MEDICAL POLICY

Excellus

SUBJECT: LUMBAR TRACTION: VERTEBRAL AXIAL DECOMPRESSION AND HOME LUMBAR TRACTION DEVICES	**EFFECTIVE DATE: 01/18/07**
	REVISED DATE: 10/18/07, 09/18/08, 09/17/09
	ARCHIVED DATE: 09/16/10
	EDITED DATE: 09/15/11, 09/20/12, 09/19/13, 09/18/14
POLICY NUMBER: 1.01.50	
CATEGORY: Technology Assessment	**PAGE: 1 OF: 4**

- ***If the member's subscriber contract excludes coverage for a specific service it is not covered under that contract. In such cases, medical policy criteria are not applied.***
- ***Medical policies apply to commercial and Medicaid products only when a contract benefit for the specific service exists.***
- ***Medical policies only apply to Medicare products when a contract benefit exists and where there are no National or Local Medicare coverage decisions for the specific service.***

POLICY STATEMENT:

Based upon our criteria and review of the peer-reviewed literature, lumbar traction by any method has not been medically proven to be effective is considered **investigational**.

POLICY GUIDELINES:

The Federal Employee Health Benefit Program (FEHBP/FEP) requires that procedures, devices or laboratory tests approved by the U.S. Food and Drug Administration (FDA) may not be considered investigational and thus these procedures, devices or laboratory tests may be assessed only on the basis of their medical necessity.

DESCRIPTION:

Lumbar traction, a widely used treatment for low back pain often in combination with other modalities, can be provided manually by a therapist or by mechanical means and may be self-administered using portable devices.

Vertebral axial decompression has been investigated as a technique to reduce intradiscal pressure and relieve low back pain associated with herniated lumbar discs or degenerative lumbar disc disease. Manufacturers of the VAX-D state the device provides traction without accompanying abdominal muscular contractions that other types of traction elicit leading to a condition where there is negative intradiscal pressure. Negative intradiscal pressure is speculated to help heal the annulus in a variety of ways. The patient lies on a powered traction table wearing a pelvic harness and grasping hand grips. The table is slowly extended, and a distraction force is applied via the pelvic harness until the desired tension is reached, followed by a gradual decrease of the tension. The cyclic nature of the treatment allows the patient to withstand stronger distraction forces compared to static lumbar traction techniques. An individual session typically includes 15 cycles of tension, and 10 to 15 daily treatments may be administered. A number of vertebral axial decompression devices have been marketed.

Pneumatic lumbar traction devices have been developed for home use. The patient wearing pelvic and lower rib cage harnesses lies on a two-piece surface. Pneumatic power provided by a hand pump moves the sections apart applying traction through the harnesses. Examples are the Saunders Lumbar HomeTrac, Saunders STx, Orthotrac, and Comfort Trac.

RATIONALE:

A number of manufacturers have received FDA 510(k) approval to market devices characterized by the FDA as powered traction devices: Accu-Spina System in 2000, Bass Antalgic-Trak in 2005, DRX9000 in 2003, Decompression Reduction Stabilization (DRS) in 1998, Healthstar Elite in 2004, Lordex Power Traction in 2003, SpineMED S200b/S200c Decompression Table in 2005, SpineRx-LDM in 2003, and the VAX-D Therapeutic Table in 1996.

There is little published scientific evidence regarding vertebral axial decompression, and the available studies do not provide evidence that the technology is equal or superior to static lumbar traction or to other conservative treatments or surgical interventions for low back pain. A single case of sudden progression of lumbar disk protrusion during VAX-D therapy requiring urgent microdiskectomy has been reported in the literature.

Published studies of traction as a treatment for low back pain lack methodological rigor and reach conflicting conclusions. A 2013 update of the Cochrane review of traction for low back pain, with or without sciatica, included a review of 37 randomized controlled trials. For people with mixed symptom patterns (acute, subacute and chronic LBP with and without sciatica), there was low- to moderate quality evidence that traction may make little or no difference in pain intensity, functional status, global improvement or return to work when compared to placebo, sham traction or no treatment. Similarly, when comparing the combination of physiotherapy plus traction with physiotherapy alone or when comparing traction with other treatments, there was very-low- to moderate-quality evidence that traction may make little or no difference in pain intensity, functional status or global improvement. For people with LBP with sciatica and acute, subacute or chronic pain, there was low- to moderate-quality evidence that traction probably has no impact on pain intensity, functional status or global improvement. This was true when traction was compared with controls and other treatments, as well as when the combination of traction plus physiotherapy was compared with physiotherapy alone. No studies reported the effect of traction on return to work. For chronic LBP without sciatica, there was moderate-quality evidence that traction probably makes little or no difference in pain intensity when compared with sham treatment. No studies reported on the effect of traction on functional status, global improvement or return to work. Adverse effects were reported in seven of the 32 studies. These included increased pain, aggravation of neurological signs and subsequent surgery. Four studies reported that there were no adverse effects. The remaining studies did not mention adverse effects. The authors concluded that traction, either alone or in combination with other treatments, has little or no impact on pain intensity, functional status, global improvement and return to work among people with LBP. There is only limited-quality evidence from studies with small sample sizes and moderate to high risk of bias. The effects shown by these studies are small and are not clinically relevant. A 2007 Agency for Healthcare Research and Quality (AHRQ) technology assessment concluded that currently available evidence is too limited in quality and quantity to allow for formulation of evidence-based conclusions regarding the efficacy of decompression therapy as a therapy for chronic back pain when compared with other nonsurgical treatment options.

CODES: Number Description

Eligibility for reimbursement is based upon the benefits set forth in the member's subscriber contract.

CODES MAY NOT BE COVERED UNDER ALL CIRCUMSTANCES. PLEASE READ THE POLICY AND GUIDELINES STATEMENTS CAREFULLY.

Codes may not be all inclusive as the AMA and CMS code updates may occur more frequently than policy updates.

Code Key: Experimental/Investigational = (E/I), Not medically necessary/ appropriate = (NMN).

CPT: No specific code

HCPCS: E0830 **(E/I)** Ambulatory traction device, all types, each

S9090 **(E/I)** Vertebral axial decompression, per session

ICD9: Investigational for all codes

ICD10: Investigational for all codes

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* key article

KEY WORDS:

Home lumbar traction device, Lumbar traction, VAX-D, DRS System, DRX, HomeTrac, Orthotrac, CormfortTrac, Saunders.

CMS COVERAGE FOR MEDICARE PRODUCT MEMBERS

There is currently a National Coverage Determination (NCD) for Lumbar Traction. Please refer to the following NCD websites for Medicare Members:

Vertebral Axial Decompression:
http://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=124&ncdver=1&bc=AgAAgAAAAAAA&

Traction Equipment:
http://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=190&ncdver=2&NCAId=3&ver=5&NcaName=Air-Fluidized+Beds+for+Pressure+Ulcers&bc=ACAAAAAAIAAA&