

Cigna Medical Coverage Policy- Therapy Services Home Traction Devices – Cervical and Lumbar

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GUIDELINES

Experimental, Investigational, Unproven

Home cervical and/or lumbar traction devices, including gravity-assisted traction devices, are considered experimental, investigational and/or unproven for any indication.

Coding Information

Notes:

1. This list of codes may not be all-inclusive since the American Medical Association (AMA) and Centers for Medicare & Medicaid Services (CMS) code updates may occur more frequently than policy updates.

2. Deleted codes and codes which are not effective at the time the service is rendered may not be eligible for reimbursement.

Considered Experimental, Investigational and/or Unproven:

HCPCS Codes	Description
E0830	Ambulatory traction device, all types, each
E0840	Traction frame, attached to headboard, cervical traction
E0849	Traction equipment, cervical, free-standing stand/frame, pneumatic, applying traction force to other than mandible
E0850	Traction stand, freestanding, cervical traction
E0855	Cervical traction equipment not requiring additional stand or frame
E0856	Cervical traction device, with inflatable air bladder(s)
E0860	Traction equipment, overdoor, cervical
E0941	Gravity-assisted traction device, any type

***Current Procedural Terminology (CPT®) ©2025 American Medical Association: Chicago, IL.**

DESCRIPTION

For the purpose of this policy, traction is the use of a pulling force to treat muscle and or skeletal disorders of the spine. Traction is intended for patients with musculoskeletal or neurological impairments of the spine; the objective is to relieve pain, relax muscle spasms, and decompress spinal structures.

Traction is used for treatment of neck and low back pain and it is typically provided in combination with other treatment modalities and an exercise program. Cervical and lumbar traction have been utilized to treat many causes of spine-related pain including radiculopathy secondary to herniated disc, narrowing of the intervertebral foramen, degenerative changes resulting in nerve root impingement, and spondylolisthesis. Beyond these broad clinical indications, the particular characteristics of patient subgroups that are likely to benefit from home traction do not appear to have been identified in clinical studies. Treatment plans are usually short-term (less than eight weeks in duration) with treatments 2–3 times per week. The type of traction used depends on the patient’s age, weight and medical condition. It can be provided manually by a therapist or by mechanical means in a clinic setting, and also may be self-administered using portable devices. Types of traction include, but are not limited to: mechanical traction, manual traction (performed by clinician), autotraction, gravity-dependent ("anti-gravity") traction, pneumatic traction, continuous traction, and intermittent traction. The suggested mechanisms through which traction might be effective include:

- Biomechanical effects, such as separation of the intervertebral motion segment which may increase intervertebral space, thus decreasing mechanical stress and/or spinal nerve root compression, altering intradiscal pressure, and perhaps reducing intervertebral disc protrusion.
- Neurophysiological effects, such as modulation of nociceptive input in either the ascending or descending pathways, thus silencing ectopic impulse generators.

These two mechanisms probably work in concert to produce clinical effects, including pain reduction, increased mobility, reduced muscle spasm, and nerve root irritation. Ideally, normalization of the neurologic deficit and relief of radicular pain occurs. However, the proposed mechanisms have not been supported by sufficient empirical information.

Traction, when applied at home, presents with additional factors that may influence clinical effectiveness and the risk of adverse events. The absence of professional supervision decreases confidence that the appropriate amount of force will be consistently applied and the desired angle of pull will be maintained. Another consideration that has the potential to affect treatment response is patient compliance with home-based traction.

While there is emerging evidence about the factors associated with poor compliance with home-based care, there has been little study on effective remediation strategies.

