Lysis of Epidural Adhesions

Policy Number: 8.01.18  Last Review: 6/2017

Policy
Blue Cross and Blue Shield of Kansas City (Blue KC) will not provide coverage for lysis of epidural adhesions. This is considered investigational.

When Policy Topic is covered
Not Applicable

When Policy Topic is not covered
Catheter-based techniques for lysis of epidural adhesions, with or without endoscopic guidance, are considered investigational. Techniques used either alone or in combination include mechanical disruption with a catheter and/or injection of hypertonic solutions with corticosteroids, analgesics, or hyaluronidase.

Considerations
Lysis of epidural adhesions using hypertonic saline may be offered as one component of a multi-modality pain management program.

Description of Procedure or Service

<table>
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<th>Populations</th>
<th>Interventions</th>
<th>Comparators</th>
<th>Outcomes</th>
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<td>• With epidural adhesions</td>
<td>Lysis</td>
<td>Medical management</td>
<td>Relevant outcomes include:</td>
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<td></td>
<td>Interventions of interest are:</td>
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<td>• Symptoms</td>
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<tr>
<td></td>
<td>• Lysis</td>
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<td>• Functional outcomes</td>
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Lysis of epidural adhesions involves passage of a catheter endoscopically or percutaneously under fluoroscopic guidance into the epidural space to break up adhesions and reduce pain and inflammation.

The evidence for lysis in patients who have epidural adhesions includes randomized controlled trials (RCTs). Relevant outcomes are symptoms, functional outcomes, quality of life, medication use, and treatment-related morbidity. Several RCTs report benefits for epidural lysis of adhesions compared with placebo treatment. Many of these trials are from the same center. The interpretation of these trials is limited by differences in patients, populations, and treatment...
protocol. The treatment for lysis of adhesions varies in the use of mechanical disruption, the type of lytic medications used, and the number of injections given. There is also a large effect seen in the placebo group, raising questions whether some component of the placebo treatment may be therapeutic. Larger trials with standardized treatment protocols would help determine whether specific treatment protocols have beneficial effects in specific patient populations. The evidence is insufficient to determine the effects of the technology on health outcomes.

Background

Epidural fibrosis with or without adhesive arachnoiditis most commonly occurs as a complication of spinal surgery and may be included under the diagnosis of "failed back syndrome." Both result from manipulation of the supporting structures of the spine. Epidural fibrosis can occur in isolation, but adhesive arachnoiditis is rarely present without associated epidural fibrosis. Arachnoiditis is most frequently seen in patients who have undergone multiple surgical procedures.

Both conditions are related to inflammatory reactions that result in the entrapment of nerves within dense scar tissue, increasing the susceptibility of the nerve root to compression or tension. The condition most frequently involves the nerves within the lumbar spine and cauda equina. Signs and symptoms indicate the involvement of multiple nerve roots and include low back pain, radicular pain, tenderness, sphincter disturbances, limited trunk mobility, muscular spasm or contracture, and motor sensory and reflex changes. Typically, the pain is characterized as constant and burning. In some cases, the pain and disability are severe, leading to analgesic dependence and chronic invalidism.

Lysis of epidural adhesions, also called the Racz procedure, which involves passage of a catheter (Racz catheter) endoscopically or percutaneously, using fluoroscopic guidance, with epidural injections of hypertonic saline in conjunction with corticosteroids and analgesics, has been investigated as a treatment option. Theoretically, the use of hypertonic saline results in a mechanical disruption of the adhesions. It may also function to reduce edema within previously scarred and/or inflamed nerves. Finally, manipulating the catheter at the time of the injection may disrupt adhesions. Spinal endoscopy has been used to guide the lysis procedure. Prior to the use of endoscopy, adhesions can be identified as nonfilling 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.

Endoscopic epidurolysis is also being investigated for the treatment of degenerative chronic low back pain, including spondylolisthesis, stenosis, and hernia associated with radiculopathy. Along with mechanical adhesiolysis, hyaluronidase, ciprofloxacin and ozone have been applied.
Rationale

This evidence review was originally created in 1998 and has been updated regularly with searches of the MEDLINE database. The most recent literature update was performed through November 11, 2015. Following is a summary of the literature to date.

