Molina Clinical Policy
Minimally Invasive Sacroiliac Joint Fusion
Policy No. 266

Last Approval: 06/10/2026
Next Review Due By: June 2027

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This Molina Clinical Policy (MCP) is intended to facilitate the Utilization Management process. Policies are not a supplementation or recommendation for treatment; Providers are solely responsible for the diagnosis, treatment, and clinical recommendations for the Member. It expresses Molina's determination as to whether certain services or supplies are medically necessary, experimental, investigational, or cosmetic for purposes of determining appropriateness of payment. The conclusion that a particular service or supply is medically necessary does not constitute a representation or warranty that this service or supply is covered (e.g., will be paid for by Molina) for a particular Member. The Member's benefit plan determines coverage – each benefit plan defines which services are covered, which are excluded, and which are subject to dollar caps or other limits. Members and their Providers will need to consult the Member's benefit plan to determine if there are any exclusion(s) or other benefit limitations applicable to this service or supply. If there is a discrepancy between this policy and a Member's plan of benefits, the benefits plan will govern. In addition, coverage may be mandated by applicable legal requirements of a State, the Federal government or CMS for Medicare and Medicaid Members. CMS's Coverage Database can be found on the CMS website. The coverage directive(s) and criteria from an existing National Coverage Determination (NCD) or Local Coverage Determination (LCD) will supersede the contents of this MCP and provide the directive for all Medicare members. References included were accurate at the time of policy approval and publication.

OVERVIEW

Sacroiliac joint (SIJ) dysfunction has been proposed as one source of chronic lower back pain. The SIJs connect the spine to the pelvis, and therefore dysfunction of these joints can result in abnormal motion and associated pain. Pain related to SIJ dysfunction typically presents in the buttock(s) with radiation to the groin or upper legs, which may lead to substantial functional impairment. Physical examination techniques that can assist in predicting the presence of SIJ dysfunction include the compression test, FABER test, Gaenslen's maneuver, thigh thrust, sacral thrust, and distraction test. Imaging tests do not typically reveal the presence of SIJ dysfunction, rather they are used to rule out other diagnoses which may have similar presentation (e.g., lesions, fracture, inflammatory arthropathy, hip pathology, lower back conditions, etc.). If SIJ dysfunction is suspected as the cause of disabling pain based on physical examination, and if diagnostic tests have ruled out other potential sources, the diagnosis of SIJ pain is confirmed by performing an image-guided intra-articular SIJ block with local anesthetic. A significant reduction in pain following the injection is indicative of a positive test, suggesting that the injected joint is a pain generator (Hayes 2023; NASS 2021).

Non-operative treatment for SIJ dysfunction may include pain medications (e.g., non-steroidal anti-inflammatory drugs), activity modification, physical therapy, and steroid injections. Surgical intervention is proposed to be an option for long-term pain relief when non-operative treatment fails.

Minimally invasive SIJ fusion is a procedure performed under general anesthesia or sedation, in which one or more implants are inserted under fluoroscopic guidance to stabilize the sacrum and ilium, the intent of promotion fusion and relieving pain and other symptoms. The procedure can be performed on an inpatient or outpatient basis and patients usually return to full activity within 6 weeks following the procedure. The percutaneous procedure may be preferred to open surgery when the patient is a candidate, since intraoperative times, hospital length of stay, and recovery times associated with open SIJ fusion are longer (Hayes 2023, 2026; NASS 2021).

The largest body of research supporting minimally invasive SIJ fusion involves the lateral approach, particularly with triangular titanium implants which are placed across the ilium and into the sacrum to transfix and immediately stabilize the joint. The posterolateral approach, often performed with screw-based implants, is less common and may or may not transfix the joint. The posterior approach, typically using allograft implants, has significantly less supporting research and generally cannot provide transfixion, thus relying on indirect stabilization. (Hayes 2026; Xu et al. 2025).

Regulatory Status

There are three major types of implants used for minimally invasive SIJ fusion: triangular titanium implants (e.g., iFuse Implant System), cylindrical threaded or screw type implants (e.g., Rialto SI Fusion System), and engineered bone allograft implants (e.g., LinQ SI Joint Stabilization System).

Triangular titanium and cylindrical screw type implants are regulated by the FDA as metallic bone fixation devices and can be found by searching the FDA 510(k) Premarket Notification Database using the product code OUR. Bone allograft implants are regulated as Human Cells, Tissues, and Cellular and Tissue-based Products (HCT/Ps) and do not require FDA premarket approval or clearance.

