Epiduroscopy (including spinal myeloscopy) is unproven for the diagnosis of back pain. There is insufficient evidence to conclude that epiduroscopy can improve patient management or disease outcomes. The available studies primarily evaluated the feasibility of the procedure and the ability to visualize normal and pathological structures with an epiduroscope. None of the studies systematically evaluated the accuracy of epiduroscopy for diagnosis of causes of back pain and neurological signs.

Percutaneous and endoscopic epidural lysis of adhesions is unproven for the treatment of back pain. There is insufficient evidence to conclude that epidural lysis of adhesions can provide sustained reduction in chronic back pain in patients with a presumptive diagnosis of epidural adhesions. No published studies have evaluated this procedure relative to open surgical procedures for chronic
back pain. Further validation with larger study populations and long term follow up is needed to verify the effectiveness of epidural adhesiolysis in the treatment of back pain.

**Functional anesthetic discography (FAD) is unproven for the diagnosis of back pain.** Although researchers are presently investigating the use of FAD for diagnosing discogenic pain, there is insufficient evidence at this time to draw conclusions.

**BACKGROUND**

Epiduroscopy involves the percutaneous insertion of a fiberoptic endoscope to view the epidural space that is inside the spinal canal. Epiduroscopy has been proposed as a technique to identify pathological structures such as epidural adhesions, fibrosis, and scars. This is also done with a myeloscope which is a video-guided catheter system and introducer system.

Epidural lysis of adhesions (adhesiolysis, percutaneous epidural neuroplasty, epidurolysis) involves injection of 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. Epidural adhesiolysis can also be performed percutaneously, using a needle to enter the epidural space at the level of the spinal column where adhesions are suspected. Adhesions are then disrupted using a catheter or solutions injected through the catheter. (Hayes, 2006) Endoscopic and percutaneous epidural adhesiolysis may also involve injection of anesthetics, steroids, hypertonic saline solutions, and/or hyaluronidase into the epidural space. Another variation of this procedure involves the use of the Racz® Catheter and RK® Needle. The Racz procedure uses a specialized catheter, x-ray contrast dye, and x-ray fluoroscopy to position the end of the catheter at the adhesions and near the affected nerve roots. Once the catheter is in place, a local anesthetic, a corticosteroid, hyaluronidase, and a concentrated saline solution are delivered multiple times through the catheter, followed by injections of contrast medium to show whether the adhesions have opened, and to monitor the flow of the solution within the affected area. After the initial injection, additional treatments are given every 24 hours for 2 – 3 days. (ECRI, 2012)

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 patient 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 patient 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.

**CLINICAL EVIDENCE**

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 these studies evaluated the impact of epiduroscopy on clinical management or patient outcomes.

Two studies concluded that epiduroscopy could identify the cause of pain and other neurological signs in some patients who had been either undiagnosed or incorrectly diagnosed by radiography or magnetic resonance imaging (MRI). Uchiyama et al. (1998) reported that in 4 out of 18 patients, epiduroscopy identified a spinal cord mass that had been diagnosed radiographically as a cyst or herniation of the spinal cord. In another study, Geurts et al. (2002) reported that epiduroscopy outperformed MRI in 8 out of 20 patients with chronic sciatica with or without FBSS. In this study, MRI findings agreed with epiduroscopy observations in 11 patients, while epiduroscopy identified an adhesion on the nerve root in 8 patients in whom MRI detected no abnormalities of the spinal structures. However, this study was very small and no conclusions regarding the relative accuracy of epiduroscopy versus MRI for diagnosis of spinal cord or epiduroscopy, Epidural Lysis of Adhesions and Functional Anesthetic Discography: Medical Policy (Effective 02/01/2014)
epidural pathology can be drawn. In this study, patients with adhesions were treated with a combination of hyaluronidase, steroid, and clonidine; this therapy appeared to provide significant pain relief in some patients, although the effect diminished within 12 months. These results were similar to those reported earlier by Richardson et al. (2001), who described reductions in pain and disability in patients with adhesions who were treated with steroids and clonidine during epiduroscopy examinations.

Igarashi et al. (2004) conducted a study of 58 patients with degenerative lumbar spinal stenosis who were placed into 2 groups, 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 low back pain for up to 1 year in both groups.

