spine Society (NASS). NASS Coverage Policy Recommendations Minimally Invasive Sacroiliac Joint Fusion. Spine.org. Published September 2021.
25. Sayed D, Deer TR, Tieppo Francio V, et al. American Society of Pain and Neuroscience Best Practice (ASPN) Guideline for the Treatment of Sacroiliac Disorders. Journal of Pain Research. 2024;17:1601-1638.
26. Calodney A, Azeem N, Buchanan P, et al. Safety, Efficacy, and Durability of Outcomes: Results from SECURE: A Single Arm, Multicenter, Prospective, Clinical Study on a Minimally Invasive Posterior Sacroiliac Fusion Allograft Implant. *J Pain Res*. 2024 Mar 20;17:1209-1222.
27. Kaye AD, Okereke JS, Howe CA, et al. Posterior Sacroiliac Fusion Surgery: A Retrospective Single Center Study. Pain Physician. 2024 Jul;27(5):321-331.

Policy history

Origination date:	12/01/2023
Review/Approval Dates:	Technology Assessment Committee: 09/26/2023, 10/24/2023 (policy origination), 03/26/2024 (annual review; updated exclusion from lateral minimally invasive sacroiliac joint fusion to posterior (dorsal) minimally invasive sacroiliac joint fusion), 04/22/2025 (annual review; adopted InterQual® Criteria; updated Summary of Evidence and References; added new sections for Medicare Variation and MassHealth Variation). Utilization Management Committee 05/20/2025 (annual review; approved).

Instructions for Use

Fallon Health complies with CMS's national coverage determinations (NCDs), local coverage determinations (LCDs) of Medicare Contractors with jurisdiction for claims in the Plan's service area, and applicable Medicare statutes and regulations when making medical necessity determinations for Medicare Advantage members. When coverage criteria are not fully established in applicable Medicare statutes, regulations, NCDs or LCDs, Fallon Health may create internal coverage criteria under specific circumstances described at § 422.101(b)(6)(i) and (ii).

Fallon Health generally follows Medical Necessity Guidelines published by MassHealth when making medical necessity determinations for MassHealth members. In the absence of Medical Necessity Guidelines published by MassHealth, Fallon Health may create clinical coverage criteria in accordance with the definition of Medical Necessity in 130 CMR 450.204.

For plan members enrolled in NaviCare, Fallon Health first follows CMS's national coverage determinations (NCDs), local coverage determinations (LCDs) of Medicare Contractors with jurisdiction for claims in the Plan's service area, and applicable Medicare statutes and regulations when making medical necessity determinations. When coverage criteria are not fully established in applicable Medicare statutes, regulations, NCDs or LCDs, or if the NaviCare member does not meet coverage criteria in applicable Medicare statutes, regulations, NCDs or LCDs, Fallon Health then follows Medical Necessity Guidelines published by MassHealth when making necessity determinations for NaviCare members.

Each PACE plan member is assigned to an Interdisciplinary Team. PACE provides participants with all the care and services covered by Medicare and Medicaid, as authorized by the interdisciplinary team, as well as additional medically necessary care and services not covered by Medicare and Medicaid. With the exception of emergency care and out-of-area urgently needed

care, all care and services provided to PACE plan members must be authorized by the interdisciplinary team.

Not all services mentioned in this policy are covered for all products or employer groups. Coverage is based upon the terms of a member's particular benefit plan which may contain its own specific provisions for coverage and exclusions regardless of medical necessity. Please consult the product's Evidence of Coverage for exclusions or other benefit limitations applicable to this service or supply. If there is any discrepancy between this policy and a member's benefit plan, the provisions of the benefit plan will govern. However, applicable state mandates take precedence with respect to fully insured plans and self-funded non-ERISA (e.g., government, school boards, church) plans. Unless otherwise specifically excluded, federal mandates will apply to all plans.