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Lysis of Epidural Adhesions

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Disclaimer

Carefully check state regulations and/or the member contract. Each benefit plan, summary plan description or contract defines which services are covered, which services are excluded, and which services are subject to dollar caps or other limitations, conditions or exclusions. Members and their providers have the responsibility for consulting the member's benefit plan, summary plan description or contract to determine if there are any exclusions or other benefit limitations applicable to this service or supply. **If there is a discrepancy between a Medical Policy and a member's benefit plan, summary plan description or contract, the benefit plan, summary plan description or contract will govern.**

Coverage

Catheter-based techniques for lysis of epidural adhesions, with or without endoscopic guidance, **are considered experimental, investigational and/or unproven.** Techniques used either alone or in combination include mechanical disruption with a catheter and/or injection of hypertonic solutions with corticosteroids, analgesics, or hyaluronidase.

Policy Guidelines

Protocols for lysis of epidural adhesions vary. The following codes may be used to describe lysis of adhesions:

- There is no specific code for endoscopic lysis of epidural adhesions therefore unlisted code 64999 is used.

- CPT 62263 describes the percutaneous insertion using a solution injection.
- CPT 62264; as noted above but limited to 1 day only.
- There is instruction following CPT 77003 that states 62263 and 62264 includes fluoroscopic guidance and localization.
- Lysis of epidural adhesions using hypertonic saline may be offered as a component of a multimodality pain management program.

Description

Lysis of epidural adhesions involves passing a catheter, either endoscopically or percutaneously, under fluoroscopic guidance into the epidural space to break up adhesions and reduce pain and inflammation.

Background

Epidural Fibrosis and Adhesive Arachnoiditis

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 surgery syndrome”. Both conditions result from the 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.

Epidural fibrosis and adhesive arachnoiditis 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, pain is characterized as constant and burning. In some cases, pain and disability are severe, leading to analgesic dependence and chronic invalidism.

Treatment

Lysis of epidural adhesions, also called the Racz procedure, has been investigated as a treatment option. The Racz procedure involves the passage of a fluoroscopically guided catheter (the Racz catheter), inserted either endoscopically or percutaneously, and the use of epidural injections of hypertonic saline in conjunction with corticosteroids and analgesics. Theoretically, the use of hypertonic saline results in mechanical disruption of the adhesions. The saline 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, but the procedure is more commonly performed percutaneously using epidurography to guide

catheter placement and identify nonfilling adhesions that indicate epidural scarring. Using endoscopy guidance, a flexible fiberoptic catheter is inserted into the sacral hiatus, providing 3-dimensional visualization to steer the catheter toward the adhesions. With the increased visualization, the catheter is more apt to 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 to treat degenerative chronic low back pain, including spondylolisthesis, stenosis, and hernia associated with radiculopathy. Along with mechanical adhesiolysis, hyaluronidase, ciprofloxacin, and ozone have been applied.

Regulatory Status

Lysis of epidural adhesions is a surgical procedure and, as such, is not subject to regulation by the U.S. Food and Drug Administration.

Rationale

This policy is based on a review of relevant professional association recommendations.

Practice Guidelines and Position Statements

American Society of Interventional Pain Physicians

The American Society of Interventional Pain Physicians published a guideline addressing epidural interventions in the management of chronic spinal pain in 2021. (1) That document included the following statements regarding the use of percutaneous adhesiolysis:

- The evidence for percutaneous adhesiolysis in managing disc herniation based on one high-quality, placebo-controlled RCT is Level II with moderate to strong recommendation for long-term improvement in patients nonresponsive to conservative management and fluoroscopically guided epidural injections
- The evidence for percutaneous adhesiolysis in lumbar stenosis based on relevant, moderate to high quality RCTs, observational studies, and systematic reviews is Level II with moderate to strong recommendation for long-term improvement after failure of conservative management and fluoroscopically guided epidural injections.
- For percutaneous adhesiolysis, based on multiple moderate to high-quality RCTs and systematic reviews, the evidence is Level I with strong recommendation for long-term improvement after failure of conservative management and fluoroscopically guided epidural injections.

ASIPP prepared these epidural intervention guidelines based on a comprehensive review of the literature, but acknowledged that limitations include a continued paucity of high-quality

studies for some techniques and various conditions including spinal stenosis, post-surgery syndrome, and discogenic pain.

National Institute for Health and Care Excellence

In 2010, NICE issued guidance on therapeutic endoscopic division of epidural adhesions, offering the following (2):

- "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."

Coding

Procedure codes on Medical Policy documents are included **only** as a general reference tool for each policy. **They may not be all-inclusive.**

The presence or absence of procedure, service, supply, or device codes in a Medical Policy document has no relevance for determination of benefit coverage for members or reimbursement for providers. **Only the written coverage position in a Medical Policy should be used for such determinations.**

Benefit coverage determinations based on written Medical Policy coverage positions must include review of the member's benefit contract or Summary Plan Description for defined coverage vs. non-coverage, benefit exclusions, and benefit limitations such as dollar or duration caps.

CPT Codes	62263, 62264, 64999
HCPCS Codes	J7131

*Current Procedural Terminology (CPT®) ©2025 American Medical Association: Chicago, IL.

References

1. 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*. Jan. 2021; 24(S1):S27-208. PMID 33492918
2. National Institute for Health and Care Excellence (NICE). Therapeutic endoscopic division of epidural adhesions. IPG333. February 2010. Available at [nice.org.uk](https://www.nice.org.uk) (accessed Dec. 27, 2025).

Centers for Medicare & Medicaid Services

The information contained in this section is for informational purposes only. HCSC makes no representation as to the accuracy of this information. It is not to be used for claims adjudication for HCSC Plans.

The Centers for Medicare & Medicaid Services does not have a national Medicare coverage position. Coverage may be subject to local carrier discretion.

A national coverage position for Medicare may have been developed since this medical policy document was written. See Medicare's National Coverage at [cms.hhs.gov](https://www.cms.hhs.gov).

Policy History/Revision

Date	Description of Change
5/7/2026	New medical document. Catheter-based techniques for lysis of epidural adhesions, with or without endoscopic guidance, are considered experimental, investigational and/or unproven. Techniques used either alone or in combination include mechanical disruption with a catheter and/or injection of hypertonic solutions with corticosteroids, analgesics, or hyaluronidase.