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RELATED POLICIES

MCP-468 Injections and Nerve Blocks for Neck and Back Pain

COVERAGE POLICY

Minimally invasive sacroiliac joint (SIJ) fusion with a transfixation device may be **considered medically necessary** for chronic, severely debilitating lower back pain when ALL the following criteria are met:

1. Member is ≥ 18 years old and skeletally mature (radiographic evidence of epiphyseal closure)

2. A complete history and physical documenting the existence of significant SIJ pain (e.g., non-radicular lower back pain below the L5 level of vertebra and/or lower extremity pain) including ALL the following:
   a. Pain rating > 6 on the Numeric Rating Scale (NRS)
   b. Significant limitations in activities of daily living
   c. Presence of localized tenderness with palpation over the sacral sulcus
   d. Absence of localized tenderness over the greater trochanter, lumbar spine, coccyx

3. A comprehensive pain evaluation and treatment plan has been performed by a qualified practitioner with pain management expertise in conjunction with a comprehensive treatment plan (e.g., pharmacotherapy, rehabilitation, and psychological evaluation and intervention)

4. SIJ pain confirmed with at least 3 physical examination provocation maneuvers that stress the SIJ (e.g., Patrick's sign, thigh thrust test, compression test, Gaenslen's test, distraction test, sacral thrust test)

5. Confirmation of the SIJ as a pain generator as evidence by a ≥ 75% reduction in pain following image-guided (fluoroscopy or CT), diagnostic intra-articular SIJ block with the onset and duration of relief being consistent with the local anesthetic employed

6. Failure to respond (e.g., continued pain that interferes with activities of daily living and/or results in functional disability) to ≥ 6 months of non-surgical treatment, including ALL the following:
   a. Non-steroidal anti-inflammatory drugs, muscle relaxants and/or opioids (if not contraindicated)
   b. Activity or exercise modification
   c. An adequate course of physical therapy wherein the physical therapist specifically documents lack of response to treatment
   d. SIJ steroid injections into the affected joint with return of pain after 6 weeks*
   *See *MCP-468 Injections and Nerve Blocks for Neck and Back Pain* for additional information on SIJ injections

7. Absence of generalized pain behavior (e.g., somatoform disorder) or generalized pain disorders such as fibromyalgia

8. All other diagnoses that could be causing Member's pain have been ruled out by ALL the following studies:
   a. Imaging (e.g., plain radiograph, computed tomography [CT], or magnetic resonance imaging [MRI]) of the SIJ joint completed and excludes the presence of tumor, infection, inflammatory arthropathy, or other pathology not amenable to correction with SIJ fusion
   b. Imaging of the pelvis (e.g., plain radiograph) completed and excludes the presence of hip pathology
   c. Imaging of the lumbar spine (CT or MRI) completed and excludes the presence of neural compression or other degenerative condition that could be the cause of symptoms

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Limitations and Exclusions

Minimally invasive SIJ fusion using *posterior placed devices or devices that do not traverse and transfix the SIJ, including intra-articular implants and structural bone allograft implants,* is considered **experimental, investigational, and unproven** due to insufficient evidence in the peer-reviewed medical literature to establish long-term safety, efficacy, and effect on net health outcomes

DOCUMENTATION REQUIREMENTS: Molina Healthcare reserves the right to require that additional documentation be made available as part of its coverage determination; quality improvement; and fraud; waste and abuse prevention processes. Documentation required may include, but is not limited to, patient records, test results and credentials of the provider ordering or performing a drug or service. Molina Healthcare may deny reimbursement or take additional appropriate action if the documentation provided does not support the initial determination that the drugs or services were medically necessary, not investigational, or experimental, and otherwise within the scope of benefits afforded to the member, and/or the documentation demonstrates a pattern of billing or other practice that is inappropriate or excessive.

SUMMARY OF MEDICAL EVIDENCE

There is moderate quality evidence that minimally invasive sacroiliac joint (SIJ) fusion is an acceptable treatment for adults with chronic SIJ dysfunction unresponsive to non-surgical treatments. Studies have consistently shown both short- and long-term improved pain and disability scores with minimal risk of complications or need for revision.

