SI FUSIONS

(AMA CPT COMMITTEE)

DR. ASHLEY BAILEY-CLASSEN

TRINITY PAIN MEDICINE ASSOCIATES

TEXAS PAIN SOCIETY: SCIENTIFIC CONFERENCE

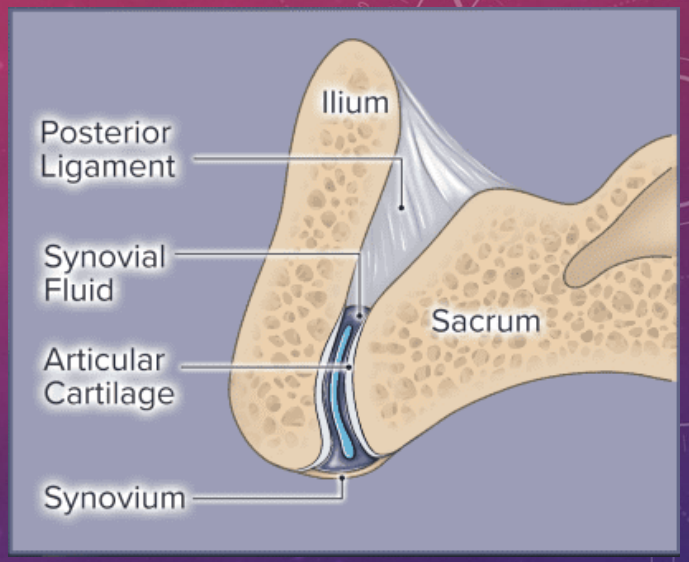
SATURDAY, OCTOBER 25, 2025

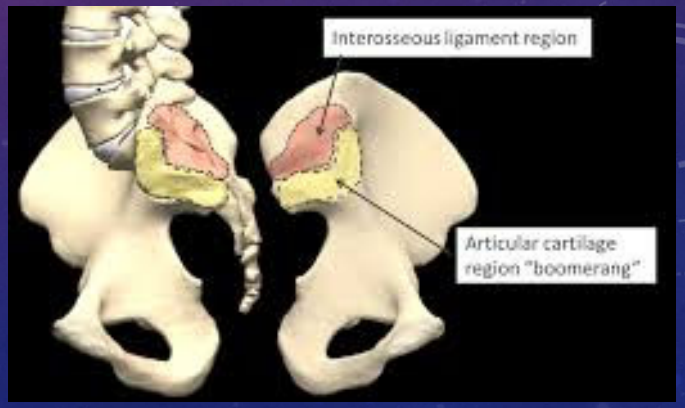
DISCLOSURES

- Nevro/Globus
- Aurora Spine
- Medtronic
- SI Bone

AGENDA

- SIJ Dysfunction
- SIJ Pathology
- Conservative Medical Management
- CPT Review
- Medical Necessity per the LCD – 27278, 27279
- How to approach an SIJ fusion





SIJ DYSFUNCTION

- 10% - 26% of the patient population
- No single clinical, imaging, or provocative test that confirms the diagnosis
- Detailed history can be very helpful
- Differential
  - L5/S1 Facets, Spinal Stenosis, IA Hip Pathology, Pelvic/Lumbar Core Deconditioning

SIJ DYSFUNCTION

- HISTORY
  - Axial, unilateral > bilateral
  - MSK by descriptors
  - Sitting off to the side
  - Preference walking up the stairs
  - Transitional movements
- PHYSICAL EXAM
  - Finger Fortin Test
  - Patrick's (FABER)
  - Gaenslen's
  - Thigh Thrust
  - Compression
  - Distractions
  - Gillet Test (Stork Test)

