MEDICAL POLICY

POLICY TITLE	MANIPULATION UNDER ANESTHESIA
POLICY NUMBER	MP 8.006

Effective Date:	8/1/2023

I. POLICY

Manipulation under anesthesia (MUA) may be considered **medically necessary** for a single treatment of isolated joint conditions for the following;

- Shoulder - when performed to treat adhesive capsulitis of the shoulder. When there is failure of conservative medical management, including medications with or without articular injections, home exercise programs, and physical therapy.

Note: This policy is not intended to apply to examinations under anesthesia, or to the one time reduction of displaced fractures and acute or traumatic joint dislocations.
MUA is considered **investigational** for the following:

- Shoulder conditions other than listed above.
- Treatment of chronic pain (such as cranial, cervical, thoracic, lumbar, sacroiliac, and pelvic)
- Spinal manipulation (and manipulation of other joints, e.g., hip joint performed during the procedure).
- Spinal manipulation after epidural anesthesia and corticosteroid injection.
- Manipulation of multiple joints.
- Manipulation of other joints such as ankle, elbow, finger, hip, wrist, temporomandibular for the treatment of pain, contractures, stiffness, or arthritis.
- Serial manipulations.

There is insufficient evidence to support a general conclusion concerning the health outcomes or benefits associated with this procedure for these indications.

Cross-references:

Note: See Turning Point for criteria on knee manipulations under anesthesia.

II. PRODUCT VARIATIONS

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This policy is only applicable to certain programs and products administered by Capital Blue Cross and subject to benefit variations as discussed in Section VI. Please see additional information below.

III. DESCRIPTION/BACKGROUND

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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. Manipulation under anesthesia (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 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 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 3 or more consecutive days for best results. Care after MUA may include 4 to 8 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 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.

REGULATORY STATUS

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

IV. RATIONALE

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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. Safety outcomes in these settings are poorly described. The evidence is insufficient to determine the effects of the technology on health outcomes.

V. DEFINITIONS

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N/A

VI. BENEFIT VARIATIONS

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The existence of this medical policy does not mean that this service is a covered benefit under the member's health benefit plan. Benefit determinations should be based in all cases on the applicable health benefit plan language. Medical policies do not constitute a description of benefits. A member's health benefit plan governs which services are covered, which are excluded, which are subject to benefit limits and which require preauthorization. There are different benefit plan designs in each product administered by Capital Blue Cross. Members and providers should consult the member's health benefit plan for information or contact Capital Blue Cross for benefit information.

VII. DISCLAIMER

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Capital Blue Cross's medical policies are developed to assist in administering a member's benefits, do not constitute medical advice, and are subject to change. Treating providers are solely responsible for medical advice and treatment of members. Members should discuss any medical policy related to their coverage or condition with their provider and consult their benefit information to determine if the service is covered. If there is a discrepancy between this medical policy and a member's benefit information, the benefit information will govern. If a provider or a member has a question concerning the application of this medical policy to a specific member's plan of benefits, please contact Capital Blue Cross' Provider Services or Member Services.

VIII. CODING INFORMATION

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Note: This list of codes may not be all-inclusive, and codes are subject to change at any time. The identification of a code in this section does not denote coverage as coverage is determined by the terms of member benefit information. In addition, not all covered services are eligible for separate reimbursement.

Manipulation Under Anesthesia (MUA), other than the shoulder, is investigational; therefore, not covered:

Procedure Codes							
21073	22505	24300	25259	26340	27275	27860	

Manipulation Under Anesthesia (MUA) of the shoulder may be considered medically necessary for a single treatment of isolated joint conditions:

Procedure Codes							
23700							

ICD-10-CM Diagnosis Code	Description
M75.00	Adhesive capsulitis of unspecified shoulder
M75.01	Adhesive capsulitis of right shoulder
M75.02	Adhesive capsulitis of left shoulder

