

National Imaging Associates, Inc.*	
Clinical guidelines:	Original Date: June 2021
SACROILIAC JOINT FUSION	
CPT Codes**:	Last Revised Date: May June 20221
- Percutaneous Sacroiliac Joint (SIJ) Fusion: 27279	
**See UM Matrix for allowable billed groupings and additional covered codes	
Guideline Number: NIA_CG_407	Implementation Date: January
	202 <u>3</u> 2

Percutaneous Sacroiliac Joint (SIJ) Fusion (all SIJ fusion surgeries will be reviewed on a caseby-case basis):

Because of variable outcomes with fusion surgery, <u>individualspatients</u> should be actively involved in the decision-making process and provided appropriate decision-support materials when considering this intervention.

- When ALL of the following are present¹⁻³ (NASS, 2015; Polly, 2016; Whang, 2019):
 - Low back/buttock pain that is typically unilateral and caudal to the lumbar spine localized over the SIJ that impairs daily activities for at least 6 months; AND
 - Failure to improve with at least 6 months of appropriate active non-operative treatment that must include medications, PT, and a home exercise program; AND
 - Physical exam demonstrating pain to palpation over the sacral sulcus in the absence of tenderness of similar severity elsewhere; AND
 - Absence of generalized pain behavior; AND
 - Positive pain response to a cluster of 3 provocative tests (e.g., thigh thrust, compression test, Gaenslen's test, distraction test, Faber test);-AND
 - Diagnostic imaging studies that include **ALL** of the following:
 - Imaging (plain radiographs and a CT or MRI) of the <u>sacroiliac (SI)</u> 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
 - Imaging of the pelvis (AP plain radiograph) to rule out concomitant hip pathology
 - 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

1— Percutaneous Sacroiliac Joint (SIJ) Fusion

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- Imaging of the SI joint that indicates evidence of injury and/or degeneration;
 AND
- At least 75% reduction of pain for the expected duration of the anesthetic used following an image-guided, contrast -enhanced intra-articular SIJ injection on 2 separate occasions; AND
- A trial of at least one therapeutic intra-articular SIJ injection (i.e., corticosteroid injection)

NOTE: Instrumentation, bone formation or grafting materials, including biologics, should be used at the surgeon's discretion; however, use should be limited to FDA approved indications regarding the specific devices or biologics.

RELATIVE CONTRAINDICATIONS FOR SPINE SURGERY (NOTE: Cases may not be approved if the below contraindications exist):

- Medical contraindications to surgery, (e.g., severe osteoporosis; infection of soft tissue adjacent to the spine and may be at risk for spreading to the spine; severe cardiopulmonary disease; anemia; malnutrition and systemic infection). (Puvanesarajah, 2016).⁴
- Psychosocial risk factors. It is imperative to rule out non-physiologic modifiers of pain
 presentation or non-operative conditions mimicking radiculopathy or instability (e.g.,
 peripheral neuropathy, piriformis syndrome, myofascial pain, sympathetically mediated
 pain syndromes, sacroiliac dysfunction, psychological conditions, etc.) prior to consideration
 of elective surgical intervention <u>(Kreiner, 2014)</u>.⁵ <u>IndividualsPatients</u> with clinically
 significant depression or other psychiatric disorders being considered for elective spine
 surgery will be reviewed on a case-by-case basis and the surgery may be denied for risk of
 failure.
- Active Tobacco or Nicotine use prior to fusion surgery. <u>IndividualsPatients</u> must be free from smoking and/or nicotine use for at least six weeks prior to surgery and during the entire period of fusion healing-(<u>Andersen, 2001; Glassman, 2000; Hermann, 2016; Jackson,</u> <u>2016; Patel, 2013</u>).⁶⁻¹⁰
- Morbid Obesity. Contraindication to surgery in cases where there is significant risk and concern for improper post-operative healing, post-operative complications related to morbid obesity, and/or an inability to participate in post-operative rehabilitation-(Epstein, 2017).¹¹ These cases will be reviewed on a case-by-case basis and may be denied given the risk of failure.

OVERVIEW

 All operative interventions must be based upon positive correlation of clinical findings, clinical course, and diagnostic tests and must be performed by surgeons with appropriate training (neurosurgery, orthopaedic surgery). A comprehensive assimilation of these factors must lead to a specific diagnosis with positive identification of pathologic condition(s). A failure of accurate correlation may be an indication for denial of cases. It is imperative to rule out non-physiologic modifiers of pain presentation or non-operative conditions (e.g., peripheral neuropathy, piriformis syndrome, myofascial pain, sympathetically mediated pain syndromes, psychological conditions, etc.) prior to consideration of elective surgical intervention.

