

(80140)

Medical Benefit		Effective Date: 10/01/11	Next Review Date: 05/21
Preauthorization	No	Review Dates: 09/09, 05/10, 05/11, 05/12, 05/13, 05/14, 05/15, 05/16, 05/17, 05/18, 05/19, 05/20	

Preauthorization is not required.

The following protocol contains medical necessity criteria that apply for this service. The criteria are also applicable to services provided in the local Medicare Advantage operating area for those members, unless separate Medicare Advantage criteria are indicated. If the criteria are not met, reimbursement will be denied and the patient cannot be billed. Please note that payment for covered services is subject to eligibility and the limitations noted in the patient's contract at the time the services are rendered.

Populations	Interventions	Comparators	Outcomes
Individuals: <ul style="list-style-type: none"> • With chronic spinal, sacroiliac, or pelvic pain 	Interventions of interest are: <ul style="list-style-type: none"> • Manipulation under anesthesia 	Comparators of interest are: <ul style="list-style-type: none"> • Conservative management 	Relevant outcomes include: <ul style="list-style-type: none"> • Symptoms • Functional outcomes • Quality of life • Treatment-related morbidity

DESCRIPTION

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).

SUMMARY OF EVIDENCE

For individuals who have chronic spinal, sacroiliac, or pelvic pain who receive MUA, the evidence includes case series and nonrandomized comparative studies. The relevant outcomes are symptoms, functional outcomes, quality of life, and treatment-related morbidity. Scientific evidence on spinal MUA, spinal manipulation with joint anesthesia, and spinal manipulation after epidural anesthesia and corticosteroid injection is very limited. No randomized controlled trials have been identified. 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.

POLICY

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 **investigational** for treatment of chronic spinal (cranial, cervical, thoracic, lumbar) pain and chronic sacroiliac and pelvic pain.

Spinal manipulation and manipulation of other joints under anesthesia involving serial treatment sessions is considered **investigational**.

Manipulation under anesthesia involving multiple body joints is considered **investigational** for the treatment of chronic pain.

POLICY GUIDELINES

This protocol 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.

BACKGROUND

MANIPULATION UNDER ANESTHESIA

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 (e.g., 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 1930's. 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 1990's. 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 are 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 is delivered with high-velocity, short-amplitude thrust applied to a spinous process by hand, while the upper torso and lower extremities are stabilized. Spinal manipulative therapy may also be applied to the thoracolumbar or cervical area when necessary to address low back pain.

MUA takes 15 to 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 four to eight weeks of active rehabilitation with manual therapy, including spinal manipulative therapy 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 post-epidural 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.

This review does not address MUA for fractures, completely dislocated joints, adhesive capsulitis (e.g., frozen shoulder), and/or fibrosis of a joint that may occur following total joint replacement.

REGULATORY STATUS

Manipulative procedures are not subject to regulation by the U.S. Food and Drug Administration.

Services that are the subject of a clinical trial do not meet our Technology Assessment and Medically Necessary Services Protocol criteria and are considered investigational. *For explanation of experimental and investigational, please refer to the Technology Assessment and Medically Necessary Services Protocol.*

It is expected that only appropriate and medically necessary services will be rendered. We reserve the right to conduct prepayment and postpayment reviews to assess the medical appropriateness of the above-referenced procedures. **Some of this protocol may not pertain to the patients you provide care to, as it may relate to products that are not available in your geographic area.**

REFERENCES

We are not responsible for the continuing viability of web site addresses that may be listed in any references below.

1. 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.
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