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.

BENEFIT APPLICATION

Vertebral axial decompression (also referred to as mechanized spinal distraction therapy) is used as traction therapy to treat chronic low back pain. Specific devices available are described in the Regulatory Status section.

In general, during treatment, the patient wears a pelvic harness and lies prone on a specially equipped table. 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 with static lumbar traction techniques. An individual session typically includes 15 cycles of tension, and 10 to 15 daily treatments may be administered.

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

Several devices used for vertebral axial decompression have been cleared for marketing by the U.S. Food and Drug Administration 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 Food and Drug Administration, 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. Food and Drug Administration product code: ITH.

RATIONALE

Summary of Evidence

For individuals who have chronic lumbar pain who receive vertebral axial decompression, the evidence includes RCTs. The 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, RCTs 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

Medicare issued a national noncoverage policy (160.16) for vertebral axial decompression in 1997.

REFERENCES


The policies contained in the FEP Medical Policy Manual are developed to assist in administering contractual benefits and do not constitute medical advice. They are not intended to replace or substitute for the independent medical judgment of a practitioner or other health care professional in the treatment of an individual member. The Blue Cross and Blue Shield Association does not intend by the FEP Medical Policy Manual, or by any particular medical policy, to recommend, advocate, encourage or discourage any particular medical technologies. Medical decisions relative to medical technologies are to be made strictly by members/patients in consultation with their health care providers. The conclusion that a particular service or supply is medically necessary does not constitute a representation or warranty that the Blue Cross and Blue Shield Service Benefit Plan covers (or pays for) this service or supply for a particular member.
POLICY HISTORY - THIS POLICY WAS APPROVED BY THE FEP® PHARMACY AND MEDICAL POLICY COMMITTEE ACCORDING TO THE HISTORY BELOW:

<table>
<thead>
<tr>
<th>Date</th>
<th>Action</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>June 2012</td>
<td>New policy</td>
<td>Policy reviewed with literature search, no additions, rationale revised</td>
</tr>
<tr>
<td>December 2013</td>
<td>Replace policy</td>
<td>and references reordered. Policy statement is unchanged</td>
</tr>
<tr>
<td>June 2017</td>
<td>Replace policy</td>
<td>Policy updated with literature review through March 27, 2017; reference 2</td>
</tr>
<tr>
<td></td>
<td></td>
<td>added. Policy statement unchanged.</td>
</tr>
<tr>
<td>June 2018</td>
<td>Replace policy</td>
<td>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 510k approval.</td>
</tr>
<tr>
<td>June 2019</td>
<td>Replace policy</td>
<td>Policy updated with literature review through February 18, 2019; no references added. Policy statement unchanged.</td>
</tr>
</tbody>
</table>

The policies contained in the FEP Medical Policy Manual are developed to assist in administering contractual benefits and do not constitute medical advice. They are not intended to replace or substitute for the independent medical judgment of a practitioner or other health care professional in the treatment of an individual member. The Blue Cross and Blue Shield Association does not intend by the FEP Medical Policy Manual, or by any particular medical policy, to recommend, advocate, encourage or discourage any particular medical technologies. Medical decisions relative to medical technologies are to be made strictly by members/patients in consultation with their health care providers. The conclusion that a particular service or supply is medically necessary does not constitute a representation or warranty that the Blue Cross and Blue Shield Service Benefit Plan covers (or pays for) this service or supply for a particular member.