Medical Policy
Vertebral Axial Decompression

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Policy Number: 603
BCBSA Reference Number: 8.03.09
NCD/LCD: National Coverage Determination (NCD) for Vertebral Axial Decompression (VAX-D) (160.16)

Related Policies
None

Policy
Commercial Members: Managed Care (HMO and POS), PPO, and Indemnity

Vertebral axial decompression is INVESTIGATIONAL.

Medicare HMO Blue℠ and Medicare PPO Blue℠ Members

Vertebral axis decompression is NOT covered in accordance with the Centers for Medicare and Medicaid Services (CMS) NCD.

Medical necessity criteria and coding guidance can be found through the link below.

National Coverage Determinations (NCDs)

National Coverage Determination (NCD) for Vertebral Axial Decompression (VAX-D) (160.16)

Note: To review the specific NCD, please remember to click “accept” on the CMS licensing agreement at the bottom of the CMS webpage.

Prior Authorization Information

Inpatient
• For services described in this policy, precertification/preauthorization IS REQUIRED for all products if the procedure is performed inpatient.

Outpatient
• For services described in this policy, see below for products where prior authorization might be required if the procedure is performed outpatient.
Outpatient

<table>
<thead>
<tr>
<th>Plan Type</th>
<th>Coverage Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Commercial Managed Care (HMO and POS)</td>
<td>This is not a covered service.</td>
</tr>
<tr>
<td>Commercial PPO and Indemnity</td>
<td>This is not a covered service.</td>
</tr>
<tr>
<td>Medicare HMO Blue&lt;sup&gt;SM&lt;/sup&gt;</td>
<td>This is not a covered service.</td>
</tr>
<tr>
<td>Medicare PPO Blue&lt;sup&gt;SM&lt;/sup&gt;</td>
<td>This is not a covered service.</td>
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**CPT Codes / HCPCS Codes / ICD Codes**

Inclusion or exclusion of a code does not constitute or imply member coverage or provider reimbursement. Please refer to the member’s contract benefits in effect at the time of service to determine coverage or non-coverage as it applies to an individual member.

Providers should report all services using the most up-to-date industry-standard procedure, revenue, and diagnosis codes, including modifiers where applicable.

**CPT Codes**

There is no specific CPT code for this service.

**HCPCS Codes**

<table>
<thead>
<tr>
<th>HCPCS codes:</th>
<th>Code Description</th>
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<tr>
<td>S9090</td>
<td>Vertebral axial decompression, per session</td>
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**Description**

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.

**Summary**

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.

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.

**Policy History**

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<tr>
<th>Date</th>
<th>Action</th>
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Information Pertaining to All Blue Cross Blue Shield Medical Policies
Click on any of the following terms to access the relevant information:
- Medical Policy Terms of Use
- Managed Care Guidelines
- Indemnity/PPO Guidelines
- Clinical Exception Process
- Medical Technology Assessment Guidelines

References