Randomized Controlled Trials

Dengler et al. (2019) completed a prospective, multicenter randomized controlled trial comparing SIJ fusion to conservative management. The study included 103 participants randomly assigned to either conservative management (n=51) or surgical SIJ fusion (n=52). Participants were followed for 2 years. The primary outcomes measured were Visual Analog Scale (VAS), Oswestry Disability Index (ODI), and quality of life. Participants undergoing SIJ fusion either underwent staged bilateral fusion for bilateral pain (n=7), unilateral fusion for bilateral pain (n=11), bilateral fusion for unilateral pain (n=6), or unilateral fusion for unilateral pain (n=28). Those randomized to the conservative group underwent 25 physical therapy sessions over the first 6 months. Deviations in the conservative group included 2 participants who received corticosteroid injections and 1 participant that received corticosteroid injections with radiofrequency ablation. The mean baseline VAS for lower back pain was 77.7 for the SIJ fusion group compared to 73.0 for the conservative management group. Mean VAS improvement at 6 months was 43.3 for the SIJ group and 5.7 for the conservative management group. Mean VAS improvement at 24 months was 45.3 for SIJ fusion compared to 11.3 for conservative management. VAS scores for leg pain were similar to those for lower back pain. ODI scores were notably lower for the SIJ group with an overall decrease by 26 points from baseline at the 24-month follow-up. ODI scores decreased by 8.0 points from baseline at the 24-month follow-up. There was no change noted in opioid usage noted from baseline to the 24-month follow-up for the conservative management group while the SIJ fusion group noted a decrease to 33% from a baseline of 56%.

Polly et al. (2016) published two-year outcomes from the INSITE trial which was a prospective, multicenter, randomized controlled study evaluating the effectiveness of minimally invasive SIJ fusion using triangular titanium implants compared to non-surgical management (NSM) in patients with chronic SIJ dysfunction. A total of 148 participants were enrolled, with 102 assigned to the SIJ fusion group and 46 to the NSM group. After six months, 89% of NSM participants who remained in the study crossed over to receive SIJ fusion using the study device. Outcomes were assessed using the VAS for pain, the ODI for disability, and the EuroQoL 5-Dimension Questionnaire (EQ-5D) and the 36-Item Short Form Health Survey (SF-36) for quality of life, with follow-ups conducted at 1, 3, 6, 12, 18, and 24 months. At 24 months, the SIJ fusion group demonstrated a substantial mean reduction in pain of 55.4 points and an average ODI improvement of 26.0 points, with significant gains in quality of life. Patients who crossed over to surgery experienced similar improvements, while those who remained in the NSM group showed minimal or no continued benefit. The procedure was associated with a low complication rate, with no device breakage or migration and only a small number of revision surgeries. Additionally, opioid use decreased by nearly 30% in the SIJ fusion group but increased in the NSM group, despite no targeted interventions for opioid reduction. The study found no significant differences in outcomes between patients with and without prior lumbar fusion, broadening the applicability of the procedure. From a health economics perspective, SIJ fusion was found to be cost-effective, with benefits comparable to hip and knee replacements, and may also improve workforce productivity by reducing the indirect costs of chronic SIJ pain. Overall, the INSITE trial provides Level 1 evidence that minimally invasive SIJ fusion offers superior, durable improvements in pain, function, and quality of life compared to conservative care, despite acknowledged limitations such as crossover design and industry sponsorship.

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Systematic Reviews and Meta-Analyses

Xu et al. (2025) performed a systematic review and meta-analysis to evaluate the therapeutic effects of minimally invasive SIJ fusion using lateral, posterior, or posterolateral approaches, for low back pain. The review included 48 studies, with 3 RCTs, 6 prospective single-arm, 6 cohort studies, and 33 case series. Thirty-two of the studies focused on the lateral approach, 10 were on the posterior approach, 4 were on the posterolateral approach, and 2 compared lateral to posterolateral. All 3 of the RCTs evaluated the lateral approach and included comparisons to conservative or sham surgery. Outcomes were measured using pooled analyses of VAS scores, complication and revision rates, and VAS scores. For each minimally invasive surgical approach, statistically significant reductions in VAS pain scores were observed at 6 and 12 months. At 6 months, pooled VAS reductions were 4.3 (95% CI 3.6-5.0) for lateral, 4.8 (95% CI 3.6-6.0) for posterior, and 3.0 (95% CI 1.6-4.4) for posterolateral. At 12 months, reductions were 5.0 (95% CI 4.5-5.4) for lateral, 4.9 (95% CI 3.6-6.3) for posterior, and 3.8 (95% CI 1.9-5.7) for posterolateral. Pooled fusion rates were 88.1% (95% CI 76.7-96.4%) for lateral, 83.1% (95% CI 69.5-93.8%) for posterior, and 95.2% (95% CI 84.7-100.0%). Pooled complication rates, which included both intraoperative and postoperative events, were 9.2% (95% CI 4.4-15.2%) for lateral, 1% (95% CI 0.1-2.6%) for posterior, and 3.7% (95% CI 0.0-21.0%) for posterolateral. Revision rates were 2.4% (95% CI 1.3-3.9%) for lateral, 0.6% (95% CI 0.0-1.8%) for posterior, and 0.9% (95% CI 0.0-2.9%) for posterolateral. Study limitations include a lack of high-quality comparative studies, predominance of case series, heterogeneity, and limited RCT data. The authors concluded that minimally invasive SIJ fusion provides significant pain relief and achieves similar fusion rates across lateral, posterior, and posterolateral approaches. However, the lateral approach may be associated with a higher risk of complications and revision.