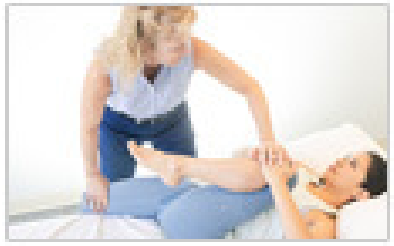
Distraction

Thigh Thrust

Compression

FABER

Gaenslen



Gillet Test

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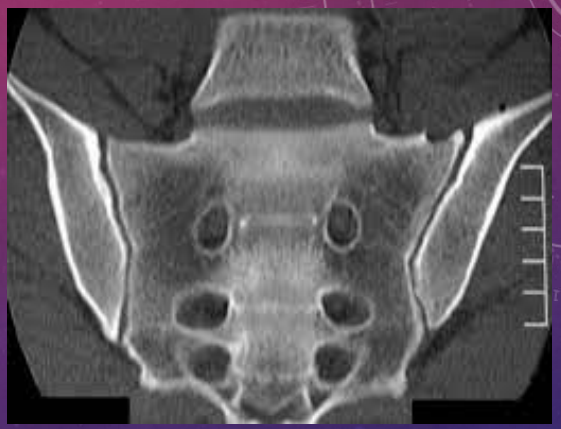
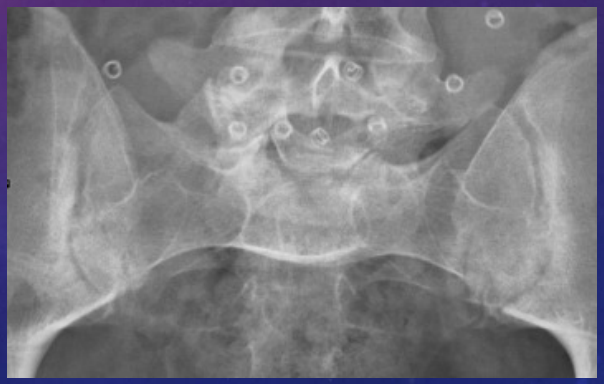
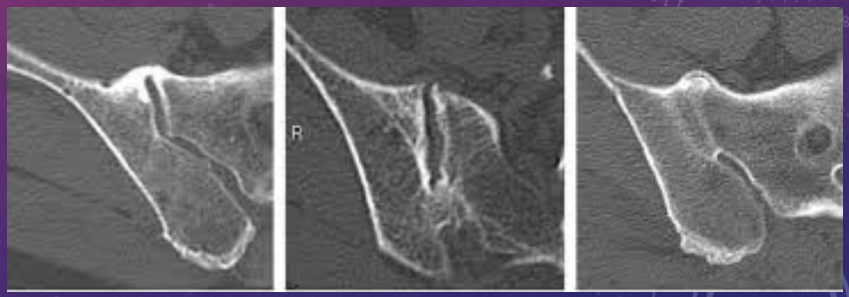




SIJ PATHOLOGY

- Degenerative or Inflammatory arthritis
- Post-Traumatic arthritis
- Post-Partum Instability
- Post-Infectious
- Degenerative post lumbar fusion
- Neoplastic



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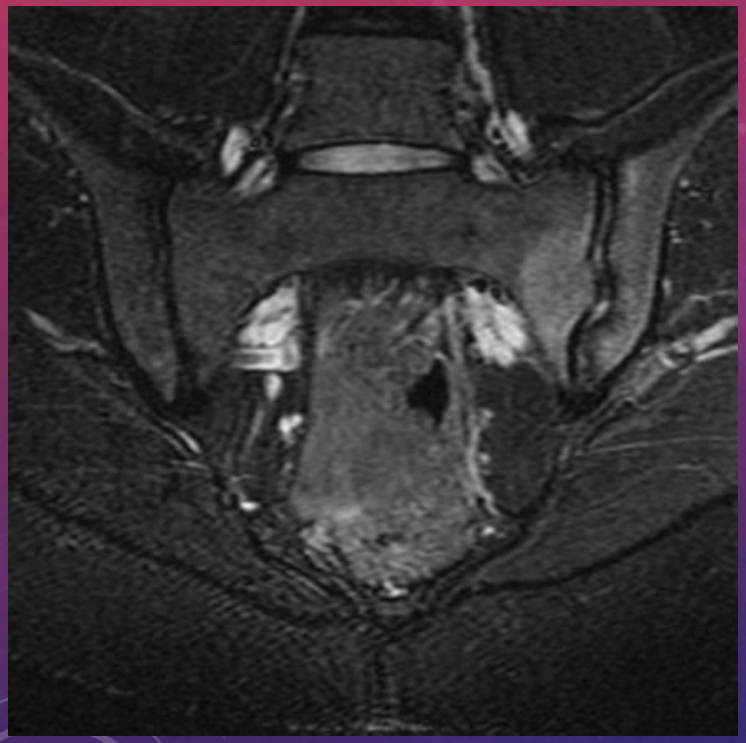

