

Cervical Traction Devices

For any item to be covered by The Health Plan, it must:

1. Be eligible for a defined Medicare or The Health Plan benefit category
2. Be reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body member
3. Meet all other applicable Medicare and/or The Health Plan statutory and regulatory requirements

For the items addressed in this medical policy, the criteria for "reasonable and necessary" are defined by the following indications and limitations of coverage and/or medical necessity. *Please refer to individual product lines certificates of coverage for possible exclusions of benefit.*

For an item to be covered by The Health Plan, the supplier must receive a written, signed, and dated order before a claim is submitted to The Health Plan. If the supplier bills for an item addressed in this policy without first receiving the completed order, the item will be denied as not reasonable and necessary.

Suppliers are to follow The Health Plan requirements for precertification, as applicable.

Cervical traction devices require precertification and physician face-to-face.

National Coverage Determination Policy	CMS Publication 100-3 Medicare National Coverage Determinations Manual, Chapter 1, Section 280.1
Local Coverage Determination Policy	J- B/C
Effective Date	For services performed on or after: 09/16/14
Review/Revision Effective Date	01/19, 10/18, 05/2018, 04/01/2017, 01/01/16, 01/01/15 05/01/14 , 09/16/14
The Health Plan	Plans will follow Coverage Determination posted on the CGS website unless otherwise indicated in sections of this policy, contractual agreements, or benefit plan documents. West Virginia Medicaid: See Health Plan Compensation Guide Schedule as quantity limits may vary from other lines of business

DESCRIPTION

Cervical traction is a type of continuous or intermittent traction in which a head halter with weights is worn by the patient to maintain proper alignment of the cervical spine.

COVERAGE GUIDELINES

A cervical traction device (E0860) is covered only if all of the following criteria are met:

1. The member has a musculoskeletal or neurologic impairment in the cervical area requiring traction equipment; and
2. The appropriate use of a home cervical traction device has been demonstrated to the member and the member has tolerated the selected device.
3. The member has a face-to face that meets Affordable Care Act guidelines.

Cervical traction devices described by code **E0849** or **E0855** are covered only when criteria 1-3 above and criteria either A, B, or C below have been met:

- A. The member has a diagnosis of temporomandibular joint (TMJ) dysfunction and has received treatment for the TMJ condition; or,

NOTE: The Health Plan does not cover treatment of TMJ for most of the fully-funded lines of business. For ASO lines of business please refer to the plan's SPD.

- B. 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; or
- C. The treating physician orders and/or documents the medical necessity for greater than 20 pounds of cervical traction in the home setting.

If the criteria for cervical traction are met, but the additional criteria for **E0849** or **E0855** are not met, they will be denied as not reasonable or necessary.

NONCOVERAGE STATEMENT

Cervical traction applied via attachment to a headboard (**E0840**) or a free-standing frame (**E0850**) has no proven clinical advantage compared to cervical traction applied via an over-the-door mechanism (**E0860**). If an **E0840** or **E0850** is ordered it will be denied.

E0856 describes a cervical traction device that can be used with ambulation. It will be denied as not covered. Cervical traction devices are covered under the DME benefit. Cervical orthoses, such as soft or rigid cervical collars, are not considered DME; however, they are eligible for Medicare coverage under the brace benefit.

REPAIR, REPLACEMENT, AND REASONABLE USEFUL LIFETIME

See Compensation Guide for reasonable useful lifetimes per HCPCS code.

Replacement due to loss, significant change in the member's condition, or irreparable accidental damage, natural disaster, or burglary is covered, if the device is still medically necessary. The reason for the replacement must be provided with the precertification or claim submission, if no precertification is required.

CODING INFORMATION

CPT/HCPCS codes: The appearance of a code in this section does not necessarily indicate coverage.

HCPCS MODIFIERS

EY	NO PHYSICIAN OR OTHER LICENSED HEALTH CARE PROVIDER ORDER FOR THIS ITEM OR SERVICE
GA	WAIVER OF LIABILITY STATEMENT ISSUED AS REQUIRED BY PAYOR POLICY, INDIVIDUAL CASE.
GZ	ITEM OR SERVICE EXPECTED TO BE DENIED AS NOT REASONABLE AND NECESSARY
KX	REQUIREMENTS SPECIFIED IN THE MEDICAL POLICY HAVE BEEN MET

