8.01.40	Manipulation Under Anesthesia		
Original Policy Date:	February 26, 1997	**Effective Date:**	June 1, 2024
Section:	8.0 Therapy	**Page:**	Page 1 of 12

Policy Statement

I. Spinal manipulation and manipulation of other joints performed during the procedure (e.g., hip joint) with the individual under anesthesia, spinal manipulation under local (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.

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

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

NOTE: Refer to Appendix A to see the policy statement changes (if any) from the previous version.

Policy Guidelines

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.

Coding
See the Codes table for details.

Description

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

Related Policies

- N/A

Benefit Application

Benefit determinations should be based in all cases on the applicable contract language. To the extent there are any conflicts between these guidelines and the contract language, the contract language will control. Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage of these services as it applies to an individual member.

Some state or federal mandates (e.g., Federal Employee Program [FEP]) prohibits plans from denying Food and Drug Administration (FDA)-approved technologies as investigational. In these instances, plans may have to consider the coverage eligibility of FDA-approved technologies on the basis of medical necessity alone.

Regulatory Status

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

Rationale

Background

Manipulation Under Anesthesia

Manipulation is intended to break up fibrous and scar tissue to relieve pain and improve range of motion.[1,] 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 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 spine, when standard care, including manipulation, and other conservative measures have failed. 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 led to decreased use of the procedure in favor of other therapies. Manipulation under anesthesia 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.

Manipulation Under Anesthesia Administration

Manipulation under anesthesia 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.[1,] 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.

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 3 or more consecutive days for best results. Care after manipulation under anesthesia 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 post epidural injection). Spinal manipulation under anesthesia 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 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.

Literature Review

Evidence reviews assess the clinical evidence to determine whether the use of a technology improves the net health outcome. Broadly defined, health outcomes are length of life, quality of life, and ability to function including benefits and harms. Every clinical condition has specific outcomes that are important to patients and to managing the course of that condition. Validated outcome measures are necessary to ascertain whether a condition improves or worsens; and whether the magnitude of that change is clinically significant. The net health outcome is a balance of benefits and harms.
To assess whether the evidence is sufficient to draw conclusions about the net health outcome of a technology, 2 domains are examined: the relevance and the quality and credibility. To be relevant, studies must represent 1 or more intended clinical use of the technology in the intended population and compare an effective and appropriate alternative at a comparable intensity. For some conditions, the alternative will be supportive care or surveillance. The quality and credibility of the evidence depend on study design and conduct, minimizing bias and confounding that can generate incorrect findings. The randomized controlled trial (RCT) is preferred to assess efficacy; however, in some circumstances, nonrandomized studies may be adequate. Randomized controlled trials are rarely large enough or long enough to capture less common adverse events and long-term effects. Other types of studies can be used for these purposes and to assess generalizability to broader clinical populations and settings of clinical practice.

Promotion of greater diversity and inclusion in clinical research of historically marginalized groups (e.g., People of Color [African-American, Asian, Black, Latino and Native American]; LGBTQIA (Lesbian, Gay, Bisexual, Transgender, Queer, Intersex, Asexual); Women; and People with Disabilities [Physical and Invisible]) allows policy populations to be more reflective of and findings more applicable to our diverse members. While we also strive to use inclusive language related to these groups in our policies, use of gender-specific nouns (e.g., women, men, sisters, etc.) will continue when reflective of language used in publications describing study populations.

Manipulation Under Anesthesia

Clinical Context and Therapy Purpose

The purpose of manipulation under anesthesia is to provide a treatment option that is an alternative to or an improvement on existing therapies, such as conservative management, in individuals with chronic spinal, sacroiliac, or pelvic pain.

The following PICO was used to select literature to inform this review.

Populations

The relevant population of interest is individuals with chronic spinal, sacroiliac, or pelvic pain.

Interventions

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

Comparators

Comparators of interest include conservative management.

Conservative management includes steroid regimens, blood pressure medication, muscle relaxers, and physical therapy.

Outcomes

The general outcomes of interest are symptoms, functional outcomes, quality of life, and treatment-related morbidity.

The existing literature evaluating manipulation under anesthesia as a treatment for chronic spinal, sacroiliac, or pelvic pain has varying lengths of follow-up, ranging from 2 weeks to 6 months. While studies described below all reported at least 1 outcome of interest, longer follow-up was necessary to fully observe outcomes. Therefore, 6 months of follow-up is considered necessary to demonstrate efficacy.

Table 1 summarizes the patient-reported outcome measures described in this review.