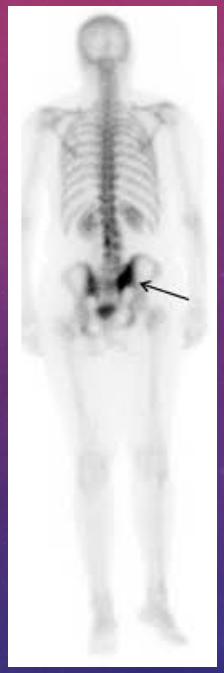

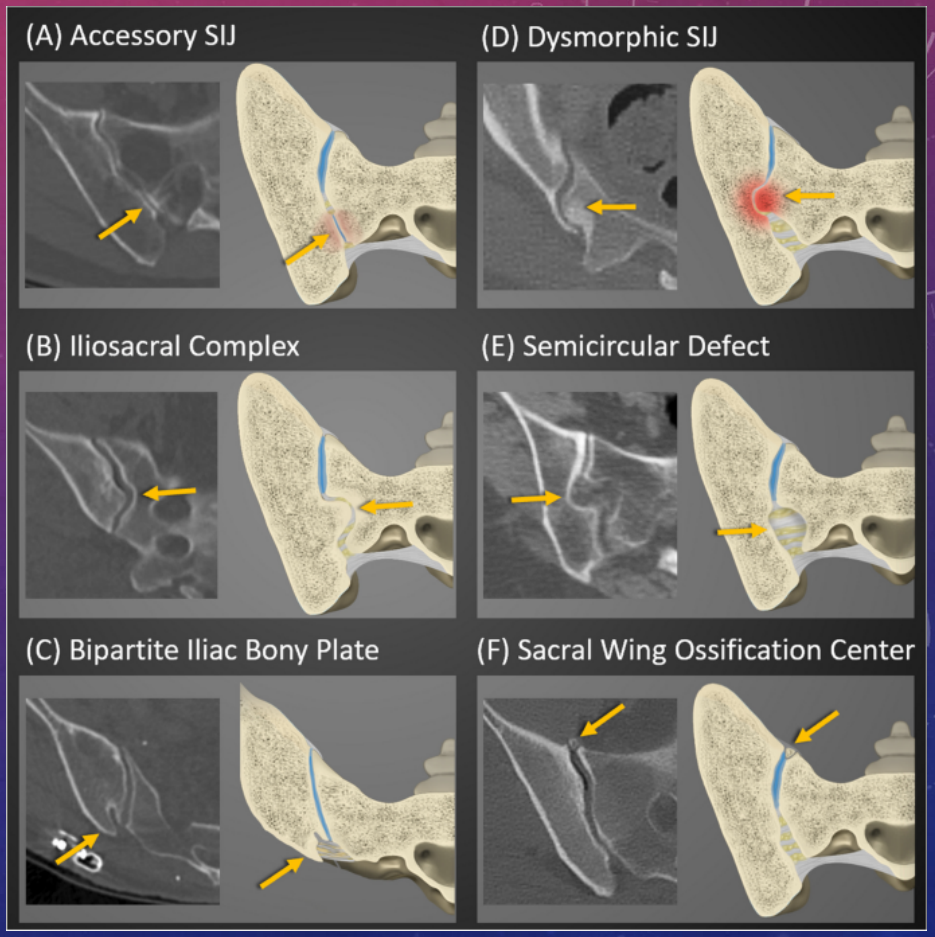

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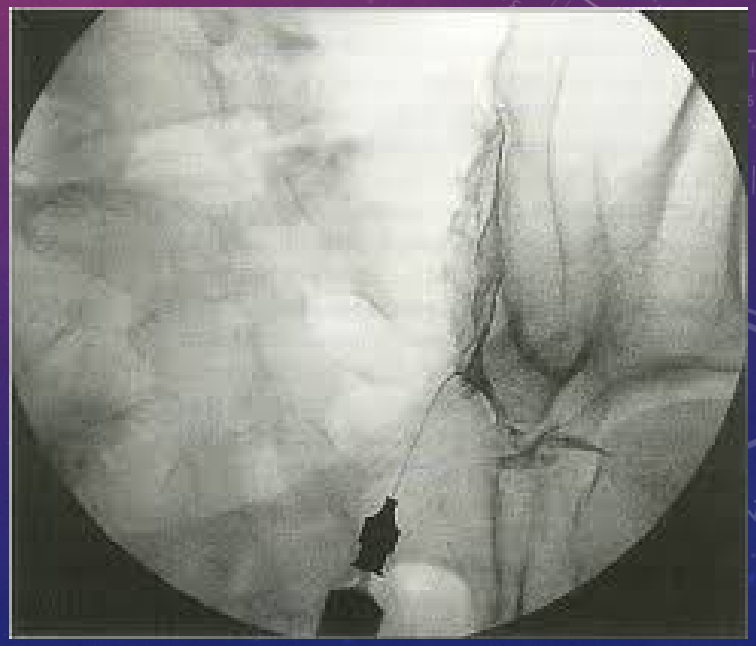

CONSERVATIVE MEDICAL MANAGEMENT

- Medications
- Chiropractic Care
- Fluro or CT guided IA Injection
  - Diagnostic or Therapeutic
- Orthobiologics
  - Prolotherapy, PRP, BMAC, Adipocyte MSCs, Amniotic fluid, Exosomes, or other
- Physical Therapy
- Home Exercise Program
- TENS
- Shockwave or Laser Therapy
- RFA
  - WC, PI, Auto, Self-pay

CONSERVATIVE MEDICAL MANAGEMENT

- SIJ INJECTION CPT REVIEW
  - Diagnostic SIJ injection is used to determine if the etiology of pain is from the SIJ complex
  - Considered reasonable and medically necessary for patients who meet ALL of the following:
    - Meet diagnostic criteria
    - Performed under CT or Fluoro guidance. US may be considered with documented dye allergy or pregnancy
    - Cannot be performed with other injections of the L/S spine
    - Documentation shows causal benefit from the SIJ injection and not other MSK treatments
    - Minimum 75% relief of index pain during the anesthetic phase when measured with the SAME pain scale
      - Pre-injection day of score, Post-intervention day of score, and days following the injection
    - Limitation: No more than 2 (two) diagnostic joint sessions, unilateral or bilateral. One diagnostic unilateral session on one side and a separate diagnostic unilateral session on the other side would equal the 2 (two) session limit.

CONSERVATIVE MEDICAL MANAGEMENT

