



MASSACHUSETTS

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Diagnosis and Treatment of Sacroiliac Joint Pain Prior Authorization Request Form #927

Medical Policy #320 Diagnosis and Treatment of Sacroiliac Joint Pain

CLINICAL DOCUMENTATION

- Clinical documentation that supports the medical necessity criteria for **Diagnosis and Treatment of Sacroiliac Joint Pain** must be submitted.
- If the patient does not meet all the criteria listed below, please submit a letter of medical necessity with a request for [Clinical Exception \(Individual Consideration\)](#) explaining why an exception is justified.

Requesting Prior Authorization Using Authorization Manager

Providers will need to use [Authorization Manager](#) to submit initial authorization requests for services. Authorization Manager, available 24/7, is the quickest way to review authorization requirements, request authorizations, submit clinical documentation, check existing case status, and view/print the decision letter. For commercial members, the requests must meet medical policy guidelines.

To ensure the request is processed accurately and quickly:

- Enter the facility's NPI or provider ID for where services are being performed.
- Enter the appropriate surgeon's NPI or provider ID as the servicing provider, *not* the billing group.

Authorization Manager Resources

- Refer to our [Authorization Manager](#) page for tips, guides, and video demonstrations.

Complete Prior Authorization Request Form for Diagnosis and Treatment of Sacroiliac Joint Pain [\(927\)](#) using [Authorization Manager](#).

For out of network providers: Requests should still be faxed to 888-282-0780.

Patient Information	
Patient Name:	Today's Date:
BCBSMA ID#:	Date of Treatment:
Date of Birth:	Place of Service: Outpatient <input type="checkbox"/> Inpatient <input type="checkbox"/>

Physician Information	Facility Information
Name:	Name:
Address:	Address:
Phone #:	Phone #:
Fax#:	Fax#:
NPI#:	NPI#:

Please check off if the patient has the following diagnosis:	
Sacroiliac pain	<input type="checkbox"/>

Please check off if the surgical procedure being requested is the following:	
Minimally invasive fixation/fusion of the sacroiliac joint using transiliac placement of a titanium triangular implant (eg, iFuse)	<input type="checkbox"/>

Please check off that the patient meets ALL of the following criteria:	
Pain is at least 5 on a 0 to 10 rating scale that impacts quality of life or limits activities of daily living; AND	<input type="checkbox"/>
There is an absence of generalized pain behavior (eg, somatoform disorder) or generalized pain disorders (eg, fibromyalgia); AND	<input type="checkbox"/>
Individual had undergone and failed a minimum 6 months of intensive nonoperative treatment that must include medication optimization, activity modification, bracing, and active therapeutic exercise targeted at the lumbar spine, pelvis, sacroiliac joint, and hip, including a home exercise program; AND	<input type="checkbox"/>
Pain is caudal to the lumbar spine (L5 vertebra), localized over the posterior sacroiliac joint, and consistent with sacroiliac joint pain; AND	<input type="checkbox"/>
A thorough physical examination demonstrates localized tenderness with palpation over the sacral sulcus (Fortin's point) in the absence of tenderness of similar severity elsewhere; AND	<input type="checkbox"/>
There is a positive response to a cluster of 3 provocative tests (eg, thigh thrust test, compression test, Gaenslen sign, distraction test, Patrick test, posterior provocation test); AND	<input type="checkbox"/>
There is at least a 75% reduction in pain for the expected duration of the anesthetic used following an image-guided, contrast-enhanced intra-articular sacroiliac joint injection on 2 separate occasions; AND	<input type="checkbox"/>
A trial of a therapeutic sacroiliac joint injection (ie, corticosteroid injection) has been performed at least once.	<input type="checkbox"/>

Please check off that the patient meets ALL of the following criteria:	
Diagnostic imaging studies include <u>ALL</u> of the following:	
<ul style="list-style-type: none"> Imaging (plain radiographs and computed tomography or magnetic resonance imaging) of the sacroiliac joint excludes the presence of destructive lesions (eg, tumor, infection) or inflammatory arthropathy of the sacroiliac joint; AND 	<input type="checkbox"/>
<ul style="list-style-type: none"> Imaging of the pelvis (anteroposterior plain radiograph) rules out concomitant hip pathology; AND 	<input type="checkbox"/>
<ul style="list-style-type: none"> Imaging of the lumbar spine (computed tomography or magnetic resonance imaging) is performed to rule out neural compression or other degenerative conditions that can be causing low back or buttock pain; AND 	<input type="checkbox"/>
<ul style="list-style-type: none"> Imaging of the sacroiliac joint indicates evidence of injury and/or degeneration. 	<input type="checkbox"/>

Please check off if the procedure is being done by the following provider:	
A surgeon who has specific training and expertise in minimally invasive sacroiliac joint fusion surgery for chronic sacroiliac joint pain and who regularly use image-guidance for implant placement.	<input type="checkbox"/>

Coding Information

Please check off all the relevant CPT codes:		
27279	Arthrodesis, sacroiliac joint, percutaneous or minimally invasive (indirect visualization), with image guidance, includes obtaining bone graft when performed, and placement of transfixing device	<input type="checkbox"/>

Providers should enter the relevant diagnosis code(s) below:

Code	Description	
		<input type="checkbox"/>
		<input type="checkbox"/>

Providers should enter other relevant code(s) below:

Code	Description	
		<input type="checkbox"/>
		<input type="checkbox"/>