Table 1. Patient Self-Administered Outcome Measure Tools

Name	Description	Scoring	MCID
Numeric Pain Scale[2,]	Numbered scale by which patients rate their pain, similar to VAS	0-10 scale: • 10=excruciating pain • 0=no pain	Reduction of ≥2 points (≈30%) to be clinically important
Roland-Morris Disability Questionnaire[3,]	24 questions that measure low back pain-related disability	"Yes" answers are totaled to determine disability (1 to 24) Score of ≥14 represents significant disability	Change of ≥4 points required for clinically applicable change to be measured accurately
Bournemouth Questionnaire[4,]	7-question, multidimensional tool to assess outcome of care in a routine clinical setting Takes into account cognitive and affective aspects of pain Two versions: low back pain and nonspecific neck pain	Each question rated on a numeric rating scale from 0 to 10: • 0=much better • 5=no change • 10=much worse Scores are totaled, for minimum of 0 and maximum of 70	Percentage improvement of 47% in back pain and 34% in neck pain
Patient's Global Impression of Change[4,]	7-point scale of how a patient perceives the efficacy of treatment, a rating of overall improvement from baseline	Scale of 1 to 7: • 1=no change or condition is worse • 2=almost the same • 3=a little better, but no noticeable change • 4=somewhat better, but no real difference • 5=moderately better, slight noticeable change • 6=better, definite improvement with real difference • 7=a great deal better, considerable improvement	Clinically relevant improvement, response of ±6

MCID: minimal clinically important difference; VAS: visual analog scale.

Study Selection Criteria

Methodologically credible studies were selected using the following principles:

- To assess efficacy outcomes, comparative controlled prospective trials were sought, with a preference for RCTs;
- In the absence of such trials, comparative observational studies were sought, with a preference for prospective studies.
- To assess long-term outcomes and adverse events, single-arm studies that capture longer periods of follow-up and/or larger populations were sought.
- Studies with duplicative or overlapping populations were excluded.

Review of Evidence

Dagenais et al (2008) conducted a comprehensive review of the history of manipulation under anesthesia or medicine-assisted manipulation and the published experimental literature.[5,] The authors noted there was no research to confirm theories about a mechanism of action for these procedures and that the only RCT identified was published in 1971 when the techniques for spinal manipulation differed from those used presently. The possibility of serious complications related to manipulative force is also noted, including reported cases of cauda equina syndrome, paralysis, and vertebral fracture and dislocation; the authors state that such complications may be more likely with older techniques, but otherwise note that most reported studies do not describe safety outcomes.

Nonrandomized Comparative Studies

No high-quality RCTs have been identified. A comprehensive review of the literature by Digiorgi (2013)[6,] described studies by Kohlbeck et al (2005)[7,] and Palmieri and Smoyak (2002)[3,] as being the best evidence available for medicine-assisted manipulation and manipulation under anesthesia of the spine.

Kohlbeck et al (2005) reported on a nonrandomized comparative study that included 68 patients with chronic low back pain.[7,] All patients received an initial 4- to 6-week trial of spinal manipulation therapy, after which 42 patients received supplemental intervention with manipulation under anesthesia and 26 continued with spinal manipulative therapy. Low back pain and disability measures favored the manipulation under anesthesia group over the spinal manipulative therapy only group at 3 months (adjusted mean difference on a 100-point scale, 4.4 points; 95% confidence interval [CI], -2.2 to 11.0). This difference attenuated at 1 year (adjusted mean difference, 0.3 points; 95% CI, -8.6 to 9.2). The relative odds of experiencing a 10-point improvement in pain and disability favored the manipulation under anesthesia group at 3 months (odds ratio [OR], 4.1; 95% CI, 1.3 to 13.6) and 1 year (OR, 1.9; 95% CI, 0.6 to 6.5).

Palmieri and Smoyak (2002) evaluated the efficacy of self-reported questionnaires to study manipulation under anesthesia in a convenience sample of 87 subjects from 2 ambulatory surgery centers and 2 chiropractic clinics.[3,] Thirty-eight patients with low back pain received manipulation under anesthesia and 49 received traditional chiropractic treatment. A numeric rating scale for pain and the Roland-Morris Disability Questionnaire were administered at baseline, after the procedure, and 4 weeks later. Average pain scale scores in the manipulation under anesthesia group decreased by 50% and by 26% in the traditional treatment group; Roland-Morris Disability Questionnaire scores decreased by 51% and 38%, respectively. Although the authors concluded that the study supported the need for large-scale studies on manipulation under anesthesia and that the assessments were easily administered and dependable, no large-scale studies comparing manipulation under anesthesia with traditional chiropractic treatment have been identified.