GENERAL BACKGROUND

Home Cervical Traction: Home traction units generally provide sustained (static) or intermittent distractive forces. Various cervical traction devices are available for use in a home setting including over-the-door pulley systems, pneumatic (inflatable) neck traction devices, rigid or foam collars, and mechanical traction systems. Some devices intended primarily for home use are limited in comparison to those usually available in supervised outpatient settings. Traction forces used in the clinic setting commonly reach between 20 and 50 pounds. The traditional over-the-door traction units are generally limited to providing less than 20 pounds of traction. This is the most commonly used device employed in which an individual wears a chin strap harness attached to a counterweight that is suspended over a door using a pulley system. The counterweight pulls the chin harness upwards, extending the neck. Variations of this device using the counterweight and pulley system include frames which attach to a headboard or freestanding units. More recently developed technologies include devices that do not cause pressure to the temporomandibular joint, and reportedly provide cervical traction in the home using forces comparable to those in the outpatient setting. These newer pneumatic devices are designed to be used in the supine position with the device beneath the head and shoulders and a strap or straps holding the head in place. Patient-controlled pressure valves/pumps or bellows allow the individual to increase the tension, pulling the head away from the body, but it also limits the amount of force transmitted to the user and allows for an immediate release of pressure. They also allow the patient to be positioned in any degree of flexion, neutral or in extension. This extends the neck, stretches the affected muscles and increases the intervertebral spaces. Pneumatic devices typically can deliver up to 50 pounds of tension, which manufacturers' state more closely mimics traction given within an outpatient setting. It is suggested that these devices manufactured for home use are sufficiently sophisticated that outpatient treatment protocols can confidently be translated to the home setting.

Home traction devices include both traditional over-the-door devices (applied in a sitting position) and more advanced technologies (applied in a supine position), such as the HomeTrac[®] (Empi, Shoreview, MN) and Pronex[®] Pneumatic Traction Unit (Glacier Cross Inc., Kalispell, MT). Standard over-the-door traction devices are traditionally limited to delivering 20 pounds or less of traction.

Devices that are used in the home and allow greater traction force include the HomeTrac and Pronex cervical traction devices. The Pronex is a patient-controlled, pneumatic traction device that is used in a supine position. The device cradles a reclining patient's head and neck between two soft foam cushions. An air-inflated bellows between the cushions provides up to 20 pounds of continuously adjustable traction. The Pronex II is a newer device capable of delivering greater than 20 pounds of force. The HomeTrac may provide up to 50 pounds of traction force at a 15° angle. Traction forces are directed at the occiput, preventing undue pressure on the TMJ. The device has an adjustable extension foot that allows additional traction angles of 20° and 25°. The patient can immediately release the traction force by using a pressure release valve.

Both HomeTrac and Pronex are operated by a patient-controlled, hand-held pump. Manufacturers and therapists propose that these devices maintain the normal cervical lordosis, resulting in uniform traction posteriorly and anteriorly across the vertebral disc, in comparison to other devices, which occlude the anterior disc space for temporary relief posteriorly. The manufacturers suggest that the use of these devices in a home setting allows treatment comparable to that provided in an outpatient setting and may provide more continuous pain relief. These devices can be used to deliver a traction force that avoids TMJ force and allows patients control of their own comfort level.

There are cervical traction devices that may be used with ambulation. They may also be referred to as a cervical support brace. The device consists of an inflatable collar that is inflated with attached bulb pumps. Cervical traction equipment that does not prevent ambulation during use has not been shown to be effective and is considered not medically necessary as a treatment for musculoskeletal and/or neurological conditions. Scientific evidence supporting the efficacy of this device is lacking. Examples of these devices include but are not limited to:

- Pneu-trac[®] Traction Collar (Trulife, Poulsbo, WA)
- TracCollar[®] (BodySport[®], Ft. Worth, Texas)

Home Lumbar Traction: Lumbar traction is used to treat low back pain, often in conjunction with other treatment modalities. The traction may be applied intermittently, using any of several methods to treat conditions of the spine, in either an outpatient setting or in a home setting. Typically, these modalities are used short term. The duration of the exerted force applied may be intermittent or continuous throughout a treatment session. Generally,

during lumbar traction a harness is attached around the pelvis (to deliver a caudal pull), and the upper body is stabilized with a chest harness or voluntary arm force (for the cephalad pull) (Wieting, et al., 2013). In some cases, 70–150 pounds of pull are required to distract lumbar vertebrae (Wieting, et al., 2013).

Some of the most commonly used lumbar traction techniques are not suited for home use. Manual traction (distractive force is exerted by and under the control of the clinician) and motorized traction (distractive force is exerted by a motorized pulley) are not practical for home application. There are also questions about the ability of lumbar traction some devices designed for home use to achieve the magnitude of distractive force (80-120 lbs or >50% of body weight) necessary to increase intervertebral joint space. Devices may include the use of a table, vest, weights, gravity or pneumatic devices. Several available home lumbar traction devices that are not pulley and weight systems may apply increased traction forces (greater than 20 pounds). This type of device is designed to provide traction (stretching) to the lumbar region (low back). Examples include Saunders Lumbar Home Traction® (DJO Global Inc., Vista, CA) and Lo-Bak TRAX™ (Allstar Products Group, Hawthorne NY).

