Motorized Spinal Traction (for Louisiana Only)

Policy Number: CS080LA.~~J~~**J**
Effective Date: ~~May 1, 2019~~**TBD**

➲ Instructions for Use

Table of Contents **Page**

Application

This Medical Policy only applies to the state of Louisiana.

Coverage Rationale

Motorized spinal traction devices are unproven and not medically necessary for treating neck and low back disorders due to insufficient evidence of efficacy.

Applicable Codes

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by federal, state, or contractual requirements and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

HCPCS Code	Description
S9090	Vertebral axial decompression, per session

Description of Services

Vertebral axial decompression is a type of spinal traction used in the treatment of back or neck pain.

This involves the use of a computer-driven table to control the disc decompression. For the treatment, a pelvic harness is applied to the patient and the patient lies on the special table and is subjected to a series of cycles as the table is slowly extended and a distraction force is applied via the harness. When the desired tension is reached, it is gradually decreased. The number of sessions varies.

Clinical Evidence

Back

There is insufficient evidence from peer-reviewed published studies to conclude that spinal unloading devices are effective in

the management of low back pain or that they improve health outcomes. Additional well-designed controlled trials are needed to determine the efficacy for this service.

A random cross over study performed by Lee et al. (2021) evaluated real-time standard spinal traction (ST) with that of lordotic curve-controlled traction (LCCT). The study included 40 participants with mild non-radicular low back pain (LBP) and randomly assigned for either standard ST or LCCT. Each participant had initial x-rays taken in a standing position. After 10 minutes of traction, another radiograph was taken in the supine position and real-time shooting was performed during both standard ST and LCCT procedures. The following angles were measured: intervertebral disc angle of all segments, disc distance anterior and posterior and all measurements were taken by a radiologist who was blinded to the study. The disc distance was defined as the distance between inferior endplate of upper vertebrae and the superior endplate of opposing lower vertebrae while applying standard ST to straighten the spine or LCCT to be applied posteriorly to maintain the lordotic curve. Standard ST was applied and gradually increased to the maximum level tolerated or until the force was 1/3 of the patient's weight. LCCT participants had a magnetic marker attached to L4/L5 disc space by physical palpation. The authors found that during standard ST the force of traction decreased the lordotic curve and had more effect on the posterior and overstretching which causes pain, muscle spasms, damage to facet joints and soft tissue without effect on discs. The LCCT group with the same amount of force showed greater distance increase in discs and fewer muscle spasms. The authors concluded that the LCCT preserved the lordotic curve whereas standard ST only straightened it. The authors felt the newly developed LCCT device was useful for increasing the disc space evenly while maintaining the lordotic curve. Limitations included small sample size and lack of long-term efficacy for low back pain; further studies are warranted.

Tanabe et al. (2021) performed a randomized controlled trial (RCT) to evaluate the efficacy and safety of traction on chronic low back pain (CLBP) patients using recently developed equipment capable of precise traction force control. The study included 95 patients with non-specific CLBP from 28 clinics and hospitals, distributed throughout Japan, between December 2016 and March 2017. Participants were randomly assigned to group A (n=49), intermittent traction with vibration (ITV) mode; and group B (n=46), intermittent traction only (ITO) mode. All patients were followed up weekly for 2 periods after study-initiation. The primary outcome measures were disability level including pain, and quality of life. Statistical analysis was performed using linear mixed model. Two types of traction devices sold in the market under the same category of classification (MINATO Medical Science, ST-2L/2CL and OG Wellness Technologies, OL-6500/6000) were used. The devices consist of two main parts: a holding part for the upper