Medani et al. (2025) performed a systematic review and meta-analysis to compare the clinical outcomes of minimally invasive SIJ fusion using the lateral vs posterior approaches. The review included 48 studies, the majority of which were observational, including prospective single-arm trials, retrospective cohort, and case series. Forty-five studies involved minimally invasive fusion, while 3 involved open fusion, with a total of 2,562 patients. Studies that involved the posterior approach varied by implant type, including cannulated, screw-type devices (e.g., Rialto SI Fusion System, SI-LOK SI Joint Fixation System) and allograft devices (e.g., LinQ SI Joint Stabilization System). Primary outcomes were pain, measured by the VAS, and disability, measured by ODI. Mean follow-up durations were approximately 21 months for VAS and 17 months for ODI. Pooled analysis showed no statistically significant difference ($p = 0.986$) in VAS scores between the lateral and posterior approach, with VAS improving by an overage of 57% in the lateral group and 58% for the posterior group. ODI scores improved by an average of 42% for the lateral group and 31% for the posterior group, which was also not statistically significant ($p = 0.272$). Substantial heterogeneity was also observed for both these outcomes. The authors concluded that there is no significant difference in pain reduction between the lateral and posterior SIJ fusion approaches, and while the lateral approach demonstrated a trend of greater functional improvement, the difference was not statistically significant. Further research, particularly RCTs, is needed to better evaluate the clinical outcomes between the two approaches.

Ghaddaf et al. (2024) performed a systematic review and meta-analysis to compare minimally invasive SIJ fusion with triangular titanium implants to nonoperative management of SIJ dysfunction. The review included 8 publications that represented 3 clinical trials, including 2 RCTs and 1 prospective single-arm trial, for a total of 423 participants. Outcomes assessed included pain using the VAS (0-100 scale), disability using the ODI, high-related quality of life using the SF-36 and EQ-5D, patient satisfaction, opioid use, and adverse events. Weighted mean VAS scores were 31.53 for the fusion group and 70.95 for the nonoperative group, with a standard mean difference (SMD) of -1.71 (95% CI -2.03 to -1.39). Weighted mean ODI scores were 34.03 in the fusion group versus 52.11 in the nonoperative group, with a SMD of -1.03 (95% CI -1.24 to -0.81). Health-related quality of life also favored minimally invasive SIJ fusion, with a SMD of 0.96 (95% CI 0.63 to 1.29) for EQ-5D, a SMD of 1.01 (95% CI 0.83 to 1.29) for the SF-36 physical component, and a SMD of 0.72 (95% CI 0.54 to 0.9) for the SF-36 mental component. Patient satisfaction at 24 months was also higher for the fusion group (69.12% vs 22.58%, odds ratio 6.87, 95% CI 3.73 to 12.64), and opioid use was lower (56.4% vs 75%, odds ratio 0.43, 95% CI 0.29 to 0.65). Adverse events between groups were comparable and not statistically significant, with a SMD of -0.03 (95% CI -0.28 to 0.23). The mean number of adverse events per patient was 1.11 in the fusion group vs 1.14 in the nonoperative group, which included events such as revision surgery and surgical wound complications. The overall quality of evidence was rated as low for most outcomes using GRADE criteria due to the small number of clinical trials, limited sample sizes, and substantial heterogeneity, particularly for pain outcomes ($I^2 = 92\%$). The authors concluded that minimally invasive SIJ fusion with triangular titanium implants provides clinically meaningful and statistically significant improvements in pain, disability, health-related quality of life, patient satisfaction, and opioid use compared with nonoperative management, while maintaining a similar adverse event profile.

