

Axial Lumbosacral Interbody Fusion

Policy # 00236

Original Effective Date: 04/15/2009

Current Effective Date: 09/01/2026

Applies to all products administered or underwritten by Blue Cross and Blue Shield of Louisiana and its subsidiary, HMO Louisiana, Inc. (collectively referred to as the "Company"), unless otherwise provided in the applicable contract. Medical technology is constantly evolving, and we reserve the right to review and update Medical Policy periodically.

Investigational or experimental services are not covered. This includes any drug, device, procedure, or service provided under the investigational arm of a clinical trial or clinical study. These services are excluded from coverage under benefits.

Note: Interspinous and Interlaminar Stabilization Distraction Devices (Spacers) is addressed separately in medical policy 00221.

Note: Interspinous Fixation (Fusion) Devices is addressed separately in medical policy 00679.

Services Are Considered Investigational

Coverage is not available for investigational medical treatments or procedures, drugs, devices or biological products.

Based on review of available data, the Company considers axial lumbosacral interbody fusion to be **investigational**.*

Background/Overview

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.

Policy # 00236

Original Effective Date: 04/15/2009

Current Effective Date: 09/01/2026

FDA or Other Governmental Regulatory Approval

U.S. Food and Drug Administration (FDA)

The U.S. FDA has cleared for marketing multiple anterior spinal intervertebral body fixation device systems through the 510(k) pathway (See Table 1). The systems are not intended to treat severe scoliosis, severe spondylolisthesis (grades 3 and 4), tumor, or trauma. The devices are also not meant for vertebral compression fractures or any other condition in which the mechanical integrity of the vertebral body is compromised. Their usage is limited to anterior supplemental fixation of the lumbar spine at the L5-S1 or L4-S1 disc spaces in conjunction with a legally marketed facet or pedicle screw systems. FDA product code: KWQ.

Table 1. Select Anterior Spinal Intervertebral Body Fixation Orthoses Cleared by U.S. Food and Drug Administration

Orthotic	Manufacturer	Date Cleared	510(k) No.
TranS1 [®] † AxiaLIF [™] † System For patients requiring fusion to treat pseudoarthrosis, unsuccessful previous fusion, spinal stenosis, spondylolisthesis (grade 1 or 2), or degenerative disc disease limited to anterior supplemental fixation of L5-S1 in conjunction with legally marketed pedicle screws	TranS1	12/04	K040426
TranS1 [®] † AxiaLIF [™] † System Indication modified to include facet screws	TranS1	06/05	K050965
TranS1 [®] † AxiaLIF [®] † II System For patients requiring fusion to treat pseudoarthrosis, unsuccessful previous fusion, spinal stenosis, spondylolisthesis (grade 1 or 2), or degenerative disc disease limited to anterior supplemental fixation of L4-S1 in conjunction with legally marketed facet and pedicle screws	TranS1	04/08	K073643
TranS1 [®] † AxiaLIF [®] † 2L System Indication unchanged, marketed with branded bone morphogenetic protein	TranS1	01/10	K092124
TranS1 [®] † AxiaLIF [®] † Plus System	TranS1	03/11	K102334

Axial Lumbosacral Interbody Fusion

Policy # 00236

Original Effective Date: 04/15/2009

Current Effective Date: 09/01/2026

• Intended to provide anterior stabilization of the L5-S1 or L4-S1 spinal segment (s) as an adjunct to spinal fusion • This device's instruments are used for independently distracting the L5-S1 or L4-S1 vertebral bodies and inserting bone graft material (Dt3M, autograft or autologous blood) into the disc space. • Use limited to anterior supplemental fixation of the lumbar spine at L5-S1 or L4-S1 in conjunction with use of legally marketed facet screw or pedicle screw systems at the same levels that are treated with AxiaLIF			
--	--	--	--

Adapted from the U.S. Food and Drug Administration (2007, 2008).

FDA: Food and Drug Administration.

Rationale/Source

This medical policy was developed through consideration of peer-reviewed medical literature generally recognized by the relevant medical community, U.S. Food and Drug Administration approval status, nationally accepted standards of medical practice and accepted standards of medical practice in this community, technology evaluation centers, reference to regulations, other plan medical policies, and accredited national guidelines.

