BlueCross BlueShield of Alabama

Name of Blue Advantage Policy:

Manipulation under Anesthesia for Treatment of Chronic Spinal or Pelvic Pain

Policy #: 154
Category: Therapy

Latest Review Date: April 2020
Policy Grade: B

BACKGROUND:

Blue Advantage *medical policy does not conflict with Local Coverage Determinations (LCDs), Local Medical Review Policies (LMRPs) or National Coverage Determinations (NCDs) or with coverage provisions in Medicare manuals, instructions or operational policy letters. In order to be covered by Blue Advantage the service shall be reasonable and necessary under Title XVIII of the Social Security Act, Section 1862(a)(1)(A). The service is considered reasonable and necessary if it is determined that the service is:*

1. *Safe and effective;*
2. *Not experimental or investigational*;*
3. *Appropriate, including duration and frequency that is considered appropriate for the service, in terms of whether it is:*
   - *Furnished in accordance with accepted standards of medical practice for the diagnosis or treatment of the patient's condition or to improve the function of a malformed body member;*
   - *Furnished in a setting appropriate to the patient's medical needs and condition;*
   - *Ordered and furnished by qualified personnel;*
   - *One that meets, but does not exceed, the patient's medical need; and*
   - *At least as beneficial as an existing and available medically appropriate alternative.*

Routine costs of qualifying clinical trial services with dates of service on or after September 19, 2000 which meet the requirements of the Clinical Trials NCD are considered reasonable and necessary by Medicare. Providers should bill* ***Original Medicare* *for covered services that are related to* ***clinical trials*** *that meet Medicare requirements (Refer to Medicare National Coverage Determinations Manual, Chapter 1, Section 310 and Medicare Claims Processing Manual Chapter 32, Sections 69.0-69.11).*

POLICY:

Effective for dates of service on or after December 1, 2014:

Blue Advantage will treat **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** as a **non-covered** benefit and as **investigational for treatment of chronic spinal (cranial, cervical, thoracic, lumbar) pain and chronic sacroiliac and pelvic pain**.

Blue Advantage will treat **spinal manipulation under anesthesia involving serial treatment sessions** as a **non-covered benefit** and as **investigational**.

This policy does not address the use of spinal manipulation under anesthesia for the treatment of vertebral fracture or dislocation.

Please refer to policy #345 for the Manipulation of Other Joints under Anesthesia.

Blue Advantage does not approve or deny procedures, services, testing, or equipment for our members. Our decisions concern coverage only. The decision of whether or not to have a certain test, treatment or procedure is one made between the physician and his/her patient. Blue Advantage administers benefits based on the members' contract and medical policies. Physicians should always exercise their best medical judgment in providing the care they feel is most appropriate for their patients. Needed care should not be delayed or refused because of a coverage determination.

DESCRIPTION OF PROCEDURE OR SERVICE:

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).

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. Manipulation under anesthesia (MUA) is generally performed with an anesthesiologist in attendance. Manipulation under anesthesia 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.

Manipulation under anesthesia has been proposed as a treatment modality for acute and chronic pain conditions, particularly of the spinal region, when standard care, including manipulation, and other conservative measures have been unsuccessful. Manipulation under anesthesia 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 resulted in decreased

use of the procedure in favor of other therapies. Manipulation under anesthesia was modified and revived in the 1990s. This revival is attributed to increased interest in spinal manipulative therapy and the advent of safer, shorter-acting anesthesia agents used for conscious sedation.

Manipulation under anesthesia of the spine 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 ta 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.

Manipulation under anesthesia 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 SMT and other modalities. 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 [MUJA]) and after epidural injection of corticosteroid and local anesthetic (manipulation post-epidural injection [MUES]}/spinal manipulation under anesthesia has also been combined with other joint manipulation during multiple sessions. Together, these may be referred to as medicine-assisted manipulation (MAM).

KEY POINTS:

The most recent update with literature review was performed using the MEDLINE database through February 11, 2020.

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. 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.