body with arm holders, and a moving part for the lower body. The upper body unit automatically measures the height of the arm pit to maintain the counter force against traction. The lower body unit produces a position of 90/90° traction adjusting the thigh length. Comparing to pre-traction data, both traction modes showed improvement except the first intervention of ITO treatment. The differences in Japan Low Back Evaluation Questionnaire (JLEQ) scores over time showed improvements in the treatment to which vibrational force was added in contrast to the conventional traction treatment; Mean difference was significant to compare ITV treatment and ITO treatment (−1.75 (p = 0.001), 95% CI; −2.69 to −0.80). However, neither difference between the two sequences (p = 0.884) nor carryover effect (p = 0.527) was observed. The authors concluded that lumbar traction could provide immediate effect in terms of the pain intensity and functional status in patients with CLBP, and a traction method added vibrational force on preload seemed to be promising. In addition, the study contributes to some evidence of the efficacy of lumbar traction. Limitations of the study include a short follow-up period of 2 weeks which did not allow for assessment of intermediate and long-term outcomes. Further investigation is needed before clinical usefulness of this procedure is proven.

Cheng et al. (2020) completed a systematic review of seven articles and a meta-analysis of literature including 403 participants. The criteria assessed in the randomized control trial included participants with low back pain (with or without sciatica), and those with herniated disc(s) confirmed by magnetic resonance imaging (MRI) or computed tomography (CT). The analysis compared participants that received any type of traction to the lumbar spine with sham or no traction and pain measurements before and after intervention. The authors concluded that lumbar traction was effective in the short term for reducing low back pain in those with a lumbar herniated disc, but further studies are needed to determine long term effectiveness. Several limitations of the study were identified including methodology, small sample size, differing interventions and outcome assessments contributing the heterogeneity; in addition, only two trials used sham controls.

A randomized controlled trial (RCT) was performed by Lee et al. (2019) to compare the effects of the newly developed lumbar lordotic curve-controlled traction (L-LCCT) (Kinetrac-9900, Hanmed Co., Gimhae, Korea) and traditional traction (TT) on functional changes in patients and morphological changes in the vertebral disc. Participants were recruited between June 2016 and February 2017. The study included a total of 40 patients with lumbar intervertebral disc disease at the L4-5 or L5-S1 level, as confirmed by magnetic resonance imaging, who were recruited and divided into two groups (L-LCCT, n=20; or TT, n=20). Participants received a total of 15 traction treatment sessions over a five-week study period. The comprehensive health status changes of the patients were recorded using pain and functional scores (the visual analogue scale (VAS), the Oswestry Disability Index (ODI), and the Roland-Morris Disability Questionnaire (RM)) and morphological changes (in the lumbar central canal area) before and after traction treatment. The L-LCCT (Kinetrac-9900, Hanmed Co., Gimhae, Korea) was used to maintain the natural lordotic curve of the spine by supporting the lumbar curve at the L3-5 intervertebral disc space. After the patient assumed a supine position, the chest and pelvis were belted. Initially, a magnetic marker was attached to the skin at the L4 intervertebral disc space by physical palpation and an automated tracking system (Figure 1). The automated tracking system ensured a lumbar lordotic curve during L-LCCT by elevating L3-5. A magnetic surface marker was attached to the patient's L4 area, where the lordotic curve is in maximum. As the highest lordotic point moved during traction, the auto-tracking system followed the magnetic surface marker, and thus constantly maintained the lordotic curve. The TT method was applied to patients without supporting

the lumbar lordotic curve. The authors followed the same protocol as for L-LCCT, except without the lordotic curve modification, and with the patient lying in a supine position. Results revealed pain scores were decreased after traction in both groups ($p < 0.05$). However, functional scores and morphological changes improved after treatment in the L-LCCT group only ($p < 0.05$). The authors concluded that L-LCCT is a viable option for resolving the technical limitations of TT by maintaining the lumbar lordotic curve in patients with lumbar intervertebral disc disease. A small sample size makes it difficult to decide whether these conclusions can be generalized to a larger population. Further investigation is needed before clinical usefulness of this procedure is proven.

