

# Epiduroscopy, Epidural Lysis of Adhesions and Discography

Guideline Number: MMG042.J  
 Effective Date: February 1, 2021

[Instructions for Use](#)

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Related Medical Management Guidelines
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• <a href="#">Discogenic Pain Treatment</a>
• <a href="#">Epidural Steroid and Facet Injections for Spinal Pain</a>
• <a href="#">Surgical Treatment for Spine Pain</a>

## Coverage Rationale

The following are unproven and not medically necessary for the diagnosis or treatment of any type of neck, back, or spinal disorder due to insufficient evidence of efficacy:

- Discography
  - Functional anesthetic discography
  - Provocative discography
- Epiduroscopy (including spinal myelography)
- Percutaneous and endoscopic epidural lysis of adhesions

## Applicable Codes

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this guideline does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

Coding Clarification: Functional anesthetic discography should be billed with CPT code 64999.

CPT Code	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
62290	Injection procedure for discography, each level; lumbar
62291	Injection procedure for discography, each level; cervical or thoracic
64999	Unlisted procedure, nervous system

CPT Code	Description
72285	Discography, cervical or thoracic, radiological supervision and interpretation
72295	Discography, lumbar, radiological supervision and interpretation

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## Description of Services

Epiduroscopy is a procedure which requires removal of adhesions and fibrosis using a laser, the tip of the flexible catheter and saline flushing. In the final stage, steroids are administered to help cleanse the inflammatory agents in the epidural space. With this technique, the epidural space can easily be monitored, anatomic structures identified, and pathologies detected (Hazer, 2018).

Epidural lysis of adhesions (LOA) (adhesiolysis, percutaneous epidural neuroplasty epidurolysis) is a minimally invasive procedure for individuals who have epidural adhesions that are thought to cause chronic low back pain (LBP). The procedure is often performed using local anesthesia and a mild sedative, so the individual is able to communicate with the surgeon about the source of the pain. The surgeon injects normal saline to distend and decompress the epidural space and mechanical manipulations of a fiberoptic endoscope to cause direct disruption of fibrosis, scar tissue, or adhesions. Percutaneous adhesiolysis (PA) (also known as the Racz procedure) can also be performed. This procedure uses a needle to enter the epidural space at the level of the spinal column where adhesions are suspected. . Nonionic contrast medium is introduced, and a lumbar epidurogram is obtained.

Functional Anesthetic Discography (FAD) is a diagnostic procedure that involves injecting an anesthetic agent directly into a spinal disc via a catheter system. Once the catheter is inserted into the disc nucleus, the individual tries to recreate the back pain by performing activities such as sitting, walking or bending. If pain is produced, an anesthetic agent is injected and the individual again attempts to recreate the back pain. The amount of pain is then compared and used to confirm the level of disc involvement and determine additional treatment options.

Provocative discography (PD) is an invasive diagnostic spine procedure that involves the administration of contrast into the nucleus pulposus of an intervertebral disc to determine if the disc is the origin of a patient's chronic spine pain. The test is based on the premise that discs can be a source of spine pain, and symptomatic, internally disrupted disc causes pain when it is mechanically loaded; therefore, it should be similarly painful when pressurized with injected contrast (Gruver and Guthmiller, 2019).

## Clinical Evidence

### Discography

The available evidence is limited and low in quality for the clinical utility of discography for diagnosis and/or treatment of spinal disorders. Additional well-designed, long-term, randomized controlled clinical trials are needed for evaluation of efficacy and long-term effects.

A Hayes (2019) report evidence base comprises 7 studies on the clinical utility of lumbar discography. The studies included 1 randomized controlled trial, 1 retrospective trial with historical controls, 1 pretest/posttest study, 1 prospective cohort study, 2 retrospective cohort studies, and 1 cohort study with a mixed prospective and retrospective design. The report concluded that the body of evidence is small in size and low in quality and suggests that discography does not improve health outcomes in patients with chronic LBP. The analyzed studies did not systematically report on the safety of discography. There is some evidence suggesting that discography may have long-term serious complications, including accelerated disc degeneration and increased likelihood of undergoing lumbar surgery. Its value in the management of these patients has not been established ().