Three case studies involving 10 patients or less per study have been performed evaluating epiduroscopy or myeloscopy. The case studies are of small sample size and do not establish safety or efficacy. (Blomberg and Olsson, 1989; Shimoji et al., 1991; Saberski and Kitahata, 1995).

Further studies, preferably randomized controlled trials, are necessary to evaluate the safety and efficacy of epiduroscopy.

**Professional Societies and Organizations**

**American College of Occupational and Environmental Medicine (ACOEM):** A 2007 guideline recommends against the use of myeloscopy and discography for evaluating and managing low back disorders.

The clinical evidence was reviewed on October 23, 2013 with no additional information identified that would change the unproven conclusion.

**Epidural Lysis of Adhesions**

Trescott et al. (2007) conducted a systematic review utilizing the methodologic quality criteria of the Cochrane Musculoskeletal Review Group for randomized trials and the criteria established by the Agency for Healthcare Research and Quality (AHRQ) for evaluation of randomized and non-randomized trials. This was done to evaluate and update the effectiveness of percutaneous adhesiolysis and spinal endoscopic adhesiolysis in managing chronic low back and lower extremity pain due to radiculopathy, with or without prior lumbar surgery, since the 2005 systematic review. The primary outcome measure was significant pain relief (50% or greater). Other outcome measures were functional improvement, improvement of psychological status, and return to work. Short-term relief was defined as less than 3 months, and long-term relief was defined as 3 months or longer. The evidence from the previous systematic review was combined with new studies since November 2004. The authors concluded that there is strong evidence for short-term and moderate evidence for long-term effectiveness of percutaneous adhesiolysis and spinal endoscopy.

A randomized controlled trial by Manchikanti et al. (2009a) compared the effectiveness of percutaneous epidural adhesiolysis 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), the Oswestry Disability Index 2.0 (ODI), employment status, and opioid intake. Follow-up occurred at 3, 6, and 12 months post treatment. The average procedures performed were 3.5 with the adhesiolysis group having relief for 42 out of 52 weeks. This resulted in significant pain relief (> 50%) and functional status improvement in 73% of the patients. The epidural steroid group average 2.2 injections and had pain relief for 13 out of 52 weeks with only 12% of patients reporting pain relief and improvement in 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 percutaneous epidural adhesiolysis is effective in patients with post lumbar surgery syndrome. The study reports
preliminary results and is limited by lack of subjective end points and the significant number of patients lost to follow-up in the epidural steroid group limits ability to compare the 2 procedures.

Another randomized controlled trial by Manchikanti et al. (2009b) compared the effectiveness of percutaneous epidural adhesiolysis with fluoroscopically directed caudal epidural injections in patients with chronic low back and lower extremity pain with lumbar central spinal stenosis. There were 25 patients in each group. Outcomes were measured using the Numeric Rating Scale (NRS), the Oswestry Disability Index 2.0 (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 placement to the level of the defect and injection of 10% sodium chloride solution. The study showed pain relief (> 50%) in 76% of the adhesiolysis group patients at one year follow-up 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 percutaneous epidural adhesiolysis 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.

Veihelmann et al. (2006) conducted a study of 99 patients with chronic lower back pain and sciatica to investigate whether minimally invasive techniques for adhesiolysis are superior to conservative treatment with physiotherapy. Patients were randomly assigned into either a group with physiotherapy (n=52) or a group undergoing epidural neuroplasty (n=47). Patients were assessed before and 3, 6, and 12 months after treatment by a blinded investigator. After 3 months, the visual analog scale (VAS) score for back and leg pain, was significantly reduced in the epidural neuroplasty group, and the need for pain medication was reduced in both groups. Furthermore, the VAS for back and leg pain as well as the Oswestry disability score were significantly reduced until 12 months after the procedure in contrast to the group that received conservative treatment. The authors concluded that epidural neuroplasty results in significant alleviation of pain and functional disability in patients with chronic low back pain and sciatica based on disc protrusion/prolapse or failed back surgery on a short-term basis as well as at 12 months of follow-up. However, a serious shortcoming of this study is that 13 (25%) of the patients who underwent physical therapy were not available for follow-up at 3 months due to refusal of re-evaluation (n=10) or treatment with open discectomy (n=3). Pain and disability were assessed at 6 and 12 months in patients who remained in the study; however, it is difficult to interpret these data since 12 (23%) of the patients who underwent physical therapy chose to undergo epidural adhesiolysis and they were also excluded from the study. For patients who underwent adhesiolysis as their initial treatment, improvements were relatively stable over time. Specifically, mean disability score was 54% better at 3 months versus 50% better at 12 months and mean leg and back pain scores were 67% to 68% better at 3 months versus 61% better at 12 months. Parallel improvements were observed in a measure of analgesic use but the statistical significance of change in this outcome measure was not reported.