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.

Summary of Evidence

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

Axial Lumbosacral Interbody Fusion

Policy # 00236

Original Effective Date: 04/15/2009

Current Effective Date: 09/01/2026

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.

Supplemental Information

The purpose of the following information is to provide reference material. Inclusion does not imply endorsement or alignment with the evidence review conclusions.

Clinical Input from Physician Specialty Societies and Academic Medical Centers

While the various physician specialty societies and academic medical centers may collaborate with and make recommendations during this process, through the provision of appropriate reviewers, input received does not represent an endorsement or position statement by the physician specialty societies or academic medical centers, unless otherwise noted.

2011 Input

In response to requests, input was received from 2 specialty medical societies and 3 academic medical centers while this policy was under review in 2011. Input considered axial lumbosacral interbody fusion to be investigational.

Practice Guidelines and Position Statements

Guidelines or position statements will be considered for inclusion in 'Supplemental Information' if they were issued by, or jointly by, a US professional society, an international society with US representation, or National Institute for Health and Care Excellence (NICE). Priority will be given to guidelines that are informed by a systematic review, include strength of evidence ratings, and include a description of management of conflict of interest.

North American Spine Society

In 2014, the North American Spine Society published guidelines on the treatment of degenerative spondylolisthesis. The North American Spine Society gave a grade B recommendation for surgical decompression with fusion in patients with spinal stenosis and spondylolisthesis. The guidelines discussed posterolateral fusion, 360° fusion, and minimally invasive fusion; it did not address axial lumbosacral interbody fusion.

National Institute for Health and Care Excellence

In July 2018, NICE provided evidence-based recommendations on transaxial interbody lumbosacral fusion for low back pain in adults. The recommendation, based on a literature review conducted in December 2017, states, "Evidence on the safety of transaxial interbody lumbosacral fusion for severe chronic low back pain shows that there are serious but well-recognized complications. Evidence on efficacy is adequate in quality and quantity. Therefore, this procedure may be used provided that standard arrangements are in place for clinical governance, consent and audit. This procedure should only be done by a surgeon with specific training in the procedure, who should carry out their initial procedures with an experienced mentor."

Axial Lumbosacral Interbody Fusion

Policy # 00236

Original Effective Date: 04/15/2009

Current Effective Date: 09/01/2026

U.S. Preventive Services Task Force Recommendations

Not applicable.

Medicare National Coverage

There is no national coverage determination. In the absence of a national coverage determination, coverage decisions are left to the discretion of local Medicare carriers.

Ongoing and Unpublished Clinical Trials

A search of ClinicalTrials.gov in March 2026 did not identify any ongoing trials that would influence this review.

References

1. U.S. Food and Drug Administration. Premarket Notification [510(K)] Summary. TranS1 AxiaLIF Fixation System. 2007; https://www.accessdata.fda.gov/cdrh_docs/pdf7/K073514.pdf.
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.
3. Shen FH, Samartzis D, Khanna AJ, et al. Minimally invasive techniques for lumbar interbody fusions. *Orthop Clin North Am*. Jul 2007; 38(3): 373-86; abstract vi. PMID 17629985
4. Schroeder GD, Kepler CK, Millhouse PW, et al. L5/S1 Fusion Rates in Degenerative Spine Surgery: A Systematic Review Comparing ALIF, TLIF, and Axial Interbody Arthrodesis. *Clin Spine Surg*. May 2016; 29(4): 150-5. PMID 26841206
5. Whang PG, Sasso RC, Patel VV, et al. Comparison of axial and anterior interbody fusions of the L5-S1 segment: a retrospective cohort analysis. *J Spinal Disord Tech*. Dec 2013; 26(8): 437-43. PMID 24196923
6. Tobler WD, Gerszten PC, Bradley WD, et al. Minimally invasive axial presacral L5-S1 interbody fusion: two-year clinical and radiographic outcomes. *Spine (Phila Pa 1976)*. Sep 15 2011; 36(20): E1296-301. PMID 21494201
7. Zeilstra DJ, Miller LE, Block JE. Axial lumbar interbody fusion: a 6-year single-center experience. *Clin Interv Aging*. 2013; 8: 1063-9. PMID 23976846
8. Gerszten PC, Tobler W, Raley TJ, et al. Axial presacral lumbar interbody fusion and percutaneous posterior fixation for stabilization of lumbosacral isthmic spondylolisthesis. *J Spinal Disord Tech*. Apr 2012; 25(2): E36-40. PMID 21964453
9. Marchi L, Oliveira L, Coutinho E, et al. Results and complications after 2-level axial lumbar interbody fusion with a minimum 2-year follow-up. *J Neurosurg Spine*. Sep 2012; 17(3): 187-92. PMID 22803626
10. Gundanna MI, Miller LE, Block JE. Complications with axial presacral lumbar interbody fusion: A 5-year postmarketing surveillance experience. *SAS J*. 2011; 5(3): 90-4. PMID 25802673
11. Lindley EM, McCullough MA, Burger EL, et al. Complications of axial lumbar interbody fusion. *J Neurosurg Spine*. Sep 2011; 15(3): 273-9. PMID 21599448
12. North American Spine Society. Diagnosis and treatment of degenerative lumbar spondylolisthesis. 2nd Ed. 2014; <https://www.spine.org/Documents/ResearchClinicalCare/Guidelines/Spondylolisthesis.pdf>.