Manchikanti et al. (2018) assessed and re-evaluated the diagnostic accuracy of lumbar, cervical, and thoracic discography in a systematic review of the literature. The search focused on systematic reviews with special emphasis on provocation and/or anesthetic discography. Eight studies were considered for review and five focused on assessment of lumbar discogenic pain. The authors conclude that the strength of evidence is limited due to various inconsistencies among the studies. Despite multiple publications, the authors concluded the value and validity of lumbar provocative discography continues to be debated.

Cuellar et al. investigated the clinical effects of lumbar PD on patients subjected to this evaluation method in a prospective, 10-year matched cohort study. Subjects (n=75) without current LBP problems were recruited to participate in a study of PD at the L3-S1 discs. A closely matched control cohort (n=75) was simultaneously recruited to undergo a similar evaluation except for discography injections. Primary outcome variables were diagnostic imaging events and lumbar disc surgery events. Secondary outcome measures were serious LBP events, disability events, and medical visits. All subjects were followed by serial protocol evaluations at 1, 2, 5, and 10 years after enrollment. Of the 150 subjects, 71 discography subjects and 72 control subjects completed the baseline evaluation. At 10 years, study and control subjects completing all interval surveillance evaluations were 57 and 53, respectively. There were 16 lumbar surgeries in the study group, compared with 4 in the control group. Medical visits, computed tomography (CT)/MRI examinations, work loss, and prolonged back pain episodes were all more frequent in the discography group compared with control subjects. The author's results demonstrated a significantly higher rate of lumbar spine surgery in patients who are exposed to discography. However, it was noted that most patients exposed to discography did not eventually require surgery. While the researchers concluded that disc puncture and pressurized injection performed during PD can increase the risk of clinical disc problems, they suggested that longer term follow-up of patients exposed to lumbar PD could provide more answers. Limitations of the study included loss to follow up over the ten year period and the inability to assess the outcomes in all patients (2016).

In a 2015 review on the evaluation and treatment of LBP, Hooten and Cohen stated that while touted as the only means to establish a relationship between disc pathology and symptoms, provocative discography (PD) is characterized by a high false-positive rate in some patients (Provenzano, 2012). Additionally, they state that the evidence that discography may improve surgical outcomes is limited to a subgroup analysis of a single randomized study (Margetic et al., 2013) comparing outcomes in individuals who did and did not undergo pre-fusion discography.

Alamin et al. compared the results of standard pressure-controlled PD to those of the FAD in a prospective series of 52 patients presenting with chronic LBP. Standard pressure-controlled PD was performed, followed by (in positive cases or in patients with clinical features and imaging studies felt to be highly suggestive of symptomatic disc degeneration) FAD. Discordant results of the 2 tests were noted in 46% of the patients in the series. Of them, 26% of patients with positive PD had negative findings on the FAD test; 16% had positive findings at a single level only, whereas the PD had been positive at 2 or more levels; 4% had new positive findings on the FAD test. The authors concluded that further studies are needed to demonstrate the clinical utility of the test (2011).

### ***Professional Societies***

#### **American Association of Neurological Surgeons (AANS)/Congress of Neurological Surgeons (CNS)**

In guidelines (Eck et al., 2014) regarding the use of discography in the evaluation of LBP prior to surgery, a joint committee of the AANS/CNS stated the following:

- Based primarily on retrospective studies, discography as a stand-alone test is not recommended to formulate treatment strategies for patients with LBP with abnormal imaging findings.
- A single randomized cohort study demonstrated an improved potential of discoblock over discography as a predictor of success following lumbar fusion. Therefore, discoblock should be considered as a diagnostic option during the evaluation of a patient presenting with chronic LBP.
- There is a possibility that an association exists between progression of degenerative disc disease and the performance of a provocative discogram. It is therefore recommended that patients be counseled regarding this potential development prior to undergoing discography.

