A separate copy of this form must accompany each policy submitted for review. Policies submitted without this form will not be considered for review.

<table>
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<tr>
<th>Plan: Aetna Better Health</th>
<th>Submission Date: 11/01/2018</th>
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<tbody>
<tr>
<td>Policy Number: 0453</td>
<td>Effective Date:</td>
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<td></td>
<td>Revision Date:</td>
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<tr>
<td>Policy Name: Cervical Traction Devices</td>
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Type of Submission – Check all that apply:
- [x] New Policy*
- [ ] Revised Policy
- [ ] Annual Review – No Revisions

*All revisions to the policy must be highlighted using track changes throughout the document. Please provide any clarifying information for the policy below:

**CPB 0453 Cervical Traction Devices**

Policy is new to Aetna Better Health of Pennsylvania.

<table>
<thead>
<tr>
<th>Name of Authorized Individual (Please type or print):</th>
<th>Signature of Authorized Individual:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr. Bernard Lewin, M.D.</td>
<td>[Signature]</td>
</tr>
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</table>
Cervical Traction Devices

Policy

*Please see amendment for Pennsylvania Medicaid at the end of this CPB.*

I. Aetna considers over-the-door cervical traction devices for home use medically necessary durable medical equipment (DME) when the following criteria are met:

A. The member has a musculoskeletal or neurologic impairment requiring traction equipment; and

B. The appropriate use of a home cervical traction device has been demonstrated to the member and the member tolerated the device.

II. Aetna considers pneumatic cervical traction devices applying traction force to other than mandible, and cervical traction equipment not requiring an additional stand or frame, medically necessary durable medical equipment (DME) when all of the following criteria are met:

A. The member has a musculoskeletal or neurologic impairment requiring traction equipment; and
B. The appropriate use of a home cervical traction device has been demonstrated to the member and the member tolerated the selected device; and

C. Any one of the following criteria is met:

1. The treating physician orders and documents the medical necessity of 20 pounds or more of home cervical traction; or

2. The member has temporomandibular joint (TMJ) dysfunction and has received treatment for the TMJ condition; or

3. The member has distortion of the lower jaw or neck anatomy (e.g., radical neck dissection) such that a chin halter is unable to be utilized.

III. Aetna considers cervical traction applied via attachment to a headboard or non-pneumatic cervical traction applied via attachment to a free-standing frame or stand experimental and investigational because it has no proven clinical advantage compared to cervical traction applied via an over-the-door mechanism.

IV. Aetna considers a cervical collar with an inflatable air bladder not medically necessary; CMS has determined that such devices (e.g., Pneu-trac Traction Collar and TracCollar), which can be used with ambulation, are not reasonable and necessary (NHIC, 2011).

V. Aetna considers the Posture Pump cervical device experimental and investigational because of a lack of evidence regarding its effectiveness.

VI. Aetna considers cervical traction devices experimental and investigational for atlanto-occipital dislocation injuries.
Background

The prevalence of non-traumatic mechanical neck disorders (neck pain) in the United States is 10%. The anatomic source may be myofascial, ligamentous, osseous, neurologic, cutaneous, or visceral. Possible causes include: (i) compression of neural structures resulting in spasm and radiculopathy; (ii) inflammatory, neoplastic, infectious, or degenerative processes; or (iii) disruption of tissue secondary to trauma. Acute phase treatment of neck pain in the physical therapy outpatient setting includes moist heat, gentle massage and temporary immobilization with a cervical collar that holds the neck in slight flexion. Ultrasonic treatments, especially combined with low-frequency current electrotherapy of the muscles may be helpful. Patients with cervical herniated nucleus pulposus and radiculopathy are usually treated with an aggressive physical rehabilitation program. For chronic neck pain, no treatment is necessary except for non-narcotic analgesics for symptoms, and avoiding any type of activity or work, which causes strain of the neck.