Koçak et al. (2017) studied and compared the efficiency of conventional motorized traction (CMT) with non-surgical spinal decompression (NSD) using the DRX9000TM device, a different form of motorized spinal traction, in patients with low back pain associated with lumbar disc herniation. Forty-eight patients were randomized into two different groups; the first group underwent CMT and the second group underwent NSD. Both groups underwent the therapy for six weeks. Participants were assessed before and after the sessions: pain was assessed using the Visual Analog Scale (VAS), functional status assessed using the Oswestry Disability Index (ODI), quality of life assessed using the Short Form-36 (SF-36), state of depression mood assessed using the Beck Depression Inventory (BDI), and the global assessment of the illness using the Patient's Global Assessment of Response to Therapy (PGART) and Investigator's Global Assessment of Response to Therapy (IGART) scales. The authors concluded the study findings showed both CMT and NSD treatments were effective methods in controlling pain, in enhancing functional status, and in reducing depressive mood in patients with chronic LBP associated with LDH. Limitations included lack of control group without motorized spinal traction, no sham groups and the inability to perform long-term follow-up of the participants; future studies are warranted.

In a randomized clinical trial, Thackeray et al. (2016) examined the effectiveness of mechanical traction in patients (n=120) with low back pain and nerve root compression. Patients were randomized to receive an extension-oriented treatment approach with or without the addition of mechanical traction, and over a 6-week period, patients received up to 12 treatment visits. Primary outcomes of pain and disability were collected at 6 weeks, 6 months, and 1 year by assessors blinded to group allocation. At the end of the 1 year time period, the authors concluded that in this patient population there was no evidence that mechanical lumbar traction in combination with an extension-oriented treatment was superior to extension-oriented exercises alone in the management of these patients at any point in the evaluation period.

In an Agency for Healthcare Research and Quality review, Chou et al. (2016) assessed the evidence on the comparative benefits and harms of noninvasive treatments for acute, subacute, and chronic low back pain from 156 studies. Excluded from the review were studies conducted among patients with low back pain related to cancer, infection, inflammatory arthropathy, high-velocity trauma, or fracture or low back pain associated with severe or progressive neurological deficits. Outcomes were mostly measured at short-term (up to 6 months) follow-up. For radicular low back pain, there was low strength of evidence demonstrating that traction was effective compared to physiotherapy and other nonpharmacological interventions on pain control.

Apfel et al. (2010) conducted a retrospective case series of 30 patients with chronic low back pain attributed to disc herniation and/or discogenic low back pain. All patients underwent 6-weeks of motorized non-surgical spinal decompression with the DRX9000. The main outcomes were changes in pain as measured on a verbal rating scale from 0 to 10

during a flexion-extension, range of motion evaluation and changes in disc height as measured on CT scans. Low back pain decreased from 6.2 (± 2.2) to 1.6 (± 2.3) and disc height increased from 7.5 (± 1.7) to 8.8 (± 1.7) mm. The authors concluded that non-surgical spinal decompression was associated with a reduction in pain and an increase in disc height; however, they note that a randomized controlled is needed to confirm these results. The study is further limited by lack of a control group, lack of long-term follow-up and small sample size.

Schimmel et al. (2009) conducted a randomized controlled trial of 60 patients to evaluate the efficacy of Intervertebral Differential Dynamics Therapy® (IDD) on low back pain vs. sham therapy. Both groups received 20 sessions in the Accu-SPINA device. The IDD group received traction weight that was systematically increased until 50% of a person's body weight plus 4.45 kg (10 lb) was reached. The SHAM group received a non-therapeutic traction weight of 4.45 kg in all sessions. Outcomes were measures using visual analog scale (VAS), Oswestry Disability Index (ODI) and Short-Form 36 (SF-36) 2, 6 and 14 weeks after initiation of treatment. VAS improved from 61 (+/-25) to 32 (+/-27) in the IDD group and from 53 (+/-26) to 36 (+/-27) in the SHAM group. Leg pain, ODI and SF-36 scores improved in both groups. The authors found no difference between the IDD Therapy and the SHAM therapy; however, patients in both groups reported a decrease in low back and leg pain and an increase in functional status and quality of life.

