

## The Department of Vermont Health Access Medical Policy

**Subject: Home Traction Units**

**Last Review:** October 3, 2016\*

**Revision 6:** June 15, 2015

**Revision 5:** October 2, 2014

**Revision 4:** October 4, 2013

**Revision 3:** April 30, 2012

**Revision 2:** October 25, 2011

**Revision 1:** April 14, 2010

**Original Effective:** 2004

**\*Please note: Most current content changes will be highlighted in yellow.**

### Description of Service or Procedure

A device which applies a distractive force to cause separation of two body parts in order to relieve compression or to assist in realignment of the body parts. The devices subject to this guideline are home traction units. These are most typically used to relieve or reduce back and neck pain.

### Disclaimer

Coverage is limited to that outlined in Medicaid Rule that pertains to the beneficiary's aid category. Prior Authorization (PA) is only valid if the beneficiary is eligible for the applicable item or service on the date of service.

### Medicaid Rule

[7102.2](#) Prior Authorization Determination

[7103](#) Medical Necessity

Medicaid Rules can be found at <http://humanservices.vermont.gov/on-line-rules>

### Coverage Position

A home traction unit may be covered for beneficiaries:

- When the home traction unit is prescribed by a licensed medical provider enrolled in the Vermont Medicaid program, operating within their scope of practice as described in their



Vermont State Practice Act, and who is knowledgeable in the use of traction, and who provides medical care to the beneficiary AND

- When the clinical criteria below are met.

### **Coverage Criteria**

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A home traction unit may be covered for beneficiaries who meet the following guidelines:

- When the medical condition is amenable to treatment by traction; **AND**
- When there is no contraindication to the use of traction; **AND**
- Where there has been a trial of mechanical traction by a knowledgeable provider, such as, but not limited to, a physical therapist or orthopedic physician, AND where there is demonstrated functional improvement; **AND**
- Where the use of the traction is part of a comprehensive program involving patient education in active modalities such as specific therapeutic exercise, postural correction, body mechanics, ergonomics, and instruction in self-management of the underlying condition, **AND** when the trial of home traction has been supervised and determined to be efficacious by a physical therapist or orthopedic physician with knowledge and experience in this service.

Providers are advised to keep documentary proof of the above information in the beneficiary's file.

### **Clinical guidelines for repeat service or procedure**

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Repeat services are covered when the device requires replacement before the DME restriction time frame, for one of the following reasons:

- When it is no longer functional through normal wear and tear (it is expected to last at least 5 years).
- A new device will be considered if repair of the current device costs more than 50% of the cost of the replacement cost.

### **Type of service or procedure covered**

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A home traction device, for non-acute conditions such as chronic muscle spasm.

### **Type of service or procedure not covered (this list may not be all inclusive)**

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Documentation indicating a failed trial or medical contraindication for less expensive appropriate devices/services is required prior to a more expensive traction devices being covered.

Contraindications to home traction use include: spinal infections, spinal cancer, rheumatoid arthritis, osteoporosis, severe spinal cord pressure such as from a large osteophyte, disorders associated with hypermobility that may result in atlanto-axial instability, such as Down Syndrome. Great caution should be used with pregnancy and individuals with significant cardiac or respiratory insufficiency.

### **References**

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