Axial Lumbosacral Interbody Fusion

Policy # 00236

Original Effective Date: 04/15/2009

Current Effective Date: 09/01/2026

13. National Institute for Health and Care Excellence (NICE). Transaxial interbody lumbosacral fusion for severe chronic low back pain [HTG478]. 2018; <https://www.nice.org.uk/guidance/htg478>.

Policy History

Original Effective Date: 04/15/2009

Current Effective Date: 09/01/2026

04/02/2009	Medical Director review
04/15/2009	Medical Policy Committee approval. New policy.
04/08/2010	Medical Director review
04/21/2010	Medical Policy Committee approval. No change to coverage.
04/07/2011	Medical Policy Committee review
04/13/2011	Medical Policy Implementation Committee approval. No change to coverage.
04/12/2012	Medical Policy Committee review
04/25/2012	Medical Policy Implementation Committee approval. No change to coverage. References added.
04/04/2013	Medical Policy Committee review
04/24/2013	Medical Policy Implementation Committee approval. Title changed. Entire policy redone.
03/06/2014	Medical Policy Committee review
03/19/2014	Medical Policy Implementation Committee approval. Coverage eligibility unchanged.
03/05/2015	Medical Policy Committee review
03/20/2015	Medical Policy Implementation Committee approval. Coverage eligibility unchanged.
06/02/2016	Medical Policy Committee review
06/20/2016	Medical Policy Implementation Committee approval. Coverage eligibility unchanged.
01/01/2017	Coding update: Removing ICD-9 Diagnosis Codes
06/01/2017	Medical Policy Committee review
06/21/2017	Medical Policy Implementation Committee approval. Coverage eligibility unchanged.
06/07/2018	Medical Policy Committee review
06/20/2018	Medical Policy Implementation Committee approval. Coverage eligibility unchanged.
06/06/2019	Medical Policy Committee review
06/19/2019	Medical Policy Implementation Committee approval. Coverage eligibility unchanged.
08/06/2020	Medical Policy Committee review
08/12/2020	Medical Policy Implementation Committee approval. Coverage eligibility unchanged.
08/05/2021	Medical Policy Committee review

Axial Lumbosacral Interbody Fusion

Policy # 00236

Original Effective Date: 04/15/2009

Current Effective Date: 09/01/2026

08/11/2021 Medical Policy Implementation Committee approval. Coverage eligibility unchanged.

08/04/2022 Medical Policy Committee review

08/10/2022 Medical Policy Implementation Committee approval. Coverage eligibility unchanged.

08/03/2023 Medical Policy Committee review

08/09/2023 Medical Policy Implementation Committee approval. Policy extensively rewritten. Title changed to Axial Lumbar Interbody Fusion.

08/01/2024 Medical Policy Committee review

08/14/2024 Medical Policy Implementation Committee approval. Body of policy extensively rewritten. Coverage still investigational. Title changed from “Axial Lumbar Interbody Fusion” to “Axial Lumbosacral Interbody Fusion.”