The evidence for lysis of epidural adhesions consists of single-center trials, most of them from a single U.S. pain management group. A number of systematic reviews of these trials have been identified for updates of this evidence review. A 2005 review article focused on 3 randomized studies by Heavner and Manchikanti and concluded that there was moderate-to-strong evidence of the effectiveness of percutaneous adhesiolysis. A 2007 update of that review also concluded that there was strong evidence for short-term and moderate evidence of long-term effectiveness of percutaneous adhesiolysis and spinal endoscopy. Applying the U.S. Preventive Services Task Force (USPSTF) criteria, a 2012 update of the review found fair evidence that percutaneous adhesiolysis is effective in relieving low back and/or leg pain caused by either post lumbar surgery syndrome or spinal stenosis. Complications were considered to be minimal.

In a 2008 paper, Racz et al concluded, based on the literature (randomized trials and case series) and expert opinion, that evidence was strong for short-term (3 months) efficacy and moderate for long-term (>3 months) efficacy. Two systematic reviews were published in 2009; one focused on endoscopic adhesiolysis and the other on the percutaneous method. Hayek et al concluded that, based on level II-1 or II-2 evidence (1 randomized trial, 5 observational studies), endoscopic adhesiolysis provides short- and long-term relief of pain based on the USPSTF criteria. Epter with Hayek and others concluded that there is level-I or -II evidence (3 randomized trials, 4 observational studies) for percutaneous adhesiolysis. A 2013 systematic review on endoscopic adhesiolysis by Helm et al included 1 randomized controlled trial (RCT) and 3 observational studies in the review and noted there is a limited amount of literature available on endoscopic adhesiolysis. Despite limitations in available evidence, using USPSTF quality of evidence criteria, the authors concluded there is fair evidence that spinal endoscopic adhesiolysis is effective in reducing chronic low back and/or leg pain in post lumbar surgery syndrome in both the short and long term (>12 months).

The primary studies cited in these reviews were assessed individually for this evidence review (see following sections).

Percutaneous Lysis of Adhesions Without Spinal Endoscopy

In 2013, Gerdesmeyer et al reported on a randomized, double-blind, placebo-controlled trial on percutaneous epidural lysis of adhesions for chronic lumbar radicular pain at 4 participating treatment centers. Of 381 patients screened, 90 patients were randomized in permuted blocks of 4 to 8 to adhesiolysis or placebo. Eligible patients had chronic lumbosacral radicular pain after disc protrusion or after failed back surgery and at least 4 months of unsuccessful conservative treatment. Patients in both groups received injections on each of 3 days and...
physical therapy after the series of injections. In the adhesiolysis group, the day 1 injection consisted of 10 mL saline with 150 U/mL hyaluronidase, plus 10 mL saline with 40 mg triamcinolone and 2 mL of 0.25% bupivacaine; this initial injection was followed by day 2 and 3 injections of saline with anesthetic. The placebo group received saline injections each of the 3 days through a catheter placed over the affected area but not into the spinal canal. After 3 months, the Oswestry Disability Index (ODI) score significantly improved in the adhesiolysis group (55.3 to 26.4) compared with the placebo group (55.4 to 41.8; \( p<0.01 \)). After 3 months, the visual analog scale (VAS) score was also significantly improved in the adhesiolysis group (6.7 to 2.9) compared with the placebo group (6.7 to 4.8; \( p<0.01 \)). The ODI and VAS scores remained significantly more improved in the adhesiolysis group than the control group at 6 and 12 months. In the adhesiolysis group, more patients experienced pain during the intervention and transient neurologic deficits (numbness, paralysis, motor weakness) after the intervention than the control group (34 vs 20 and 42 vs 6, respectively). All of the neurologic deficits resolved during hospitalization. Limitations of this study include failure to place the catheter near the anterolateral epidural space of the targeted pathology, and the unknown effect of each component of treatment. The large effect seen in the placebo group also brings into question whether placement of the catheter in the subcutaneous tissue produces a beneficial effect.