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Whang et al. (2023) conducted a systematic review and meta-analysis of 57 patient cohorts, encompassing 2,851 individuals, to evaluate the safety and efficacy of various minimally invasive SIJ fusion techniques. These were categorized into three surgical approaches: lateral transiliac (LTI), posterolateral transiliac (PLTI), and posterior interpositional (PI) procedures. All approaches demonstrated post-operative improvements in patient-reported outcomes (PROs), including pain (measured by numeric rating scale) and disability (measured by the ODI). The LTI technique showed the most significant improvements, with a mean pain reduction of 4.8 points and a mean ODI improvement of 25.9 points. PLTI and PI procedures also yielded clinical benefit, though to a lesser extent. Notably, only the LTI approach was supported by RCTs and had independent radiographic evidence confirming implant placement and fusion. Safety outcomes were favorable across all techniques, with low rates of complications. Implant malposition occurred in 0.43% of LTI cases and was not reported in PLTI or PI groups. Wound infections and bleeding events were rare, and no device breakage or migration was observed. The overall quality of the literature was considered moderate, with most studies being retrospective case series and only a minority designed prospectively. No prospective studies were available for the PLTI approach, and comparative prospective data were limited to a single cohort study showing no significant difference between LTI and PLTI. These findings support the use of minimally invasive SI joint fusion, particularly the LTI technique, as a safe and effective treatment for appropriately selected patients, while also highlighting the need for further high-quality comparative research.

Hermans et al. (2022) completed a systematic review and meta-analysis that included 4 studies comparing minimally invasive SIJ fusion to conservative management. The analysis included a total of 388 patients with 207 managed using conservative management and 181 undergoing minimally invasive SIJ fusion. The primary outcomes observed were pain using the VAS and disability using the ODI. Secondary outcomes included adverse events, serious adverse events, and costs. SIJ dysfunction was confirmed in both groups using image-guided intraarticular injection of a local anesthetic. Patient characteristics were similar among both groups. VAS and ODI scores were significantly improved with the minimally invasive SIJ fusion group in all studies. There was a mean difference of -33.40 to -40.20 for VAS scores at 6 months and a mean difference of -20.00 to -23.10 for ODI at 6 months. A total of 81 adverse or serious adverse events were reported among 341 patients. There were 50 events reported for the minimally invasive SIJ fusion group with 10 of those considered serious. The serious adverse events consisted of 5 surgical wound problems and 5 implant malposition. The remaining adverse events were related to hypertensive crises, herpes infection, depression, carpal tunnel syndrome, stress incontinence, medication overdose, worsening ulcerative colitis, and brain metastases. There were 31 adverse events reported in the conservative management group related to new pain in the pelvic or lower back areas, SIJ or back pain related to physical therapy, and pain or shortness of breath related to steroid injections. Upfront costs were noted to be higher for the minimally invasive SIJ fusion group. However, minimally invasive SIJ was shown to be more cost effective in the long-term.

Non-Randomized Studies, Retrospective Reviews and Other Sources of Evidence

Hayes (2026) conducted an evolving evidence review of minimally invasive posterior SIJ fusion using bone allograft for the management of SIJ pain. A review of full-text clinical studies and systematic review suggest minimal support for the use of minimally invasive posterior SIJ fusion using engineered bone allograft implants. The author cited the existing clinical studies as “very poor quality,” noting the lack of control or comparator groups. In the 3 studies that reported adverse events, 1 device migration, 1 mortality, and 1 serious adverse event were reported. Additionally, the author found no/unclear support for minimally invasive posterior fusion with bone allograft based on a review of clinical practice guidelines and position statements. Follow-up data beyond 20 months is not available for the implants currently on the market for their use in minimally invasive posterior SIJ fusion.

