Policy: MP138
Section: Medical Benefit Policy
Subject: Lysis of Epidural Adhesions

I. Policy: Lysis of Epidural Adhesions

II. Purpose/Objective:
To provide a policy of coverage regarding Lysis of Epidural Adhesions

III. Responsibility:
A. Medical Directors
B. Medical Management

IV. Required Definitions
1. Attachment – a supporting document that is developed and maintained by the policy writer or department requiring/authoring the policy.
2. Exhibit – a supporting document developed and maintained in a department other than the department requiring/authoring the policy.
3. Devised – the date the policy was implemented.
4. Revised – the date of every revision to the policy, including typographical and grammatical changes.
5. Reviewed – the date documenting the annual review if the policy has no revisions necessary.

V. Additional Definitions
Medical Necessity or Medically Necessary means Covered Services rendered by a Health Care Provider that the Plan determines are:

a. appropriate for the symptoms and diagnosis or treatment of the Member's condition, illness, disease or injury;
b. provided for the diagnosis, and the direct care and treatment of the Member's condition, illness disease or injury;
c. in accordance with current standards of good medical treatment practiced by the general medical community.
d. not primarily for the convenience of the Member, or the Member's Health Care Provider; and
e. the most appropriate source or level of service that can safely be provided to the Member. When applied to hospitalization, this further means that the Member requires acute care as an inpatient due to the nature of the services rendered or the Member's condition, and the Member cannot receive safe or adequate care as an outpatient.

Medicaid Business Segment
Medical Necessity shall mean a service or benefit that is compensable under the Medical Assistance Program and if it meets any one of the following standards:

(i) The service or benefit will, or is reasonably expected to, prevent the onset of an illness, condition or disability.
(ii) The service or benefit will, or is reasonably expected to, reduce or ameliorate the physical, mental or development effects of an illness, condition, injury or disability.
(iii) The service or benefit will assist the Member to achieve or maintain maximum functional
capacity in performing daily activities, taking into account both the functional capacity of the Member and those functional capacities that are appropriate for members of the same age.

DESCRIPTION:
Percutaneous lysis of epidural adhesions (also known as epidural neuroplasty or epidural adhesiolysis) has been investigated as an interventional pain management treatment of chronic back pain thought to be caused by epidural adhesions. Theoretically, the injection of hypertonic saline causes a mechanical disruption of the fibrotic tissue. Additional agents such as, but not limited to steroids and/or hyaluronidase may also be introduced. The procedure may be performed either with or without endoscopic guidance.

INDICATIONS: Requires Prior Medical Director or designee Authorization. Consideration for coverage is limited to the Medicare Business Segment, in compliance with CMS directives.

EXCLUSIONS:
The Plan does NOT provide coverage for percutaneous lysis of epidural adhesions using hypertonic saline injections, with or without hyaluronidase or steroids, and with or without endoscopic guidance because it is considered experimental, investigational or unproven. The Geisinger Technology Assessment Committee evaluated this technology and concluded that there is insufficient evidence in the peer-reviewed published medical literature to establish the effectiveness of this test on health outcomes when compared to established tests or technologies.

Note: A complete description of the process by which a given technology or service is evaluated and determined to be experimental, investigational or unproven is outlined in MP 15 - Experimental Investigational or Unproven Services or Treatment.

CODING ASSOCIATED WITH: Lysis of epidural adhesions
The following codes are included below for informational purposes and may not be all inclusive. Inclusion of a procedure or device code(s) does not constitute or imply coverage nor does it imply or guarantee provider reimbursement. Coverage is determined by the member specific benefit plan document and any applicable laws regarding coverage of specific services.

HCPCS/CPT Codes:
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  1 day
76005  Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinous diagnostic or therapeutic injection procedures (epidural, subarachnoid, paravertebral facet joint, paravertebral facet joint nerve or sacroiliac joint), including neurolytic agent destruction


LINE OF BUSINESS:
Eligibility and contract specific benefits, limitations and/or exclusions will apply. Coverage statements found in the line of business specific benefit document will supersede this policy. For PA Medicaid Business segment, this policy applies as written.

REFERENCES:
Geisinger Technology Assessment Committee Triage Group review. “Lysis of Epidural Adhesions”. September 2009


This policy will be revised as necessary and reviewed no less than annually.

**Devised:** 6/04  
**Revised:** 8/04  
**Reviewed:** 12/05; 12/06, 12/07, 12/08, 12/09, 12/10, 1/12, 1/13, 1/14, 1/15, 1/16, 1/17