For decades, cervical traction has been applied widely for pain relief of neck muscle spasm or nerve root compression. It is a technique in which a force is applied to a part of the body to reduce paravertebral muscle spasms by stretching soft tissues, and in certain circumstances separating facet joint surfaces or bony structures. Additional pounds for cervical traction is usually utilized in the hospitals or clinics for temporary use and in certain situations and under observation with occasional imaging, making sure of not to destabilize the spine. Studies have shown that traction must be constant so that the muscles may tire and the strain falls on the joints. It generally takes 2 minutes of sustained traction before the intervertebral spaces begin to widen. Forces between 20 and 50 pounds are commonly used to achieve intervertebral separation.
Cervical traction is administered by various techniques ranging from supine mechanical motorized cervical traction to seated cervical traction using an over-the-door pulley support with attached weights. Duration of cervical traction can range from a few minutes to 30 minutes, once- or twice-weekly to several times per day. Anecdotal evidence suggests efficacy and safety, but there is no documentation of efficacy of cervical traction beyond short-term pain reduction. In general, over-the-door traction at home is limited to providing less than 20 pounds of traction.

Pneumatic cervical traction devices (e.g., Saunders Cervical Hometrac, ComforTrac Cervical Traction, Pronex Pneumatic Traction Unit) were developed to deliver cervical traction in the home comparable to forces applied by physical therapists in the outpatient setting. The patient is instructed in home traction to relieve symptoms, an exercise routine to relieve spasm and discomfort, and to report any weaknesses, eye symptoms, and bladder or bowel incontinence immediately.

There are some who argue that pneumatic cervical traction should be offered as first line therapy in preference to over-the-door cervical traction, asserting that pneumatic cervical traction is superior to over-the-door cervical traction. There are, however, no studies in the peer-reviewed published medical literature comparing over-the-door cervical traction with pneumatic traction devices. Although pneumatic devices are able to provide more force than over-the-door traction devices, there are no peer-reviewed published clinical studies proving that clinical outcomes are improved by applying greater traction force. In addition, the potential adverse effects of the application of large amounts of cervical traction with pneumatic devices in the home setting have not been sufficiently evaluated in well-designed published clinical studies. There is also no published peer-reviewed evidence proving that pneumatic traction devices result in less irritation, improved compliance, or improved outcomes compared to over-the-door traction. For these reasons, the use of
pneumatic cervical traction devices are reserved for persons with neck pain who have failed over-the-door cervical traction.

No matter how clinically effective a therapy is found to be, the treatment process, especially when it is dependent upon home use, is highly dependent upon patient compliance. So, these patients must undergo adequate follow-up to assure proper usage.

Cleland and colleagues (2005) described the outcomes of a consecutive series of patients presenting to physical therapy with cervical radiculopathy and managed with the use of manual physical therapy, cervical traction, and strengthening exercises. A total of 11 consecutive patients (mean age of 51.7 years) who presented with cervical radiculopathy on the initial examination were treated with a standardized approach, including manual physical therapy, cervical traction, and strengthening exercises of the deep neck flexors and scapulothoracic muscles. At the initial evaluation all patients completed self-report measures of pain and function, including a numeric pain rating scale, the Neck Disability Index, and the Patient-Specific Functional Scale. All patients again completed the outcome measures, in addition to the global rating of change (GROC), at the time of discharge from therapy and at a 6-month follow-up session. Ten of the 11 patients (91%) demonstrated a clinically meaningful improvement in pain and function following a mean of 7.1 physical therapy visits and at the 6-month follow-up. Ninety-one % (10 of 11) of patients with cervical radiculopathy in this case series improved, as defined by the patients classifying their level of improvement as at least "quite a bit better" on the GROC. However, because a cause-and-effect relationship can not be inferred from a case series, follow-up randomized clinical trials (RCTs) should be performed to further investigate the effectiveness of manual physical therapy, cervical traction, and strengthening exercises in a homogeneous group of patients with cervical radiculopathy.
Borenstein (2007) noted that chronic neck pain is a common patient complaint. Despite its frequency as a clinical problem, there are few evidence-based studies that document effectiveness of therapies for neck pain. The treatment of this symptom is based primarily on clinical experience. Preventing the development of chronic neck pain can be achieved by modification of the work environment with chairs that encourage proper musculoskeletal movement. The use of neck supports for sleep and active neck exercises together can improve neck pain. Passive therapies, including massage, acupuncture, mechanical traction, and electrotherapy, have limited benefit when measured by clinical trial results. Non-steroidal anti-inflammatory drugs, muscle relaxants, and pure analgesics are the mainstays of therapy. Furthermore, the American College of Occupational and Environmental Medicine's guideline on neck and upper back complaints (2004) did not recommend the use of traction.

