Medical Coverage Policy | Manipulation Under Anesthesia

EFFECTIVE DATE: 05|18|2016
POLICY LAST UPDATED: 05|01|2018

OVERVIEW
Manipulation under anesthesia (MUA) consists of a series of mobilization, stretching, and traction procedures performed while the patient is sedated (usually with general anesthesia or moderate sedation).

MEDICAL CRITERIA
Not applicable

PRIOR AUTHORIZATION
Not applicable

POLICY STATEMENT
BlueCHiP for Medicare
Spinal manipulation and manipulation of other joints performed during the procedure (e.g., hip joint) with the patient under anesthesia, spinal manipulation under joint anesthesia, and spinal manipulation after epidural anesthesia and corticosteroid injection are considered not covered for treatment of chronic spinal (cranial, cervical, thoracic, lumbar) pain and chronic sacroiliac and pelvic pain as the evidence is insufficient to determine the effects of the technology on health outcomes.

Spinal manipulation and manipulation of other joints under anesthesia involving serial treatment sessions is considered not covered as the evidence is insufficient to determine the effects of the technology on health outcomes.

Manipulation under anesthesia (MUA) involving multiple body joints is considered not covered for treatment of chronic pain as the evidence is insufficient to determine the effects of the technology on health outcomes.

Manipulation under anesthesia for fractures, completely dislocated joints, adhesive capsulitis (eg, frozen shoulder), and/or fibrosis of a joint that may occur following total joint replacement may be considered medically necessary.

Commercial Products
Spinal manipulation and manipulation of other joints performed during the procedure (e.g., hip joint) with the patient under anesthesia, spinal manipulation under joint anesthesia, and spinal manipulation after epidural anesthesia and corticosteroid injection are considered not medically necessary for treatment of chronic spinal (cranial, cervical, thoracic, lumbar) pain and chronic sacroiliac and pelvic pain as the evidence is insufficient to determine the effects of the technology on health outcomes.

Spinal manipulation and manipulation of other joints under anesthesia involving serial treatment sessions is considered not medically necessary as the evidence is insufficient to determine the effects of the technology on health outcomes.

Manipulation under anesthesia (MUA) involving multiple body joints is considered not medically necessary for treatment of chronic pain as the evidence is insufficient to determine the effects of the technology on health outcomes.

Manipulation under anesthesia for fractures, completely dislocated joints, adhesive capsulitis (eg, frozen shoulder), and/or fibrosis of a joint that may occur following total joint replacement may be considered medically necessary.

COVERAGE

Benefits may vary between groups and contracts. Please refer to the appropriate section of the Benefit Booklet, Evidence of Coverage or Subscriber Agreement for applicable not medically necessary/not covered benefits/coverage.

BACKGROUND

Manipulation is intended to break up fibrous and scar tissue to relieve pain and improve range of motion. Anesthesia or sedation is used to reduce pain, spasm, and reflex muscle guarding that may interfere with the delivery of therapies and to allow the therapist to break up joint and soft-tissue adhesions with less force than would be required to overcome patient resistance or apprehension. MUA is generally performed with an anesthesiologist in attendance. MUA is an accepted treatment for isolated joint conditions, such as arthrofibrosis of the knee and adhesive capsulitis. It is also used to reduce fractures (eg, vertebral, long bones) and dislocations.

MUA has been proposed as a treatment modality for acute and chronic pain conditions, particularly of the spine, when standard care, including manipulation, and other conservative measures have failed. MUA of the spine has been used in various forms since the 1930s. Complications from general anesthesia and forceful long-lever, high-amplitude nonspecific manipulation procedures led to decreased use of the procedure in favor of other therapies. MUA was modified and revived in the 1990s. This revival has been attributed to increased interest in spinal manipulative therapy and the advent of safer, shorter-acting anesthesia agents used for conscious sedation.

MUA Administration

MUA of the spine is described as follows: after sedation, a series of mobilization, stretching, and traction procedures to the spine and lower extremities is performed and may include passive stretching of the gluteal and hamstring muscles with straight leg raise, hip capsule stretching and mobilization, lumbosacral traction, and stretching of the lateral abdominal and paraspinal muscles. After the stretching and traction procedures, spinal manipulative therapy (SMT) is delivered with high-velocity, short-amplitude thrust applied to a spinous process by hand while the upper torso and lower extremities are stabilized. SMT may also be applied to the thoracolumbar or cervical area when necessary to address the low back pain.