- Operative treatment is indicated when the natural history of surgically treated lesions is better than the natural history for non-operatively treated lesions.
 - All <u>individuals</u> being considered for surgical intervention should first undergo a comprehensive neuro-musculoskeletal examination to identify mechanical pain generators that may respond to non-surgical techniques or may be refractory to surgical intervention
 - While sufficient time allowances for non-operative treatment are required to determine the natural cause and response to non-operative treatment of low back pain disorders, timely decision making for operative intervention is critical to avoid de-conditioning and increased disability
- In general, if the program of non-operative treatment fails, operative treatment is indicated when:
 - Improvement of the symptoms has plateaued or failed to occur, and the residual symptoms of pain and functional disability are unacceptable at the end of 6 months of active treatment, or at the end of longer duration of non-operative programs for debilitated <u>individualspatients</u> with complex problems; and/or
 - Frequent recurrences of symptoms cause serious functional limitations even if a non-operative active treatment program provides satisfactory relief of symptoms, and restoration of function on each recurrence

• Claims Billing & Coding:

• NIA uses a combination of internally developed edits in addition to an enhanced set of industry standard editing. NIA's Claims Edit Module is a group of system edits that run multiple times per day. Edits that are part of this module include industry standard edits that apply to spine surgery services and NIA custom edits developed specifically for spine surgery. The following describes each of the edits, NIA applies:

- Outpatient Code Editor (OCE):
 - This edit performs all functions that require specific reference to HCPCS codes, HCPCS modifiers, and ICD-9-CM diagnosis codes. The OCE only functions on a single claim and does not have any cross-claim capabilities. NIA is consistent with CMS.

• National Correct Coding Initiative (NCCI) editing:

• The edit prevents improper payment when incorrect code combinations are reported. The NCCI contains two tables of edits. The Column One/Column Two

Correct Coding Edits table and the Mutually Exclusive Edits table include code pairs that should not be reported together for a number of reasons explained in the Coding Policy Manual. NIA is consistent with CMS.

- Incidental edits: This edit applies if a procedure being billed is a component of another procedure that occurred on the same date of service for the same provider and tax ID and claimant.
- Mutually exclusive editing: This edit applies if a procedure being billed is mutually exclusive with a procedure that occurred on the same date of service for the same provider tax ID and claimant.

• Multiple Procedure Discounts (MPD):

This edit applies a reduction to the second and any other subsequent services by the same provider, in the same setting, for the same member. We typically apply a 50% reduction. NIA follows the CMS methodology that began in January 2011 which allows for application of MPD to codes within CMS's two specific advanced imaging code families. However, NIA differs from CMS in that we apply MPD to all provider types unless health plan contracts prohibit this.

POLICY HISTORY

Date	Summary
<u>May 2June 2022</u>	Replaced "patients" with "individuals" where appropriate
<u>June 2021</u>	New guideline

REFERENCES

Andersen T, Christensen FB, Laursen M, et al. Smoking as a predictor of negative outcome in lumbar spinal fusion. *Spine.* 2001; 26(23):2623-28. http://www.ncbi.nlm.nih.gov/pubmed/11725245.

Epstein NE. More risks and complications for elective spine surgery in morbidly obese patients. Surg Neurol Int. 2017; 8:153.

Glassman SD, Anagnost SC, Parker A, et al. The effect of cigarette smoking and smoking cessation on spinal fusion. *Spine*. 2000; 25(20):2608-15. http://journals.lww.com/spinejournal/Abstract/2000/10150/The_Effect_of_Cigarette_Smoking_and_Smoking.11.aspx.

Hermann PC, Webler M, Bornemann R, et al. Influence of smoking on spinal fusion after spondylodesis surgery: A comparative clinical study. *Technol Health Care*. 2016 Sep 14; 24(5):737-44.

Jackson KL, Devine JG. The effects of smoking and smoking cessation on spine surgery: A systematic review of the literature. *Global Spine J.* 2016 Nov; 6(7):695–701.

Kreiner DS, Hwang SW, Easa JE, et al. An evidence based clinical guideline for the diagnosis and treatment of lumbar disc herniation with radiculopathy. *Spine J.* 2014 Jan; 14(1):180-91.

North American Spine Society (NASS). Coverage Policy Recommendation: Percutaneous Sacroiliac Joint Fusion. 2015.

Patel RA, Wilson FR, Patel PA, et al. The effect of smoking on bone healing, A systematic Review. *Bone Joint Res.* 2013; 2(6):102-11. http://www.ncbi.nlm.nih.gov/pubmed/23836474.