Manchikanti et al. (2004) conducted another 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. Visual Analogue Scale pain scores, Oswestry Disability Index, work status, opioid intake, range of motion measurement, and P-3 was 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-month follow up. 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 +/- 1.49 months in Group II and 3.8 +/- 3.37 months in Group III. The
authors concluded that percutaneous adhesiolysis, with or without hypertonic saline neurolysis, is
an effective treatment for chronic low back pain.

Heavner et al. (1999) performed an early randomized controlled trial that evaluated 4 variations of
percutaneous epidural adhesiolysis. For this study, 59 patients were randomized to and
completed adhesiolysis with or without hypertonic saline and with or without hyaluronidase. All
treatment groups had similar outcomes, both at discharge and at 12 months follow-up. For
instance, pain scores at discharge were decreased at least 3 points on a 10-point scale in 80% to
88% of patients in every treatment group; however, approximately 70% of patients underwent 1
or more additional treatments such as repeat adhesiolysis, lumbar facet injection, hypogastric
plexus blocks, muscle injections, nerve root injections, or spinal cord stimulation. The mean time
between adhesiolysis and the first additional treatment was approximately 2.3 months for all
groups. This study did not include a conservatively treated control group and there was a financial
conflict-of-interest for one of the investigators.

A systematic review by Epter et al. (2009) which included the 3 studies above (Veihelmann et al.,
2006; Manchikanti et al., 2004; Heavner et al., 1999) evaluated the effectiveness of percutaneous
adhesiolysis 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. Of the 3 randomized trials evaluating percutaneous adhesiolysis, all showed positive
results for short and long-term relief. Of the 4 observational studies, 3 studies showed positive
results for both short- and long-term improvement, whereas one study was positive for short-term
and negative for long-term relief. The authors concluded that percutaneous adhesiolysis 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. It is unclear why evidence was not
included in the review during the timeframe of 1999 and 2009.

Sakai et al. (2008) evaluated the effect of adhesiolysis followed by the injection of steroid and
local anesthetic during epiduroscopy on sensory nerve function, pain, and functional disability in
patients with chronic sciatica in 19 patients with chronic sciatica refractory to lumbar epidural
block. At all frequencies, the current perception threshold (CPT) values in the affected legs of
patients before the epiduroscopy were significantly higher than those in the unaffected legs.
Epidural adhesiolysis was successfully performed in 16 of the 19 patients. In these patients, the
CPT values at 2000 and 250 Hz, and the pain and RMDQ scores 1 and 3 months after the
epiduroscopy were significantly lower than those before the epiduroscopy, while the CPT value at
5 Hz did change. The authors concluded that epidural adhesiolysis followed by the injection of
steroid and local anesthetic during epiduroscopy alleviated pain, and functional disability, and
reduced dysfunction of Abeta (the largest in diameter and fastest in sensory conduction of the
sensory nerve fibers) and Adelta (smaller in diameter and slower in sensory conduction than A-
beta sensory nerve fibers) fibers in patients with chronic sciatica.

In a literature review by Racz et al. (2008), primary sources of information included: (1) 2
systematic literature reviews that include literature published through September 2006; (2) expert
opinions; and (3) peer-reviewed publications from September 2006 to January 2008. The focus
was on percutaneous entry using catheters via the sacral hiatus to treat pain in the lumbosacral
region. The evidence is strong for short-term efficacy (3 months) and moderate for long-term
efficacy (greater than 3 months). Complications do occur, but there is limited literature that
documents incidence. The authors concluded that the cumulative evidence through January 2008
showed that percutaneous adhesiolysis with targeted drug delivery is an effective treatment for
LBP and/or radiculopathy.
Another study of percutaneous epidural adhesiolysis by Manchikanti et al. (2001) evaluated this treatment in comparison with conservative, noninvasive treatments for chronic, severe low back pain. This study was a quasi-randomized controlled trial since the 45 patients were assigned to treatment groups based on patient preference and/or insurance coverage of adhesiolysis. For this study, adhesiolysis was combined with epidural injection of steroid and hypertonic saline. Although patient outcomes were assessed over an 18-month period, the true length of follow-up (time elapsed after the final treatment) was not reported and patients assigned to adhesiolysis underwent a mean of 5.8 full adhesiolysis procedures. At the final assessment, the 30 patients who underwent adhesiolysis had a 49% decrease in mean pain score, 42% increase in mean physical health score, 71% increase in mean functional status score, and 52% increase in mean mental health score. All of these improvements were statistically significant compared with conservative treatment, which provided a 10% decrease in mean pain score and no improvement in the other three measures. Compared with conservative treatment, adhesiolysis was also associated with statistically significant improvements in heavy narcotic use. However, these seem to be short-term benefits since the mean duration of 50% or more of pain relief was only 2.1 months after treatment or retreatment.