08/07/2025 Medical Policy Committee review

08/13/2025 Medical Policy Implementation Committee approval. Coverage eligibility unchanged.

08/06/2026 Medical Policy Committee review

08/12/2026 Medical Policy Implementation Committee review

08/20/2026 Medical Quality Management Committee approval. Coverage eligibility unchanged.

Next Scheduled Review Date: 08/2027

Coding

The five character codes included in the Louisiana Blue Medical Policy Coverage Guidelines are obtained from Current Procedural Terminology (CPT®)†, copyright 2025 by the American Medical Association (AMA). CPT is developed by the AMA as a listing of descriptive terms and five character identifying codes and modifiers for reporting medical services and procedures performed by physician.

The responsibility for the content of Louisiana Blue Medical Policy Coverage Guidelines is with Louisiana Blue and no endorsement by the AMA is intended or should be implied. The AMA disclaims responsibility for any consequences or liability attributable or related to any use, nonuse or interpretation of information contained in Louisiana Blue Medical Policy Coverage Guidelines. Fee schedules, relative value units, conversion factors and/or related components are not assigned by the AMA, are not part of CPT, and the AMA is not recommending their use. The AMA does not directly or indirectly practice medicine or dispense medical services. The AMA assumes no liability for data contained or not contained herein. Any use of CPT outside of Louisiana Blue Medical Policy Coverage Guidelines should refer to the most current Current Procedural Terminology which contains the complete and most current listing of CPT codes and descriptive terms. Applicable FARS/DFARS apply.

CPT is a registered trademark of the American Medical Association.

Axial Lumbosacral Interbody Fusion

Policy # 00236

Original Effective Date: 04/15/2009

Current Effective Date: 09/01/2026

Codes used to identify services associated with this policy may include (but may not be limited to) the following:

Code Type	Code
CPT	22586, 22899
HCPCS	No codes
ICD-10 Diagnosis	All related diagnoses

*Investigational – A medical treatment, procedure, drug, device, or biological product is Investigational if the effectiveness has not been clearly tested and it has not been incorporated into standard medical practice. Any determination we make that a medical treatment, procedure, drug, device, or biological product is Investigational will be based on a consideration of the following:

- A. Whether the medical treatment, procedure, drug, device, or biological product can be lawfully marketed without approval of the U.S. Food and Drug Administration (FDA) and whether such approval has been granted at the time the medical treatment, procedure, drug, device, or biological product is sought to be furnished; or
- B. Whether the medical treatment, procedure, drug, device, or biological product requires further studies or clinical trials to determine its maximum tolerated dose, toxicity, safety, effectiveness, or effectiveness as compared with the standard means of treatment or diagnosis, must improve health outcomes, according to the consensus of opinion among experts as shown by reliable evidence, including:
 1. Consultation with technology evaluation center(s);
 2. Credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community; or
 3. Reference to federal regulations.

‡ Indicated trademarks are the registered trademarks of their respective owners.

NOTICE: If the Patient's health insurance contract contains language that differs from the BCBSLA Medical Policy definition noted above, the definition in the health insurance contract will be relied upon for specific coverage determinations.

NOTICE: Medical Policies are scientific based opinions, provided solely for coverage and informational purposes. Medical Policies should not be construed to suggest that the Company recommends, advocates, requires, encourages, or discourages any particular treatment, procedure, or service, or any particular course of treatment, procedure, or service.

NOTICE: Federal and State law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over Medical Policy and must be considered first in determining eligibility for coverage.

NOTICE: If an authorization for an ongoing course of treatment has been provided to a member and the member changes from one health plan to another health plan (e.g., a member moves from carrier A to Louisiana Blue), Louisiana Blue may honor the previous health plan's authorization for

Axial Lumbosacral Interbody Fusion

Policy # 00236

Original Effective Date: 04/15/2009

Current Effective Date: 09/01/2026

the same service under the same type of in-network benefit for a 90-day transition period. Documentation of the authorization for the ongoing course of treatment from the previous health plan must be provided to us by the member or their provider and the services provided for the course of treatment must otherwise be a covered service under the Louisiana Blue health plan. This provision does not apply to medications covered under the plan's pharmacy benefit.