BlueCross BlueShield of North Carolina

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Corporate Medical Policy

Vertebral Axial Decompression (VAD-X)

File Name:	vertebral_axial_decompression_(VAD-X)
Origination:	4/1999
Last CAP Review:	7/2013
Next CAP Review:	7/2014
Last Review:	7/2013

Description of Procedure or Service

Vertebral Axial Decompression is one type of mechanical lumbar traction that has been investigated as a treatment method to reduce intradiscal pressure and relieve low back pain associated with lumbar disc herniation, degenerative disc disease, posterior facet syndrome, sciatica or radiculopathy. Herniated and degenerated discs can cause pain by compressing the spinal nerves near the bulging disc.

Decompression therapy is a noninvasive, nonsurgical approach to treating chronic low back pain and is based on the theory that reducing pressure in the intervertebral discs and/or intervertebral joint spaces will relieve back pain.

The decompression procedure is performed using a specially designed computerized mechanical table. Several types of automated tables are marketed specifically for disc decompression. The patient is strapped to the lower part of the table using a pelvic harness. The table is then mechanically separated in the middle and distractive force is applied until the desired tension is reached. The amount of distractive force used is individually tailored and lasts about 60 seconds per application. Each treatment session lasts approximately 30 minutes. The process of distraction and relaxation is fully computerized and should be monitored by a licensed healthcare practitioner. Repeated cycles of this negative pressure over multiple treatment sessions are reported to be necessary for permanent results.

******Note: This Medical Policy is complex and technical. For questions concerning the technical language and/or specific clinical indications for its use, please consult your physician.***

Policy

Vertebral Axial Decompression is considered investigational. BCBSNC does not cover investigational services or procedures.

Benefits Application

This medical policy relates only to the services or supplies described herein. Please refer to the Member's Benefit Booklet for availability of benefits. Member's benefits may vary according to benefit design; therefore member benefit language should be reviewed before applying the terms of this medical policy.

When Vertebral Axial Decompression is covered

Not applicable

When Vertebral Axial Decompression is not covered

Vertebral Axial Decompression is considered investigational. BCBSNC does not cover investigational services.

Policy Guidelines

Evidence for the efficacy of vertebral axial decompression on health outcomes is limited. Since a placebo effect may be expected with any treatment that has pain relief as the principal outcome, randomized trials with validated outcome measures are required to determine if there is an independent effect of active treatment. The only sham-controlled randomized trial published to date did not show a benefit of vertebral axial decompression compared to the control group.

The American Medical Association, the U.S. Food and Drug Administration, and Medicare all consider decompression therapy to be a form of traction. The use of traction for back pain continues to be debated.

Billing/Coding/Physician Documentation Information

This policy may apply to the following codes. Inclusion of a code in this section does not guarantee that it will be reimbursed. For further information on reimbursement guidelines, please see Administrative Policies on the Blue Cross Blue Shield of North Carolina web site at www.bcbsnc.com. They are listed in the Category Search on the Medical Policy search page.

Applicable codes: *S9090*

BCBSNC may request medical records for determination of medical necessity. When medical records are requested, letters of support and/or explanation are often useful, but are not sufficient documentation unless all specific information needed to make a medical necessity determination is included.

Scientific Background and Reference Sources

BCBSA Medical Policy Reference Manual - 5/97

Specialty Matched Consultant Advisory Panel - 11/1999

Medical Policy Advisory Group - 12/2/1999

Specialty Matched Consultant Advisory Panel - 5/2001

BCBSA Medical Policy Reference Manual - 7/12/2002; 8.03.09

Specialty Matched Consultant Advisory Panel - 5/2003

ECRI Target Report #832 (2002, October). Decompression therapy for chronic low back pain.

BCBSA Medical Policy Reference Manual [Electronic Version]. 8.03.09, 10/9/03.

ECRI Custom Hotline Response (2005, September). Decompression therapy for chronic low back pain.

Centers for Medicare and Medicaid Services. National Coverage Determination 160.16. Retrieved

from
http://www.cms.hhs.gov/mcd/viewncd.asp?ncd_id=160.16&ncd_version=1&basket=ncd%3A160%2E16%3A1%3AVertebral+Axial+Decompression+%28VAX%2DD%29

Washington State Department of Labor and Industries. Health Technology Assessment Update for Powered Traction Devices for Intervertebral Decompression (June 14, 2004). Retrieved from http://www.lni.wa.gov/ClaimsIns/Files/OMD/TractionTechAssessJun142004.pdf

Washington State Department of Labor and Industries. Health Technology Assessment Update for Vertebral Axial Decompression (Vax-D) (1999). Retrieved from http://www.lni.wa.gov/ClaimsIns/Files/OMD/VAXDTA.pdf

