



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/Distractor 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**.

	Outpatient
Commercial Managed Care (HMO and POS)	This is not a covered service.
Commercial PPO and Indemnity	This is not a covered service.
Medicare HMO Blue SM	This is not a covered service.
Medicare PPO Blue SM	This is not a covered service.

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:

CPT Codes

CPT Codes	Description
22586	Arthrodesis, pre-sacral interbody technique, including disc space preparation, discectomy, with posterior instrumentation, with image guidance, includes bone graft when performed, L5-S1 interspace

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 that the technology results in an improvement in the net health outcome.

Policy History

Date	Action
6/2025	Annual policy review. References updated. Policy statements unchanged.
6/2024	Annual policy review. References updated. Policy statements unchanged.
6/2023	Annual policy review. Policy statements unchanged.
6/2022	Annual policy review. Description, summary, and references updated. Policy statements unchanged.
5/2021	BCBSA National medical policy review. Description, summary, and references updated. Policy statements unchanged.
6/2020	BCBSA National medical policy review. Description, summary and references updated. Policy statements unchanged.
5/2019	BCBSA National medical policy review. Description, summary and references updated. Policy statements unchanged.
1/2019	Clarified coding information.
1/2018	Clarified coding information.
5/2016	New references added from BCBSA National medical policy.
12/2015	Added coding language.
12/2014	New references added from BCBSA National medical policy.
2/2014	New references added from BCBSA National medical policy.
12/2012	Updated to add new CPT code 22586.
9/2012	Updated with New medical policy describing ongoing non-coverage. Information was transferred from medical policy 617, Minimally Invasive Lumbar Interbody Fusion.
1/2012	Reviewed at MPG – Neurology and Neurosurgery, no changes in coverage were made.
12/1/2011	New policy, effective 12/1/2011

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

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2. U.S. Food and Drug Administration. Premarket Notification [510(K)] Summary. TranS1 AxiaLIF II System. 2008; https://www.accessdata.fda.gov/cdrh_docs/pdf7/K073643.pdf. Accessed March 27, 2025.
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12. North American Spine Society. Diagnosis and treatment of degenerative lumbar spondylolisthesis. 2nd Ed. 2014; <https://www.spine.org/Documents/ResearchClinicalCare/Guidelines/Spondylolisthesis.pdf>. Accessed March 28, 2025.
13. National Institute for Health and Care Excellence (NICE). Transaxial interbody lumbosacral fusion for severe chronic low back pain [IPG620]. 2018; <https://www.nice.org.uk/guidance/ipg620>. Accessed March 28, 2025.