- Here is what's confusing…the LCD (L39475) states that a Diagnostic Injection can contain local anesthetic and anti-inflammatory steroid. And, that the 75% benefit must be of both the local anesthetic and the steroid, hence the pre-injection and post-injection day of scores, along with the days following pain scores to validate the anesthetic and the steroid.
- My take – perform two diagnostic injections with anesthetic only. Vary the anesthetics, and hope to achieve >75% improvement. Then perform one therapeutic injection with steroid.

CONSERVATIVE MEDICAL MANAGEMENT

- SIJ INJECTION CPT REVIEW
  - Therapeutic SIJ injection is considered reasonable and medically necessary for patients who meet ALL of the following:
    - Meet diagnostic criteria
    - Diagnostic injection gives >75% improvement during the anesthetic phase.
    - Subsequent SIJ injections are performed at the same site AND the injection provided consistent >50% relief AND consistent >50% improvement in ADLs for at least 3 (three) months.
    - Must be performed under Fluoro or CT guidance unless documented dye allergy or pregnancy
    - Limitations: No more than 4 (four) injection sessions per 12 (twelve) month rolling cycle
  - SIJ RFA is NOT considered reasonable and necessary

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CPT REVIEW

- 27278
  - Created in 2024 to replace 0775T
  - “Athrodesis SIJ, Percutaneous, without Transfixation device”
  - Supporting ICD-10 codes: see below
  - No National Coverage Determination
  - Novitas Supports
- 27279
  - “Arthrodesis SIJ, Percutaneous or MIS (indirect visualization) with image guidance, includes obtaining bone graft when performed, and placement of Transfixation device”
  - Supporting ICD-10 codes: see below