Medicare Services Advisory Committee (MSAC). Assessment report for Vertebral axial decompression (VAX-D). MSAC Application number 1012. Canberra, Australia: MSAC; June 2001. Retrieved from http://www.health.gov.au/internet/msac/publishing.nsf/Content/FA4579BED311BC15CA2575AD0082FD8A/$File/1012%20-%20Vertebral%20axial%20decompression%20therapy%20for%20chronic%20low%20back%20pain%20Report.pdf

BCBSA Medical Policy Reference Manual [Electronic Version]. 8.03.09, 3/7/06

VAX-D Medical Technologies LLC. 310 Mears Blvd, Oldsmar, FL, 24677. http://www.vaxd.com/company-profile

Wang G. Powered traction devices for intervertebral decompression. Health Technology Assessment Update. Olympia, WA: Washington State Department of Labor and Industries, Office of the Medical Director; June 14, 2004. Retrieved from www.lni.wa.gov/ClaimsIns/Files/OMD/TractionTechAssessJun142004.pdf.

Workers Compensation Board, (WCB) Evidence Based Practice Group. Vertebral axial decompression for low back pain. February 2005.

Jurecki-Tiller M, Bruening W, Tregear S, et al. Decompression therapy for the treatment of lumbosacral pain. Prepared by the ECRI Institute Evidence-Based Practice Center for the Agency for Healthcare Research and Quality (AHRQ) (Contract No. 290-02-0019). Rockville, MD: AHRQ; April 26, 2007. Retrieved from http://www.cms.hhs.gov/determinationprocess/downloads/id47TA.pdf.

BCBSA Medical Policy Reference Manual [Electronic Version]. 8.03.09, 7/10/08

BCBSA Medical Policy Reference Manual [Electronic Version]. 8.03.09, 10/6/09

Specialty Matched Consultant Advisory Panel review 7/2010

Schimmel JJ, de Kleuver M, Horsting PP et al. No effect of traction in patients with low back pain: a single centre, single blind, randomized controlled trial of Intervertebral Differential Dynamics Therapy. Eur Spine J 2009; 18(12):1843-50. Retrieved from http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2899427/?tool=pubmed

BCBSA Medical Policy Reference Manual [Electronic Version]. 8.03.09, 10/8/10

BCBSA Medical Policy Reference Manual [Electronic Version]. 8.03.09, 10/4/11

Specialty Matched Consultant Advisory Panel review 7/2012

BCBSA Medical Policy Reference Manual [Electronic Version]. 8.03.09, 10/11/12

Workers Compensation Board, (WCB) Evidence Based Practice Group. Vertebral axial decompression for low back pain. July 2012. Retrieved from http://worksafebc.com/health_care_providers/Assets/PDF/VAX-D2012.pdf

Specialty Matched Consultant Advisory Panel review 7/2013

Medical Director review 7/2013

Policy Implementation/Update Information

4/99 Original policy issued

7/99 Reformatted, Medical Term Definitions added.

12/99 Reaffirmed, Medical Policy Advisory Group

5/01 System change. Revised. Added statement under Benefits Application to refer to the policy for Urinary Incontinence, Treatment. Specialty Matched Consultant Advisory Panel. No changes to policy. Coding format change.

5/03 Specialty Matched Consultant Advisory Panel review. No criteria changes.

6/2/2005 Specialty Matched Consultant Advisory Panel Review on 5/23/2005. No changes made to the policy statement. OTH 8160 added as key word. Benefits application and Billing/Coding sections updated for consistent policy language. References added.

11/3/05 Revised description of procedure. Removed FDA statement from Policy Guidelines and added rationale. Added "DRX9000, DRS System and mechanical traction" to Policy Key Words. Added Medical Term Definitions. Updated Reference Source. No changes to policy criteria.

6/18/07 Routine biennial review. Updated references. Specialty Matched Consultant Advisory Panel Review on 5/18/07. No changes to policy coverage criteria. (adn)

7/6/09 References updated. Specialty Matched Consultant Advisory Panel Review meeting 5/21/09. No change to policy statement. (adn)

8/17/10 Specialty Matched Consultant Advisory Panel review 7/2010. Removed Medical Policy number. References updated. (mco)

8/16/11 Specialty Matched Consultant Advisory Panel review 7/2011. References updated. Policy Guidelines updated. No changes to policy statement. (mco)

12/6/11 References updated. No changes to Policy Statement. (mco)

8/7/12 Specialty Matched Consultant Advisory Panel review 7/2012. No changes to Policy Statement. (mco)

12/11/12 References updated. No changes to Policy Statement. (mco)

7/30/13 Specialty Matched Consultant Advisory Panel review 7/2013. References updated. Medical Director review 7/013. No changes to Policy Statements. (mco)