A randomized controlled trial by Unlu et al. (2008) compared the use of motorized traction, ultrasound and low-power laser (LPL) therapies in 60 patients (equally distributed) with acute leg pain and low back pain caused by lumbar disc herniation. Treatment consisted of 15 sessions over a 3 week period. All patients had pre- and post-treatment magnetic resonance imaging (MRI). Additional outcomes measurements included physical examination of the lumbar spine, visual analog scale, Roland Disability Questionnaire and Modified Oswestry Disability Questionnaire to evaluate functional disability at baseline, after each session, and at 1 and 3 months after treatment. The authors reported similar improvement across treatment conditions for the outcomes measured (pain intensity and functional disability) at the end of the 3-week treatment period, and at 1 and 3-month follow-up assessments. Additionally, there were similar reductions in disc herniation on post-treatment MRI evaluations. The authors concluded that all the modalities were effective in the treatment of these patients with acute lumbar disc herniation. The study is limited by lack of a comparison group that did not receive treatment for similar complaints and small sample size.

~~Shealy and Borgmeyer (1997) completed a randomized study of decompression reduction stabilization (DRS) versus traction therapy. Pain reduction was the only outcome measure evaluated in this randomized study. Patients were randomized to complete either 20 sessions of DRS therapy or traction therapy. All patients received ice packs and TENS for 30 minutes after their assigned therapy. Pain reduction was defined as good or excellent improvement. The scale used to quantify the pain was not described. The authors concluded that 86% of patients with ruptured intervertebral discs had good to excellent results after DRS therapy compared to 55% of the traction treated patients. Of the patients with facet arthrosis, 75% obtained good to excellent results with DRS therapy as compared to 55% of the traction-treated group. The procedure related complications were not analyzed nor were follow-up evaluations completed. The primary author is the developer of the DRS system.~~

~~Schimmel et al. (2009) conducted a randomized controlled trial of 60 patients to evaluate the efficacy of Intervertebral Differential Dynamics Therapy® (IDD) on low back pain vs. sham therapy. Both groups received 20 sessions in the Accu-SPINA device. The IDD group~~

~~received traction weight that was systematically increased until 50% of a person's body weight plus 4.45 kg (10 lb) was reached. The SHAM group received a non-therapeutic traction weight of 4.45 kg in all sessions. Outcomes were measures using visual analog scale (VAS), Oswestry Disability Index (ODI) and Short-Form 36 (SF-36) 2, 6 and 14 weeks after initiation of treatment. VAS improved from 61 (+/-25) to 32 (+/-27) in the IDD group and from 53 (+/-26) to 36 (+/-27) in the SHAM group. Leg pain, ODI and SF-36 scores improved in both groups. The authors found no difference between the IDD Therapy and the SHAM therapy; however, patients in both groups reported a decrease in low back and leg pain and an increase in functional status and quality of life.~~

~~Cose et al. (1998) completed a multicenter, retrospective chart review of 778 patients treated with VAX-D at 22 medical centers. VAX-D therapy was considered successful in 71% of the low back pain patients. The majority of the patients reported some improvements in pain of at least one level (92%); spinal mobility (77%) and ability to carry out the usual activities of daily living (63%) following VAX-D therapy. Although this study involved a larger number of patients compared to previous studies, it lacks a comparison group, had poorly defined patient selection criteria and did not discuss safety.~~

~~Apfel et al. (2010) conducted a retrospective study of 30 patients with chronic low back pain attributed to disc herniation and/or discogenic low back pain. All patients underwent 6 weeks of motorized non-surgical spinal decompression with the DRX9000. The main outcomes were changes in pain as measured on a verbal rating scale from 0 to 10 during a flexion-extension, range of motion evaluation and changes in disc height as measured on CT scans. Low back pain decreased from 6.2 (± 2.2) to 1.6 (± 2.3) and disc height increased from 7.5 (± 1.7) to 8.8 (± 1.7) mm. The authors concluded that non-surgical spinal decompression was associated with a reduction in pain and an increase in disc height; however, they note that a randomized controlled is needed to confirm these results. The study is further limited by lack of a control group, lack of long term follow-up and small sample size.~~