- ICD-10 Codes: M43.27, M43.28, M46.1, M51.17, M53.2X7, M53.2X8, M53.3, M53.87, M53.88, M99.14, S33.2XXA, S33.2XXD, S33.2XXS, S33.6XXA, S33.6XXD, S33.6XXS, S33.8XXA, S33.8XXD, S33.8XXS

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MEDICAL NECESSITY

- MIS fusion of the SIJ is considered medically necessary with ALL of the following are met:
  - Moderate to severe pain with functional impairment and pain >6mo despite intensive CMM
  - Typically unilateral pain located below the anatomical level of L5, localized over the SIJ
  - Positive Finger Fortin's test with negative testing over the L-spine, GTB, Coccyx, or other non-SIJ areas
  - 3 positive tests: FABER, Gaenslen's, Thigh Thrust, Compression, Distraction, Posterior Provocation
  - Absence of Somatoform disorder or Generalized pain (Fibromyalgia)
  - Diagnostics to include ALL: Imaging of the SIJs, Pelvis, Lumbar spine
  - >75% improvement with 2 diagnostic injections of different duration anesthetics with ability to perform the painful provocative maneuver
  - 1 trial of an IA SIJ injection

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27278 APPROACH

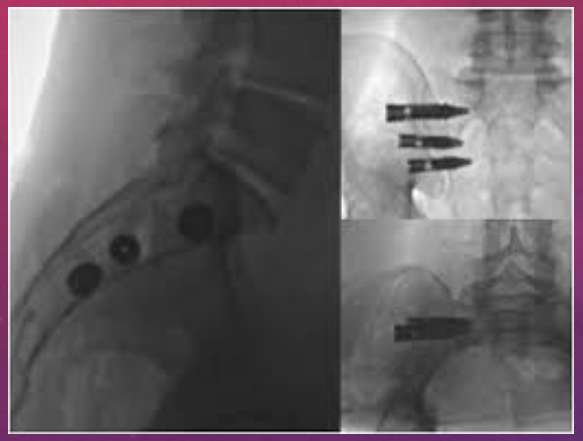
- Posterior
- Short Axis or Long Axis Approach
- Small incision followed by tissue dilators
- Rasps to decorticate the articular cartilage in preparation for arthrodesis
- Placement of the allograft
- Removal of instrumentation, wound irrigation, and multi-layer closure

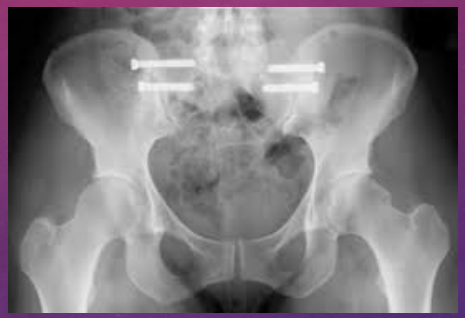
27278 APPROACH

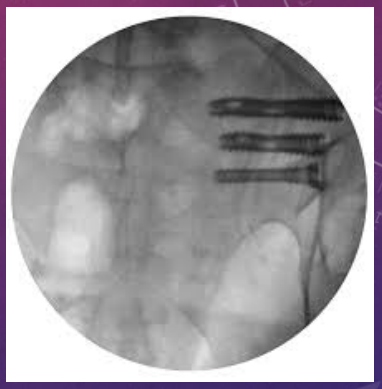
27279 APPROACH

- LATERAL
- - Transfixing dowels and screws. Titanium v 3D printed. Self-tapping. Self-Harvesting. Cannulated v Non-Cannulated. Fenestrated v Non-Fenestrated.
- - 1, 2, & 3 screw/dowel techniques
- PROS: most evidence behind this technique. Most taught and used in the surgical community.
- CONS: use of drill or impacting mallet. Not typically familiar to the interventionalist. General Anesthesia. Arterial injury with high risk for both morbidity and mortality. Concern for neural injury or breech into the neural foramen(s). More likely to use a two C-arm technique

