Home Traction Therapy (for Kansas Only)

Policy Number: CS058KS.02
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➲ Instructions for Use

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Related Policies

- Electrical Stimulation for the Treatment of Pain and Muscle Rehabilitation (for Kansas Only)
- Mechanical Stretching Devices (for Kansas Only)
- Motorized Spinal Traction (for Kansas Only)

Application

This Medical Policy only applies to the state of Kansas.

Coverage Rationale

Home traction therapy is unproven and not medically necessary for treating low back and neck disorders, with or without radiculopathy, due to insufficient evidence of efficacy.

Applicable Codes

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by federal, state, or contractual requirements and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

HCPCS Code	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

Description of Services

Traction is the act of drawing or pulling and relates to forces applied to the body to stretch a given part or to separate two or more parts. Traction is intended for individuals with musculoskeletal or neurological impairments of the spine; the

objective is to relieve pain, relax muscle spasms, and decompress spinal structures. The type of traction used depends on the individual's age, weight, and medical condition.

Cervical Traction

Cervical traction is noninvasive traction that is used to stretch the soft tissues of the neck and to separate the spinal joint structures to relieve neck pain. Constant traction results in tiring of the muscles, allowing the strain to rest on the joints. It is theorized that this results in a widening of the joint spaces, promoting pain relief. Cervical traction uses a free weight and pulley system or a mechanical motorized device, often involving a head or chin sling to allow pulling in a cephalad direction.

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 in the short term. Various techniques have been reported to widen or decompress disc spaces, unload the vertebrae, decrease disc protrusion, or muscle spasm, separate the vertebrae, or lengthen and stabilize the spine. The duration of the exerted force applied may be intermittent or continuous throughout a treatment session.

Clinical Evidence

For low back and neck disorders with or without radiculopathy, there is insufficient, conflicting, or poor clinical evidence in the published, peer-reviewed, scientific literature to demonstrate the net benefit vs harm and effectiveness of home traction. Additional research is recommended.

Cervical Traction

In a single-center randomized controlled trial evaluating the efficacy of a traction exercise neck brace (TENB) for the treatment of cervical spondylotic radiculopathy (CSR), Xiao et al. (2021) concluded that TENB treatment significantly improved the curvature of the cervical spine and increased the size of the intervertebral foramen, which reduced the symptoms of CSR. The study included 40 adults aged 21 to 51 years with CSR who were randomly assigned to either the treatment group (n = 20) that received cervical traction with TENB for 30 minutes at home, twice a day, for 4 weeks or to the control group (n = 20) that received jaw-occipital belt traction (JOBT) for vertical traction while sitting in a chair in the hospital. The authors reported that after treatment, visual analog scale scores in the TENB group decreased from 6.10 to 2.45, and Neck Disability Index (NDI) scores decreased from 22.05 to 9.60, which were lower scores than those in the control group that only received JOBT. They also reported that the curvature of the cervical vertebra, which was evaluated using the method of Borden and Cervical Curvature Index, improved significantly more in the TENB group than in the JOBT group. Limitations of the study include the small sample size, narrow age range of the participants, and single-center design.

Colombo et al. (2020) conducted a systematic literature review with meta-analysis of randomized controlled trials that compared the effectiveness of cervical traction therapy in reducing pain with that of other treatment modalities for cervical radicular syndrome. Once the literature review was completed, 81 studies were assessed, and seven randomized controlled trials (589 individuals) were included in the systematic review, of which six were used for meta-analysis. The authors concluded that cervical traction appears to be superior to other conservative treatments when combined with these other treatments, with mechanical traction and continuous delivery providing better pain relief than manual traction and intermittent delivery. The meta-analysis demonstrated a low quality of evidence. Many of the studies had a high risk of bias because of a lack of blinding, inconsistent outcome reporting, inappropriate methods for randomization, and unacceptable dropout rates. Other limitations include the lack of investigation of other functional outcomes (such as activities of daily living or adverse events), inclusion of only publications in English, and inclusion of a wide variety of control groups. Future studies are needed to evaluate head-to-head comparisons of active vs passive interventions, other therapeutic interventions for cervical radicular syndrome, and study designs to minimize biases. (The following publications, previously cited in this policy, are included in this systematic review: Fritz et al., 2014, and Young et al., 2009).

