Medical Policy

Mechanized Spinal Distraction Therapy

Policy Number:  OCA 3.84
Version Number:  10
Version Effective Date:  04/01/16

Product Applicability

<table>
<thead>
<tr>
<th>Well Sense Health Plan</th>
<th>Boston Medical Center HealthNet Plan</th>
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<tbody>
<tr>
<td>☐ New Hampshire Medicaid</td>
<td>☒ MassHealth</td>
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<tr>
<td>☐ NH Health Protection Program</td>
<td>☒ Qualified Health Plans/ConnectorCare/Employer Choice Direct</td>
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<td>☒ Senior Care Options ◊</td>
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Notes:
+ Disclaimer and audit information is located at the end of this document.
◊ The guidelines included in this Plan policy are applicable to members enrolled in Senior Care Options only if there are no criteria established for the specified service in a Centers for Medicare & Medicaid Services (CMS) national coverage determination (NCD) or local coverage determination (LCD) on the date of the prior authorization request. Review the member’s product-specific benefit documents at www.SeniorsGetMore.org to determine coverage guidelines for Senior Care Options.

Policy Summary

The Plan considers mechanized spinal distraction therapy for the treatment of low back pain or for any other indication to be experimental and investigational. Plan prior authorization is required.

It will be determined during the Plan’s prior authorization process if the service is considered experimental and investigational for the requested use. See the Plan’s policy, Experimental and Investigational Treatment (policy number OCA 3.12), for the product-specific definitions of experimental or investigational treatment.
**Description of Item or Service**

**Mechanized Spinal Distraction Therapy:** Also known as vertebral axial decompression therapy, mechanized spinal distraction therapy utilizes a computer-controlled mechanical table or device to apply distractive tension or stretching along the spinal axis for the treatment of low back pain. These tables or devices provide gradual and controlled stretch designed to overcome muscle resistance, thereby allowing effective distraction of the intervertebral discs and/or the intervertebral joint spaces. Axial spinal distraction therapy is based on the theory that reducing intradiscal pressure will relieve back pain. This policy includes but is not limited to the following products: VAX-D® Therapy, Decompression Reduction Stabilization (DRS)® System, and Accu-Spina System™ IDD Therapy.

**Medical Policy Statement**

The Plan considers mechanized spinal distraction therapy for the treatment of low back pain or for any other indication to be experimental and investigational.

**Limitations**

This service is considered experimental and investigational.

**Applicable Coding**

The Plan uses and adopts up-to-date Current Procedural Terminology (CPT) codes from the American Medical Association (AMA), International Statistical Classification of Diseases and Related Health Problems, 10th revision (ICD-10) diagnosis codes developed by the World Health Organization and adapted in the United Stated by the National Center for Health Statistics (NCHS) of the Centers for Disease Control under the U.S. Department of Health and Human Services, and the Health Care Common Procedure Coding System (HCPCS) established and maintained by the Centers for Medicare & Medicaid Services (CMS). Because the AMA, NCHS, and CMS may update codes more frequently or at different intervals than Plan policy updates, the list of applicable codes included in this Plan policy is for informational purposes only, may not be all inclusive, and is subject to change without prior notification. Whether a code is listed in the Applicable Coding section of this Plan policy does not constitute or imply member coverage or provider reimbursement. Providers are responsible for reporting all services using the most up-to-date industry-standard procedure and diagnosis codes as published by the AMA, NCHS, and CMS at the time of the service.

Providers are responsible for obtaining prior authorization for the services specified in the Medical Policy Statement section and Limitation section of this Plan policy, even if an applicable code appropriately describing the service that is the subject of this Plan policy is not included in the Applicable Coding section of this Plan policy. Coverage for services is subject to benefit eligibility under the member’s benefit plan. Please refer to the member’s benefits document in effect at the time of the service to determine coverage or non-coverage as it applies to an individual member. See Plan reimbursement policies for Plan billing guidelines.

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HCPCS Code | Description: Code Considered Experimental and Investigational
--- | ---
S9090 | Vertebral axial decompression, per session

Clinical Background Information

Mechanized spinal distraction devices utilize a computerized split table device that applies tension or stretching along the spinal axis. The patient is placed in a prone position and restraints are placed around the shoulder and upper body to assure that the tensions are applied accurately along the spine and pelvis regions utilizing a pelvic harness. The table is then mechanically separated in the middle to apply distractive force along the spinal axis. Each treatment session lasts about 30 minutes and is comprised of about 15 cycles of decompression alternating with relaxation. Mechanized spinal distraction is based on the theory that the reduction of intradiscal pressure will relieve back pain. There are many devices that are on the market that have been approved by the Food and Drug Administration (FDA). These devices are proposed as a non-surgical alternative for the relief of low back pain that is associated with disc protrusion, herniated disc, degenerative disc disease, facet syndrome, and/or radiculopathy. Examples of mechanized spinal distraction devices include but are not limited to the following, as specified below in items 1 through 15:

