Priority Health	BILLING POLICY No. 109
CERVICAL TRACTION DEVICES	
Date of origin: July 11, 2025	**Review dates: None yet recorded**

APPLIES TO

- Commercial
- Medicare follows CMS unless otherwise specified
- Medicaid follows MDHHS unless otherwise specified

DEFINITION

Cervical traction devices gently stretch the neck to relieve pain and reduce pressure on the cervical spine.

MEDICAL POLICY

- Durable Medical Equipment (#91110) – reference for coverage details

FOR MEDICARE

For indications that don't meet criteria of NCD, local LCD or specific medical policy a Pre-Service Organization Determination (PSOD) will need to be completed. Get more information on PSOD in our Provider Manual.

POLICY SPECIFIC INFORMATION

Coding specifics

Code	Description	Key features
E0855	Cervical traction without door/external frame	Uses mandibular or occipital pressure; no door or frame required
E0856	Cervical traction with inflatable bladder(s)	May or may not use a frame; uses inflatable bladders for traction
E0860	Door-mounted cervical traction	Uses pulleys and ropes; attaches to a door; upright or supine use
E0849	Free-standing frame cervical traction	Uses pneumatic displacement (not mandibular); >20 lbs force; allows angled traction (e.g., lateral flexion)

Documentation requirements

We align with the Centers for Medicare & Medicaid Services (CMS) standard documentation requirements for supplies and DME. Reference CMS Article A55426 – Standard Documentation Requirements for All Claims Submitted to DME MACs for documentation requirements.

Modifiers

Priority Health follows standard billing and coding guidelines which include CMS NCCI. Modifiers should be applied when applicable based on this guidance and only when supported by documentation.

Incorrect application of modifiers will result in denials. The modifier list below may not be an all-inclusive list. Get more information about modifier use in our Provider Manual.

As indicated in our Durable Medical Equipment medical policy, the below modifiers will be required:

HCPCS modifiers:

- **KX modifier**: Modifier should be appended to indicate that policy criteria has been met for all wheelchair DME items (includes base, seating, power devices, and additional accessories). Claims reported without KX modifier will deny as non-payable per medical policy. (Commercial, Medicaid products)
- **KX, GA, GY, GZ modifiers**: Per CMS local coverage determinations, one of these modifiers are required for claim processing all wheelchair DME items (includes base, power bases, seating, and additional accessories). See more information about these modifiers in our Provider Manual.

Place of service

Coverage will be considered for services furnished in the appropriate setting to the patient's medical needs and condition. Authorization may be required. Get more information in our Provider Manual.

Review specific information regarding DME place of service billing requirements in our Durable Medical Equipment (DME) place of services (POS) billing policy.

Reimbursement rates

Find reimbursement rates for the codes listed on this page in our standard fee schedules for your contract. See our fee schedules (login required).

REFERENCES

- Article - Cervical Traction Devices - Policy Article (A52476) (CMS)
- LCD - Cervical Traction Devices (L33823) (CMS)
- CMS Manual System, Pub. 100-3, Medicare National Coverage Determinations Manual, Chapter 1, Section 280.1

DISCLAIMER

Priority Health's billing policies outline our guidelines to assist providers in accurate claim submissions and define reimbursement or coding requirements if the service is covered by a Priority Health member's benefit plan. The determination of visits, procedures, DME, supplies and other services or items for coverage under a member's benefit plan or authorization isn't being determined for reimbursement. Authorization requirements and medical necessity requirements appropriate to procedure, diagnosis and frequency are still required. We use Current Procedural Terminology (CPT), Centers for Medicare and Medicaid Services (CMS), Michigan Department of Health and Human Services (MDHHS) and other defined medical coding guidelines for coding accuracy.

An authorization isn't a guarantee of payment when proper billing and coding requirements or adherence to our policies aren't followed. Proper billing and submission guidelines must be followed. We require industry standard, compliant codes defined by CPT, HCPCS and revenue codes for all claim submissions. CPT, HCPCPS, revenue codes, etc., can be reported only when the service has been performed and fully documented in the medical record to the highest level of specificity. Failure to document for services rendered or items supplied will result in a denial. To validate billing and coding accuracy, payment integrity pre- or post-claim reviews may be performed to prevent fraud, waste and abuse. Unless otherwise detailed in the policy, our billing policies apply to both participating and non-participating providers and facilities.

If guidelines detailed in government program regulations, defined in policies and contractual requirements aren't followed, Priority Health may:

- Reject or deny the claim
- Recover or recoup claim payment

An authorization on file for an item or services doesn't supersede coding, billing or reimbursement requirements.

These policies may be superseded by mandates defined in provider contracts or state, federal or CMS contracts or requirements. We make every effort to update our policies in a timely manner to align to these requirements or contracts. If there's a delay in implementation of a policy or requirement defined by state or federal law, as well as contract language, we reserve the right to recoup and/or recover claim payments to the effective dates per our policy. We reserve the right to update policies when necessary. Our most current policy will be made available in our Provider Manual.

CHANGE / REVIEW HISTORY

Date	Revisions made