Manchikanti et al. (2005) randomized 83 patients with chronic lower back pain to adhesiolysis with steroid injection (n=50) or steroid injection alone (n=33). These patients had failed to obtain significant relief with conservative treatments including percutaneous adhesiolysis. During this study, patients were not allowed to undergo a second adhesiolysis or other procedure. Endoscopic adhesiolysis was associated with statistically significant improvements in all outcome measures at 12 months follow-up. For instance, mean pain score was 37% lower for patients who underwent adhesiolysis versus 3% lower for patients who only underwent steroid injection, a statistically significant difference. Improvements were also seen in measures of functional improvement. A 31% improvement in mean Oswestry disability score was seen 12 months after adhesiolysis versus a 3% improvement after steroid injection alone. Similarly, 41% to 86% improvements were seen in three measures of spinal range-of-motion after adhesiolysis versus 5% worsening to 12% improvement for the steroid injection Control Group. For assessments of depression, anxiety, and somatization, mean scores were 14% to 16% lower after adhesiolysis versus 1% higher to 2% lower after steroid injection alone. In addition, employment increased from 2% at baseline to 32% at 12 months after adhesiolysis versus no change after steroid injection alone. An analysis of 50% or more of pain relief over time indicated that the average duration of this benefit was 7.6 to 4.7 months. The average duration of other improvements was not reported. A significant shortcoming of this study is that 33 (40%) patients were not available for follow-up at 12 months.

Professional Societies and Organizations
American College of Occupational and Environmental Medicine (ACOEM) practice guidelines on low back disorders, (2007) state that adhesiolysis is not recommended to treat acute, subacute or chronic low back pain, spinal stenosis, or radicular pain syndromes.

The American Society of Interventional Pain Physicians updated their practice guidelines on the management of chronic spinal pain in 2009. The guideline states that “evidence for percutaneous adhesiolysis is strong in managing chronic low back and lower extremity pain in post surgery syndrome. The evidence is moderate in managing low back and lower extremity pain secondary to disc herniation producing radiculopathy. The evidence is limited in managing back and/or lower extremity pain secondary to spinal stenosis.” It further states that “the evidence is Level II-1 or II-2 for endoscopic adhesiolysis in post lumbar laminectomy syndrome in management of pain secondary to post-lumbar surgery syndrome based on one randomized controlled trial.” The studies cited in the guideline have been reviewed for this policy.

National Institute for Health and Clinical Excellence (NICE): A 2010 assessment by NICE 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. This
procedure therefore should only be used with special arrangements for consent and audit or research.”

The clinical evidence was reviewed on October 23, 2013 with no additional information identified that would change the unproven conclusion.

**Functional Anesthetic Discography (FAD)**

No significant evidence was found in the peer-reviewed literature to support the use of FAD for diagnosing discogenic pain. In addition, there is insufficient evidence to assess the safety and efficacy of FAD.

Luchs et al. (2007) presented their preliminary experience with FAD in the evaluation of patients with suspected discogenic low back pain at the 2007 American Roentgen Ray Society Annual Meeting (Abstract #152, May 8th). For the study, investigators performed FAD in 19 patients (13 men, 6 women; mean age 47.2 years) who underwent lumbar discography for suspected discogenic low back pain. A total of 29 discs were injected with anesthetic and then studied using discography and CT examination. In addition, patients were asked to perform maneuvers that would typically elicit their pain symptoms. Nineteen of the 29 (65.5%) injected discs showed a favorable response (pain relief greater than 3 visual analog pain scale units) compared with ten (34.5%) injected discs that did not show a favorable response. In those patients with a favorable FAD response, 19 discs showed a provocative response during discography and 18 discs showed the presence of disc pathology on CT examination. In patients with an unfavorable FAD response, 8 discs showed a provocative discographic response, and 6 discs showed the presence of disc pathology on CT examination. The authors cautioned that even though FAD seemed to work in some cases, it often actually raised more questions as to diagnosis.

