Clinical Policy: Lysis of Epidural Lesions

Reference Number: CP.MP.116
Last Review Date: 05/18

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

Epidural adhesiolysis, also known as epidural neuroplasty, lysis of epidural adhesions, or caudal neuroplasty, is a minimally invasive surgery for patients with chronic back pain associated with epidural fibrosis or adhesions. Adhesions are commonly caused by scarring after spinal interventions, and are associated with post-laminectomy syndrome or failed back surgery syndrome. Adhesions may also be caused by normal aging of the spine and spinal disorders such as lumbar disc herniation and spinal stenosis.

Policy/Criteria

I. It is the policy of health plans affiliated with Centene Corporation® that lysis of epidural lesions, including percutaneous epidural adhesiolysis and endoscopic epidural adhesiolysis, with or without use of an indwelling epidural Racz catheter, is considered **investigational.** This treatment continues to be evaluated in clinical studies, however current medical literature does not support its efficacy.

Background

Percutaneous lysis of epidural adhesions with epidural injections of hypertonic saline, in conjunction with steroids and analgesics or hyaluronidase, is an interventional pain management technique that has been investigated as a treatment option in managing chronic intractable low back pain caused by extensive peridural scarring. In theory, the use of hypertonic saline results in a mechanical disruption of the adhesions. Adhesions may also be disrupted by the manipulation of the catheter at the time of the injection. The hypertonic saline may also function to reduce edema within previously scarred and/or inflamed nerves. Hyaluronidase may be added to the injectate to further the penetration of the drugs into the scar tissue.

Spinal endoscopy has been used to guide the lysis of adhesions. Prior to use of endoscopy, adhesions can be identified as non-filling lesions on fluoroscopy. Using endoscopy guidance, a flexible fiberoptic catheter is inserted into the sacral hiatus, providing 3-D visualization to steer the catheter toward the adhesions, to more precisely place the injectate in the epidural space and onto the nerve root. Various protocols for lysis have been described; in some situations the catheter may remain in place for several days for serial treatment sessions.

Evidence for percutaneous adhesiolysis

Controlled trials have found short-term positive effects of percutaneous epidural adhesiolysis in patients with chronic, refractory back pain and lower extremity pain.[1-5] However, these studies are limited by methodological limitations including somewhat high attrition rates, insufficient blinding and inadequate statistical power to establish safety. Furthermore, many of the studies were conducted at the same interventional pain management center, which could limit the representativeness of the results obtained by the researchers.[1]

Evidence for endoscopic adhesiolysis
Research conducted on endoscopic epidural adhesiolysis is generally positive, with significant improvements in pain with endoscopic adhesiolysis compared to control groups.[6-9] The studies conducted thus far have been largely observational, however.[6-9] In a 2012 randomized controlled trial (RCT) conducted by Manchikanti et al., endoscopic adhesiolysis was found to significantly improve pain at three, six, and 12 months in patients who had failed conservative treatment for low back pain, compared to endoscopy alone.[10] A systematic review of endoscopic adhesiolysis was conducted by Helm et al. and included three observational studies and one RCT.[11] The systematic review concluded that there is fair quality evidence of positive effects, citing paucity of literature as a limitation.[11]

Guideline Recommendations
A 2013 Guideline Update by the American Society of Interventional Pain Physicians rates the quality of evidence for lumbar percutaneous adhesiolysis as fair for managing chronic low back and lower extremity pain due to post surgery syndrome and spinal stenosis.[12] This is due largely to limited number of high quality RCTs assessing the intervention. The guideline update does not address endoscopic adhesiolysis due to limited evidence.[12] Additionally, the UK National Institute for Clinical Excellence (NICE) has concluded that "current evidence on therapeutic endoscopic division of epidural adhesions is limited to some evidence of short-term efficacy, and there are significant safety concerns. Therefore this procedure should only be used with special arrangements for clinical governance, consent and audit or research."[13]

Given the limited high quality research conducted on percutaneous and endoscopic adhesiolysis, these procedures are considered investigational.

Coding Implications
This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2018, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

CPT® Codes	Description
62263	Percutaneous lysis of epidural adhesions using solution injection (eg, hypertonic saline, enzyme) or mechanical means (e.g., catheter) including radiologic localization (includes contrast when administered), multiple adhesiolysis sessions; 2 or more days
62264	Percutaneous lysis of epidural adhesions using solution injection (eg, hypertonic saline, enzyme) or mechanical means (e.g., catheter) including radiologic localization (includes contrast when administered), multiple adhesiolysis sessions; 1 day

