

Intervertebral Differential Dynamics Therapy (IDD Therapy®)

MPM 9.6

Disclaimer Refer to the member's specific benefit plan and Schedule of Benefits to determine coverage. This may not be a benefit on all plans or the plan may have broader or more limited benefits than those listed in this medical policy

Description Intervertebral Differential Dynamics Therapy (IDD Therapy®) provides a program of treatments for relief from pain and disability for those patients suffering with low back pain. These effects are achieved through decompression of intervertebral discs.¹

The IDD Therapy® system falls into the broader category of motorized mechanical traction that is advertised to provide nonsurgical spinal decompression therapy.

**Coverage Determination/
Clinical Indications** This technology has been reviewed by the Technology Assessment Committee and the Medical Policy Committee (formerly known as the Benefit Interpretation Committee).

IDD Therapy® is **not** a covered benefit, due to insufficient evidence to support the benefits of this technique.

Coding The coding listed in this medical policy is for reference only. Covered and non-covered codes are within this list.

CPT Codes	Description
95831	Muscle testing, manual (separate procedure) with report; extremity (excluding hand) or trunk
95851	Range of motion measurements and report (separate procedure); each extremity (excluding hand) or each trunk section (spine)
97012	Application of a modality to one or more areas; traction, mechanical
97039	Unlisted modality (specify type and time if constant attendance)
97750	Physical performance test or measurement (eg, musculoskeletal, functional capacity), with written report, each 15 minutes

HCPCS® Codes	Description
E0830	Ambulatory traction device, all types, each
E0941	Gravity-assisted traction device, any type
E1399	Durable medical equipment, miscellaneous
S9090	Vertebral axial decompression, per session

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[MPMPPC120801]

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ICD-9© Diagnosis Codes	Description
722.10	Displacement of lumbar disc
722.73	Herniated lumbar disc with myelopathy
721.3	Lumbosacral spondylosis, no myelopathy
722.52	Degeneration of lumbar disc
722.93	Lumbar disc calcification
721.42	Spondylogenic compression of lumbar spinal cord
721.5	Kissing spine
721.9– 721.91	Spondylosis, unspecified site
722.2	Herniated disc, unspecified site
722.39	Schmorl's node, site unspecified
722.6	Degeneration intervertebral disc, unspecified site
722.70	Intervertebral disc disorder with myelopathy, site unspecified
722.80	Post-laminectomy syndrome, unspecified region
724.0	Stenosis, unspecified site, not cervical
724.09	Stenosis, other, not cervical
724.02	Lumbar stenosis
724.4	Thoracic or lumbosacral neuritis or radiculitis
724.5	Backache, unspecified
724.6	Disorders of sacrum: includes instability of lumbosacral joint
724.8	Other symptoms referable to back
724.9	Other unspecified back disorders
738.4	Acquired spondylolisthesis
756.11	Spondylolysis, lumbar
756.12	Spondylolisthesis
722.32	Schmorl's node, Lumbar region
722.83	Postlaminectomy syndrome, lumbar
724.2	Lumbago
724.3	Sciatica
739.3	Non-allopathic lesions, lumbar spine
739.4	Non-allopathic lesions, sacral region
846.0-846.9	Sprains and strains, lumbosacral and other sacral ligaments
847.2	Sprains and strains, lumbar
847.3	Sprains and strains, sacral
847.9	Sprain and strain, unspecified part of back

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- References:**
1. U.S. Food and Drug Administration, Center for Devices and Radiological Health. 510(k) Number K033231. Accessed 1-28-09 at: <http://www.fda.gov/cdrh/pdf3/K033231.pdf>
 2. Hayes Directory. © 2008 Winifred S. Hayes, Inc. Mechanized Spinal Distraction Therapy for Low Back Pain. Published 1-13-03. Update Search 1-3-08.
 3. Centers for Medicare and Medicaid Services. National Coverage Determination 160.16 for Vertebral Axial Decompression (VAX-D). Effective date: 4-15-1997.

Approval Signatures: **Clinical Quality Committee:** _____ Mark Whitaker, MD

Medical Director: _____ Al Rizzoli, MD

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01-28-09: Transitioned to Medical Policy
01-19-11: Biennial Review

This Medical Policy is intended to represent clinical guidelines describing medical appropriateness and is developed to assist Presbyterian Health Plan and Presbyterian Insurance Company, Inc. (Presbyterian) Health Services staff and Presbyterian medical directors in determination of coverage. The Medical Policy is not a treatment guide and should not be used as such.

For those instances where a member does not meet the criteria described in these guidelines, additional information supporting medical necessity is welcome and may be utilized by the medical director in reviewing the case. Please note that all Presbyterian medical policies are available online at: <http://www.phs.org/resources/documents/HLTHCRIT.pdf>.