Two 2009 papers by Manchikanti et al\(^9,10\) report 1-year outcomes of 2 comparative effectiveness RCTs. Patients in 1 trial had failed back surgery syndrome (planned enrollment, 200 patients), and patients in the other had chronic low back pain (planned enrollment, 120 patients). The comparator in both trials was epidural corticosteroid injection. In both studies, the procedure in the intervention group included epidurography, introduction of the Racz catheter to the level of defect, adhesiolysis and/or targeted catheter positioning, repeat epidurography with confirmation of ventral and lateral filling, and injection of lidocaine, all performed in the operating room, followed by transfer to the recovery room and injection of 10% sodium chloride solution and injection of betamethasone. The control group received epidurography, introduction of the catheter up to S3 or S2, repeat epidurography, injection of lidocaine in the operating room, and injection of normal saline and betamethasone in the recovery room. For the patients with failed back surgery, significant pain relief, as defined by a greater than 50% reduction in VAS, was achieved by 73% of patients in the lysis group compared with 12% in the control group (\( p<0.001 \)). For patients with spinal stenosis, there were no outcomes reported at the time of publication. In the 2-year follow-up report on the study with 120 patients treated for chronic low back pain, Manchikanti et al reported 82% of patients receiving adhesiolysis had significant improvement in functional status and relief of pain of at least 50% compared with only 5% improvement in the epidural corticosteroid injection group.\(^11\) If patients had improved functioning and pain reductions of at least 50% for at least 3 months following adhesiolysis, repeat adhesiolysis was permitted. Patients in the adhesiolysis group received an average of 6.4 adhesiolysis procedures while patients in the epidural corticosteroid injection group averaged 2.4 procedures over the 2-year period.
A number of limitations are apparent in these studies. Losses to follow-up in the control groups were large in both studies (10/60 at 6 months, 43/60 at 12 months, 52/60 at 2 years in the failed back surgery study; 10/25 at 6 months, 18/25 at 12 months in the spinal stenosis study). There were few dropouts in the intervention groups. Thus, differential loss in follow-up is a major concern. Patients received additional treatments if needed (criteria for repeat treatment not given), and the type of treatment was based on the response to the previous injections, either after unblinding or without unblinding. Physicians performing procedures could not be blinded to treatment group but did not know which patients were participating in the studies. Several other case series have been reported, but without a control group, the independent contribution of the lysis cannot be assessed.

There are several earlier, smaller, randomized trials reported by Manchikanta and colleagues. In 2004, Manchikanti et al published the results of a trial that randomized 75 patients to 1 of 3 groups, either a control group consisting of catheterization without adhesiolysis, or to adhesiolysis with or without additional hypertonic saline. All patients received epidural injections of local anesthetic and corticosteroids. Significant differences in pain relief, ODI, and range of motion were noted between the 2 treatment groups and the control group. A 2001 trial by Manchikanti included 45 patients who were randomized to receive either a 1- or a 3-day course of lysis of epidural adhesions. A total of 97% of the treatment group with 1 to 3 injections reported at least 50% pain relief at 3 months, which fell to 93% at 6 months, and 47% at 1 year. There was no significant improvement in the control group.

Serious adverse events from epidural lysis have been reported. In 2012, Manchikanti et al reported on a prospective observational study of complications in 10,000 fluoroscopically directed epidural injections, including more than 800 cases treated by percutaneous adhesiolysis at their institution. Measured outcomes included intravascular entry of the needle, profuse bleeding, local bleeding, local hematoma, bruising, dural puncture and headache, nerve root or spinal cord irritation, infection, numbness, postoperative soreness, and increased pain. There was intravascular entry in 11.6% of cases, return of blood in 3.6%, transient nerve root irritation in 1.9%, and dural puncture in 1.8% of adhesiolysis cases. Other complications occurred in less than 1% of cases. There were no major complications in this cohort.