In a prospective case series, Cai et al. (2011) evaluated potential prognostic variables and the validity of a clinical prediction rule for improvement in spondylosis neck pain after home cervical traction in 103 consecutive participants with cervical pain. The participants used a traction device with an adjustable cervical halter and a traction force equaling 10% to 15% of their body weight. They were instructed to pull the rope of the pulley system until the determined traction force was reached. The participants were instructed to perform two traction treatments for 20 minutes daily for 2 weeks; this was reinforced by a treatment diary. A standard physical examination of the cervical spine was conducted before

intervention. Data on the Numerical Pain Scale score, NDI, Fear-Avoidance Beliefs Questionnaire scores, and a global rating of perceived improvement were collected before and after treatment. A positive treatment response was defined as a 50% improvement between before and post treatment of Numerical Pain Scale or NDI or rated as much improved or completely recovered in the global rating scheme. Overall, 47 participants had a positive response to home cervical traction, while 56 did not. This study is limited by its short-term follow-up and lack of controls.

A Cochrane review of seven randomized controlled trials (n = 958) by Graham et al. (2008) assessed the effects of mechanical traction for neck disorders. The outcomes included pain, function, disability, global perceived effect, individuals' satisfaction, and quality-of-life measures. The review found no statistically significant difference between continuous traction and placebo traction in reducing pain or improving function for chronic neck disorders with radicular symptoms. The authors concluded that there is no evidence to clearly support or refute the use of either continuous or intermittent traction for neck disorders. Further studies are needed to assess the safety and efficacy of traction for neck disorders.

Lumbar Traction

In November 2016, the National Institute for Health and Care Excellence published a guideline on low back pain and sciatica, which addressed noninvasive treatments and specifically cited not to offer traction for managing low back pain with or without sciatica. The guideline did recommend consideration of manual therapy (spinal manipulation, mobilization, or soft tissue techniques such as massage) for managing low back pain with or without sciatica but only as part of a treatment package that included exercise, with or without psychological therapy, for low back pain and sciatica.

Wegner et al. (2013) published an update to a 2007 Cochrane review (Clarke et al., 2007) that assessed the effects of traction compared with those of placebo, sham traction, reference treatments, and no treatment in people with low back pain. The review included 32 randomized controlled trials, with 2,762 individuals, involving traction to treat acute (less than 4 weeks' duration), subacute (4-12 weeks' duration), or chronic (more than 12 weeks' duration) nonspecific low back pain with or without sciatica. The review found that for individuals with mixed symptom patterns (acute, subacute, and chronic low back pain with or without sciatica), there is low- to moderate-quality evidence that traction may make little or no difference in pain intensity, functional status, global improvement, or return to work compared with placebo, sham traction, or no treatment. The review noted that for people with low back pain with sciatica and acute, subacute, or chronic pain, there is low- to moderate-quality evidence that traction probably has no impact on pain intensity, functional status, or global improvement. Regarding chronic low back pain without sciatica, the review found that there is moderate-quality evidence that traction probably makes little or no difference in pain intensity compared with sham treatment. The authors concluded that the 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 low back pain. The review found that there is only limited quality evidence from studies, with small sample sizes and a moderate to high risk of bias, and that the effects shown by these studies are small and not clinically relevant.

The Cochrane systematic review referenced by Wegner et al. was conducted for the purpose of determining the effectiveness of traction in the management of low back pain with or without sciatica (Clarke et al., 2007). The study included randomized controlled trials involving traction to treat acute, subacute, or chronic nonspecific low back pain with or without sciatica. The review included 25 studies. The studies included 2,206 individuals, with 1,045 receiving traction. Five of these trials were considered high quality. The authors concluded that traction is probably not effective, and traction as a single treatment for low back pain is not supported by the studies. In addition, the authors noted that future research on traction for individuals with low back pain should distinguish between symptom pattern and duration and should be carried out according to the highest methodological standards.