In a retrospective chart audit by Macario et al. (2008), 100 outpatients with discogenic low back pain lasting more than 12 weeks were treated with a 20--month course of motorized spinal decompression via the DRX9000. Overall, this preliminary analysis suggests that treatment with the DRX9000 nonsurgical spinal decompression system reduced patient's chronic low back pain with patients requiring fewer analgesics, and achieving better function. However, without control groups, it is difficult to know how much of the benefit was placebo, spontaneous recovery, or the treatment itself. Randomized double-blind trials are needed to measure the efficacy of such systems.

~~Sherry et al. (2001) completed an Australian study of 40 patients with chronic low back pain (>3 months), associated leg pain and disc protrusion documented by MRI or CT treated with either VAX-D or transcutaneous electrical nerve stimulation (TENS). Nineteen patients were randomized to receive VAX-D. Of these patients, 13 (68.4%) had successful treatment which as defined as a 50 percent or greater reduction in the patient's pain and an improvement in their disability rating. None of the 21 patients in the TENS group had success. Six-month follow up of the 13 "success" cases showed that 7 of the 10 who could still be evaluated, still met the criteria for success.~~

~~A study by Ramos (2004) compared the effects of two different regimens of VAX-D treatments on the level of low back pain. One group of patients received an average course of treatment consisting of 18 daily sessions and the other group received half that number of daily treatments. The treatment parameters were the same for all patients except for the number of treatments completed. Seventy-six percent of the higher dosage~~

~~group achieved remission of low back pain compared to 43% of the lower dosage group. This study did not compare results to patients treated with other modalities or no treatment at all.~~

Beattie et al. (2008) conducted a prospective case series study of 296 patients to examine outcomes after administration of a prone lumbar traction protocol, using the VAX-D system. All patients had low back pain with evidence of a degenerative and/or herniated intervertebral disk at one or more levels of the lumbar spine. Patients involved in litigation or and those receiving workers' compensation were excluded. Patients underwent an 8-week course of prone lumbar traction consisting of five 30-minute sessions a week for 4 weeks, followed by one 30-min session a week for 4 additional weeks. The numeric pain rating scale and the Roland-Morris Disability Questionnaire were completed at pre-intervention, discharge (within two weeks of the last visit), and at 30 days and 180 days after discharge. Intention-to-treat strategies were used to account for those patients lost to follow-up. A total of 250 (84.4%) patients completed the treatment protocol with 247 (83.4%) of patients available on 30 day follow-up and 241 (81.4%) patients available at 180-day follow-up. The researchers noted significant improvements for all post-intervention outcome scores when compared with pre-intervention scores ($p < 0.01$). The authors concluded that causal relationships between the outcomes and the intervention cannot be made until further study is performed using randomized comparison groups.

~~In an Agency for Healthcare Research and Quality review, Chou et al., 2016 assessed the evidence on the comparative benefits and harms of noninvasive treatments for acute, subacute, and chronic low back pain from 156 studies. Excluded from the review were studies conducted among patients with low back pain related to cancer, infection, inflammatory arthropathy, high-velocity trauma, or fracture or low back pain associated with severe or progressive neurological deficits. Outcomes were mostly measured at short-term (up to 6 months) follow-up. For radicular low back pain, there was low strength of evidence demonstrating that traction was effective compared to physiotherapy and other nonpharmacological interventions on pain control.~~

Macario et al. (2006) completed a systematic review of the literature to assess the efficacy of nonsurgical spinal decompression achieved with motorized traction for chronic discogenic lumbosacral back pain. The authors found that the efficacy of spinal decompression achieved with motorized traction for chronic discogenic low back pain remains unproven. This may be, in part, due to heterogeneous patient groups and the difficulties involved in properly blinding patients to the mechanical pulling mechanism. Randomized double-blind trials are needed to measure the efficacy of such systems.

