MEDICAL POLICY

Back: Sacroiliac Joint Fusion or Stabilization
(Medicare Only)

**Effective Date:** 12/1/2019

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**SCOPE:**

Providence Health Plan, Providence Health Assurance, Providence Plan Partners, and Ayin Health Solutions as applicable (referred to individually as “Company” and collectively as “Companies”).

**APPLIES TO:**

Medicare Only

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**MEDICARE POLICY CRITERIA**

The following Centers for Medicare & Medicaid Service (CMS) guidelines should be utilized for medical necessity coverage determinations. Click the link provided in the table below to access applicable medical necessity criteria. All listed guidelines apply.

<table>
<thead>
<tr>
<th>Service</th>
<th>Medicare Guidelines</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percutaneous Minimally Invasive Fusion/Stabilization of the Sacroiliac Joint</td>
<td>Local Coverage Determination (LCD): Percutaneous minimally invasive fusion/stabilization of the sacroiliac joint for the treatment of back pain ([L36000][1])</td>
</tr>
<tr>
<td>Open Sacroiliac Joint Fusion</td>
<td>See commercial medical policy: Back: Sacroiliac Joint Fusion or Stabilization (All Lines of Business Except Medicare), SUR132</td>
</tr>
</tbody>
</table>

Per the Providence Health Assurance Medicare Policy Manual commercial medical policies may be applied to Medicare coverage determinations in the absences of an appropriate NCD, LCD, LCA, or CMS Coverage Manual.

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**BILLING GUIDELINES**

Per the LCD (L36000), there are three ICD-10 codes that support medical necessity:

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- M43.18 Spondylolisthesis, sacral and sacrococcygeal region
- M46.1 Sacroiliitis, not elsewhere classified
- Q74.2 Other congenital malformations of lower limb(s), including pelvic girdle

CPT CODES

<table>
<thead>
<tr>
<th>Medicare Only</th>
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<tbody>
<tr>
<td>Prior Authorization Required</td>
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<tr>
<td>27280</td>
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<tr>
<td>27279</td>
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</tbody>
</table>

Unlisted Codes

All unlisted codes will be reviewed for medical necessity, correct coding, and pricing at the claim level. If an unlisted code is billed related to services addressed in this policy then prior-authorization is required.

- 22899 Unlisted procedure, spine
- 27299 Unlisted procedure, pelvis or hip joint

INSTRUCTIONS FOR USE

Company Medical Policies serve as guidance for the administration of plan benefits. Medical policies do not constitute medical advice nor a guarantee of coverage. Company Medical Policies are reviewed annually and are based upon published, peer-reviewed scientific evidence and evidence-based clinical practice guidelines that are available as of the last policy update. The Companies reserve the right to determine the application of Medical Policies and make revisions to Medical Policies at any time. Providers will be given at least 60-days’ notice of policy changes that are restrictive in nature.

The scope and availability of all plan benefits are determined in accordance with the applicable coverage agreement. Any conflict or variance between the terms of the coverage agreement and Company Medical Policy will be resolved in favor of the coverage agreement.

REGULATORY STATUS

Mental Health Parity Statement

Coverage decisions are made on the basis of individualized determinations of medical necessity and the experimental or investigational character of the treatment in the individual case.
REFERENCES