

**Policy: MP077**

**Section: Medical Benefit Policy**

**Subject: Non-invasive Mechanical Treatments for Low Back Pain**

### Applicable Lines of Business

|                   |          |             |          |
|-------------------|----------|-------------|----------|
| <b>Commercial</b> | <b>X</b> | <b>CHIP</b> | <b>X</b> |
| <b>Medicare</b>   | <b>X</b> | <b>ACA</b>  | <b>X</b> |
| <b>Medicaid</b>   | <b>X</b> |             |          |

### I. Policy: Non-invasive Mechanical Treatments for Low Back Pain

#### II. Purpose/Objective:

To provide a policy of coverage regarding Non-invasive Mechanical Treatments for Low Back Pain

#### III. Responsibility:

- A. Medical Directors
- B. Medical Management

#### IV. Required Definitions

1. Attachment – a supporting document that is developed and maintained by the policy writer or department requiring/authoring the policy.
2. Exhibit – a supporting document developed and maintained in a department other than the department requiring/authoring the policy.
3. Devised – the date the policy was implemented.
4. Revised – the date of every revision to the policy, including typographical and grammatical changes.
5. Reviewed – the date documenting the annual review if the policy has no revisions necessary.

#### V. Additional Definitions

Medical Necessity or Medically Necessary means Covered Services rendered by a Health Care Provider that the Plan determines are:

- a. appropriate for the symptoms and diagnosis or treatment of the Member's condition, illness, disease or injury;
- b. provided for the diagnosis, and the direct care and treatment of the Member's condition, illness disease or injury;
- c. in accordance with current standards of good medical treatment practiced by the general medical community.
- d. not primarily for the convenience of the Member, or the Member's Health Care Provider; and
- e. the most appropriate source or level of service that can safely be provided to the Member. When applied to hospitalization, this further means that the Member requires acute care as an inpatient due to the nature of the services rendered or the Member's condition, and the Member cannot receive safe or adequate care as an outpatient.

#### Medicaid Business Segment

Medically Necessary — A service, item, procedure, or level of care that is necessary for the proper treatment or management of an illness, injury, or disability is one that:

- Will, or is reasonably expected to, prevent the onset of an illness, condition, injury or disability.
- Will, or is reasonably expected to, reduce or ameliorate the physical, mental or developmental effects of an illness, condition, injury or disability.
- Will assist the Member to achieve or maintain maximum functional capacity in performing daily activities, taking

into account both the functional capacity of the Member and those functional capacities that are appropriate for Members of the same age

#### **DESCRIPTION:**

Vertebral axial decompression (Vax-D) and MedX lumbar/cervical extension machines are devices designed for the purpose of isokinetic testing and rehabilitation in the treatment of back pain. The Orthotrac Vest is a custom made vest that utilizes pneumatic pressure to stabilize the lumbar spine and off-load body weight. The Isostation B-2000 Lumbar Dynamometer allows measurement of increasing fatigue by measuring a decrease in performance and documenting an increase in motion as the muscle substitution begins.

#### **EXCLUSIONS:**

There is currently insufficient evidence in the published, peer reviewed medical literature to show the medical efficacy of devices such as, but not limited to those listed in this policy. At this time, utilization of any of the following devices is considered **experimental, investigational or unproven** and is **NOT COVERED**.

- *Quantitative muscle testing and treatment devices* (e.g. Med-X Lumbar/Cervical Extension Machine, Isostation B 2000 Lumbar Dynamometer, Biodex System 3, Cybex Back System)
- *Vertebral Axial Decompression* (e.g. Vax-D, DRX Decompression Systems, DTS Spinal Decompression Therapy, Decompression Reduction Stabilization (DRS) System, IDD Therapy, Lordex Spinal Decompression Unit, SpineMED® Decompression, Accu-SPINA System, Antalgic-Trak, Ever-Trac ET-800, Dynatron 900, Integrity Spinal Care System, Rich-Mar Spina-Mobilizor, Triton® DTS / Tru-Trac/ TX Traction System)
- *Patient-operated spinal unloading devices* (e.g. Orthotrac™ Pneumatic Vest, Dr. Ho's Decompression Belt)