#### **American College of Radiology (ACR)**

In its appropriateness criteria for patients with LBP, the ACR finds PD to be controversial when attempting to identify a discogenic source of lumbar pain, secondary to the subjective nature of the test. X-ray discography, also controversial, may be useful for patients with chronic LBP lasting longer than 3 months. The criteria are silent on FAD (Patel et al., 2016).

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

The Comprehensive Evidence-Based Guidelines for Interventional Techniques in Chronic Spinal Pain states that evidence is fair for lumbar and limited for cervical and thoracic provocation discography, and offers the following recommendations:

- The recommendations for lumbar provocation discography include appropriate indications with patients with low back pain to prove the diagnostic hypothesis of the discogenic pain specifically after exclusion of other sources of lumbar pain, only when a treatment is available.
- Cervical discography is indicated only when a treatment is available to test the diagnostic hypothesis of discogenic pain of the cervical spine in individuals who have been properly selected and screened to eliminate other sources of cervical pain.
- Thoracic discography is recommended to decide if an intervertebral disc is painful or not in rare circumstances.

There are no recommendations for Functional Anesthetic Discography. The use of anesthetic discography has generated significant interest as a means to reduce the high false-positive rates associated with provocation discography in certain patient subgroups. The ability of anesthetic discography used as either an adjunct or replacement for provocation discography, to enhance the accuracy of diagnosis, is mixed (Manchikanti et al., 2013).

## Epiduroscopy

Results of earlier feasibility/observational studies suggest that epiduroscopy can aid in the visualization of the anatomy and pathology of spinal structures; in particular, the cauda equina and epidural space. However, none of those studies evaluated the impact of epiduroscopy on clinical management or patient outcomes.

Hazer et al. (2018) conducted a retrospective study of 88 patients with chronic LBP and radicular pain secondary to lumbar disc herniation to evaluate the efficacy of epiduroscopy in this patient population, whether or not they have undergone prior surgery. Of the study group, 66 participants had a history of prior back surgery and 22 did not. Diagnostic epiduroscopy was performed on all patients, including washing of the epidural space with saline and removal of inflammatory agents from the space via adhesiolysis. Each procedure ended with a steroid injection into the epidural space. All patients received a clinical examination on the day of the procedure, and then after 1, 6, and 12 months. All the patients evaluated their pain on a Visual Analog Scale (VAS) and validated their disability using the Oswestry Disability Index (ODI) questionnaire on all visits. All patients improved significantly in pain (VAS) and disability (ODI) at 1 month and 1 year. No differences were found between men and women at the different follow-up times. A slight worsening in VAS and ODI was noticed over time except for the non-operated group. The authors concluded that epiduroscopy with adhesiolysis and steroid injection helps to relieve pain and reduce disability in patients with back and leg pain due to lumbar disc herniation, regardless of gender. Patients who had not had previous surgery seemed to benefit more from the treatment. The improvement in pain relief and reduced disability seemed to last for at least 1 year. The findings are however limited by lack of comparison group undergoing a different or no intervention.

A prospective observational study by Bosscher and Heavner (2014) evaluated the significance of diagnostic markers obtained through epiduroscopy by evaluating the accuracy of outcome prediction after treatment of epidural pathology using epiduroscopy. Of the 150 patients who underwent epiduroscopy in the year 2008 at a single U.S. hospital, 139 were available for evaluation at 1 month. A prediction of outcome was made in 114 of 139 patients (82%). This prediction was correct in 89 of the 114 patients (accuracy of 78%). The sensitivity and specificity of epiduroscopy with respect to the prediction of outcome were 75% and 82%, respectively. The sensitivity and specificity of epiduroscopy in the diagnosis of epidural pathology were 91% and 39%, respectively. The authors concluded that lumbosacral epiduroscopy predicts outcome of treatment accurately in the majority of patients. This suggests that information obtained through epiduroscopy may carry significant diagnostic and prognostic value.