In a Cochrane review on mechanical traction for neck pain with or without radiculopathy, Graham et al (2008) concluded that the current literature does not support or refute the efficacy or effectiveness of continuous or intermittent traction for pain reduction, improved function or global perceived effect when compared to placebo traction, tablet or heat or other conservative treatments in patients with chronic neck disorders. The authors stated that large, well-conducted RCTs are needed to first determine the efficacy of traction, then the effectiveness, for individuals with neck disorders with radicular symptoms.

Borman and associates (2008) examined the effectiveness of intermittent cervical traction in the treatment of chronic neck pain. A total of 42 patients with at least 6 weeks of non-specific neck pain were selected for the study. Data about demographical characteristics including age, sex, body mass index, duration of cervical pain, working status, smoking status, and regular exercise were recorded. Each patient was
randomly assigned to one of 2 groups: (i) group 1 -- receiving only standard physical therapy including hot pack, ultrasound therapy and exercise program, and (ii) group 2 -- treated with traction therapy in addition to standard physical therapy. Patients were re-evaluated at the end of the therapy. The main outcome measures of the treatment were pain intensity by visual analog scale (VAS), disability by neck disability index (NDI), and quality of life assessed by Nottingham Health Profile (NHP). A total fo 24 female and 18 male patients with mean age of 48.2 +/- 11.5 years and a mean disease duration of 4.3 +/- 2.9 years were included to the study. There were no differences between the groups in terms of age, sex, pain intensity, and scores of NHP and NDI at entry. There were 21 patients in both groups. Both groups improved significantly in pain intensity and the scores of NDI and physical subscales of NHP at the end of the therapies (p < 0.05). There was an association between NDI and VAS pain scores in both groups (p < 0.05). No correlation was observed between clinical variables and age and duration of disease. The authors concluded that no specific effect of traction over standard physiotherapeutic interventions was observed in adults with chronic neck pain. They suggested the clinicians to consider this condition and to focus on exercise therapy in the management of patients suffering from this condition.

Raney et al (2009) developed a clinical prediction rule (CPR) to identify patients with neck pain likely to improve with cervical traction. The study design included prospective cohort of patients with neck pain referred to physical therapy. A total of 80 patients with neck pain received a standardized examination and then completed 6 sessions of intermittent cervical traction and cervical strengthening exercises twice-weekly for 3 weeks. Patient outcome was classified at the end of treatment, based on perceived recovery according to the global rating of change. Patients who achieved a change greater than or equal to +6 ("a great deal better" or "a very great deal better") were classified as having a successful
outcome. Uni-variate analyses (t-tests and chi-square) were conducted on historical and physical examination items to determine potential predictors of successful outcome.

Variables with a significance level of "p < or = 0.15" were retained as potential prediction variables. Sensitivity, specificity and positive and negative likelihood ratios (LRs) were then calculated for all variables with a significant relationship with the reference criterion of successful outcome. Potential predictor variables were entered into a step-wise logistic regression model to determine the most accurate set of clinical examination items for prediction of treatment success. Sixty-eight patients (38 females) were included in data analysis of which 30 had a successful outcome. A CPR with 5 variables was identified: (i) patient reported peripheralization with lower cervical spine (C4 to C7) mobility testing; (ii) positive shoulder abduction test; (iii) age greater than or equal to 55; (iv) positive upper limb tension test A; and (v) positive neck distraction test. Having at least 3 out of 5 predictors present resulted in a +LR equal to 4.81 (95 % confidence interval [CI]: 2.17 to 11.4), increasing the likelihood of success with cervical traction from 44 % to 79.2 %. If at least 4 out of 5 variables were present, the +LR was equal to 23.1 (2.5 to 227.9), increasing the post-test probability of having improvement with cervical traction to 94.8 %. The authors stated that this preliminary CPR provides the ability to a priori identify patients with neck pain likely to experience a dramatic response with cervical traction and exercise. However, they noted that before the rule can be implemented in routine clinical practice, future studies are needed to validate the rule.