Observational Studies

Peterson et al (2014) reported on a prospective study of 30 patients with chronic pain (17 lower back, 13 neck) who underwent a single manipulation under anesthesia session with follow-up at 2 and 4 weeks.[8,] The primary outcome measure was the Patient's Global Impression of Change. At 2 weeks, 52% of the patients reported clinically relevant improvement (better or much better), with 45.5%

improved at 4 weeks. There was a statistically significant reduction in numeric rating scale scores for pain at 4 weeks (p=.01), from a mean baseline score of 4.0 to 3.5 at 2 weeks post-manipulation under anesthesia. Bournemouth Questionnaire scores improved from 24.17 to 20.38 at 2 weeks (p=0.008) and 19.45 at 4 weeks (p=.001). This study lacked a sham group to control for a potential placebo effect. Also, the clinical significance of improved numeric rating scale and Bournemouth Questionnaire scores is unclear, although Hurst and Bolton (2004) described the Bournemouth Questionnaire as a percentage improvement of 47% in back pain and 34% in neck pain.[4,]

West et al (1999) reported on a series of 177 patients with pain arising from the cranial, cervical, thoracic, and lumbar spine, as well as the sacroiliac and pelvic regions, who had failed conservative and surgical treatment.[9,] Patients underwent 3 sequential manipulations with intravenous sedation followed by 4 to 6 weeks of spinal manipulation and therapeutic modalities; all had 6 months of follow-up. On average, visual analog scale scores improved by 62% in patients with cervical pain and by 60% in patients with lumbar pain. Dougherty et al (2004) retrospectively reviewed outcomes of 20 cervical and 60 lumbar radiculopathy patients who underwent spinal manipulation after epidural injection.[10,] After epidural injection of lidocaine (guided fluoroscopically or with computed tomography), methylprednisolone acetate flexion distraction mobilization and then high-velocity, low-amplitude spinal manipulation were delivered to the affected spinal regions. Outcome criteria were empirically defined as a significant improvement, temporary improvement, or no change. Among lumbar spine patients, 22 (37%) noted significant improvement, 25 (42%) reported temporary improvement, and 13 (22%) no change. Among patients receiving a cervical epidural injection, 10 (50%) had significant improvement, 6 (30%) had temporary relief, and 4 (20%) had no change.

Tables 2 and 3 summarize the characteristics and results, respectively, of the key observational studies.

The only study on manipulation under joint anesthesia or analgesia evaluated 4 subjects; it was reported by Dreyfuss et al (1995).[11,] Later, Michaelsen (2000) noted that joint-related manipulation under anesthesia should be viewed with "guarded optimism because its success is based solely on anecdotal experience."[12,]

Table 2. Summary of Characteristics of Key Observational Studies of Manipulation Under Anesthesia

Study	Study Type	Country	Dates	Participants	Treatment	Follow-Up
Peterson (2014)[8,]	Prospective	Switzerland	NR	Patients (N=30) with chronic pain who underwent a single MUA session	MUA for those with low back pain (n=17); MUA for those with neck pain (n=13)	2 and 4 weeks
West (1999)[9,]	Case series	US	July 1995-Feb 1997	177 patients with pain arising from the cranial, cervical, thoracic, and lumbar spine, as well as the sacroiliac and pelvic regions who had failed conservative and surgical treatment	Patients underwent 3 sequential manipulations with intravenous sedation followed by 4 to 6 weeks of spinal manipulation and therapeutic modalities	6 months
Dougherty (2004)[10,]	Retrospective	US	Nov 1996-Nov 2000	20 cervical and 60 lumbar radiculopathy patients who underwent spinal manipulation after	Following epidural injection of lidocaine (guided fluoroscopically or with computed tomography), methylprednisolone	1 year

Study	Study Type	Country	Dates	Participants	Treatment	Follow-Up
				epidural injection. The patients ranged in age from 21-76 years with an average age of 43 years. Forty-three percent of the patients were female and 57% were male.	acetate flexion distraction mobilization and high-velocity, low-amplitude spinal manipulation were delivered to the affected spinal regions	

MUA: manipulation under anesthesia; NR: not reported.

Table 3. Summary of Results of Key Observational Studies of Manipulation Under Anesthesia

Study	Improvement as Reported by Participant	Bournemouth Questionnaire Scores	Patient's Global Impression of Change
Peterson (2014)[8,]			
Baseline		24.17	
2 weeks post		20.38 (p=.008)	
4 weeks post		19.45 (p=.001)	
"better or much better" reported at 2 weeks post			52%
"better or much better" reported at 4 weeks post			45.5%
West (1999)[9,]			
% of cervical patients with improvement			62%
% of lumbar patients with improvement			60%
Dougherty (2004)[10,]			
Lumbar spine patients			
% noting significant improvement	22 (37%)		
% noting temporary improvement	25 (42%)		
% noting no improvement	13 (22%)		
Patients receiving cervical epidural injection			
% noting significant improvement	10 (50%)		
% noting temporary improvement	6 (30%)		
% noting no improvement	4 (20%)		

Supplemental Information

The purpose of the following information is to provide reference material. Inclusion does not imply endorsement or alignment with the evidence review conclusions.

Clinical Input from Physician Specialty Societies and Academic Medical Centers

While the various physician specialty societies and academic medical centers may collaborate with and make recommendations during this process, through the provision of appropriate reviewers, input received does not represent an endorsement or position statement by the physician specialty societies or academic medical centers, unless otherwise noted.

2009 Input

Clinical input was sought to help determine whether the use of manipulation under anesthesia for individuals with chronic spinal and pelvic pain would provide a clinically meaningful improvement in

net health outcome and whether the use is consistent with generally accepted medical practice. In response to requests, input was received from 2 physician specialty societies and 4 academic medical centers while this policy was under review. Input from the 7 reviewers agreed that manipulation under anesthesia for chronic spinal and pelvic pain is investigational.

Practice Guidelines and Position Statements

Guidelines or position statements will be considered for inclusion in 'Supplemental Information' if they were issued by, or jointly by, a US professional society, an international society with US representation, or National Institute for Health and Care Excellence (NICE). Priority will be given to guidelines that are informed by a systematic review, include strength of evidence ratings, and include a description of management of conflict of interest.

American Association of Manipulation Under Anesthesia Providers

In 2014, The American Association of Manipulation Under Anesthesia Providers published consensus-based guidelines for the practice and performance of manipulation under anesthesia.[13,] The guidelines included patient selection criteria (see below), establishing medical necessity, frequency and follow-up procedures, parameters for determining manipulation under anesthesia progress, general post-manipulation under anesthesia 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 manipulation under anesthesia that included all fibrosis release and manipulative procedures performed during the manipulation under anesthesia 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 manipulation under anesthesia. A sufficient time period is usually considered a minimum of 4 to 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 to 8 week period prior to recommending manipulation under anesthesia.
- "Diagnosed conditions must fall within the recognized categories of conditions responsive to manipulation under anesthesia. The following disorders are classified as acceptable conditions for utilization of manipulation under anesthesia:
    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, manipulation under anesthesia 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."[13,]

U.S. Preventive Services Task Force Recommendations
Not applicable.

Medicare National Coverage
There is no national coverage determination. In the absence of a national coverage determination, coverage decisions are left to the discretion of local Medicare carriers.

Ongoing and Unpublished Clinical Trials
There were no ongoing or unpublished trials regarding this policy as of February 2024.

References

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11. 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): 537-46. PMID 8583177
12. 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): 127-9. PMID 10714542
13. 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

Documentation for Clinical Review

- No records required

Coding

This Policy relates only to the services or supplies described herein. Benefits may vary according to product design; therefore, contract language should be reviewed before applying the terms of the Policy.

The following codes are included below for informational purposes. Inclusion or exclusion of a code(s) does not constitute or imply member coverage or provider reimbursement policy. Policy Statements are intended to provide member coverage information and may include the use of some codes for clarity. The Policy Guidelines section may also provide additional information for how to interpret the Policy Statements and to provide coding guidance in some cases.

Type	Code	Description
CPT®	00640	Anesthesia for manipulation of the spine or for closed procedures on the cervical, thoracic or lumbar spine
	21073	Manipulation of temporomandibular joint(s) (TMJ), therapeutic, requiring an anesthesia service (i.e., general or monitored anesthesia care)
	22505	Manipulation of spine requiring anesthesia, any region
	23700	Manipulation under anesthesia, shoulder joint, including application of fixation apparatus (dislocation excluded)
	27275	Manipulation, hip joint, requiring general anesthesia
	27570	Manipulation of knee joint under general anesthesia (includes application of traction or other fixation devices)
	27860	Manipulation of ankle under general anesthesia (includes application of traction or other fixation apparatus)
HCPCS	None	

Policy History

This section provides a chronological history of the activities, updates and changes that have occurred with this Medical Policy.

