



# FEP Medical Policy Manual

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## FEP 8.03.09 Vertebral Axial Decompression

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**Effective Policy Date: July 1, 2020**

**Related Policies:**

None

**Original Policy Date: June 2012**

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## Vertebral Axial Decompression

### Description

Vertebral axial decompression applies traction to the vertebral column to reduce intradiscal pressure, and in doing so, potentially relieves low back pain associated with herniated lumbar discs or degenerative lumbar disc disease.

### OBJECTIVE

The objective of this evidence review is to evaluate whether the use of vertebral axial decompression improves the net health outcome for individuals with chronic lumbar pain due to disc-related causes.

### POLICY STATEMENT

Vertebral axial decompression is considered **investigational**.

### POLICY GUIDELINES

None

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## BENEFIT APPLICATION

Experimental or investigational procedures, treatments, drugs, or devices are not covered (See General Exclusion Section of brochure).

## FDA REGULATORY STATUS

### Regulatory Status

Several devices used for vertebral axial decompression have been cleared for marketing by the U.S. Food and Drug Administration (FDA) through the 510(k) process. Examples of these devices include the VAX-D, Decompression Reduction Stabilization (DRS) System, Accu-SPINA System, DRX-3000, DRX9000, SpineMED Decompression Table, Antalgic-Trak, Lordex Traction Unit, and Triton DTS. According to labeled indications from the FDA, vertebral axial decompression may be used as a treatment modality for patients with incapacitating low back pain and for decompression of the intervertebral discs and facet joints.

FDA product code: ITH.

## RATIONALE

### Summary of Evidence

For individuals who have chronic lumbar pain who receive vertebral axial decompression, the evidence includes randomized controlled trials. Relevant outcomes are symptoms, functional outcomes, quality of life, and treatment-related morbidity. Evidence for the efficacy of vertebral axial decompression on health outcomes is limited. Because a placebo effect may be expected with any treatment that has pain relief as the principal outcome, randomized controlled trials with sham controls and validated outcome measures are required. The only sham-controlled randomized trial published to date did not show a benefit of vertebral axial decompression compared with the control group. The evidence is insufficient to determine the effects of the technology on health outcomes.

## SUPPLEMENTAL INFORMATION

### Practice Guidelines and Position Statements

No guidelines or statements were identified.

### U.S. Preventive Services Task Force Recommendations

Not applicable.

### Medicare National Coverage

In 1997, Medicare issued a national noncoverage policy (160.16) for vertebral axial decompression.<sup>7</sup>

## REFERENCES

1. Peloza J. Non-Surgical Treatments for Lower Back Pain. Spine-health. <https://www.spine-health.com/conditions/lower-back-pain/non-surgical-treatments-lower-back-pain>. Updated April 20, 2017. Accessed February 13, 2020.

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2. 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.* Dec 2009;18(12):1843-1850. PMID 19484433
3. Isner-Horobeti ME, Dufour SP, Schaeffer M, et al. High-force versus low-force lumbar traction in acute lumbar sciatica due to disc herniation: a preliminary randomized trial. *J Manipulative Physiol Ther.* Nov - Dec 2016;39(9):645-654. PMID 27838140
4. Sherry E, Kitchener P, Smart R. A prospective randomized controlled study of VAX-D and TENS for the treatment of chronic low back pain. *Neurol Res.* Oct 2001;23(7):780-784. PMID 11680522
5. Fritz JM, Lindsay W, Matheson JW, et al. Is there a subgroup of patients with low back pain likely to benefit from mechanical traction? Results of a randomized clinical trial and subgrouping analysis. *Spine (Phila Pa 1976).* Dec 15 2007;32(26):E793-800. PMID 18091473
6. Harte AA, Baxter GD, Gracey JH. The effectiveness of motorised lumbar traction in the management of LBP with lumbo sacral nerve root involvement: a feasibility study. *BMC Musculoskelet Disord.* Nov 29 2007;8:118. PMID 18047650
7. Centers for Medicare & Medicaid Services. National Coverage Decision (NCD) for Vertebral Axial Decompression (VAX-D) (160.16). 1997; [https://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=124&ncdver=1&DocID=160.16&ncd\\_id=160.16&ncd\\_version=1&basket=ncd\\*3a%24160.16\\*3a%241\\*3a%24Vertebral+Axial+Decompression+\(VAX-D\)&bc=gAAAAAgAAAAAA%3d%3d&](https://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=124&ncdver=1&DocID=160.16&ncd_id=160.16&ncd_version=1&basket=ncd*3a%24160.16*3a%241*3a%24Vertebral+Axial+Decompression+(VAX-D)&bc=gAAAAAgAAAAAA%3d%3d&). Accessed February 20, 2020.

## POLICY HISTORY - THIS POLICY WAS APPROVED BY THE FEP® PHARMACY AND MEDICAL POLICY COMMITTEE ACCORDING TO THE HISTORY BELOW:

Date	Action	Description
June 2012	New policy	
December 2013	Replace policy	Policy reviewed with literature search, no additions, rationale revised and references reordered. Policy statement is unchanged
June 2017	Replace policy	Policy updated with literature review through March 27, 2017; reference 2 added. Policy statement unchanged.
June 2018	Replace policy	Policy updated with literature review through February 5, 2018; no references added. Policy statement unchanged except "not medically necessary" corrected to "investigational" due to FDA 510(k) approval.
June 2019	Replace policy	Policy updated with literature review through February 18, 2019; no references added. Policy statement unchanged.
June 2020	Replace policy	Policy updated with literature review through February 11, 2020; no references added. Policy statement unchanged.

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