In a prospective, randomized, study, Jellad and colleagues (2009) evaluated the effect of mechanical and manual intermittent cervical traction on pain, use of analgesics and disability during the recent cervical radiculopathy (CR). A total of 39 patients were divided into 3 groups of 13 patients each: (i) group A treated by conventional rehabilitation with
manual traction, (ii) group B treated with conventional rehabilitation with intermittent mechanical traction, and (iii) group C treated with conventional rehabilitation alone. These investigators evaluated cervical pain, radicular pain, disability and the use of analgesics at baseline, at the end and at 1, 3 and 6 months after treatment. At the end of treatment, improvements of cervical pain, radicular pain and disability are significantly better in groups A and B compared to group C. The decrease in consumption of analgesics is comparable in the 3 groups. At 6 months improvements of cervical and radicular pain and disability are still significant compared to baseline in both groups A and B. The gain in consumption of analgesics is significant in the 3 groups. The authors concluded that manual or mechanical cervical traction appears to be a major contribution in the rehabilitation of CR particularly if it is included in a multi-modal approach of rehabilitation.

In a multi-center, randomized, clinical study, Young et al (2009) examined the effects of manual therapy and exercise, with or without the addition of cervical traction, on pain, function, and disability in patients with CR. A total of 81 patients were randomly assigned to 1 of 2 groups: (i) a group that received manual therapy, exercise, and intermittent cervical traction (MTEXTraction group), and (ii) a group that received manual therapy, exercise, and sham intermittent cervical traction (MTEX group). Patients were treated, on average, 2 times per week for an average of 4.2 weeks. Outcome measurements were collected at baseline and at 2 weeks and 4 weeks using the Numeric Pain Rating Scale (NPRS), the Patient-Specific Functional Scale (PSFS), and the Neck Disability Index (NDI). There were no significant differences between the groups for any of the primary or secondary outcome measures at 2 weeks or 4 weeks. The effect size between groups for each of the primary outcomes was small (NDI = 1.5, 95 % CI: -6.8 to 3.8; PSFS = 0.29, 95 % CI: -1.8 to 1.2; and NPRS = 0.52, 95 % CI: -1.8 to 1.2). The authors
concluded that these findings suggested that the addition of mechanical cervical traction to a multi-modal treatment program of manual therapy and exercise yields no significant additional benefit to pain, function, or disability in patients with CR. It is interesting to note that Van Zundert et al (2010) remarked that Cochrane reviews (citing Graham et al, 2008 and Haines et al, 2009) did not find sufficient proof of efficacy for either education or cervical traction.

The American Association of Neurological Surgeons’ clinical guideline on “The diagnosis and management of traumatic atlanto-occipital dislocation injuries” (Theodore et al, 2013) stated that “Traction is not recommended in the management of patients with AOD, and is associated with a 10 % risk of neurological deterioration”.

Rhee et al (2013) conducted a systematic review investigating the evidence of (i) efficacy, effectiveness, and safety of non-operative treatment of patients with cervical myelopathy; (ii) whether the severity of myelopathy affects outcomes of non-operative treatment; and (iii) whether specific activities or minor injuries are associated with neurological deterioration in patients with myelopathy or asymptomatic stenosis being treated non-operatively. A systematic search was conducted in PubMed and the Cochrane Collaboration Library for articles published between January 1, 1956, and November 20, 2012. These researchers included all articles that compared non-operative treatments or observation with surgery for patients with cervical myelopathy or asymptomatic cervical cord compression to determine their effects on clinical outcomes, including myelopathy scales (Japanese Orthopaedic Association, Nurick), general health scores (36-Item Short Form Health Survey), and pain (neck and arm). Non-operative treatments included physical therapy, medications, injections, orthoses, and traction. These investigators also searched for articles evaluating the effect of specific activities or minor trauma in neurological outcomes.
Case reports and studies with less than 10 patients in the exposure group were excluded. Of 54 citations identified from the search, 5 studies reported in 6 articles met inclusion criteria. In 1 RCT, there was low evidence that non-operative treatment may yield equivalent or better outcomes than surgery in those with mild myelopathy. For moderate to severe myelopathy, non-operative treatment had inferior outcomes versus surgery in 2 cohort studies, despite the fact that surgically treated patients were worse at baseline. There was insufficient evidence to determine whether specific activities or minor trauma is a risk factor for neurological deterioration in those with myelopathy or asymptomatic cord compression. The authors concluded that there is a paucity of evidence for non-operative treatment of cervical myelopathy, and further studies are needed to determine its role more definitively. In particular, for the patient with milder degrees of myelopathy, randomized studies comparing non-operative with surgical treatment would be particularly helpful, as would trials comparing specific types of non-operative treatments with the natural history of myelopathy.