Clinical Practice Guidelines

Department of Veterans Affairs (VA)/Department of Defense (DoD)

The 2022 clinical practice guideline for the diagnosis and treatment of low back pain states that there is insufficient evidence to recommend for or against mechanical lumbar traction in patients with low back pain with or without radicular symptoms.

North American Spine Society (NASS)

The NASS evidence-based clinical guideline (Kreiner et al., 2020) for the diagnosis and treatment of low back pain indicates that traction is not recommended, as it provides no clinically significant improvement in pain or function in patients with subacute or chronic low back pain.

The NASS evidence-based clinical guideline (Kreiner et al., 2011) for the diagnosis and treatment of lumbar disc herniation with radiculopathy notes that there is insufficient evidence to make a recommendation for or against the use of traction in the treatment of lumbar disc herniation with radiculopathy.

The NASS evidence-based clinical guideline for the diagnosis and treatment of cervical radiculopathy from degenerative disorders notes that regarding the role of traction in the treatment of cervical radiculopathy from degenerative disorders, 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. They noted that such modalities may be considered, recognizing that no improvement relative to the natural history of cervical radiculopathy has been demonstrated (Bono et al., 2010).

American College of Physicians (ACP)/American Pain Society

A joint clinical practice guideline from the ACP and the American Pain Society for the diagnosis and treatment of low back pain notes that intermittent or continuous traction in patients with or without sciatica has not been proven effective for chronic low back pain (Chou et al., 2007).

American College of Physicians (ACP)

In 2017, the ACP developed a clinical practice guideline to present the evidence and provide clinical recommendations on the noninvasive treatment of low back pain. The committee based these recommendations on a systematic review of randomized controlled trials and systematic reviews published through April 2015 on noninvasive pharmacological and nonpharmacological treatments for low back pain. Updated searches were performed through November 2016. The clinical outcomes evaluated included reduction or elimination of low back pain, improvement in back-specific and overall function, improvement in health-related quality of life, reduction in work disability and return to work, global improvement, number of back pain episodes or time between episodes, patient satisfaction, and adverse effects.

The 2017 clinical practice guideline on acute, subacute, and chronic low back pain in adults continued to find insufficient evidence to evaluate the effectiveness of spine traction alone or in combination with other therapies. Low-quality evidence failed to reveal a difference between traction and other treatments for radicular low back pain (Qaseem et al., 2017).

World Health Organization (WHO)

In 2023, WHO developed guidelines for the nonsurgical management of chronic primary low back pain in adults in primary and community settings. The guidelines state that traction should not be used as part of routine care for adults, including older people, with chronic primary low back pain. This is a conditional recommendation against the use of traction, which was driven by harms outweighing benefits. It was deemed a conditional recommendation based on the very low certainty of evidence and limited evidence of harm from the included trials.

U.S. Food and Drug Administration (FDA)

This section is to be used for informational purposes only. FDA approval alone is not a basis for coverage.

Nonpowered orthopedic traction devices are classified by the FDA as Class I devices. There are numerous FDA-registered traction devices, including foam or rigid collars, and over-the-door pulley, pneumatic, or mechanical systems. The devices are exempt from the premarket notification procedures. Additional information is available at: https://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfPCD/classification.cfm. (Accessed November 19, 2025)

References

Bono C, Ghiselli G, Gilbert TJ, et al. North American Spine Society (NASS). Evidence-based clinical guidelines for multidisciplinary spine care. Diagnosis and treatment of cervical radiculopathy from degenerative disorders. 2010.

Cai C, Ming G, Ng LY. Development of a clinical prediction rule to identify patients with neck pain who are likely to benefit from home-based mechanical cervical traction. Eur Spine J. 2011;20(6):912-922.