~~The Work Loss Data Institute's clinical practice guideline for low back - lumbar and thoracic (acute and chronic) (2011) does not recommend the use of powered traction devices.~~

Neck

Published clinical evidence for treating neck pain with vertebral axial decompression or other types of motorized traction is limited to case studies. Well-designed randomized controlled trials are needed to determine the efficacy of vertebral axial decompression for this indication.

~~Professional Societies~~ Clinical Practice Guidelines

American College of Physicians (ACP)

In an updated clinical practice guideline on non-invasive treatments for low back pain, the ACP (Qaseem et al., 2017) states that evidence is insufficient to determine the effectiveness of several therapies including traction, for acute, subacute, or chronic low back pain. Low-quality evidence showed no clear differences between traction and other active treatments, between traction with physiotherapy versus physiotherapy alone, or between different types of traction in patients with low back pain with or without radiculopathy.

North American Spine Society (NASS)

The NASS evidenced based guideline (Kriener et al., 2020) on the diagnosis and treatment for low back pain considers the evidence to be insufficient to recommend the use of traction for patients with subacute or chronic low back pain.

The NASS evidence-based guideline (Kriener et al., 2011) on the diagnosis and treatment of degenerative lumbar spinal stenosis considers the evidence to be insufficient to recommend the use of any type of traction in the treatment of lumbar disc herniation with radiculopathy, and lumbar spinal stenosis.

The NASS evidence-based guideline (Bono et al., 2011) on the diagnosis and treatment of cervical radiculopathy from degenerative disorders recommends that future outcome studies for patients in this population treated only with ancillary treatments (such as traction) should include subgroup analysis.

U.S. Food and Drug Administration (FDA)

This section is to be used for informational purposes only. FDA approval alone is not a basis for coverage.

Powered traction equipment is regulated by the FDA but products are too numerous to list. See the following website for more information (product code ITH): http://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfPMN/pmn.cfm. (Accessed ~~February 12, 2019~~**April 11, 2022**)

References

Apfel C, Cakmakkaya O, Martin W, et al. Restoration of disc height through non-invasive spinal decompression is associated with decreased discogenic low back pain: a retrospective cohort study. BMC Musculoskelet Disord. 2010 Jul 8;11:155.

Beattie PF, Nelson RM, Michener LA, et al. Outcomes after a prone lumbar traction protocol for patients with activity-limiting low back pain: a prospective case series study. Arch Phys Med Rehabil. 2008 Feb;89(2):269-74.

Bono C, Ghiselli G, Gilbert TJ, et al. North American Spine Society (NASS). Evidence-based clinical guidelines for multidisciplinary spine care. Diagnosis and treatment of cervical radiculopathy from degenerative disorders. Spine J. 2011 Jan;11(1):64-72.

Cheng Y-H, Hsu C-Y, Lin Y-N. The effect of mechanical traction on low back pain in patients with herniated intervertebral disks: a systemic review and meta-analysis. Clinical Rehabilitation. 2020;34(1):13-22.

Chou R, Deyo R, Friedly J, et al. Noninvasive treatments for low back pain [internet]. Agency for Healthcare Research and Quality (US); 2016 Feb. Report No.: 16-EHC004-EF.

Koçak FA, Tunç H, Tomruk Sütbeyaz S, et al. Comparison of the short-term effects of the conventional motorized traction with non-surgical spinal decompression performed with a DRX9000 device on pain, functionality, depression, and quality of life in patients with low back pain associated with lumbar disc herniation: A single-blind randomized-controlled trial. *Turk J Phys Med Rehabil*. 2017;64(1):17-27.

Kriener DS, Shaffer WO, Summers J., et al. North American Spine Society (NASS). Evidence-based clinical guidelines for multidisciplinary spine care. Diagnosis and treatment of degenerative lumbar spinal stenosis. 2011.

Lee C-H, Heo SJ, Park SH. The real time geometric effect of a lordotic curve-controlled spinal traction device: a randomized cross over study. Healthcare. 2021; 9(2):125.