Igarashi et al. (2004) conducted a study of 58 patients with degenerative lumbar spinal stenosis who were placed into a monosegmental or multisegmental group, based on leg symptoms. All patients underwent epiduroscopy with epidural injection of steroid or local anesthetic. The findings of epiduroscopy corresponded to the symptoms, and the study results demonstrated positive effects of epiduroscopy on LBP for up to 1 year in both groups. The study is limited by lack of comparison group undergoing a different intervention.

## Epidural Lysis of Adhesions (LOA)

Evidence in peer review literature evaluating epidural lysis of adhesions for the diagnosis and/or treatment of spinal disorders is limited. Future robust randomized controlled trial studies are warranted along with long-term outcomes to establish the safety and efficacy of this procedure.

A 2019 Hayes report reviewed percutaneous adhesiolysis (PA) for chronic LBP. The evidence base comprises 6 randomized controlled trials (RCTs) (7 publications, including 1 study with a longer-term follow-up study) and groups of 50-120 participants

per study. The report concluded that a small body of low-quality evidence supports the use of PA for chronic LBP refractory to conservative treatment, including epidural steroid injections, given consistent findings of benefits in pain relief and function compared with sham PA and epidural steroid injections, and a lack of serious complications in the evidence base. There is insufficient evidence pertaining to the comparison of adhesiolysis with physical therapy (PT) to draw definitive conclusions. However, it appears that in many cases, the adhesiolysis procedure must be repeated more than once a year to maintain its benefits. While the evidence suggests potential short- and intermediate-term efficacy of this procedure in patients with chronic LBP, 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. The report concludes that there is potential but unproven benefit for this approach.

Brito-García et al. (2019) assessed the efficacy, safety, effectiveness, and cost-effectiveness of epidural adhesiolysis for treating patients with chronic pain attributed to failed back surgery syndrome (FBSS) in a systematic review of the literature. Out of the studies that met the inclusion criteria, only two of them were RCTs which included a total of 212 participants; the other seven studies were observational. The authors assessed that even though the results from both RCTs had a favorable outcome for adhesiolysis, there was a high risk of bias and serious methodology flaws in the studies which included lack of blinding for participants, informing the participants of which treatment they had received and a high dropout rate. The observational studies were of low quality and did not provide any data indicating positive clinical development. The authors concluded the evidence on the efficacy and safety for adhesiolysis is insufficient in patients with FBSS and that further high quality RCTs should be done to assess for efficacy, effectiveness and cost.

Rapčan et al. (2018) conducted a randomized, multicenter, double-blind parallel pilot study comparing the efficacy of drugs (the enzyme hyaluronidase and corticosteroid DEPO-Medrol) administered during epiduroscopy with standard treatment, focusing on releasing foraminal adhesions. Study participants (n=48) with a diagnosis of chronic back surgery syndrome were randomized into 2 groups prior to epiduroscopy. Group A received mechanical lysis of fibrotic tissue in the epidural space (considered standard treatment), while Group B received medications. Subjects were followed for 6 and 12 months via scheduled double-blinded examinations by pain physicians. Leg and back pain intensity were assessed by an 11-point numerical rating scale, and patients' functional disability was assessed by the ODI. Participants in both groups showed a significant decrease in ODI score as well as significantly lower scores for leg and back pain in both groups at 6 months. However, the 1-year follow-up showed a return to the baseline ODI values of most monitored pain scores in both groups. Improvement was only noted on the numerical rating scale for back pain at 1 year. No significant difference between groups were observed. The authors concluded that while epiduroscopy with either standard treatment or drug therapy resulted in significant improvement of leg and back pain after 6 months, drug treatment was more durable for this study group.

