

Medical Coverage Policy | Manipulation Under Anesthesia



EFFECTIVE DATE: 05|18|2012

POLICY LAST UPDATED: 08|22|2016

OVERVIEW

Manipulation under anesthesia (MUA) consists of a series of mobilization, stretching, and traction procedures performed while the patient receives anesthesia (usually general anesthesia or moderate sedation). This policy does not address manipulation under anesthesia for fractures, completely dislocated joints, adhesive capsulitis (e.g., frozen shoulder), and/or fibrosis of a joint that may occur following total joint replacement.

MEDICAL CRITERIA

Not applicable.

PRIOR AUTHORIZATION

Not applicable.

POLICY STATEMENT

BlueCHiP for Medicare and Commercial

Spinal manipulation (and manipulation of other joints, e.g., hip joint, performed during the procedure) 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 there is insufficient peer-reviewed scientific literature that demonstrates that the procedure/service is not medically necessary.

Spinal manipulation and manipulation of other joints under anesthesia involving serial treatment sessions is considered not medically necessary as there is insufficient peer-reviewed scientific literature that demonstrates that the procedure/service is not medically necessary.

Manipulation under anesthesia (MUA) involving multiple body joints is considered not medically necessary for treatment of chronic pain as the evidence regarding the efficacy of MUA over several sessions or for multiple joints is lacking peer-reviewed scientific literature that demonstrates that the procedure/service is not medically necessary.

COVERAGE

Benefits may vary by group/contract. Please refer to the appropriate Member Certificate or Subscriber Agreement for services not medically necessary and 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. Manipulation has also been performed after injection of local anesthetic into lumbar zygapophyseal and/or sacroiliac joints under fluoroscopic guidance (manipulation under joint anesthesia/analgesia) and after epidural injection of corticosteroid and local anesthetic (manipulation postepidural injection).

MUA is described as follows: after sedation is achieved, 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 if considered necessary to address the low back pain. The 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 consecutive days for best results. Care after MUA may include 4–8 weeks of active rehabilitation with manual therapy including SMT and other modalities.

Scientific evidence regarding spinal manipulation under anesthesia, spinal manipulation with joint anesthesia, and spinal manipulation after epidural anesthesia and corticosteroid injection is limited to observational case series and nonrandomized comparative studies. For individuals who have chronic spinal, sacroiliac, or pelvic pain who receive manipulation under anesthesia, the evidence includes case series and nonrandomized comparative studies. Relevant outcomes are symptoms, functional outcomes, quality of life, and treatment-related morbidity. Scientific evidence regarding spinal MUA, spinal manipulation with joint anesthesia, and spinal manipulation after epidural anesthesia and corticosteroid injection is very limited. No RCTs have been identified. Evidence regarding 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, thus it is considered not medically necessary.

CODING

BlueCHiP for Medicare and Commercial

The following code is not medically necessary when used for the indications listed above:

22505: Manipulation of spine requiring anesthesia, any region

RELATED POLICIES

Not applicable.

PUBLISHED

Provider Update, November 2016

Provider Update, May 2015

Provider Update, May 2014

Provider Update, June 2013

Provider Update, May 2012

Provider Update, July 2011

Provider Update, July 2010

REFERENCES

1. 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
2. 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
3. Dagenais S, Mayer J, Wooley JR et al. Evidence-informed management of chronic low back pain with medicine-assisted manipulation. *Spine J* 2008; 8(1):142-91

4. 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 1999; 22(5):299-308.
5. 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 2005; 28(4):245-52.

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