Lee CH, Heo SJ, Park SH, et al. (2019). Functional changes in patients and morphological changes in the lumbar intervertebral disc after applying lordotic curve-controlled traction: a double-blind randomized controlled study. Medicina (Kaunas). 2019 Dec 19;56(1):4.

Macario A, Pergolizzi JV. Systematic literature review of spinal decompression via motorized traction for chronic discogenic low back pain. Pain Pract. 2006 Sep;6(3):171-8.

Macario A., Pergolizzi J. Systematic Literature Review of Spinal Decompression Via Motorized Traction for Chronic Discogenic Low Back Pain Pain Practice 2006; 6(3),171-178.

~~Kriener DS, Shaffer WO, Summers J., et al. North American Spine Society (NASS). Evidence-based clinical guidelines for multidisciplinary spine care. Diagnosis and treatment of degenerative lumbar spinal stenosis. 2011.~~

Macario A, Richmond C, Auster M, et al. Treatment of 94 outpatients with chronic discogenic low back pain with the DRX9000: a retrospective chart review. Pain Pract. 2008 Mar;8(1):11-7.

Qaseem A, Wilt TJ, McLean RM, et al. Noninvasive treatments for acute, subacute, and chronic low back pain: a clinical practice guideline from the American College of Physicians. Ann Intern Med. 017;166:514-530.

~~Ramos G. Efficacy of vertebral axial decompression on chronic low back pain: study of dosage regimen. Neurol Res 2004Apr;26(3):320-4.~~

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 Dec;18(12):1843-50.

~~Shealy CN, Borgmeyer V. Decompression, reduction and stabilization of the lumbar spine: a cost -effective treatment for lumbosacral pain. Am J Pain Manage. 1997;7(2): 63-65.~~

~~Sherry E, Kitchener P, Smart R. A prospective randomized controlled study of VAX-D and TENS for the treatment of chronic low back pain. Journal of Neurological Research. April 2001; 23; 780-4.Thackeray A, Fritz JM, Childs JD, et al. The effectiveness of mechanical traction among subgroups of patients with low back pain and leg pain: a randomized trial. J Orthop Sports Phys Ther. 2016 Mar;46(3):144-54.~~

Tanabe H, Akai M, Doi T, et al. Immediate effect of mechanical lumbar traction in patients with chronic low back pain: A crossover, repeated measures, randomized controlled trial. J Orthop Sci. 2021 Nov;26(6):953-961.

Thackeray A, Fritz JM, Childs JD, et al. The effectiveness of mechanical traction among subgroups of patients with low back pain and leg pain: a randomized trial. J Orthop Sports Phys Ther. 2016 Mar;46(3):144-54.

Unlu Z, Tasci S, Tarhan S, et al. Comparison of 3 physical therapy modalities for acute pain in lumbar disc herniation measured by clinical evaluation and magnetic resonance imaging. Journal of Manipulative and Physiological Therapeutics. 2008; 31(3):191-198.

~~Work Loss Data Institute. Low back - lumbar & thoracic (acute & chronic). Encinitas, CA: Work Loss Data Institute; 2011.~~

Policy History/Revision Information

Date	Summary of Changes
TBD	**Supporting Information** • **Updated *Clinical Evidence* and *References* sections to reflect the most current information** • **Archived previous policy version CS080LA.I**

Instructions for Use

This Medical Policy provides assistance in interpreting UnitedHealthcare standard benefit plans. When deciding coverage, the federal, state or contractual requirements for benefit plan coverage must be referenced as the terms of the federal, state or contractual requirements for benefit plan coverage may differ from the standard benefit plan. In the event of a conflict, the federal, state or contractual requirements for benefit plan coverage govern. Before using this policy, please check the federal, state or contractual requirements for benefit plan coverage. UnitedHealthcare reserves the right to modify its Policies and Guidelines as necessary. This Medical Policy is provided for informational purposes. It does not constitute medical advice.

UnitedHealthcare may also use tools developed by third parties, such as the InterQual® criteria, to assist us in administering health benefits. The UnitedHealthcare Medical Policies are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice.