



Medical Review Institute of America, Inc.
America's External Review Network

Amended Review June 30, 2010

Amended Review June 29, 2010

DATE OF REVIEW: June 25, 2010

IRO Case #:

Description of the services in dispute: Atlanto-Occipital/Joint MUA; Cervical Spine MUA; Thoracic MUA; Lumbar Spine MUS; Right and Left Hip MUA

A description of the qualifications for each physician or other health care provider who reviewed the decision

The physician who provided this review is board certified by the American Board of Orthopaedic Surgery. This reviewer is a fellow of the American College of Surgeons. This reviewer is a member of the American Medical Association and the American Academy of Orthopedic Surgery. This reviewer has been in active practice since 1975.

Review Outcome

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be upheld. Manipulation under anesthesia is not medically necessary.

Information provided to the IRO for review

Received from the State 06/17/10:

Patient clinical history [summary]

The patient is a female who reported that she slipped on grease and fell into a trashcan. The patient reported that she injured her left arm and back. On xxxxxx, Dr. indicated the diagnoses to be lumbar strain, lumbar pain, and an upper arm contusion. The patient later reported left-sided pain that radiated into the dorsum and plantar surface of her left foot. The patient was treated with prescription medication and six sessions of physical therapy with xxxxxx and reported slight relief. Dr. released the patient to work on restricted duty.

X-rays of the lumbar spine dated 11/05/09 were reported to be normal.

An x-ray of the pelvis dated 11/05/09 was reported to be unremarkable.

An MRI of the lumbar spine dated 01/05/10 revealed the following: No central or right foraminal stenosis is seen in the lumbar spine. A 2 mm central protrusion at L4-5 mildly indents the thecal sac. An annular fissure is seen in the protrusion. A 2 mm bulge and 4 mm right paracentral protrusion are present at L5-S1. The protrusion narrows the right subarticular recess containing the right S1 nerve root. The bulge at L5-S1 disc narrowing and left facet joint hypertrophy cause mild stenosis of the left L5-S1 foramen. No other foraminal stenosis is seen in the lumbar spine

On 03/29/10, Dr. performed injections. The preoperative and postoperative diagnoses were indicated to be lumbar discogenic pain and lumbar radiculopathy.

On a follow-up note dated 04/27/10, Dr. indicated the diagnosis to be lumbar radiculopathy, worse on the left than right. Dr. advised to proceed with an injection on 05/07/10.

Dr. evaluated the patient on 11/09/09, and the diagnosis was noted to be lumbar sprain/strain and right leg radiculopathy. Dr. referred the patient to physical therapy and prescribed medication.

The patient engaged in physical therapy with xxxxx from 11/11/09 through 12/16/09.

X-rays of the lumbar spine dated 05/24/10 reported no scoliosis, spondylolisthesis, or segmental instability, but there is some loss of disk height visible at the L5-S1 level.

The patient was released to work, but she reported that it caused too much aggravation of the pain.

On 05/24/10, Dr. indicated that the diagnoses included L4-5 foraminal stenosis, and L4-S1 herniated disk with foraminal stenosis and lumbar radicular syndrome. Dr. indicated that the patient was a candidate for lumbar decompression and discectomy but not spinal fusion.

On 06/10/10, Dr. reported that the patient had continued low back pain that radiated into the left leg. Dr. did not feel that chiropractic treatment would aid the patient's recovery, as some adjustments hurt her.

The patient has been treated with prescription medication, extensive physical therapy, and sacroiliac injections with continued reports of pain. The request for manipulation under anesthesia of the atlanto-occipital joint, cervical spine, thoracic spine, lumbar spine, and right and left hip was deemed to not be medically necessary.

Analysis and explanation of the decision include clinical basis, findings and conclusions used to support the decision.

According to Official Disability Guidelines (ODG), manipulation under anesthesia (MUA) is not medically necessary for back conditions in the absence of vertebral fracture or dislocation. Patient does not meet the medical necessity for manipulation under anesthesia.

In the spine, manipulation under anesthesia may be performed as a closed treatment of vertebral fracture or dislocation. In the absence of vertebral fracture or dislocation, MUA, performed either with the patient sedated or under general anesthesia, is intended to overcome the conscious patient's protective reflex mechanism, which may limit the success of prior attempts of spinal manipulation or adjustment in the conscious patient. Manipulation under anesthesia (MUA) is not medically necessary at the present time. Existing studies are not high quality and the outcomes were not great, plus the procedure is expensive and has risks. There is a need for high quality studies before supporting this. There is not enough evidence to support the value of medicine-

assisted manipulation (MAM), but patient satisfaction and the clinician's belief that the treatment has a positive benefit is not enough in today's evidence-based medicine. MAM refers to the use of spinal manipulation after any type of pain control has been given. The pain control may be from pills or injections. When intravenous sedation is used, the procedure is referred to as manipulation under anesthesia (MUA); when injections are used (i.e., facet joint intra-articular anesthetic or epidural steroid injection) the procedure can be referred to as MUJA (manipulation under joint anesthesia) or MUEA (manipulation under epidural anesthesia). MAM is used with patients who have loss of motion and who have not responded to other conservative methods of treatment. Barring the inability to render manipulative treatment due to intense pain levels or spasm, in general, four to eight weeks of spinal manipulation and other conservative care should be attempted before giving consideration to MUA. Patients who have had a failed back surgery or who have nerve entrapment

or muscle contracture may be good candidates for this treatment; however, these indications for MUA have yet to be verified via controlled trials.

A description and the source of the screening criteria or other clinical basis used to make the decision:

Official Disability Guidelines, Online Edition

Kohlbeck FJ, Haldeman S, Hurwitz EL, Dagenais S. Supplemental care with medication-assisted manipulation versus spinal manipulation therapy alone for patients with chronic low back pain. J Manipulative Physiol Ther. 2005 May;28(4): 245-52.

Dagenais S, Mayer J, Wooley JR, Haldeman S. Evidence-informed management of chronic low back pain with medicine-assisted manipulation. Spine J. 2008 Jan-Feb;8(1): 142-9.