Practice Guidelines and Position Statements

American Association of Manipulation Under Anesthesia Providers

The American Association of Manipulation Under Anesthesia Providers (2014) published consensus-based guidelines for the practice and performance of manipulation under anesthesia (MUA). The guidelines included patient selection criteria, establishing medical necessity,

frequency and follow-up procedures, parameters for determining MUA progress, general post-MUA therapy, and safety. The guidelines recommended 3 consecutive days of treatment, based on the premise that serial procedures allow a gentler yet effective treatment plan with better control of biomechanical force. The guidelines also recommended follow-up therapy without anesthesia over 8 weeks after MUA that includes all fibrosis release and manipulative procedures performed during the MUA procedure to help prevent re-adhesion.

Patient selection criteria include, but are not limited to, the following:

- "The patient has undergone an adequate trial of appropriate care...and continues to experience intractable pain, interference to activities of daily living, and/or biomechanical dysfunction.
- "Sufficient care has been rendered prior to recommending MUA. A sufficient time period is usually considered a minimum of 4-8 weeks, but exceptions may apply depending on the patient's individual needs....
- "Physical medicine procedures have been utilized in a clinical setting during the 6-8 week period prior to recommending MUA.
- "Diagnosed conditions must fall within the recognized categories of conditions responsive to MUA. The following disorders are classified as acceptable conditions for utilization of MUA:

    1. "Patients for whom manipulation of the spine or other articulations is the treatment of choice; however, the patient's pain threshold inhibits the effectiveness of conservative manipulation.
    2. "Patients for whom manipulation of the spine or other articulations is the treatment of choice; however, due to the extent of the injury mechanism, conservative manipulation has been minimally effective...and a greater degree of movement of the affected joint(s) is needed to obtain patient progress.
    3. "Patients for whom manipulation of the spine or other articulations is the treatment of choice by the doctor; however due to the chronicity of the problem, and/or the fibrous tissue adhesions present, in-office manipulation has been incomplete and the plateau in the patient's improvement is unsatisfactory.
    4. "When the patient is considered for surgical intervention, MUS is an alternative and/or an interim treatment and may be used as a therapeutic and/or diagnostic tool in the overall consideration of the patient's condition.
    5. "When there are no better treatment options available for the patient in the opinions of the treating doctor and patient."

American Academy of Osteopathy

The American Academy of Osteopathy (AAO) published a consensus statement in 2005 on osteopathic manipulation of somatic dysfunction under anesthesia and conscious sedation. The AAO states that manipulation under anesthesia may be appropriate in cases of restrictions and

abnormalities of function that include recurrent muscle spasm, range-of-motion restrictions, persistent pain secondary to injury and/or repetitive motion trauma, and is in general limited to patients who have somatic dysfunction which:

1. Has failed to respond to conservative treatment in the office or hospital that has included the use of osteopathic manipulative therapy, physical therapy and medication; and/or
2. Is so severe that muscle relaxant medication, anti-inflammatory medication or analgesic medications are of little benefit; and/or
3. Results in biomechanical impairment which may be alleviated with use of the procedure.

U.S. Preventive Services Task Force Recommendations
The U.S. Preventive Services Task Force has not addressed MUA.

KEY WORDS:
Spinal manipulation under anesthesia, SMUA, pelvic pain, MUA, MAM

APPROVED BY GOVERNING BODIES:
Manipulative procedures are not subject to regulation by the U.S. Food and Drug Administration.

BENEFIT APPLICATION:
Coverage is subject to member's specific benefits. Group specific policy will supersede this policy when applicable.

CODING:
CPT:

00640	Anesthesia for manipulation of the spine or for closed procedures on the cervical, thoracic or lumbar spine
22505	Manipulation of spine requiring anesthesia, any region

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POLICY HISTORY:

Adopted for Blue Advantage, March 2005
Available for comment May 1-June 14, 2005
Medical Policy Group, March 2006
Medical Policy Group, March 2008
Medical Policy Group, March 2010
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Medical Policy Group, June 2010
Medical Policy Group, October 2010
Medical Policy Group, January 2014
Medical Policy Group, December 2014
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Medical Policy Group, September 2017
Medical Policy Group, May 2018
Medical Policy Group, April 2019
Medical Policy Group, April 2020