MEDICAL POLICY STATEMENT
OHIO MARKETPLACE

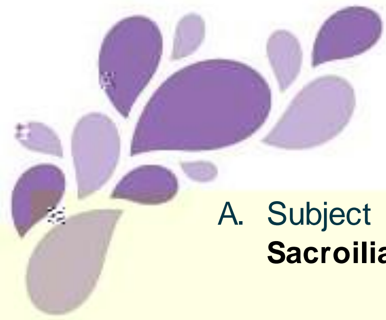
Policy Name		Policy Number	Date Effective
Sacroiliac Joint Fusion		MM-0840	09/01/2020
Policy Type			
MEDICAL	Administrative	Pharmacy	Reimbursement

Medical Policy Statement prepared by CSMG Co. and its affiliates (including CareSource) 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.

Medical Policy Statements prepared by CSMG Co. and its affiliates (including CareSource) do not ensure an authorization or payment of services. Please refer to the plan contract (often referred to as the Evidence of Coverage) for the service(s)

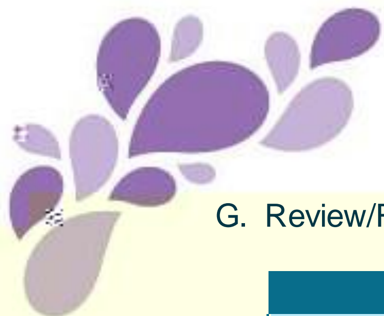
Table of Contents

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



A. Subject

Sacroiliac



G. Review/Revision History

	DATE	ACTION
Date Issued	05/13/2020	New Policy
Date Revised		
Date Effective	09/01/2020	
Date Archived	09/01/2021	

H. References

1. Centers for Medicare & Medicaid Services. Local Coverage Determination (LCD): Percutaneous minimally invasive fusion/stabilization of the sacroiliac joint for the treatment of back pain. (L36000). (11/01/2019). Retrieved on December 14, 2019 from www.cms.gov
2. Chou, Roger, MD, (2019, January 2). Subacute and chronic low back pain: Nonsurgical interventional treatment.0 11.2 Tf520.67 542.15 Td[(f)64 (r)47 (o)56 (m)]TJETQ0 0 1.2 T