A case series by Alamin et al. (2008) presented the findings of 3 patients in whom FAD was used for the evaluation of presumptive discogenic low back pain. Of the 3 patients, only 1 patient had the results from a provocative discography confirmed by FAD. The authors concluded that further studies are needed in order to make more definitive recommendations with regards to the validity and utility of this new technique.

Alamin et al (2011) compared the results of standard pressure-controlled provocative discography (PD) to those of the functional anesthetic discogram (FAD) in a prospective series of 52 patients presenting with chronic low back pain. 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) an FAD. Discordant results of the two 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 provocative discogram had been positive at two 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.

In a systemic review by the Work Loss Data Institute on low back pain (2011), functional anesthetic discography was not recommended for the diagnosis of low back pain.

**Professional Societies and Organizations**

There are no position statements or consensus documents from the major medical societies that specifically address FAD.

**U.S. FOOD AND DRUG ADMINISTRATION (FDA)**

Endoscopes, catheters, and needles that can be used for epidural lysis of adhesions are regulated by the FDA as Class II devices and a number of these devices have been approved via the FDA 510(k) process. The Racz Catheter received FDA approval on October 8, 1996 (K954584). The Myelotec Myeloscope received 510(k) approval on September 4, 1996.

**Epiduroscopy, Epidural Lysis of Adhesions and Functional Anesthetic Discography: Medical Policy (Effective 02/01/2014)**

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The FAD System (originally developed by InnoSpine and later acquired by Kyphon Inc.) received 510(k) approval through the U.S. Food and Drug Administration (FDA) in April 2005 (FDA, K043500). According to the FDA, the intended use of the system is to deliver either a single dose or continuous administration of radiopaque contrast, local anesthetics, and/or saline solution to the intradiscal space. Additional information is available at: http://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfPMN/pmncfm. Accessed November 7, 2013


**CENTERs FOR MEDICARE AND MEDICAID SERVICES (CMS)**

Medicare does not have a National Coverage Determination (NCD) for discography, epiduroscopy or epidural lysis of adhesions. Local Coverage Determinations (LCDs) do exist. Refer to the LCDs for Endoscopic and Percutaneous Lysis of Epidural Adhesions, Non-Covered Services and Pain Management. Accessed November 11, 2013

**APPLICABLE CODES**

The codes listed in this policy are for reference purposes only. Listing of a service or device code in this policy does not imply that the service described by this code is a covered or non-covered health service. Coverage is determined by the benefit document. This list of codes may not be all inclusive.

<table>
<thead>
<tr>
<th>CPT® Code</th>
<th>Description</th>
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<tr>
<td>62263</td>
<td>Percutaneous lysis of epidural adhesions using solution injection (e.g., hypertonic saline, enzyme) or mechanical means (eg, 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 (eg, catheter) including radiologic localization (includes contrast when administered), multiple adhesiolysis sessions; 1 day</td>
</tr>
<tr>
<td>62292</td>
<td>Injection procedure for chemonucleolysis, including discography, intervertebral disc, single or multiple levels, lumbar</td>
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<tr>
<td>64999</td>
<td>Unlisted procedure, nervous system</td>
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**Coding Clarification:**
Functional anesthetic discography should be billed with CPT code 64999.

**REFERENCES**


Epiduroscopy, Epidural Lysis of Adhesions and Functional Anesthetic Discography: Medical Policy (Effective 02/01/2014)

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Epiduroscopy, Epidural Lysis of Adhesions and Functional Anesthetic Discography: Medical Policy (Effective 02/01/2014)


### POLICY HISTORY/REVISION INFORMATION

<table>
<thead>
<tr>
<th>Date</th>
<th>Action/Description</th>
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| 02/01/2014 | • Updated description of services to reflect most current clinical evidence, FDA information and references; no change to coverage rationale or list of applicable codes  
            | • Archived previous policy version 2013T0206K                                      |