Effective Date	Action
02/26/1997	New Policy Adoption
04/01/2001	Policy Review Policy unchanged
06/26/2009	Policy Revision and Title change. Policy title changed from Chiropractic Manipulation Under Anesthesia to Spinal Manipulation Under Anesthesia
06/20/2012	Policy Review
07/06/2012	Policy revision without position change
06/30/2015	Coding update
01/01/2016	Policy title change from Spinal Manipulation Under Anesthesia Policy revision without position change
10/01/2016	Policy revision without position change
10/01/2017	Policy revision without position change
06/01/2018	Policy revision without position change
09/01/2018	Policy statement clarification
07/01/2019	Policy revision without position change
07/01/2020	Annual review. No change to policy statement. Literature review updated.
06/01/2021	Annual review. No change to policy statement. Literature review updated.
06/01/2022	Annual review. No change to policy statement. Literature review updated.
03/01/2023	Coding update

Effective Date	Action
06/01/2023	Annual review. Policy statement and literature review updated.
06/01/2024	Annual review. Policy statement, guidelines, and literature review updated.

Definitions of Decision Determinations

Medically Necessary: Services that are Medically Necessary include only those which have been established as safe and effective, are furnished under generally accepted professional standards to treat illness, injury or medical condition, and which, as determined by Blue Shield, are: (a) consistent with Blue Shield medical policy; (b) consistent with the symptoms or diagnosis; (c) not furnished primarily for the convenience of the patient, the attending Physician or other provider; (d) furnished at the most appropriate level which can be provided safely and effectively to the patient; and (e) not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the Member's illness, injury, or disease.

Investigational/Experimental: A treatment, procedure, or drug is investigational when it has not been recognized as safe and effective for use in treating the particular condition in accordance with generally accepted professional medical standards. This includes services where approval by the federal or state governmental is required prior to use, but has not yet been granted.

Split Evaluation: Blue Shield of California/Blue Shield of California Life & Health Insurance Company (Blue Shield) policy review can result in a split evaluation, where a treatment, procedure, or drug will be considered to be investigational for certain indications or conditions, but will be deemed safe and effective for other indications or conditions, and therefore potentially medically necessary in those instances.

Prior Authorization Requirements and Feedback (as applicable to your plan)

Within five days before the actual date of service, the provider must confirm with Blue Shield that the member's health plan coverage is still in effect. Blue Shield reserves the right to revoke an authorization prior to services being rendered based on cancellation of the member's eligibility. Final determination of benefits will be made after review of the claim for limitations or exclusions.

Questions regarding the applicability of this policy should be directed to the Prior Authorization Department at (800) 541-6652, or the Transplant Case Management Department at (800) 637-2066 ext. 3507708 or visit the provider portal at www.blueshieldca.com/provider.

We are interested in receiving feedback relative to developing, adopting, and reviewing criteria for medical policy. Any licensed practitioner who is contracted with Blue Shield of California or Blue Shield of California Promise Health Plan is welcome to provide comments, suggestions, or concerns. Our internal policy committees will receive and take your comments into consideration.

For utilization and medical policy feedback, please send comments to: MedPolicy@blueshieldca.com

Disclaimer: This medical policy is a guide in evaluating the medical necessity of a particular service or treatment. Blue Shield of California may consider published peer-reviewed scientific literature, national guidelines, and local standards of practice in developing its medical policy. Federal and state law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over medical policy and must be considered first in determining covered services. Member contracts may differ in their benefits. Blue Shield reserves the right to review and update policies as appropriate.

Appendix A

POLICY STATEMENT	
BEFORE Red font: Verbiage removed	**AFTER** Blue font: Verbiage Changes/Additions
Manipulation Under Anesthesia 8.01.40 **Policy Statement:** I. Spinal manipulation done with or without manipulation of other joints (e.g., hip joint at the same time) with the individual under anesthesia, spinal manipulation under local (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. II. Spinal manipulation or manipulation of other joints under anesthesia involving serial treatment sessions is considered **investigational** (see Policy Guidelines). III. Manipulation under anesthesia involving multiple body joints is considered **investigational** for the treatment of chronic pain.	**Manipulation Under Anesthesia 8.01.40** **Policy Statement:** I. Spinal manipulation and manipulation of other joints performed during the procedure (e.g., hip joint) with the individual under anesthesia, spinal manipulation under local (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. II. Spinal manipulation or manipulation of other joints under anesthesia involving serial treatment sessions is considered **investigational.** III. Manipulation under anesthesia involving multiple body joints is considered **investigational** for the treatment of chronic pain.