HCPCS CODES

E0840	TRACTION FRAME ATTACHED TO HEADBOARD, CERVICAL TRACTION
E0849	TRACTION EQUIPMENT, CERVICAL, FREE-STANDING STAND/FRAME, PNEUMATIC, APPLYING TRACTION FORCE TO OTHER THEN MANDIBLE. DEVICES MUST BE CAPABLE OF GENERATING TRACTION FORCES GREATER THEN 20 LBS AND ALTERNATIVE VECTORS OF FORCE (E.G., 15° OF LATERAL NECK FLEXION)
E0850	TRACTION STAND, FREE-STANDING, CERVICAL TRACTION
E0855	CERVICAL TRACTION EQUIPMENT NOT REQUIRING ADDITIONAL STAND OR FRAME, TRACTION APPLIED BY MEANS OF MANDIBLE OR OCCIPITAL PRESSURE
E0856	CERVICAL TRACTION DEVICE, WITH INFLATABLE AIR BLADDER(S)
E0860	TRACTION EQUIPMENT, OVERDOOR, CERVICAL, TRACTION ON THE CERVICAL ANATOMY THROUGH A SYSTEM OF PULLEYS AND ROPES ATTACHED TO A DOOR. TRACTION MAY BE APPLIED EITHER IN THE UPRIGHT OR SUPINE POSITION

There are no specified diagnoses or ICD-10 codes that indicate medical necessity.

DOCUMENTATION REQUIREMENTS

For the purposes of this policy, it is expected that the medical record will support the need for the care provided. It is generally understood that the medical record includes the physician's office records, hospital records, nursing home records, home health agency records, records from other health care professionals and test reports.

This documentation must be available with precertification.

Medicare has made changes to its requirements for dispensing orders, detailed written orders, and proof of delivery. The Health Plan will require the following:

1. Physician detailed written order. Order must include the following:
 - a. Member's name
 - b. Date of order and date of face-to-face

- c. Description of item. The medical record must contain the information that supports the request for each item and must be submitted with the precertification if the item requires precertification, or with the claim, if no precertification was required
- d. Order must include diagnosis code
- e. Physician signature with date. Date stamps are not appropriate
- f. Quantity of items required and duration. A new order is required if there is an increase in the quantity of the supply used per month and/or the type of supply used

The supplier is to contact The Health Plan in this instance to update referral

2. There must be documentation in the supplier's records to support the medical necessity of that item. This information must be available upon request usually with precertification per The Health Plan policy.
3. Proof of delivery to be kept on file by the provider of the item.

Note: If templates or forms are submitted, (i.e., a Medicare Certificate of Medical Necessity, and/or a provider created form), The Health Plan reserves the right to request the medical record, that may include, but not limited to, the physician office notes, hospital and nursing facility records, and home health records.

Note: Template provider forms, prescriptions, and attestation letters are not considered part of the medical record, even if signed by the ordering physician.

Precertification is required when supplies used are greater than the usual maximum quantity listed in above. There must be adequate, clear documentation in the medical record corroborating the medical necessity of this amount. This documentation is to be submitted with precertification.

PROVIDED WHILE MEMBER IN PART A FACILITY

Reimbursement for Traction devices provided to a member while covered in a Part A facility is based on specific contract information with the individual facility, and whether or not the device is intended for use while the member is in the facility or intended for the member to take home.

Payment for the device is included in the payment to a hospital if:

1. The device is provided to a patient during an inpatient hospital stay prior to the day of discharge; and
2. The patient uses the device for medically necessary inpatient treatment or rehabilitation.

A claim must not be submitted in this situation.

Reimbursement for a cervical traction provided while a member is in a SNF receiving Part A services, will be reimbursed according to individual facility contracts.

KX, GA, and GZ MODIFIERS

Suppliers may submit a claim with a KX modifier only if all the criteria for that item is met.

If coverage criteria are not met, the GA or GZ modifier must be used. When there is an expectation of a medical denial, suppliers must enter the GA modifier on the claim line if they have obtained a properly executed Advance Beneficiary Notice (ABN) or the GZ modifier, if they have not obtained a valid ABN.

ADVANCED BENEFICIARY NOTICE

The Health Plan expects providers to follow the Medicare policy on ABN across all Medicare, Medicaid, and Commercial plans.

NOTE: Providers may be held financially responsible if they furnish the above items without notifying the member, verbally and in writing, that the specific service being provided is not covered. This must be done prior to the dispensing of the device. The provider must submit the waiver or ABN to The Health Plan with the claim showing the member agreed to pay for the device. Generalized statements on waivers or ABN are not acceptable.

MEDICARE DEFINITIONS AND DESCRIPTION

Code **E0855** 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.

Code **E0860** 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.

Code **E0849** describes cervical traction devices that provide traction on the cervical anatomy through the use of a free-standing frame. Traction force is applied by means of pneumatic displacement to anatomical areas other than the mandible (e.g., the occipital region of the skull). Devices described by code **E0849** must be capable of generating traction forces greater than 20 lbs. In addition, code **E0849** devices allow traction to be applied with alternative vectors of force (e.g., 15° of lateral neck flexion).

PRICING, DATA ANALYSIS, AND CODING (PDAC)

The Health Plan has implemented use of Medicare's PDAC contractor for review of authorizations. Suppliers should contact the PDAC contractor for guidance on the correct coding of these items. dmepdac.com/

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INTERNET LINKS AND SOURCES

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