Hong Park and Ho Lee (2017) conducted a prospective study of 78 patients with degenerative lumbar spinal stenosis to assess the relationship between improvement shown on epidurogram and subjective patient response after undergoing PA. Each subject underwent magnetic resonance imaging (MRI) of the lumbar spine, with all therapeutic procedures conducted in the operating room. Two weeks later, a second epidurography was performed to assess any change in epidural filling defects. Outcome measures were obtained using the VAS score at 2, 4, and 12 weeks post-treatment. All of the participants displayed epidural filling defects at baseline. After PA, epidurographic filling defects were absent in 73% of patients. In the presence or absence of filling defects, mean VAS scores were 5.2 and 4.5 at 2 weeks, respectively. There was no significant correlation between postprocedural VAS score and status of filling defects (yes or no) at 3 months. The authors' conclusion was that epidurographic findings following PA failed to correlate with level of pain reduction achieved in patients with degenerative lumbar spinal stenosis.

Lee et al. (2014) conducted a systematic review on the subject of epidural LOA. Evidence based literature considered in the review included clinical trials, various studies (observational, retrospective, prospective, and animal), review articles, case series and reports, and guidelines published between 1970 and 2013. The efficacy of epidural LOA in the cervical region has been addressed in several studies, none of which were RCTs. In one cited study (Park et al., 2013), baseline data was not reported, making it difficult to accurately interpret data during the follow-up period. Interventions performed on the cervical spine were noted to be associated with higher complication rates and possible additional risks when compared to like procedures at other spinal levels. Regarding the lumbar region, epidural LOA was evaluated in diagnoses including but not limited to pain in the low back and lower extremities, post lumbar surgery syndrome, and refractory radiculopathy. Many studies (including Manchikanti, 2004 described below) indicate that epidural LOA has good long-term benefit and is superior to conventional epidural steroid injection and conservative therapy; however, discrepancy exists among systematic reviews regarding the strength of the evidence. Limitations to the studies include conclusions and recommendations being impacted by the paucity of high-quality

randomized studies and the lack of trials performed by a broader group of clinician investigators, as well as the lack of randomized studies comparing percutaneous and endoscopic LOA and lack of factors associated with outcomes. The authors concluded that the evidence surrounding LOA at any vertebral level is still controversial. Larger, more methodologically sound studies that compare adhesiolysis to placebo and to other treatments are needed to better determine effectiveness.

A randomized, multi-center, double-blind trial was conducted by Gerdesmeyer et al. to analyze the clinical efficacy of percutaneous epidural LOA in chronic radicular pain. Out of 381 patients with pain lasting longer than 4 months which failed to respond to conservative treatments, 90 individuals were enrolled. Participants were randomly assigned to receive either percutaneous neurolysis or placebo. The primary outcome measure was the differences in percent change of ODI scores 3 months post-procedure. Secondary outcome measures were difference in percent change of ODI scores and VAS scores. The ODI and VAS scores as well as the success rates for ODI vs VAS were significantly better at 3, 6, and 12 months in the lysis group vs the control group. The ODI in the lysis group improved from 55.3 to 26.4 after 3 months. The placebo group improved from 55.4 to 41.8. VAS improved from 6.7 to 2.9 in the active group and from 6.7 to 4.8 after placebo. Twelve month follow-up shows further improvement, with the differences remaining significant. A limitation of the study noted by the authors is that specific effects of single treatment components cannot be specified because there was no imaging examination after treatment (2013).

In 2013, Helm et al. published a systematic review evaluating and updating the effectiveness of spinal endoscopic adhesiolysis in treating post lumbar surgery syndrome. Of the 21 studies identified, only 4 met inclusion criteria (1 RCT and 3 observational studies). Pain relief and functional improvement were the primary outcome measures. Other outcome measures were improvement of psychological status, opioid intake, and return to work. Short-term effectiveness was defined as improvement of 12 months or less, and long-term efficacy was 12 months or more. Using USPSTF criteria, the authors concluded that the evidence is fair that endoscopic adhesiolysis is effective in treating chronic low back and/or lower extremity pain caused by post lumbar surgery syndrome, and should be considered to be low risk for serious adverse complications. Limitations of this study include the paucity of literature. There are also noted conflicts of interest with several of the researchers which may limit the conclusions that can be drawn from the study.

