# Clinical Policy: Lysis of Epidural Lesions

Reference Number: WNC.CP.305 Coding Implications
Last Review Date: 08/25 Revision Log

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

**Note:** 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.

## Description[1]

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[1]

**I.** It is the policy of WellCare of North Carolina® that current medical literature does not support the efficacy of lysis of epidural lesions, including percutaneous epidural adhesiolysis and endoscopic epidural adhesiolysis, with or without use of an indwelling epidural Racz catheter.:

## Background[1]

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. To provide 3-D visualization using endoscopy guidance, a flexible fiberoptic catheter is inserted into the sacral hiatus to steer the catheter toward the adhesions allowing the practitioner the ability 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]

A Hayes review of six randomized controlled trials (RCTs) with search data through September 7, 2018 was completed for percutaneous epidural adhesiolysis treatment for adults with chronic low back pain (CLBP) unresponsive to other treatments.[6] This review showed a small body of low-quality evidence, suggesting that percutaneous adhesiolysis may cause improvement in patients with CLBP who have failed conservative treatment.[6] Hayes states that "while the evidence suggests potential short- and intermediate-term efficacy of this procedure in patients with CLBP, whether or not epidural adhesions are the actual source of the pain in these patients has been debated, and long-term outcomes remain to be determined in well-designed trials."[6] Additionally, there has been a lack of RCTs published in the past five years, and there are currently no registered clinical studies researching percutaneous adhesiolysis.[6]

***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.[7-10] The studies conducted thus far have been largely observational, however.[7-10] In a 2012 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.[11] A systematic review of endoscopic adhesiolysis was conducted by Helm et al. and included three observational studies and one RCT.[12] The systematic review concluded that there is fair quality evidence of positive effects, citing paucity of literature as a limitation.[12]

***Guideline Recommendations***

***American Society of Interventional Pain Physicians (ASIPP)***

A 2021 update of epidural interventions from guidelines published in 2013 by the American Society of Interventional Pain Physicians now rates the quality of evidence for percutaneous adhesiolysis as moderate to strong for managing chronic low back and lower extremity pain due to disc herniation and spinal stenosis and strong for post-surgery syndrome after failure of conservative treatment and fluoroscopically guided epidural injections.[13] The limitation of this guideline update continues to be a paucity of high quality RCTs assessing the intervention.[13] The guideline update does not address endoscopic adhesiolysis.

***National Institute for Health and Care Excellence (NICE)***
In a 2010 statement, the UK National Institute for Clinical Excellence (NICE) concluded, "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."[12]

## 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 2025, 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 (e.g., 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 (e.g., hypertonic saline, enzyme) or mechanical means (e.g., catheter) including radiologic localization (includes contrast when administered), multiple adhesiolysis sessions; 1 day |

| Reviews, Revisions, and Approvals | Reviewed Date | Approval Date |
|---|---|---|
| Original approval date | 08/25 | 08/25 |