Thoomes et al (2013) evaluated the effectiveness of conservative treatments for patients with cervical radiculopathy, a term used to describe neck pain associated with pain radiating into the arm. Little is known about the effectiveness of conservative treatment for patients with cervical radiculopathy. These researchers electronically searched the Cochrane Controlled Trials Register, MEDLINE, EMBASE, and CINAHL for RCTs. Conservative therapies consisted of physiotherapy, collar, traction etc. Two authors independently assessed the risk of bias using the criteria recommended by the Cochrane Back Review Group and extracted the data. If studies were clinically homogenous, a meta-analysis was performed. The overall quality of the body of evidence was evaluated using the GRADE method. A total of 15 articles were included that corresponded to 11 studies; 2 studies scored low risk of bias. There is low-level evidence that a collar is no more effective than physiotherapy at short-
term follow-up and very low-level evidence that a collar is no more effective than traction. There is low-level evidence that traction is no more effective than placebo traction and very low level-evidence that intermittent traction is no more effective than continuous traction. The authors concluded that on the basis of low-level to very low-level evidence, no one intervention seems to be superior or consistently more effective than other interventions. Furthermore, regardless of the intervention assignment, patients seem to improve over time, indicating a favorable natural course; use of a collar and physiotherapy show promising results at short-term follow-up.

Bryans et al (2014) developed evidence-based treatment recommendations for the treatment of non-specific (mechanical) neck pain in adults. Systematic literature searches of controlled clinical trials published through December 2011 relevant to chiropractic practice were conducted using the databases MEDLINE, EMBASE, EMCARE, Index to Chiropractic Literature, and the Cochrane Library. The number, quality, and consistency of findings were considered to assign an overall strength of evidence (strong, moderate, weak, or conflicting) and to formulate treatment recommendations. A total of 41 RCTs meeting the inclusion criteria and scoring a low risk of bias were used to develop 11 treatment recommendations. Strong recommendations were made for the treatment of chronic neck pain with manipulation, manual therapy, and exercise in combination with other modalities. Strong recommendations were also made for the treatment of chronic neck pain with stretching, strengthening, and endurance exercises alone. Moderate recommendations were made for the treatment of acute neck pain with manipulation and mobilization in combination with other modalities. Moderate recommendations were made for the treatment of chronic neck pain with mobilization as well as massage in combination with other therapies. A weak recommendation was made for the treatment of acute neck pain with exercise alone and the treatment of chronic neck pain with manipulation alone. Thoracic manipulation and
trigger point therapy could not be recommended for the
treatment of acute neck pain. Transcutaneous nerve
stimulation, thoracic manipulation, laser, and traction could not
be recommended for the treatment of chronic neck pain.

An UpToDate review on “Treatment of cervical radiculopathy” (Robinson and Kathari, 2016) states that
“Cervical traction is the application of a distracting force to the
neck, which can in theory separate the cervical segments,
expand the intervertebral joint spaces, and relieve
compression of the nerve roots. However, controlled studies of
cervical traction delivered in the course of a physical therapy
program for a variety of causes of neck and arm pain have not
demonstrated benefit over sham traction or placebo ….
Traction should not be used unless neuroimaging has been
performed, and should be discontinued if symptoms worsen
with the application of distracting force. Traction is not
recommended in the presence of spinal cord compression or
large disc protrusion …. We generally do not prescribe cervical
traction as initial therapy for patients with cervical
radiculopathy. Nevertheless, cervical traction is a reasonably
safe alternative for patients with persistent or refractory pain
who do not want epidural glucocorticoid injections or surgery”.

Cervical Traction Device for Pediatric Atlantoaxial
Rotatory Subluxation:

Masoudi and colleagues (2017) introduced a novel traction
device for management of pediatric atlanto-axial rotatory
subluxation (AARS) in source-limiting areas. Atlanto-axial (C1
to C2) joint is accountable for up to 2/3 of total axial cranio-
cervical rotation. Its major role in pivotal rotation of cervical
spine makes it more vulnerable to a certain type of injury
known as AARS. Management of AARS is based on the
Fielding classification that includes closed reduction and
immobilization and cervical fusion in unstable cases. There
are several cervical traction devices including the Gardner-
Wells tongs and halter traction device. All the available
devices require insertion of pins into the calvarial periosteum which is a painful, invasive and intolerable procedure especially for the pediatric patients. These researchers designed a simple hand-made cervical traction device that is composed of 2 soft padded straps (40 × 4 cm) and 2 connecting strings that can be applied easily under the chin and occipital areas of the patients. These researchers successfully treated a 9-year old girl with AARS with the device. The advantage of the device was its available, inexpensive and non-invasive; and the patient might tolerate it more easily compared to the previously designed instruments. The authors concluded that this hand-made simple cervical traction device in source-limiting centers and hospitals was a good example of doing more with less. It was effective and the tolerance of the patient was acceptable. Moreover, they stated that further studies with larger series are needed for providing appropriate evidence.