#### **Medicaid Business Segment:**

Any requests for services, that do not meet criteria set in the PARP, may be evaluated on a case by case basis

**Note: A complete description of the process by which a given technology or service is evaluated and determined to be experimental, investigational or unproven is outlined in MP 15 - Experimental Investigational or Unproven Services or Treatment.**

**CODING ASSOCIATED WITH:** Non-invasive Mechanical Treatments for Low Back Pain

***The following codes are included below for informational purposes and may not be all inclusive. Inclusion of a procedure or device code(s) does not constitute or imply coverage nor does it imply or guarantee provider reimbursement. Coverage is determined by the member specific benefit plan document and any applicable laws regarding coverage of specific services. Please note that per Medicare coverage rules, only specific CPT/HCPCS Codes may be covered for the Medicare Business Segment. Please consult the CMS website at [www.cms.gov](http://www.cms.gov) or the local Medicare Administrative Carrier (MAC) for more information on Medicare coverage and coding requirements.***

- 97799 Unlisted physical medicine/rehabilitation service or procedure
- E1399 Durable medical equipment, miscellaneous
- S9090 Vertebral axial decompression, per session
- L0631 Lumbar-sacral orthosis, sagittal control, with rigid anterior and posterior panels, posterior extends from sacrococcygeal junction to T-9 vertebra, produces intracavitary pressure to reduce load on the intervertebral discs, includes straps, closures, may include padding, shoulder straps, pendulous abdomen design, prefabricated item that has been trimmed, bent, molded, assembled, or otherwise customized to fit a specific patient by an individual with expertise

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#### **LINE OF BUSINESS:**

**Eligibility and contract specific benefits, limitations and/or exclusions will apply. Coverage statements found in the line of business specific benefit document will supersede this policy. For Medicare, applicable LCD's and NCD's will supercede this policy. For PA Medicaid Business segment, this policy applies as written.**

#### **REFERENCES:**

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This policy will be revised as necessary and reviewed no less than annually.

**Devised:** 7/02

**Revised:** 11/02 (title change); 11/03 (add definition); 11/04 (re-title); 11/05 (added exclusion, references); 11/07 (added exclusion); 12/08; 12/11 (removed indication); 11/17 (added product examples); 11/20 (added product examples)

**Reviewed:** 11/06; 12/09; 12/10 (ref), 12/12, 12/13, 12/14; 12/15, 12/16, 11/18, 11/19, 11/21, 11/22, 11/23

Geisinger Health Plan may refer collectively to health care coverage sponsors Geisinger Health Plan, Geisinger Quality Options, Inc., and Geisinger Indemnity Insurance Company, unless otherwise noted. Geisinger Health Plan is part of Geisinger, an integrated health care delivery and coverage organization.

Coverage for experimental or investigational treatments, services and procedures is specifically excluded under the member's certificate with Geisinger Health Plan. Unproven services outside of an approved clinical trial are also specifically excluded under the member's certificate with Geisinger Health Plan. This policy does not expand coverage to services or items specifically excluded from coverage in the member's certificate with Geisinger Health Plan. Additional information can be found in MP015 Experimental, Investigational or Unproven Services.

Prior authorization and/or pre-certification requirements for services or items may apply. Pre-certification lists may be found in the member's contract specific benefit document. Prior authorization requirements can be found at <https://www.geisinger.org/health-plan/providers/ghp-clinical-policies>

Please be advised that the use of the logos, service marks or names of Geisinger Health Plan, Geisinger Quality Options, Inc. and Geisinger Indemnity Insurance Company on a marketing, press releases or any communication piece regarding the contents of this medical policy is strictly prohibited without the prior written consent of Geisinger Health Plan. Additionally, the above medical policy does not confer any endorsement by Geisinger Health Plan, Geisinger Quality Options, Inc. and Geisinger Indemnity Insurance Company regarding the medical service, medical device or medical lab test described under this medical policy.