Kucharzyk et al. (2022) published a 1-year follow-up on the EVoluSIon (EVSI) clinical study. The EVSI study was a prospective, multicenter study using the SImmetry SIJ Fusion System. Inclusion criteria for the study included patient age ≥ 18 years, at least 6 months of nonoperative management of SIJ pain, 3 positive provocative tests, at least 1 positive diagnostic SIJ injection with at least 50% reduction in pain, a VAS ≥ 60, and an ODI ≥ 40. The study included 250 patients. Median age at baseline was 60.5 years with 70.8% of patients being female. Approximately 56% of patients had a SIJ-related pain duration ≥ 2 years. The primary outcomes measured including VAS, ODI, quality of life, and opioid use. The mean VAS at baseline was 76.4, mean ODI 54.4, and mean quality of life 60.9. Patients were asked to rank their quality of life using a scale of 0-100 with 100 being the best quality of life. A total of 80.4% of patients were available for follow-up at the 1-year mark. The mean VAS at the 1-year follow-up was 33.0, mean ODI 30.5, and mean quality of life 72.8. Opioid use was reported as use of opioids, non-opioid pain medications, non-steroidal anti-inflammatory drugs (NSAIDs), and steroids. At baseline, 62.7% were using opioids, 51.7% were using NSAIDs, 37.3% were using non-opioid analgesics, and 9.0% were using steroids. At the 1-year follow-up, 26.9% of patients were

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continuing to use opioids, 14.4% using NSAIDs, 9.0% using non-opioid analgesics, and no patients were using steroids.

National and Specialty Organizations

The **National Association of Spinal Specialists (NASS)** published coverage policy recommendations for minimally invasive SIJ fusion, stating that it may be appropriate for carefully selected patients who meet the following criteria (NASS 2021):

- The individual has tried and failed a minimum of 6 months of intensive nonoperative treatment (medication, activity modification, physical therapy, and home exercise program).
- Pain is consistent with SIJ pain (non-radicular, typically unilateral pain below the L5 vertebrae, localized over the posterior SIJ).
- Physical examination and positive response to at least three provocative tests is present.
- Generalized pain behavior or disorders are absent.
- An image-guided, contrast-enhanced, intra-articular SIJ injection of anesthetic provides at least 75% pain relief for the expected duration of anesthetic used, on 2 separate occasions.
- A trial of at least one therapeutic (i.e., corticosteroid) intra-articular SIJ injection
- Diagnostic imaging includes all the following:
  - Plain radiographs, CT, or MRI of the SIJ that excludes the presence of destructive lesions (e.g., tumor, infection) or autoimmune arthropathy that would not be addressed properly by percutaneous fusion
  - Pelvic radiographs rule out hip pathology that would better explain patient's symptoms.
  - CT or MRI of the lumbar spine rules out neural compression or another degenerative condition that is more likely to be the source of pain.

The **International Society for the Advancement of Spine Surgery (ISASS)** published an update to their policy statement about minimally invasive SIJ fusion for chronic SIJ pain. The update reviewed and analyzed the expanding evidence regarding the differences between the lateral and dorsal approaches. The guideline emphasizes a structured diagnostic approach, including the use of provocative physical examination maneuvers (e.g., thigh thrust, Gaenslen maneuver, distraction test, compression test, Flexion Abduction External Rotation [FABER] test). The authors cite a systematic review by Peterson et al. (2017), which determined there is significant evidence to use a diagnostic rule of 3 out of 5 positive provocation tests for SIJ pain. While no imaging modality has demonstrated acceptable sensitivity and specificity for diagnosis SIJ pain directly, imaging is used to rule out alternative diagnoses that could mimic SIJ pain, such as hip osteoarthritis or spine degeneration. Diagnosis of SIJ pain is confirmed with an image-guided intra-articular SIJ block that demonstrates significant pain relief. The authors note that periarticular blocks are not considered a reference standard for the diagnosis of SIJ pain, and that these blocks will likely anesthetize soft tissues. The authors also state that a higher response to a SIJ block does not predict higher responses to "definitive treatment," and that using "an overly stringent selection criteria (i.e., 75% response) has no basis in evidence," based on a subgroup analysis of 320 participants enrolled in two prospective, single-arm clinical trials (Lorio et al. 2020).

The ISASS notes that there are two different minimally invasive SIJ fusion approaches: lateral transiliac and posterior (dorsal). The lateral approach traverses the ilium from a lateral or posterolateral position, traverses across the SIJ and into the sacrum. As of 2020, there are approximately 25 lateral transiliac transfixing devices with FDA clearance for minimally invasive SIJ fusion. Clinically evidence for the lateral approach is "now substantial," and includes 2 primary RCTs and 5 multicenter prospective studies that support its safety and efficacy. Alternatively, there is limited published clinical evidence supporting the safety and efficacy of minimally invasive posterior SIJ fusion. The posterior approach involves placement of bone allograft implants into the ligamentous also Additionally, the ISASS underscores the importance of exhausting conservative treatment options, such as physical therapy, medications, and injections, before considering surgical intervention. The policy endorses SIJF as a safe and effective treatment for patients with chronic SIJ dysfunction who have not responded to non-surgical care (Lorio et al. 2020).