Polly DW, Swofford J, Whang PG, et al. 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; 10: Article 28.

Puvanesarajah V, Shen FH, Cancienne JM, et al. Risk factors for revision surgery following primary adult spinal deformity surgery in patients 65 years and older. *J Neurosurg Spine*. 2016; 25(4):486-493.

Whang PG, Darr E, Meyer SC, et al. Long term prospective clinical and radiographic outcomes after minimally invasive lateral transiliac sacroiliac joint fusion using triangular titanium implants. *Med Devices (Auckl)*. 2019 Sep 26; 12:411-422.

Reviewed / Approved by NIA Clinical Guideline Committee

GENERAL INFORMATION

It is an expectation that all patients receive care/services from a licensed clinician. All appropriate supporting documentation, including recent pertinent office visit notes, laboratory data, and results of any special testing must be provided. If applicable: All prior relevant imaging results and the reason that alternative imaging cannot be performed must be included in the documentation submitted.

Disclaimer: Magellan Healthcare service authorization policies do not constitute medical advice and are not intended to govern or otherwise influence the practice of medicine. These policies are not meant to supplant your normal procedures, evaluation, diagnosis, treatment or care plans for your patients. Your professional judgement must be exercised and followed in all respects with regard to the treatment and care of your patients. These policies apply to all Magellan Healthcare subsidiaries including, but not limited to, National Imaging Associates ("Magellan"). The policies constitute only the reimbursement and coverage guidelines of Magellan. Coverage for services varies for individual members in accordance with the terms and conditions of applicable Certificates of Coverage, Summary Plan Descriptions, or contracts with governing regulatory agencies. Magellan reserves the right to review and update the guidelines at its sole discretion. Notice of such changes, if necessary, shall be provided in accordance with the terms and conditions of provider agreements and any applicable laws or regulations.

1. Polly DW, Swofford J, Whang PG, et al. 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;10:28. doi:10.14444/3028

 Whang PG, Darr E, Meyer SC, et al. Long-Term Prospective Clinical And Radiographic Outcomes After Minimally Invasive Lateral Transiliac Sacroiliac Joint Fusion Using Triangular Titanium Implants. *Med Devices (Auckl)*. 2019;12:411-422. doi:10.2147/mder.S219862
 Coverage Recommendations: Percutaneous Sacroiliac Joint Fusion. North American Spine Society (NASS). Accessed June 15, 2015.

<u>https://www.spine.org/PolicyPractice/CoverageRecommendations/CoverageRecommendations</u> <u>.aspx</u>

4. Puvanesarajah V, Shen FH, Cancienne JM, et al. Risk factors for revision surgery following primary adult spinal deformity surgery in patients 65 years and older. *J Neurosurg Spine*. Oct 2016;25(4):486-493. doi:10.3171/2016.2.Spine151345

5. Kreiner DS, Hwang SW, Easa JE, et al. An evidence-based clinical guideline for the diagnosis and treatment of lumbar disc herniation with radiculopathy. *Spine J*. Jan 2014;14(1):180-91. doi:10.1016/j.spinee.2013.08.003

6. Andersen T, Christensen FB, Laursen M, Høy K, Hansen ES, Bünger C. Smoking as a predictor of negative outcome in lumbar spinal fusion. *Spine (Phila Pa 1976)*. Dec 1 2001;26(23):2623-8. doi:10.1097/00007632-200112010-00018

7. Glassman SD, Anagnost SC, Parker A, Burke D, Johnson JR, Dimar JR. The effect of cigarette smoking and smoking cessation on spinal fusion. *Spine (Phila Pa 1976)*. Oct 15 2000;25(20):2608-15. doi:10.1097/00007632-200010150-00011

8. Hermann PC, Webler M, Bornemann R, et al. Influence of smoking on spinal fusion after spondylodesis surgery: A comparative clinical study. *Technol Health Care*. Sep 14 2016;24(5):737-44. doi:10.3233/thc-161164

9. Jackson KL, 2nd, Devine JG. The Effects of Smoking and Smoking Cessation on Spine Surgery: A Systematic Review of the Literature. *Global Spine J*. Nov 2016;6(7):695-701. doi:10.1055/s-0036-1571285

Patel RA, Wilson RF, Patel PA, Palmer RM. The effect of smoking on bone healing: A systematic review. *Bone Joint Res.* 2013;2(6):102-11. doi:10.1302/2046-3758.26.2000142
 Epstein NE. More risks and complications for elective spine surgery in morbidly obese patients. *Surg Neurol Int.* 2017;8:66. doi:10.4103/sni.sni_49_17

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