**Section Summary: Percutaneous Lysis of Adhesions Without Spinal Endoscopy**

Several RCTs report benefits for epidural lysis of adhesions compared with placebo treatment. The interpretation of these trials is limited by differences in patients, populations, and treatment protocol. The treatment for lysis of adhesions varied in the use of mechanical disruption, the type of lytic medications used, and the number of injections given. There is also a large effect seen in the placebo group, raising questions about whether some component of the placebo treatment may be therapeutic. Larger trials with standardized treatment protocols would be
helpful in determining whether specific treatment protocols have beneficial effects in specific patient populations.

**Percutaneous Lysis of Adhesions With Spinal Endoscopy**

In 2003, a new category III CPT code was introduced to describe lysis of epidural lesions using endoscopic guidance. One small RCT was identified in 2003 by Manchikanti et al. Twenty-three patients with back pain of greater than 6 months in duration were randomized to receive either spinal endoscopy followed by injection of local anesthetic or corticosteroid (control group) or the above procedure with the addition of lysis of adhesions with normal saline and mechanical disruption with the fiberoptic endoscope.\(^\text{16}\) The trial was double-blinded. Patient selection criteria included failure of conservative management, including failure of prior attempts at lysis of adhesions using hypertonic saline. The principal outcomes included changes in VAS and ODI scores at 6 months. In the control group, the mean VAS score dropped from 8.7 at baseline to 7.6 at 6 months, while the scores in the intervention group dropped from 9.2 at baseline to 5.7 at 6 months. The difference between the control and the intervention groups was statistically significant. There was also a significant difference between the 2 groups in the percentage of patients experiencing at least a 50% reduction in pain. Blinding appeared to be successful as 6 of the 16 patients in the control group believed they were in the intervention group, and 8 of 23 patients in the intervention group believed they were in the control group. While this study reports promising results, its small size limits interpretation.

In 2011, Di Donato et al reported 48-month follow-up from a prospective case series of 234 patients with chronic low back pain due to failed back surgery syndrome, spondylolisthesis, stenosis, or hernia.\(^\text{17}\) In addition to mechanical removal of adherences, targeted ozone, hyaluronidase, and ciprofloxacin were applied. Efficacy was prospectively evaluated by an independent investigator at 1 week and 3, 6, 12, 24, 36, and 48 months. Significant improvements in VAS and ODI scores were reported throughout the 48-month follow-up. Adverse events included 32 patients (13.7%) who had sacral pain lasting at least 2 weeks and 13 patients (5.5%) who experienced a nonpainful paresthesia and subsequently underwent surgical intervention. This study has a number of limitations, including the lack of information on the number of patients available for long-term follow-up and the lack of a control group.

Two additional articles by Manchikanti et al were identified that retrospectively examined the outcomes of patients who underwent lysis with (n=120) or without (n=60) adjunctive endoscopy.\(^\text{18,19}\) As these articles are authored by the same investigator, it is likely that they include overlapping patients. However, these studies did not include a control group, and thus scientific conclusions regarding the contribution of endoscopy are not possible.

**Ongoing and Unpublished Clinical Trials**

Some currently unpublished trials that might influence this review are listed in Table 1.
Table 1. Summary of Key Trials

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<th>NCT No.</th>
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<th>Completion Date</th>
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<td>Evaluation of the Role of Steroids and 10% Hypertonic Sodium Chloride in Adhesiolysis in Post Lumbar Surgery Syndrome Patients: A Prospective, Randomized, Double-Blind, Equivalence, Controlled Trial of Percutaneous Lumbar Adhesiolysis</td>
<td>240</td>
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<td>NCT01053273a</td>
<td>Comparative Effectiveness of Percutaneous Adhesiolysis and Caudal Epidural Steroid Injections in Low Back and/or Lower Extremity Pain: A Randomized, Equivalence Trial</td>
<td>120</td>
<td>Jan 2014 (unknown)</td>
</tr>
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</table>

NCT: national clinical trial.

* Denotes industry-sponsored or cosponsored trial.