The **National Institute for Health and Care Excellence (NICE)** published the HealthTech guidance HTG436 supporting the use of minimally invasive SIJ fusion surgery for chronic SIJ pain. The recommendations state patients "should have a confirmed diagnosis of unilateral or bilateral SIJ dysfunction due to degenerative sacroiliitis or SIJ disruption." Current evidence on the safety and efficacy of the procedure for chronic SIJ pain is adequate. The NICE guidelines only discuss the procedure using the lateral approach. The committee also noted that while stabilization of the joint can be achieved with the procedure, there is evidence that fusion does not occur in many patients.

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SUPPLEMENTAL INFORMATION

The Numeric Rating Scale (NRS-11): Rating Pain Level
0: No Pain
1 – 3: Mild Pain (nagging, annoying, interfering little with ADLs)
4 – 6: Moderate Pain (interferes significantly with ADLs)
7 – 10: Severe Pain (disabling; unable to perform ADLs)

CODING & BILLING INFORMATION

CPT (Current Procedural Terminology)

Code	Description
27279	Arthrodesis, sacroiliac joint, percutaneous or minimally invasive, with image guidance, includes obtaining bone graft when performed, unilateral; placement of transarticular device(s) and/or intra-articular device(s) piercing the lateral or medial cortices of the ilium and the lateral cortex of the sacrum
27278	Arthrodesis, sacroiliac joint, percutaneous or minimally invasive, with image guidance, includes obtaining bone graft when performed, unilateral; placement of intra-articular device(s), without cortical piercing

HCPCS (Healthcare Common Procedure Coding System)

Code	Description
C1737	Joint fusion and fixation device(s), sacroiliac and pelvis, including all system components (implantable)

CODING DISCLAIMER. Codes listed in this policy are for reference purposes only and may not be all-inclusive. Deleted codes and codes which are not effective at the time the service is rendered may not be eligible for reimbursement. Listing of a service or device code in this policy does not guarantee coverage. Coverage is determined by the benefit document. Molina adheres to Current Procedural Terminology (CPT®), a registered trademark of the American Medical Association (AMA). All CPT codes and descriptions are copyrighted by the AMA; this information is included for informational purposes only. Providers and facilities are expected to utilize industry standard coding practices for all submissions. When improper billing and coding is not followed, Molina has the right to reject/deny the claim and recover claim payment(s). Due to changing industry practices, Molina reserves the right to revise this policy as needed.

APPROVAL HISTORY

06/10/2026	Policy revised. Added a limitations and exclusions section for posterior placed and non-transfixing devices. Added CT as an acceptable imaging-guidance modality for the diagnostic SIJ block. IRO peer reviewed on May 13, 2026 by a practicing physician board certified in orthopedic surgery.
06/11/2025	Policy reviewed. No changes to coverage criteria. Updated Summary of Medical Evidence and References.
06/12/2024	Policy reviewed, no changes to criteria.
02/14/2024	Coding and billing updated.
06/14/2023	Policy reviewed, no changes to criteria. Grammatical edits to Disclaimer section and Documentation Requirements disclaimer. Overview, Summary of Medical Evidence, and References updated. Added code 0775T. IRO Peer Review on June 3, 2023, by a practicing, board-certified physician with a specialty in orthopedic surgery.
06/08/2022	Policy updated to pertain to minimally invasive sacroiliac joint fusion rather than the iFuse implant system specifically.
06/09/2021	Policy reviewed, no changes.
06/17/2020	Policy reviewed, no changes.
06/19/2019	Policy reviewed, no changes to criteria for iFuse implant. Revisions made to the addition of the iFuse 3D implant (FDA approved in 2017). Implant system is considered experimental, investigational. Updated professional guidelines. IRO Peer Review on March 26, 2019, by a practicing, board-certified physician in the area of Orthopedic Surgery.
03/08/2018	Policy reviewed, no changes.
06/22/2017	Policy reviewed, no changes.
01/13/2016	New policy.

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