The Back Bubble® (Back Bubble, Solana Beach, CA) is an inflatable lumbar traction device that is suspended from a door and connects with a buoyancy spring to an inflatable body harness which encircles and suspends the patient in air-cushioned weightlessness. The manufacturer's website states that the patient's own body weight will provide a gentle stretch which relaxes the lower back. There is insufficient evidence in the medical literature regarding the efficacy of inflatable traction devices in the treatment of back pain.

Gravity-Assisted Traction: Inversion therapy is a form of traction facilitated by gravity as the patient is either hung or laid upside down typically at an angle of greater than 45° below the horizontal axis. This therapy is used in the treatment of back pain and is believed to help in the decompression of the disks and joints. This therapy takes many forms, from gravity boots to inversion tables the patient lies on before inverting the table. Contraindications to inversion therapy include hernia, glaucoma, retinal detachment, conjunctivitis, high blood pressure, recent stroke, heart or circulatory disorders, spinal injury, cerebral sclerosis, swollen joints, osteoporosis, unhealed fractures, surgically implanted supports, use of anticoagulants, ear infection, and obesity.

U.S. Food and Drug Administration (FDA)

Home traction devices are classified as Class I devices by the U.S. Food and Drug Administration (FDA). The FDA has described these devices as “A non-powered orthopedic traction apparatus is a device that consists of a rigid frame with nonpowered traction accessories, such as cords, pulleys, or weights, and that is intended to apply a therapeutic pulling force to the skeletal system.”

LITERATURE REVIEW

Cervical Traction: There is very little published evidence on home cervical traction for neck pain and the existing studies are uncontrolled and of poor quality. Overall, the quality of the body of evidence is very low, and is insufficient in the published, peer-reviewed scientific literature for drawing conclusions about the efficacy and safety of home cervical traction.

Cai et al. (2011) completed a study with the purpose of identifying neck pain patients who would demonstrate a short-term improvement from the home-based mechanical cervical traction (HMCT) approach. In order to separate the responders from the non-responders, three different outcome criteria were used which were considered clinically important: reduction of pain intensity, global rating of perceived improvement and improvement of Neck Disability Index (NDI). All patients were given HMCT treatment for 2 weeks. The traction method was standardized, with written instructions about the use of a simplified over-the-door traction suspension and a standard adjustable cervical halter. The traction force was determined by 10–15% of the subject's body weight. Patients were instructed to pull the pulley string to generate traction force, until the determined traction force was reached. The traction force generator is designed to generate 0.5 kg of traction force per pull from the patient, and to self-lock at the end of each pull. This design allowed the patient to generate traction force independently, and the force to be sustained by the device itself. Patients were also instructed to use a mirror to read the force meter in order to confirm that the determined traction force had been reached. In general, patients were instructed to generate a traction force that should be “moderate to moderately strong” without increasing symptoms. The patients were told to use the traction device for 20 minutes a day for 2 weeks, reinforced by a treatment diary, in which they recorded both the compliant sessions and missed sessions. All 103 participants completed the treatment with overall high compliance to the treatment program. The mean compliance rate was 91.0% according to participant's response, which was considered a “courtesy” answer by the investigators and therefore was not

entered into the statistical analysis. Several limitations were present for this study: no control group, heterogeneous sample given the wide range of episode duration (from acute to chronic), lack of diagnoses clarity (non-specific vs. cervical radiculopathy), lack of compliance rate formally monitored and analyzed, 60% unknown variance, short duration of study creating lack of generalizability, traction force of 10-15% may be considered too much or too little given there is a lack of agreement about the force that should be used in clinical practice, and lastly, the small sample size. Four predictors have been identified for predicting responders to short-term HMCT. The prediction model in this study suggested that having 3 of 4 predictors increased the probability of the treatment success. These predictors included Fear-Avoidance Beliefs Questionnaire- Work Subscale (FABQW) score < 13, pre-intervention Numerical Pain Scale (NPS) $\geq 7/10$, pain below shoulder present, and positive cervical distraction test.