1. Accu-SPINA System  
2. Antalgic-Trak  
3. Decompression Reduction Stabilization (DRS) System  
4. DRX and DRX 2000-9000  
5. Exentrac Elite Multidirectional Disc Decompression (M3D)  
6. Intervertebral Differential Dynamics (IDD) with Spina System  
7. Lordex Decompression Unit (LORDEX Lumbar Spine System)  
8. NuChoice Medical Healthstar Elite Decompression Therapy  
9. Saunder 3D ActiveTrac  
10. SpineMED  
11. SpineRx LDM  
12. SpineRx Lumbar Decompression Machine  
13. Triton DTS

Mechanized Spinal Distraction Therapy

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14. Tru Tac 401

15. Vertebral axial decompression (VAX-D)

There is insufficient scientific evidence in the peer reviewed medical literature to support the effectiveness of any device used for mechanized spinal therapy for the treatment of patients with low back pain. The majority of the published literature to date consists of uncontrolled case studies that are inadequate to permit scientific conclusions.

At the time of the Plan’s most recent policy review, the Centers for Medicare & Medicaid Services (CMS) national coverage determination (NCD) #160.16 for VAX-D states there are insufficient scientific data to support the benefits of this technique, and therefore VAX-D is not covered by Medicare. No CMS clinical guidelines were found for other devices related to mechanized spinal distraction therapy. Verify CMS criteria in the applicable NCD or local coverage determination (LCD) in effect on the date of the prior authorization request for a Senior Care Options member.

References


### Original Approval Date

- **Regulatory Approval:** N/A
- **Internal Approval:**
  - 01/08/08: MPCTAC
  - 01/10/08: QIC

### Original Effective Date* and Version Number

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<th>Policy Owner</th>
<th>Approved by</th>
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<tr>
<td>04/01/08 Version 1</td>
<td>Medical Policy Manager as Chair of Medical Policy, Criteria, and Technology Assessment Committee (MPCTAC) and member of Quality Improvement Committee (QIC)</td>
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*Effective Date for the BMC HealthNet Plan Commercial Product(s): 01/01/12
*Effective Date for Senior Care Options Product(s): 01/01/16

### Policy Revisions History

<table>
<thead>
<tr>
<th>Review Date</th>
<th>Summary of Revisions</th>
<th>Revision Effective Date and Version Number</th>
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<tr>
<td>12/01/10</td>
<td>Updated references and list of spinal distraction devices. No changes to criteria.</td>
<td>Version 4</td>
<td>12/28/10: MPCTAC 01/26/11: QIC</td>
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<td>12/01/11</td>
<td>Updated references. No criteria changes.</td>
<td>Version 5</td>
<td>12/12/11: MPCTAC 12/20/11: QIC</td>
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<td>02/01/13</td>
<td>References updated, updated code definitions, revised introductory paragraph in Applicable Coding section, revised Summary section and referenced Experimental and Investigational Treatment policy, revised Medical Policy Statement section (formerly named the Clinical Guideline Statement section) and Limitations section, moved examples of devices from Description of Item or Service section to Clinical Background Information section, changed name of policy category from “Clinical Coverage”</td>
<td>Version 6</td>
<td>02/20/13: MPCTAC 03/21/13: QIC</td>
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Mechanized Spinal Distraction Therapy

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<td>and Employer Choice from the list of applicable products because the</td>
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<td>products are no longer available.</td>
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Last Review Date
02/01/16

Next Review Date
02/01/17

Authorizing Entity
QIC

Other Applicable Policies
Medical Policy - Experimental and Investigational Treatment, policy number OCA 3.12

Reference to Applicable Laws and Regulations

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Disclaimer Information: +

Medical Policies are the Plan’s guidelines for determining the medical necessity of certain services or supplies for purposes of determining coverage. These Policies may also describe when a service or supply is considered experimental or investigational, or cosmetic. In making coverage decisions, the Plan uses these guidelines and other Plan Policies, as well as the Member’s benefit document, and when appropriate, coordinates with the Member’s health care Providers to consider the individual Member’s health care needs.

Plan Policies are developed in accordance with applicable state and federal laws and regulations, and accrediting organization standards (including NCQA). Medical Policies are also developed, as appropriate, with consideration of the medical necessity definitions in various Plan products, review of current literature, consultation with practicing Providers in the Plan’s service area who are medical experts in the particular field, and adherence to FDA and other government agency policies. Applicable state or federal mandates, as well as the Member’s benefit document, take precedence over these guidelines. Policies are reviewed and updated on an annual basis, or more frequently as needed. Treating providers are solely responsible for the medical advice and treatment of Members.

The use of this Policy is neither a guarantee of payment nor a final prediction of how a specific claim(s) will be adjudicated. Reimbursement is based on many factors, including member eligibility and benefits on the date of service; medical necessity; utilization management guidelines (when applicable); coordination of benefits; adherence with applicable Plan policies and procedures; clinical coding criteria; claim editing logic; and the applicable Plan – Provider agreement.

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