In an update conducted 3 years later by Helm and associates (2016) the researchers evaluated the efficacy of PA and spinal endoscopic adhesiolysis in the treatment of chronic refractory low back and lower extremity pain. In this systematic review, 45 studies were identified. Of these, 7 RCTs and 3 observational studies on PA met the inclusion criteria. For spinal endoscopy, there was 1 RCT and 3 observational studies. Primary outcome measures were pain relief of at least 50% and functional improvement of at least 40%. Short-term efficacy was defined as improvement of 6 months or less, and long-term efficacy was more than 6 months. The researchers concluded that PA to treat refractory low back and lower extremity pain is safe and effective, supported by multiple RCTs. However, endoscopic adhesiolysis is a technique which has limited evidence supporting its use. Additional studies regarding this technology are in progress. Conflicts of interest are again cited with several of the researchers which may limit the study's conclusions.

A RCT by Manchikanti et al. (2009a) compared the effectiveness of PA with epidural steroid injections in post surgical patients with chronic low back and lower extremity pain. There were 60 patients in each group. Outcomes were measured using the Numeric Rating Scale (NRS), ODI, employment status, and opioid intake. Follow-up occurred at 3, 6, and 12 months post treatment. In the adhesiolysis group, the average number of procedures performed was 3.5 with pain relief reported for 42 out of 52 weeks. Pain relief and functional status improvement were >50% and 73% of patients, respectively. The epidural steroid group averaged 2.2 injections and achieved pain relief for 13 out of 52 weeks. Only 12% of patients reported pain relief and improved functional status. A total of 43 patients in the epidural steroid group were lost to follow-up compared with 2 patients from the adhesiolysis group. The authors concluded that PA is effective in patients with post lumbar surgery syndrome. The study reports preliminary results and is limited by lack of subjective end points. The significant number of patients lost to follow-up in the epidural steroid group limits the ability to accurately compare the 2 procedures.

Another RCT by Manchikanti et al. (2009b) compared the effectiveness of PA with fluoroscopically directed caudal epidural injections in patients with chronic low back and lower extremity pain associated with lumbar central spinal stenosis. There were 25 patients in each group. Outcomes were measured using the NRS, ODI, employment status, and opioid intake. Follow-up occurred at 3, 6, and 12 months post treatment. Significant pain relief was described as 50% or more, whereas significant improvement in the disability score was defined as a reduction of 40% or more. All patients underwent similar procedures with the exception of 2 main differences; Group I had the catheter introduced up to S3 and injection of normal saline while Group II had targeted catheter placement to the level of the defect and injection of 10% sodium chloride solution. The study showed

pain relief in 76% of the adhesiolysis group at 1 year compared to 4% in the control group. A total of 18 patients (72%) in the control group were lost to follow-up. The authors concluded that PA is effective in patients with lumbar spinal stenosis. The study reports preliminary results and is limited by small sample size, lack of comparison to a placebo group or conservative treatment, subjective outcomes and inability to generalize across all populations.

A systematic review by Epter et al. (2009) which includes the Manchikanti (2004) study below, evaluated the effectiveness of PA in managing chronic low back and lower extremity pain due to post lumbar surgery syndrome. Of the 263 studies identified, 13 were considered for inclusion with only 7 meeting the inclusion criteria. The primary outcome measure was pain relief (short-term relief of at least 6 months and long-term relief of more than 6 months). Secondary outcome measures were improvement in functional status, psychological status, return to work, and change in opioid intake. All of the 3 randomized trials showed positive results for short and long-term relief. All 4 of the 4 observational studies reflected positive short-term improvement, but only 3 of 4 reported positive long-term relief. The authors concluded that PA is an effective treatment, it is superior to epidural steroid injections, and it is a safe procedure for failed back surgery syndrome when performed appropriately

