Medical Policy
Axial Lumbosacral Interbody Fusion

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Policy Number: 404
BCBSA Reference Number: 7.01.130
NCD/LCD: NA

Related Policies
- Interspinous and Interlaminar Stabilization/Distraction Devices (Spacers), #584
- Interspinous Fixation - Fusion Devices, #436
- Total Facet Arthroplasty, #174
- Ultrasound Accelerated Fracture Healing Device, #497

Policy
Commercial Members: Managed Care (HMO and POS), PPO, and Indemnity
Medicare HMO BlueSM and Medicare PPO BlueSM Members

Axial lumbosacral interbody fusion (axial LIF) is considered INVESTIGATIONAL.

Prior Authorization Information

Inpatient
- For services described in this policy, precertification/preauthorization IS REQUIRED for all products if the procedure is performed inpatient.

Outpatient
- For services described in this policy, see below for products where prior authorization might be required if the procedure is performed outpatient.

<table>
<thead>
<tr>
<th>Outpatient</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Commercial Managed Care (HMO and POS)</td>
<td>This is not a covered service.</td>
</tr>
<tr>
<td>Commercial PPO and Indemnity</td>
<td>This is not a covered service.</td>
</tr>
<tr>
<td>Medicare HMO BlueSM</td>
<td>This is not a covered service.</td>
</tr>
<tr>
<td>Medicare PPO BlueSM</td>
<td>This is not a covered service.</td>
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</tbody>
</table>
**CPT Codes / HCPCS Codes / ICD Codes**

Inclusion or exclusion of a code does not constitute or imply member coverage or provider reimbursement. Please refer to the member’s contract benefits in effect at the time of service to determine coverage or non-coverage as it applies to an individual member.

Providers should report all services using the most up-to-date industry-standard procedure, revenue, and diagnosis codes, including modifiers where applicable.

The following codes are included below for informational purposes only; this is not an all-inclusive list.

The following CPT codes are considered investigational for **Commercial Members: Managed Care (HMO and POS), PPO, Indemnity, Medicare HMO Blue and Medicare PPO Blue:**

<table>
<thead>
<tr>
<th>CPT Codes</th>
<th>Description</th>
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<tbody>
<tr>
<td>22586</td>
<td>Arthrodesis, pre-sacral interbody technique, including disc space preparation, discectomy, with posterior instrumentation, with image guidance, includes bone graft when performed, L5-S1 interspace</td>
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</table>

**Description**

**Interbody Fusion**

Interbody fusion is a surgical procedure that fuses 2 adjacent vertebral bodies of the spine. Lumbar interbody fusion may be performed in patients with spinal stenosis and instability, spondylolisthesis, scoliosis, following a discectomy, or for adjacent-level disc disease.

**Axial Lumbosacral Interbody Fusion**

Axial lumbosacral interbody fusion (also called presacral, transsacral, or paracoccygeal interbody fusion) is a minimally invasive technique designed to provide anterior access to the L4-S1 disc spaces for interbody fusion while minimizing damage to muscular, ligamentous, neural, and vascular structures. It is performed under fluoroscopic guidance.

An advantage of axial lumbosacral interbody fusion is that it preserves the annulus and all paraspinal soft tissue structures. However, there is an increased need for fluoroscopy and an inability to address intracanal pathology or visualize the discectomy procedure directly. Complications of the axial approach may include perforation of the bowel and injury to blood vessels and/or nerves.

**Summary**

Axial lumbosacral interbody fusion (also called presacral, transsacral, or paracoccygeal interbody fusion) is a minimally invasive technique designed to provide anterior access to the L4-S1 disc spaces for interbody fusion while minimizing damage to muscular, ligamentous, neural, and vascular structures. It is performed under fluoroscopic guidance.

For individuals who have degenerative spine disease at the L4-S1 disc spaces who receive axial lumbosacral interbody fusion, the evidence includes a comparative systematic review of case series and a retrospective comparative study. Relevant outcomes are symptoms, functional outcomes, quality of life, and treatment-related morbidity. The systematic review found that fusion rates were higher following transforaminal lumbosacral interbody fusion than following axial lumbosacral interbody fusion, although this difference decreased with use of bone morphogenetic protein or pedicle screws. The findings of this systematic review were limited by the lack of prospective comparative studies and differences in how fusion rates were determined. Studies have suggested that complication rates may be increased with 2-level axial lumbosacral interbody fusion. Controlled trials with clinical outcome measures are needed to better define the benefits and risks of this procedure compared with treatment alternatives. The evidence is insufficient to determine the effects of the technology on health outcomes.
Policy History

<table>
<thead>
<tr>
<th>Date</th>
<th>Action</th>
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<tbody>
<tr>
<td>1/2019</td>
<td>Clarified coding information.</td>
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<tr>
<td>1/2018</td>
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<tr>
<td>5/2016</td>
<td>New references added from BCBSA National medical policy.</td>
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<tr>
<td>12/2015</td>
<td>Added coding language.</td>
</tr>
<tr>
<td>12/2014</td>
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<tr>
<td>2/2014</td>
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<tr>
<td>12/2012</td>
<td>Updated to add new CPT code 22586.</td>
</tr>
<tr>
<td>9/2012</td>
<td>Updated with New medical policy describing ongoing non-coverage.</td>
</tr>
<tr>
<td>1/2012</td>
<td>Reviewed at MPG – Neurology and Neurosurgery, no changes in coverage were made.</td>
</tr>
<tr>
<td>12/1/2011</td>
<td>New policy, effective 12/1/2011</td>
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Information Pertaining to All Blue Cross Blue Shield Medical Policies
Click on any of the following terms to access the relevant information:

Medical Policy Terms of Use
Managed Care Guidelines
Indemnity/PPO Guidelines
Clinical Exception Process
Medical Technology Assessment Guidelines

References