IX. REFERENCES

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1. Dagenais S, Mayer J, Wooley JR, et al. Evidence-informed management of chronic low back pain with medicine assisted 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

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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
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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
12. Blue Cross Blue Shield Association Medical Policy Reference Manual. 8.01.40, manipulation Under Anesthesia. May 2023

Other:
1. *Ng CY, Amin AK, Narborough S, et al. Manipulation under anesthesia and early physiotherapy facilitate recovery of patients with frozen shoulder syndrome. Scott Med J. 2009; 54(1):29-31.*
2. *Taber's Cyclopedic Medical Dictionary 19th edition.*

X. POLICY HISTORY

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MP-8.006	**CAC 01/28/2003**
	CAC 01/25/2005
	CAC 02/28/2006 Consensus
	CAC 02/27/2007
	CAC 11/27/2007
	CAC 01/27/2009
	CAC 01/26/2010 Consensus
	CAC 04/26/2011 Minor revision. A policy statement was added that spinal manipulation and manipulation of other joints under anesthesia involving serial treatment sessions is considered investigational. A policy statement was also added that manipulation under anesthesia involving multiple body joints is considered investigational for treatment of chronic pain.
	CAC 08/28/2012 Adopting BCBSA for the following changes**.**

	• Use of manipulation under anesthesia for treatment of arthrofibrosis of the knee – ROM limitation of <90 degrees was deleted. • Added MN statement for use in treatment of long bone fractures or dislocations. Previously limited to vertebral fractures • Added investigational statement on use for manipulation with patient under anesthesia, spinal manipulation under joint anesthesia, and spinal manipulation after epidural anesthesia and corticosteroid injection for treatment of chronic spinal (cranial, cervical, thoracic, lumbar) pain and chronic sacroiliac and pelvic pain. Also, added note "Manipulation under anesthesia (MUA) of the shoulder or knee should be attempted only after an adequate trial of conservative measures (physical therapy and joint injections) have failed to restore range of motion and relieve pain" for further clarification of policy statement. Added FEP variation to reference FEP Medical Policy Manual MP-8.01.40 Manipulation Under Anesthesia for Treatment of Chronic Spinal or Pelvic Pain
	04/08/2013 Administrative code review
	CAC 07/30/2013 Consensus review**.** References updated but no changes to the policy statements.
	CAC 03/25/2014 Consensus review. References updated but no changes to the policy statements. Rationale added**.** No coding changes.
	03/24/2015 CAC Consensus review. No changes to the policy statements. Codes reviewed, not unmanaged.
	03/29/2016 CAC Consensus review. No change to policy statement. Rationale and references updated. ICD-9 coding removed.
	11/23/2016 Administrative update. Variation section reformatted.
	07/26/2016 CAC Minor review. Added criteria for coverage of shoulder and knee manipulation under anesthesia. Listed and clarified investigational indications. Added note indication policy is not intended to apply to examinations under anesthesia, or to the one time reduction of displaced fractures and acute or traumatic joint dislocations. Coding reviewed/updated based on policy.
	07/25/2017 CAC Consensus review. No change to the policy statements. References reviewed. Coding reviewed.
	05/09/2018 Consensus review. No changes to the policy statements. Background and rationale revised. References updated.
	07/23/2018 Administrative update. Removed indications for knee manipulation. See Turning Point policy for criteria related to knee manipulations effective 9/1/18.
	05/16/2019 Consensus review. No changes to the policy statements
	10/01/2019 Administrative update. Code review completed. Unlisted code added for shoulder.

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	06/25/2020 Consensus Review. No change to policy statement. References reviewed and updated. Coding reviewed with no changes. Product variation statement updated.
	05/25/2021 Consensus Review. No change to policy statement. Product Variation statement updated. References reviewed and updated.
	05/25/2022 Consensus review. No change to policy statement. Coding table format updated. No coding changes. References reviewed and updated.
	4/28/2023 Consensus review. No changes to policy statement. Rationale updated. References reviewed and updated. No changes to coding.

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