Manchikanti et al. (2004) conducted a study on 75 patients who were randomized into 3 treatment groups. Three types of interventions were included, with Group I serving as control with catheterization without adhesiolysis, followed by injection of local anesthetic, normal saline, and steroid. Group II consisted of catheterization and adhesiolysis, followed by injection of local anesthetic, normal saline, and steroid. Group III consisted of adhesiolysis followed by injection of local anesthetic, hypertonic saline, and steroid. VAS pain scores, ODI, work status, opioid intake, range of motion measurement, and P-3 were utilized to measure outcomes. Significant pain relief was defined as average relief of 50% or greater. Significant improvement was seen in patients in Group II and III, at 3 months, 6 months, and 12 months, compared to baseline measurements, as well as compared to Group I without adhesiolysis. Seventy-two percent of patients in Group III, 60% of patients in Group II, compared to 0% in Group I showed significant improvement at 12 months. The average number of treatments was 2.1 to 2.8 to obtain the improvements reported. Duration of improvement after the initial treatment was 2.8 months (+/- 1.49 months) in Group II and 3.8 months (+/- 3.37 months) in Group III. The authors concluded that PA, with or without hypertonic saline neurolysis, is an effective treatment for chronic LBP.

There are open clinical trials studying epiduroscopy and epidural LOA for LBP. There are no trials identified studying these procedures for cervical spine conditions. For more information, go to [www.clinicaltrials.gov](http://www.clinicaltrials.gov). (Accessed November 5, 2020)

### ***National Institute for Health and Care Excellence (NICE)***

A 2010 statement 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. Further research on this procedure should clearly describe case selection. Outcomes should include pain relief, duration of effectiveness and whether other treatments are subsequently required.

### ***Professional Societies***

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

The ASIPP recommends PA in patients with post lumbar surgery syndrome and lumbar central spinal stenosis after failure of conservative management of PT, chiropractic, drug therapy, structured exercise program, and fluoroscopically directed epidural injections. Due to limited evidence and rare use of spinal epidural endoscopic adhesiolysis, this technique was not discussed. (Manchikanti et al, 2013a)

## **U.S. Food and Drug Administration (FDA)**

This section is to be used for informational purposes only. FDA approval alone is not a basis for coverage.

Products such as endoscopes, catheters, and needles that can be used for epidural LOA are numerous. See the following website for more information and search by product name in the device name section:

<http://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfPMN/pmn.cfm> (Accessed November 9, 2020).

Products intended to help diagnose the cause of chronic LBP are numerous. See the following website for more information and search by product name in the device name section: <http://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfPMN/pmn.cfm> (Accessed November 9, 2020).

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## Guideline History/Revision Information

Date	Summary of Changes
02/01/2021	<p><b>Applicable Codes</b></p> <ul style="list-style-type: none"><li>Added CPT codes 62291 and 72285</li></ul> <p><b>Supporting Information</b></p> <ul style="list-style-type: none"><li>Updated <i>Description of Services, Clinical Evidence, and References</i> sections to reflect the most current information</li><li>Archived previous policy version MMG042.I</li></ul>

## Instructions for Use

This Medical Management Guideline provides assistance in interpreting UnitedHealthcare standard benefit plans. When deciding coverage, the member specific benefit plan document must be referenced as the terms of the member specific benefit plan may differ from the standard plan. In the event of a conflict, the member specific benefit plan document governs. Before using this guideline, please check the member specific benefit plan document and any applicable federal or state mandates. UnitedHealthcare reserves the right to modify its Policies and Guidelines as necessary. This Medical Management Guideline is provided for informational purposes. It does not constitute medical advice.

UnitedHealthcare may also use tools developed by third parties, such as the MCG™ Care Guidelines, to assist us in administering health benefits. UnitedHealthcare West Medical Management Guidelines are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.

Member benefit coverage and limitations may vary based on the member's benefit plan Health Plan coverage provided by or through UnitedHealthcare of California, UnitedHealthcare Benefits Plan of California, UnitedHealthcare of Oklahoma, Inc., UnitedHealthcare of Oregon, Inc., UnitedHealthcare Benefits of Texas, Inc., or UnitedHealthcare of Washington, Inc.