ICD-10-CM Diagnosis Codes

ICD-10-CM Code	Description
G96.12	Meningeal adhesions (cerebral) (spinal)
G96.19	Other disorders of meninges, not elsewhere classified
M48.00-M48.08	Spinal Stenosis
M50.00-M50.03	Cervical disc disorder with myelopathy
M50.20-M50.23	Other cervical disc displacement
M50.30-M50.33	Other cervical disc degeneration
M51.04-M51.06	Thoracic, thoracolumbar, and lumbosacral intervertebral disc disorders with myelopathy
M51.24-M51.27	Other thoracic, thoracolumbar, and lumbosacral intervertebral disc displacement
M51.34-M51.37	Other thoracic, thoracolumbar, and lumbosacral intervertebral disc degeneration
M96.1	Postlaminectomy syndrome, not elsewhere classified

Reviews, Revisions, and Approvals	Date	Approval Date
Policy split from CP.MP.63 Pain Management Procedures. Background information added.	07/16	07/16
References reviewed & updated.	06/17	07/17
References reviewed and updated. Codes reviewed and updated	04/18	05/18

References

1. Heavner JE, Racz GB, Raj P. Percutaneous epidural neuroplasty: prospective evaluation of 0.9% NaCl versus 10% NaCl with or without hyaluronidase. Reg Anesth Pain Med. 1999;24(3):202-207.
2. Veihelmann A, Devens C, Trouillier H, et al. . Epidural neuroplasty versus physiotherapy to relieve pain in patients with sciatica: a prospective randomized blinded clinical trial. J Orthop Sci. 2006;11(4):365-369.
3. Manchikanti L, Rivera JJ, Pampati V, et al. One day lumbar epidural adhesiolysis and hypertonic saline neurolysis in treatment of chronic low back pain: A randomized, double-blind trial. Pain Physician. 2004;7(2):177-186.
4. Manchikanti L, Singh V, Cash KA, Pampati V. Assessment of effectiveness of percutaneous adhesiolysis and caudal epidural injections in managing post lumbar surgery syndrome: 2-year follow-up of a randomized, controlled trial. J Pain Res. 2012;5:597-608.
5. Richardson J, McGurgan P, Cheema S, et al. . Spinal endoscopy in chronic low back pain with radiculopathy. A prospective case series. Anaesthesia. 2001;56(5):454-460.
6. Geurts JW, Kallewaard JW, Richardson J, Groen GJ. Targeted methylprednisolone acetate/hyaluronidase/clonidine injection after diagnostic epiduroscopy for chronic sciatica: a prospective, 1-year follow-up study. Reg Anesth Pain Med. 2002;27(4):343-352.
7. Donato AD, Fontana C, Pinto R, et al. . The effectiveness of endoscopic epidurolysis in treatment of degenerative chronic low back pain: a prospective analysis and follow-up at 48 months. Acta Neurochir Suppl. 2011;108:67-73.

8. Manchikanti L, Boswell MV, Rivera JJ, et al. A randomized, controlled trial of spinal endoscopic adhesiolysis in chronic refractory low back and lower extremity pain [ISRCTN 16558617]. BMC Anesthesiol. 2005;5:10.
9. Helm S, Hayek SM, Colson J, et al. . Spinal endoscopic adhesiolysis in post lumbar surgery syndrome: an update of assessment of the evidence. Pain Physician. 2013;16(2 Suppl):SE125-150.
10. Manchikanti L, Abdi S, Atluri S, et al. ASIPP-IPM. An update of comprehensive evidence-based guidelines for interventional techniques in chronic spinal pain. Part II: guidance and recommendations. Pain Physician. 2013;16(2 Suppl):S49-283.
11. National Institute for Clinical Evidence. Interventional procedure guidance IPG333: Therapeutic endoscopic division of epidural adhesions. February 2010. Accessed 0424/18.
12. Rapcan R, Kocan L, Mláka J, et al. A Randomized, Multicenter, Double-Blind, Parallel Pilot Study Assessing the Effect of Mechanical Adhesiolysis vs Adhesiolysis with Corticosteroid and Hyaluronidase Administration into the Epidural Space During Epiduroscopy. Pain Med. 2018 Mar 23. doi: 10.1093/pm/pnx328.
13. Choi EJ, Yoo YJ, Lee PB, et al. A Retrospective Study to Evaluate the Effect of Concentration of Hypertonic Saline on Efficacy and Safety of Epidural Adhesiolysis. Anesth Analg. 2017 Jun;124(6):2021-2029. doi: 10.1213/ANE.0000000000001925.
14. Tuijp SJ, Van Zundert J, De Vooght P, et al. Does the Use of Epiduroscopic Lysis of Adhesions Reduce the Need for Spinal Cord Stimulation in Failed Back Surgery Syndrome? A Short-Term Pilot Study. Pain Pract. 2018 Jan 18. doi: 10.1111/papr.12681 .

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

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Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at http://www.cms.gov for additional information.