Chou R, Qaseem A, Snow V, et al. Clinical Efficacy Assessment Subcommittee of the American College of Physicians; American College of Physicians; American Pain Society Low Back Pain Guidelines Panel. Diagnosis and treatment of low back pain: a joint clinical practice guideline from the American College of Physicians and the American Pain Society. Ann Intern Med. 2007 Oct 2;147(7):478-91.

Clarke JA, van Tulder MW, Blomberg SE, et al. Traction for low back pain with or without sciatica. Cochrane Database Syst Rev. 2007 Apr 18;(2):CD003010.

Colombo C, Salvioli S, Gianola S, et al. Traction therapy for cervical radicular syndrome is statistically significant but not clinically relevant for pain relief. A systematic literature review with meta-analysis and trial sequential analysis. J Clin Med. 2020 Oct 22;9(11):3389.

Fritz JM, Thackeray A, Brennan GP, et al. Exercise only, exercise with mechanical traction, or exercise with over-door traction for patients with cervical radiculopathy, with or without consideration of status on a previously described subgrouping rule: a randomized clinical trial. J Orthop Sports Phys Ther. 2014 Feb;44(2):45-57.

Graham N, Gross A, Goldsmith CH, et al. Mechanical traction for neck pain with or without radiculopathy. Cochrane Database Syst Rev. 2008 Jul 16;(3):CD006408.

Kreiner DS, Matz P, Bono CM, et al. North American Spine Society (NASS). Evidence-based clinical guidelines for multidisciplinary spine care. Diagnosis and treatment of Low Back Pain. 2020.

Kreiner DS, Shaffer WO, Summers J, et al. North American Spine Society (NASS). Evidence-based clinical guidelines for multidisciplinary spine care. Diagnosis and treatment of degenerative lumbar spinal stenosis. 2011.

NICE. Low back pain and sciatica in over 16s: assessment and management. NICE guideline [NG59] Published date: 30 November 2016.

Qaseem A, Wilt TJ, McLean RM, et al.; Clinical Guidelines Committee of the American College of Physicians. Noninvasive treatments for acute, subacute, and chronic low back pain: a clinical practice guideline from the American College of Physicians. Annals of Internal Medicine 2017;166(7):514-530.

Veterans Affairs and Department of Defense (VA/DoD) Clinical Practice Guidelines: the diagnosis and treatment of low back pain. Version 3.0. 2022.

Wegner I, Widyahening IS, van Tulder MW, et al. Traction for low-back pain with or without sciatica. Cochrane Database Syst Rev. 2013 Aug 19;8.

WHO guideline for non-surgical management of chronic primary low back pain in adults in primary and community care settings [Internet]. Geneva: World Health Organization; 2023.

Xiao LX, Liu CS, Zhong SZ, et al. Effect of a traction exercise neck brace on cervical spondylopathy radiculopathy: a clinical study and finite element analysis. Evid Based Complement Alternat Med. 2021 Apr 13;2021:8825150.

Young IA, Michener LA, Cleland JA, et al. Manual therapy, exercise, and traction for patients with cervical radiculopathy: a randomized clinical trial. Phys Ther. 2009 Jul;89(7):632-42. Erratum in: Phys Ther. 2009 Nov;89(11):1254-5. Phys Ther. 2010 May;90(5):825.

Policy History/Revision Information

Date	Summary of Changes
05/01/2026	**Supporting Information** • Updated *Clinical Evidence* and *References* sections to reflect the most current information • Archived previous policy version CS058KS.01

Instructions for Use

This Medical Policy provides assistance in interpreting UnitedHealthcare standard benefit plans. When deciding coverage, the federal, state, or contractual requirements for benefit plan coverage must be referenced as the terms of the federal, state, or contractual requirements for benefit plan coverage may differ from the standard benefit plan. In the event of a conflict, the federal, state, or contractual requirements for benefit plan coverage govern. Before using this policy, heck the federal, state, or contractual requirements for benefit plan coverage. UnitedHealthcare reserves the right to modify its policies and guidelines as necessary. This Medical Policy is provided for informational purposes. It does not constitute medical advice.

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