Summary of Evidence
The evidence for lysis in patients who have epidural adhesions includes randomized controlled trials (RCTs). Relevant outcomes are symptoms, functional outcomes, quality of life, medication use, and treatment-related morbidity. Several RCTs report benefits for epidural lysis of adhesions compared with placebo treatment. Many of these trials are from the same center. The interpretation of these trials is limited by differences in patients, populations, and treatment protocol. The treatment for lysis of adhesions varies in the use of mechanical disruption, the type of lytic medications used, and the number of injections given. There is also a large effect seen in the placebo group, raising questions whether some component of the placebo treatment may be therapeutic. Larger trials with standardized treatment protocols would help determine whether specific treatment protocols have beneficial effects in specific patient populations. The evidence is insufficient to determine the effects of the technology on health outcomes.

Practice Guidelines and Position Statements

American Society of Interventional Pain Physicians
The American Society of Interventional Pain Physicians updated its practice guidelines on the management of chronic spinal pain in 2013.20 The guideline states that “for lumbar percutaneous adhesiolysis, the evidence is fair in managing chronic low back and lower extremity pain secondary to post surgery syndrome and spinal stenosis.” Percutaneous adhesiolysis is recommended “after failure of conservative management of physical therapy, chiropractic, drug therapy, structured exercise program, and fluoroscopically directed epidural injections.” The guideline also states spinal epidural endoscopic adhesiolysis is not discussed.
because there is limited evidence and the procedure is rarely used. The studies cited in the guideline were evaluated for this evidence review.

**American Pain Society**
The American Pain Society clinical practice guideline on Interventional Therapies, Surgery, and Interdisciplinary Rehabilitation for Low Back Pain, published in 2009, does not include a discussion or conclusion on adhesiolysis, and stated that “for other interventions or specific clinical circumstances, the panel found insufficient evidence from randomized controlled trials to reliably judge benefits or harms.”

**U.S. Preventive Services Task Force Recommendations**
Not applicable.

**Medicare National Coverage**
There is no national coverage determination (NCD). In the absence of an NCD, coverage decisions are left to the discretion of local Medicare carriers.

References

Billing Coding/Physician Documentation Information

B62263 Percutaneous lysis of epidural adhesions using solution injection (eg, hypertonic saline, enzyme) or mechanical means (eg, catheter) including radiologic localization (includes contrast when administered), multiple adhesiolysis sessions; 2 or more days
B62264 Percutaneous lysis of epidural adhesions using solution injection (eg, hypertonic saline, enzyme) or mechanical means (eg, catheter) including radiologic localization (includes contrast when administered), multiple adhesiolysis sessions; 1 day
B77003 Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinal diagnostic or therapeutic injection procedures (epidural, subarachnoid, or sacroiliac joint), including neurolytic agent destruction

ICD-10 Codes

G96.8 Other specified disorders of central nervous system
G96.9 Disorder of central nervous system unspecified
G97.1 Other reaction to spinal and lumbar puncture
G98.8 Other disorders of the nervous system

Category III code 0027T was deleted effective 1/1/2009.
The following CPT codes specifically identify the injection of hypertonic saline, which may be performed over the course of multiple or single days.

62263: Percutaneous lysis of epidural adhesions using solution injection (eg, hypertonic saline, enzyme) or mechanical means (eg, catheter) including radiologic localization (includes contrast when administered), multiple adhesiolysis sessions; 2 or more days

62264; as above but limited to 1 day only

As noted here, the protocols for lysis of epidural adhesions vary. Some institutions may perform lysis of epidural adhesions as an inpatient procedure, performed in multiple sessions over a course of several days through an indwelling catheter. In the descriptor of the CPT book, it is noted that CPT code 62263 describes the percutaneous insertion and removal of an epidural catheter and that code 62263 is not reported for each adhesiolysis treatment, but should be reported once to describe the entire series of injection/infusion spanning 2 or more treatment days.

In 2008, CPT code 0027T - Endoscopic lysis of epidural adhesions with direct visualization using mechanical means (eg, spinal endoscopic catheter system) or solution injection (eg, normal saline) – was deleted. Endoscopic lysis of epidural adhesions should now be coded using miscellaneous code 64999.

There is instruction following CPT code 77003 in the CPT book that states 62263 and 62264 include fluoroscopic guidance and localization.

**Additional Policy Key Words**

Epidurolysis

**Policy Implementation/Update Information**

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