MUA takes 15–20 minutes, and after recovery from anesthesia, the patient is discharged with instructions to remain active and use heat or ice for short-term analgesic control. Some practitioners recommend performing the procedure on three or more consecutive days for best results. Care after MUA may include 4–8 weeks of active rehabilitation with manual therapy including SMT and other modalities.

Manipulation has also been performed after injection of local anesthetic into lumbar zygapophyseal (facet) and/or sacroiliac joints under fluoroscopic guidance (manipulation under joint anesthesia/analgesia) and after epidural injection of corticosteroid and local anesthetic (manipulation postepidural injection). Spinal MUA has also been combined with other joint manipulation during multiple sessions. Together, these therapies may be referred to as medicine-assisted manipulation.

For individuals who have chronic spinal, sacroiliac, or pelvic pain who receive MUA, the scientific evidence on spinal MUA, spinal manipulation with joint anesthesia, and spinal manipulation after epidural anesthesia and corticosteroid injection is very limited. Evidence on the efficacy of MUA over several sessions or for multiple joints is also lacking. The evidence is insufficient to determine the effects of the technology on health outcomes. Therefore, MUA is considered not medically necessary.

CODING

The following code is not covered for BlueCHiP for Medicare and not medically necessary for Commercial Products when used for the indications listed above:

22505 Manipulation of spine requiring anesthesia, any region

RELATED POLICIES

Not applicable

PUBLISHED

Provider Update, July 2018
Provider Update, October 2017
Provider Update, November 2016
Provider Update, May 2015
Provider Update, May 2014
Provider Update, June 2013
Provider Update, May 2012

REFERENCES

1. Dagenais S, Mayer J, Wooley JR, et al. Evidence-informed management of chronic low back pain with medicineassisted manipulation. Spine J. Jan-Feb 2008;8(1):142-149. PMID 18164462

2. Digiorgi D. Spinal manipulation under anesthesia: a narrative review of the literature and commentary. Chiropr Man Therap. May 14 2013;21(1):14. PMID 23672974

3. Kohlbeck FJ, Haldeman S, Hurwitz EL, et al. Supplemental care with medication-assisted manipulation versus spinal manipulation therapy alone for patients with chronic low back pain. J Manipulative Physiol Ther. May 2005;28(4):245-252. PMID 15883577

4. Palmieri NF, Smoyak S. Chronic low back pain: a study of the effects of manipulation under anesthesia. J Manipulative Physiol Ther. Oct 2002;25(8):E8-E17. PMID 12381983

5. Peterson CK, Humphreys BK, Vollenweider R, et al. Outcomes for chronic neck and low back pain patients after manipulation under anesthesia: a prospective cohort study. J Manipulative Physiol Ther. Jul-Aug 2014;37(6):377-382. PMID 24998720

6. West DT, Mathews RS, Miller MR, et al. Effective management of spinal pain in one hundred seventy-seven patients evaluated for manipulation under anesthesia. J Manipulative Physiol Ther. Jun 1999;22(5):299-308. PMID 10395432

7. Dougherty P, Bajwa S, Burke J, et al. Spinal manipulation postepidural injection for lumbar and cervical radiculopathy: a retrospective case series. J Manipulative Physiol Ther. Sep 2004;27(7):449-456. PMID 15389176

8. Dreyfuss P, Michaelsen M, Horne M. MUJA: manipulation under joint anesthesia/analgesia: a treatment approach for recalcitrant low back pain of synovial joint origin. J Manipulative Physiol Ther. Oct 1995;18(8):537-546. PMID 8583177

9. Michaelsen MR. Manipulation under joint anesthesia/analgesia: a proposed interdisciplinary treatment approach for recalcitrant spinal axis pain of synovial joint origin. J Manipulative Physiol Ther. Feb 2000;23(2):127-129. PMID 10714542

10. Gordon R, Cremata E, Hawk C. Guidelines for the practice and performance of manipulation under anesthesia. Chiropr Man Therap. Feb 03 2014;22(1):7. PMID 24490957

11. American Academy of Osteopathy. Consensus statement for osteopathic manipulation of somatic dysfunction under anesthesia and conscious sedation. AAO J. Jun 2005;15(2):26-27.

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