27279 APPROACH



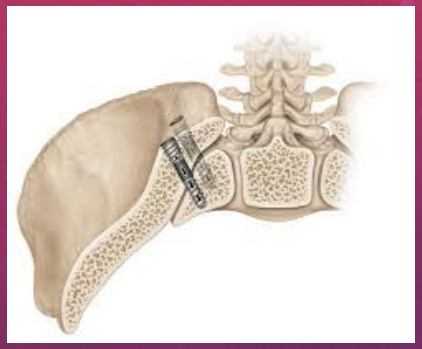


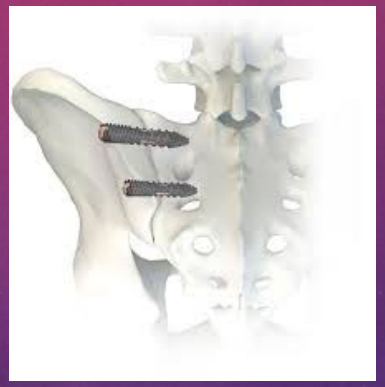


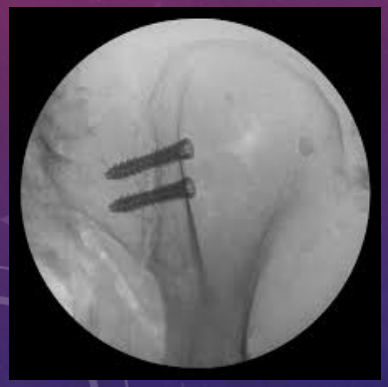
27279 APPROACH

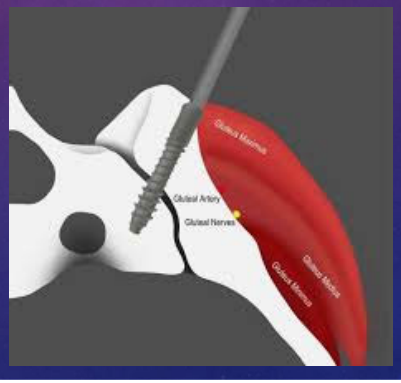
- OBLIQUE
- - Similar instrumentation and equipment set up as the lateral approach. Exclusively screws.
- PROS: nearly no risk for arterial injury. Easier to teach to the interventionalist given radiographic forte. Can be done under MAC/IV Sedation. Typically accomplished with 1 c-arm.
- CONS: longer post-op pain when compared to other approaches. Limited compelling data sets when compared to the lateral approach. Concern for neural injury or breech of the neural foramen(s).

27279 APPROACH









27279 APPROACH

- POSTERIOR INTRA-ARTICULAR: Short Axis
- - Most common posterior approach. Various devices have a metallic component which sits within the IA space that is packed with bone graft material while having deployable components that transfix themselves across the sacrum and ilium
- PROS: Easiest technique to teach. No risk for major vascular compromise. Nearly no risk for major neural injury. Short post-operative recovery time.
- CONS: Some degree of evolving data, many of which are company sponsored. Steinman pin can easily breech the cortex leading to an implant not within the IA space. Risk of subsidence in the osteoporotic patient. Shape of the joint on contralateral Y view may not allow device to sit within the IA joint space.
- POSTERIOR INTRA-ARTICULAR: Long Axis
- - Less common of the two approaches. Fewer device options
- PROS: Can accommodate for variously shaped joints
- CONS: Little to no data.

27279 APPROACH

27279 APPROACH

- POSTERIOR TRANS-ARTICULAR
- - Least used technique, but not newest. A medial to lateral approach used with screws entering into the sacrum first and placed in lateral trajectory crossing the SIJ and terminating in the ilium. Typically a 2-screw technique.
- PROS: Transfixation of the joint. No major risk for vascular or neural injury
- CONS: Least studied of all the techniques described today

SUMMARY

- SIJ Dysfunction – 10% - 26% of patient population
- Multiple etiologies and Multiple CMM treatment options
- History and Physical Exam are critical to honing in on this diagnosis
- CPT – 27278 and 27279. With or Without Transfixation
- Medical Necessity has a clear algorithm
- 27278 – one approach technique
- 27279 – four approach techniques
  - Each one with their own PROS and CONS that offer every clinician an opportunity to customize and rationalize an approach for each patient and each variously shaped SI Joint

QUESTIONS?

THANK YOU