Appendix

Documentation Requirements: It is expected that the patient's medical records will reflect the need for the care provided. The patient’s medical records include the physician’s office records, hospital records, nursing home records, home health agency records, records from other healthcare professionals and test reports. This documentation must be available upon request. An order for the cervical traction device must be signed and dated by the treating physician, kept on file by the supplier, and be available upon request.

Cervical traction equipment not requiring a stand or frame describes cervical traction devices that provide traction on the cervical anatomy without the use of a door or external frame or stand. Traction may be applied by means of mandibular or occipital pressure.
Overdoor cervical traction equipment describes cervical traction devices that provide traction on the cervical anatomy through a system of pulleys and rope and are attached to a door. Traction may be applied in either the upright or supine position.

Pneumatic cervical traction devices describe cervical traction devices that provide traction on the cervical anatomy by means of pneumatic displacement to anatomical areas other than the mandible (e.g., the occipital region of the skull). These devices must be capable of generating traction forces greater than 20 pounds. In addition, these devices allow traction to be applied with alternative vectors of force (e.g., 15 degrees of lateral neck flexion).

### CPT Codes / HCPCS Codes / ICD-10 Codes

Information in the [brackets] below has been added for clarification purposes. Codes requiring a 7th character are represented by "+":

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<th>Code</th>
<th>Code Description</th>
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<td>E0849</td>
<td>Traction equipment, cervical, free-standing stand/frame, pneumatic, applying traction force to other than mandible</td>
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<td>E0860</td>
<td>Traction equipment, overdoor, cervical</td>
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**HCPCS codes not covered for indications listed in the CPB:**

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<th>Code</th>
<th>Code Description</th>
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<tr>
<td>E0840</td>
<td>Traction frame, attached to headboard, cervical traction</td>
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<tr>
<td>E0850</td>
<td>Traction stand, freestanding, cervical traction</td>
</tr>
<tr>
<td>E0856</td>
<td>Cervical traction device, with inflatable air bladder(s)</td>
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**Other HCPCS codes related to the CPB:**
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<th>Code</th>
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<tr>
<td>E0830</td>
<td>Ambulatory traction device, all types, each</td>
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<tr>
<td>E0855</td>
<td>Cervical traction equipment not requiring additional stand or frame</td>
</tr>
<tr>
<td>J0475</td>
<td>Injection baclofen, 10 mg</td>
</tr>
<tr>
<td>J0476</td>
<td>Injection, baclofen, 50 mcg for intrathecal trial</td>
</tr>
<tr>
<td>J1885</td>
<td>Injection, ketorolac tromethamine, per 15 mg</td>
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<tr>
<td>J2360</td>
<td>Injection, orphenadrine citrate, up to 60 mg</td>
</tr>
<tr>
<td>J2800</td>
<td>Injection, methocarbamol, up to 10 ml</td>
</tr>
<tr>
<td>J3360</td>
<td>Injection, diazepam, up to 5 mg</td>
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</table>

ICD-10 codes not covered for indications listed in the CPB:
- S13.110A, Closed or open dislocation, first cervical vertebra [atlanto-occipital]
- S13.111A

The above policy is based on the following references:

4. Frankel VH, Shore NA, Hoppenfeld S. Stress distribution in cervical traction: Prevention of


48. NHIC, Corp. Local Coverage Determination (LCD) for Cervical Traction Devices (L33823). Durable Medical Equipment Medicare Administrative Contractor (DME MAC) Jurisdiction A. Hingham, MA: NHIC; revised October 1, 2015.
49. NHIC, Corp. Local Coverage Article for Cervical Traction Devices (A52476). Durable Medical Equipment Medicare Administrative Contractor (DME MAC) Jurisdiction A. Hingham, MA: NHIC; revised October 2015.


AETNA BETTER HEALTH® OF PENNSYLVANIA

Amendment to
Aetna Clinical Policy Bulletin Number: 0453 Cervical Traction Devices

There are no amendments for Medicaid.