1. **Purpose**  
The purpose of this policy is to establish the criteria for the medical necessity of epidural adhesiolysis.

2. **Definitions**  
“Epidural adhesiolysis” is also known as epidural neurolysis, epidural decompressive neuroplasty, and Racz neurolysis. It is defined as a treatment for chronic back pain that involves disruption, reduction, and/or elimination of fibrous tissue from the epidural space, which is carried out by either catheter manipulation or the injection of saline or other adhesiolytic agents. A catheter is used to enter the epidural space through a caudal, interlaminar, or transforaminal approach. The goal is to free the nerve root of adhesions and allow introduction of medications to the affected nerve root. An anesthetic along with a glucocorticosteroid may also be injected as part of the procedure. These procedures may also involve spinal endoscopy to visually address the adhesions.

3. **Statement of Policy**  
3.1. The determination of medical necessity for the use of epidural adhesiolysis is always made on a case-by-case basis.

3.2. Epidural Adhesiolysis **may be considered medically necessary** if the following criteria are met:
  
- The patient has undergone a surgical procedure which could clinically explain the adhesions; and
- The physician documents adhesions blocking access to the nerve and has identified the adhesions by either Gadolinium enhanced MRI or CT myelography; and
- The patient has demonstrated a sufficient trial of all reasonable treatment options which could potentially provide benefit with a reasonable expectation that the treatment could possibly render the need for epidural adhesiolysis medically unnecessary; and
- The epidural adhesiolysis is being performed with the intention to administer medications closer to a nerve.
3.3. Epidural adhesiolysis should be performed utilizing a one-day protocol. Performing a series of three procedures (3-day protocol) may be considered not medically necessary.

3.4. A response is considered positive when the patient experiences approximately 50% reduction in pain for a minimum of four (4) months or a clinically meaningful reduction in pain medication or an increase in the patient’s functional abilities. When considering repeat epidural adhesiolysis procedures, they should not be performed more frequently than once every six (6) months. Performance of the procedure more frequently than every six (6) months may be considered not medically necessary.

3.5. Based on the limited long-term benefit of performing epidural adhesiolysis as an isolated intervention with regard to pain and improved function, all epidural adhesiolysis procedures should be performed in conjunction with active rehabilitative care/therapeutic exercise. Epidural adhesiolysis procedures performed in isolation without the patient participating in an active rehabilitation program/home exercise program/functional restoration program may be considered not medically necessary.

4. References

4.1. Scientific:

The following scientific references were utilized in the formulation of this medical policy. Triad Healthcare, Inc. will continue to review clinical evidence surrounding epidural adhesiolysis and may modify this policy at a later date based upon the evolution of the published clinical evidence. Should additional scientific studies become available and they are not included in the list, please forward the reference(s) to Triad Healthcare, Inc. so the information can be reviewed by the Academic Advisory Committee (AAC) and the Medical Quality Improvement Committee (MQIC) to determine if a modification of the policy is in order.


4.2. Related Triad Medical Policies:

- **TMMP 18 – Medical Necessity**

**CPT Codes**

This policy relates to the use of the following CPT Codes:

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description (AMA CPT Guide)</th>
</tr>
</thead>
<tbody>
<tr>
<td>62263</td>
<td>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.</td>
</tr>
<tr>
<td>62264</td>
<td>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</td>
</tr>
<tr>
<td>62280</td>
<td>Injection/infusion of neurloytic substance (e.g., alcohol, phenol, iced saline solutions), with or without other therapeutic substance; subarachnoid</td>
</tr>
<tr>
<td>62281</td>
<td>Injection/infusion of neurloytic substance (e.g., alcohol, phenol, iced saline solutions), with or without other therapeutic substance; epidural, cervical or thoracic.</td>
</tr>
</tbody>
</table>
### CPT Code | Description (AMA CPT Guide)
---|---
62282 | Injection/infusion of neurlytic substance (e.g., alcohol, phenol, iced saline solutions), with or without other therapeutic substance; epidural, lumbar, sacral (caudal).

This list may not be all inclusive and is not intended to be used for coding/billing purposes.

### Table of Revisions

<table>
<thead>
<tr>
<th>Revision Date</th>
<th>Modified By</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>02/20/2015</td>
<td>Level 1, 2, 3</td>
<td>Annual Review. No changes.</td>
</tr>
<tr>
<td>02/19/2014</td>
<td>Level 1, 2, 4</td>
<td>Annual Review. §3.2. changed from “the patient has undergone a lumbar surgical procedure which could clinically explain the adhesions” to “the patient has undergone a surgical procedure which could clinically explain the adhesions.”</td>
</tr>
<tr>
<td>03/03/2013</td>
<td>Level 1, 2, 3</td>
<td>Annual Review. Minor cosmetic change in Definitions and in §3.2 (second bullet) not requiring 30 day review.</td>
</tr>
<tr>
<td>03/27/2012</td>
<td>Level 1, 2, 3</td>
<td>Annual Review. Added CPT code table.</td>
</tr>
<tr>
<td>03/09/2011</td>
<td>Level 1, 2, 3</td>
<td>Annual Review. No changes.</td>
</tr>
<tr>
<td>03/18/2010</td>
<td>Level 1, 2, 3</td>
<td>Annual Review. No changes.</td>
</tr>
<tr>
<td>02/18/2009</td>
<td>Level 1, 2, 3</td>
<td>New medical policy.</td>
</tr>
</tbody>
</table>

Triad’s Medical Policies are not recommendations for treatment and providers are expected to exercise their clinical judgment in providing the most appropriate care. Health care providers and patients should not rely on these Medical Policies in making health care decisions. These Medical Policies are guidelines and do not constitute an authorization, certification, explanation of benefits or guarantee of payment. Applications of Triad’s Medical Policies are determined by the enrollee’s benefit documents and contracts and as such individual benefits must be verified. Determinations of medical necessity apply only if the benefit exists and no contract exclusions are applicable. In the event of a conflict, a participant’s benefit plan document shall supersede the information contained in Triad’s Medical Policies.