**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 to 207. doi:10.1016/s1098-7339(99)90128-1
2. Veihelmann A, Devens C, Trouillier H, Birkenmaier C, Gerdesmeyer L, Refior HJ. Epidural neuroplasty versus physiotherapy to relieve pain in patients with sciatica: a prospective randomized blinded clinical trial. J Orthop Sci. 2006;11(4):365 to 369. doi:10.1007/s00776-006-1032-y
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 to 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 to 608. doi:10.2147/JPR.S38999
5. Richardson J, McGurgan P, Cheema S, Prasad R, Gupta S. Spinal endoscopy in chronic low back pain with radiculopathy. A prospective case series. Anaesthesia. 2001;56(5):454 to 460. doi:10.1046/j.1365-2044.2001.01524-3.x
6. Health Technology Assessment. Percutaneous epidural adhesiolysis for chronic low back pain. Hayes. www.hayesinc.com. Published September 27, 2018 (annual review October 24, 2022). Accessed March 18, 2025.
7. 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 to 352. doi:10.1053/rapm.2002.27175
8. Donato AD, Fontana C, Pinto R, Beltrutti D, Pinto G. 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 to 73. doi:10.1007/978-3-211-99370-5_11
9. Manchikanti L, Boswell MV, Rivera JJ, et al. [ISRCTN 16558617] A randomized, controlled trial of spinal endoscopic adhesiolysis in chronic refractory low back and lower extremity pain. BMC Anesthesiol. 2005;5:10. Published 2005 Jul 6. doi:10.1186/1471-2253-5-10
10. 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 to SE150.
11. Manchikanti L, Abdi S, Atluri S, et al. 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 to S283.
12. National Institute for Health and Care Excellence. Therapeutic endoscopic division of epidural adhesions. Interventional procedures guidance [IPG333]. https://www.nice.org.uk/guidance/ipg333. Published February 24, 2010. Accessed March 18, 2025
13. Manchikanti L, Knezevic NN, Navani A, et al. Epidural Interventions in the Management of Chronic Spinal Pain: American Society of Interventional Pain Physicians (ASIPP) Comprehensive Evidence-Based Guidelines. Pain Physician. 2021;24(S1):S27 to S208.
14. Rapčan R, Kočan 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;19(7):1436 to 1444. doi:10.1093/pm/pnx328
15. Choi EJ, Yoo YJ, Lee PB, Kim YC, Lee SC, Moon JY. A Retrospective Study to Evaluate the Effect of Concentration of Hypertonic Saline on Efficacy and Safety of Epidural Adhesiolysis. Anesth Analg. 2017;124(6):2021 to 2029. doi:10.1213/ANE.0000000000001925
16. 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;18(7):839 to 844. doi:10.1111/papr.12681.

**North Carolina Guidance**

*Eligibility Requirements*

1. An eligible beneficiary shall be enrolled in the NC Medicaid Program (Medicaid is NC Medicaid program, unless context clearly indicates otherwise);
2. Provider(s) shall verify each Medicaid beneficiary's eligibility each time a service is rendered.
3. The Medicaid beneficiary may have service restrictions due to their eligibility category that would make them ineligible for this service.

*EPSDT Special Provision: Exception to Policy Limitations for a Medicaid Beneficiary under 21 Years of Age*

- 42 U.S.C. § 1396d(r) [1905(r) of the Social Security Act]

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that requires the state Medicaid agency to cover services, products, or procedures for Medicaid beneficiary under 21 years of age if the service is medically necessary health care to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination (includes any evaluation by a physician or other licensed practitioner).

This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his or her health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

Medically necessary services will be provided in the most economic mode, as long as the treatment made available is similarly efficacious to the service requested by the beneficiary's physician, therapist, or other licensed practitioner; the determination process does not delay the delivery of the needed service; and the determination does not limit the beneficiary's right to a free choice of providers.

EPSDT does not require the state Medicaid agency to provide any service, product, or procedure:

**I.** that is unsafe, ineffective, or experimental or investigational.

**II.** that is not medical in nature or not generally recognized as an accepted method of medical practice or treatment.

Service limitations on scope, amount, duration, frequency, location of service, and other specific criteria described in clinical coverage policies may be exceeded or may not apply as long as the provider's documentation shows that the requested service is medically necessary "to correct or ameliorate a defect, physical or mental illness, or a condition" [health problem]; that is, provider documentation shows how the service, product, or procedure meets all EPSDT criteria, including to correct or improve or maintain the beneficiary's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

**EPSDT and Prior Approval Requirements**

- If the service, product, or procedure requires prior approval, the fact that the beneficiary is under 21 years of age does NOT eliminate the requirement for prior approval.
- **IMPORTANT ADDITIONAL INFORMATION** about EPSDT and prior approval is found in the *NCTracks Provider Claims and Billing Assistance Guide*, and on the EPSDT provider page. The Web addresses are specified below:

*NCTracks Provider Claims and Billing Assistance Guide*:
https://www.nctracks.nc.gov/content/public/providers/provider-manuals.html
*EPSDT provider page*: https://medicaid.ncdhhs.gov/

*Provider(s) Eligible to Bill for the Procedure, Product, or Service*
To be eligible to bill for the procedure, product, or service related to this policy, the provider(s) shall:

i. meet Medicaid qualifications for participation;
ii. have a current and signed Department of Health and Human Services (DHHS) Provider Administrative Participation Agreement; and
iii. bill only for procedures, products, and services that are within the scope of their clinical practice, as defined by the appropriate licensing entity.

*Compliance*
Provider(s) shall comply with the following in effect at the time the service is rendered:

**A.** All applicable agreements, federal, state, and local laws and regulations including the Health Insurance Portability and Accountability Act (HIPAA) and record retention requirements; and
**B.** All NC Medicaid's clinical (medical) coverage policies, guidelines, policies, provider manuals, implementation updates, and bulletins published by the Centers for Medicare and Medicaid Services (CMS), DHHS, DHHS division(s) or fiscal contractor(s).

*Claims-Related Information*
Provider(s) shall comply with the NC Tracks Provider Claims and Billing Assistance Guide, Medicaid bulletins, fee schedules, NC Medicaid's clinical coverage policies and any other relevant documents for specific coverage and reimbursement for Medicaid:

- Claim Type - as applicable to the service provided:
  Professional (CMS-1500/837P transaction)
  Institutional (UB-04/837I transaction)
  Unless directed otherwise, Institutional Claims must be billed according to the National Uniform Billing Guidelines. All claims must comply with National Coding Guidelines.
- International Classification of Diseases and Related Health Problems, Tenth Revisions, Clinical Modification (ICD-10-CM) and Procedural Coding System (PCS) - Provider(s) shall report the ICD-10-CM and Procedural Coding System (PCS) to the highest level of specificity that supports medical necessity. Provider(s) shall use the current ICD-10

edition and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for code description, as it is no longer documented in the policy.

- Code(s) - Provider(s) shall report the most specific billing code that accurately and completely describes the procedure, product or service provided. Provider(s) shall use the Current Procedural Terminology (CPT), Health Care Procedure Coding System (HCPCS), and UB-04 Data Specifications Manual (for a complete listing of valid revenue codes) and any subsequent editions in effect at the time of service. Provider(s) shall refer to the applicable edition for the code description, as it is no longer documented in the policy. If no such specific CPT or HCPCS code exists, then the provider(s) shall report the procedure, product or service using the appropriate unlisted procedure or service code.
  *Unlisted Procedure or Service*
  CPT: The provider(s) shall refer to and comply with the Instructions for Use of the CPT Codebook, Unlisted Procedure or Service, and Special Report as documented in the current CPT in effect at the time of service.
  HCPCS: The provider(s) shall refer to and comply with the Instructions For Use of HCPCS National Level II codes, Unlisted Procedure or Service and Special Report as documented in the current HCPCS edition in effect at the time of service
- Modifiers - Providers shall follow applicable modifier guidelines.
- Billing Units - Provider(s) shall report the appropriate code(s) used which determines the billing unit(s).
- Co-payments -
  For Medicaid refer to Medicaid State Plan:
  https://medicaid.ncdhhs.gov/meetingsnotices/medicaid-state-plan-public-notices

- Reimbursement - Provider(s) shall bill their usual and customary charges. For a schedule of rates, refer to: https://medicaid.ncdhhs.gov/.

**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.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage

decisions and the administration of benefits are subject to all terms, conditions, conditions, exclusions, and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment, or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members/enrollees. This clinical policy is not intended to recommend treatment for members/enrollees. Members/enrollees should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members/enrollees, and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members/enrollees and their representatives agree to be bound by such terms and conditions by providing services to members/enrollees and/or submitting claims for payment for such services.