Fritz et al. (2014) completed a RCT that examined the effectiveness of cervical traction in addition to exercise for specific subgroups of patients with neck pain. Eighty-six patients with neck pain and signs of radiculopathy were randomized to one of three groups: exercise, exercise with mechanical traction, or exercise with over-the-door traction. All patients were scheduled to receive 10 individual physical therapy sessions over a 4-week treatment. The primary outcome measure was the Neck Disability Index (NDI) and secondary outcome measure was neck and arm pain intensity. Assessment periods were at four weeks, six months, and 12 months. Intention-to-treat analysis found lower NDI scores at six months in the mechanical traction group compared to the exercise group and over-the-door traction group, and at 12 months in the mechanical traction group compared to the exercise group. Secondary outcomes favored mechanical traction. Limitations of the study existed with several patients crossing over to a different treatment group during the first four weeks and differences in baseline characteristics at the outset of the study between groups (i.e., duration of symptoms).

The NASS clinical guideline for the diagnosis and treatment of cervical radiculopathy from degenerative disorders (Bono, et al., 2011) lists Question 10: What is the role of ancillary treatments such as bracing, traction, electrical stimulation, acupuncture, and transcutaneous electrical nerve stimulation in the treatment of cervical radiculopathy from degenerative disorders? Ozone injections, cervical halter traction and combinations of medications, physical therapy, injections, and traction have been associated with improvements in patient-reported pain in uncontrolled case series. Such modalities may be considered recognizing that no improvement relative to the natural history of cervical radiculopathy has been demonstrated (Work Group Consensus Statement).

According to a Clinical Practice Guideline for Physical Therapy Assessment and Treatment in Patients With Nonspecific Neck Pain, Bier et al. (2018) recommend against using cervical traction for nonspecific neck pain.

Bounds et al. (2024) sought to determine the efficacy of nonsurgical interventions, such as physiotherapy, exercise, pharmacology, and multidisciplinary programs, to manage MSK conditions in active serving military populations. Nineteen articles (1,408 participants) met the eligibility criteria. Low back pain (LBP) was the most frequently investigated condition, followed by knee pain, neck pain, and shoulder pain. Early physiotherapy, exercise and adjunct chiropractic manipulation (for LBP), and multidisciplinary pain programs (physiotherapy, occupational therapy, and psychology) (for chronic MSK pain) improved pain. Participation in multidisciplinary pain programs, adjunct chiropractic manipulation, and early physiotherapy improved disability (for LBP). Dietary supplements (glucosamine, chondroitin sulfate, and manganese ascorbate), electrotherapy, isolated lumbar muscle exercises, home cervical traction, or training in virtual reality showed no benefit. The studies had a high risk of bias, were typically underpowered, and demonstrated high clinical heterogeneity. Future research is essential to enable evidence-based recommendations for the effective management of MSK pain conditions in this unique population.

Lumbar Traction: There is a lack of/insufficient evidence in the published, peer-reviewed scientific literature to demonstrate that home traction is effective in the treatment of lumbar spine disorders including low back pain. In general, studies have been of poor methodological quality, with small sample sizes and lack of randomization and only include mechanical traction devices used in the clinical setting. Further randomized controlled clinical trials are needed assessing effectiveness of home traction devices.

The American Physical Therapy Association (APTA) published a clinical practice guideline regarding low back pain (Delitto, et al., 2013). The guideline reported, "There is conflicting evidence for the efficacy of intermittent lumbar tractions for patients with low back pain. There is moderate evidence that clinicians should not utilize intermittent or static lumbar traction for reducing symptoms in patients with chronic low back pain."

The North American Spine Society (NASS) clinical guideline for the diagnosis and treatment of lumbar disc herniation with radiculopathy (Kreiner, et al., 2014) lists Question 9: what is the role of traction (manual or mechanical) in the treatment of lumbar disc herniation with radiculopathy? There is insufficient evidence to make a recommendation for or against the use of traction in the treatment of lumbar disc herniation with radiculopathy. Grade of recommendation: I (insufficient evidence). The NASS clinical guideline for the diagnosis and treatment of degenerative lumbar spinal stenosis (Kreiner, et al., 2013) lists Question 12: What is the role of ancillary treatments such as bracing, traction, electrical stimulation and transcutaneous electrical stimulation (TENS) in the treatment of lumbar spinal stenosis? There is insufficient evidence to make a recommendation for or against traction, electrical stimulation, or transcutaneous electrical stimulation for the treatment of patients with lumbar spinal stenosis. Grade of Recommendation: I (insufficient evidence). Wegner et al. (2013) assessed the effects of traction compared to placebo, sham traction, reference treatments and no treatment in people with LBP. RCTs involving traction to treat acute (less than four weeks' duration), subacute (four to 12 weeks' duration) or chronic (more than 12 weeks' duration) non-specific LBP with or without sciatica. They included 32 RCTs involving 2762 participants in this review. For people with mixed symptom patterns (acute, subacute and chronic LBP with and without sciatica), there was low- to moderate-quality evidence that traction may make little or no difference in pain intensity, functional status, global improvement or return to work when compared to placebo, sham traction or no treatment. Similarly, when comparing the combination of physiotherapy plus traction with physiotherapy alone or when comparing traction with other treatments, there was very-low- to moderate-quality evidence that traction may make little or no difference in pain intensity, functional status or global improvement. For people with LBP with sciatica and acute, subacute or chronic pain, there was low- to moderate-quality evidence that traction probably has no impact on pain intensity, functional status or global improvement. This was true when traction was compared with controls and other treatments, as well as when the combination of traction plus physiotherapy was compared with physiotherapy alone. No studies reported the effect of traction on return to work. For chronic LBP without sciatica, there was moderate-quality evidence that traction probably makes little or no difference in pain intensity when compared with sham treatment. No studies reported on the effect of traction on functional status, global improvement or return to work. Adverse effects were reported in seven of the 32 studies. These included increased pain, aggravation of neurological signs and subsequent surgery. Four studies reported that there were no adverse effects. The remaining studies did not mention adverse effects. These findings indicate that traction, either alone or in combination with other treatments, has little or no impact on pain intensity, functional status, global improvement and return to work among people with LBP. There is only limited-quality evidence from studies with small sample sizes and moderate to high risk of bias. The effects shown by these studies are small and are not clinically relevant.

Gravity-Assisted Traction: A review of the literature revealed only a small body of work specific to inversion therapy. DeVries and Cailliet (1985), Gianakopoulos et al., (1985), Haskvitz and Hanten (1986) and Nosse et al. (1988) all describe small case control studies evaluating varying aspects of inversion therapy. DeVries and Cailliet (1985) concluded that inversion had a measurable effect on neuromuscular tension as measured by EMG. Gianakopoulos et al. (1985) found that there was some improvement in low back pain in patients who underwent inversion therapy. Haskvitz and Hanten (1986) found that inversion therapy raised the blood pressure of patients receiving inversion therapy. Nosse et al. (1988) found that inversion therapy reduced the depth of low back contour more than sitting. All of these studies are small and methodologically weak; as such it is difficult to apply their findings to the general population. However, all four of the papers support the use of inversion therapy. Two RCTs (n = 69; n = 108) evaluating the effectiveness of inversion therapy combined with mechanical percussion for treatment of lower pole renal stones after shockwave lithotripsy (SWL) found positive effects for this therapy compared with observation or SWL alone (Chiong et al., 2005; Pace et al., 2001). Prasad et al. (2012) sought to study the feasibility of a randomized controlled trial on the effect of inversion therapy in patients with single level lumbar discogenic disease, who had been listed for surgery. It was a prospective randomized controlled trial where patients awaiting surgery for pure lumbar discogenic disease Post-treatment assessment was completed at 6 weeks for various outcome measures. Avoidance of surgery was considered a treatment success. Twenty-six patients were enrolled and 24 were randomized [13 to inversion + physiotherapy and 11 to physiotherapy alone (control)]. Surgery was avoided in 10 patients (76.9%) in the inversion group, whereas it was averted in only two patients (22.2%) in the control group. Intermittent traction with an inversion device resulted in a significant reduction in the need for surgery. Authors suggest that a larger multi-center prospective randomized controlled trial is justified in patients with sciatica due to single level lumbar disc protrusions. Inversion may form part of the conservative rehabilitation of patients with single level unilateral lumbar disc protrusion alongside other forms of physiotherapy.

Mechanical traction on a horizontal surface within a clinic setting are more commonly practiced possibly due to reduced contraindications and lower risk of adverse events compared to inversion therapy. Lerebours et al. (2017) reported bilateral retinal detachments with use of an inversion table in a case report. Jung et al. (2021) describes 3 patients with cervical spinal cord injuries when using inversion tables correctly in a case series, highlighting the potential danger when utilizing these devices.

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