Medical Policy

Suction Pumps

Description

Suction pumps are a lightweight, compact, electric aspirator designed for home use. Use of the device does not require technical or professional supervision.

Policy

Suction pumps are considered **reasonable and necessary** for Members meeting coverage criteria.

GASTRIC SUCTION

A gastric suction pump (E2000) is used to remove gastrointestinal fluids under continuous or intermittent suction via a tube. Use of a gastric suction pump and related supplies are covered for beneficiaries who are unable to empty gastric secretions through normal gastrointestinal functions. Use of a gastric suction pump for other conditions will be denied as not reasonable and necessary.

Supplies (tubing, tape, dressings, etc.) are covered and are separately payable when they are medically necessary and used with a medically necessary E2000 pump. Supplies used with DME that is denied as not reasonable and necessary, will also be denied as not reasonable and necessary.

RESPIRATORY SUCTION

A respiratory suction pump (E0600) is only covered for beneficiaries who have difficulty raising and clearing secretions secondary to:

1. Cancer or surgery of the throat or mouth
2. Dysfunction of the swallowing muscles
3. Unconsciousness or obtunded state
4. Tracheostomy

Use of a respiratory suction pump for other conditions will be denied as not reasonable and necessary.

Suction catheters (A4605, A4624, A4628) and sterile water/saline (A4216, A4217) are covered and are separately payable when they are medically necessary and used with a medically necessary E0600 pump. Supplies used with DME that is denied as not reasonable and necessary will also be denied as not reasonable and necessary.

Codes A4605 and A4624 are only covered for beneficiaries with a tracheostomy (Reference the Diagnosis Codes that Support Medical Necessity section) as described below:

Claims for A4605 and A4624 suction catheters that do not meet all of the criteria above will be denied as not reasonable and necessary.

More than three A4624 catheters per day will be denied as not reasonable and necessary for tracheostomy suctioning.

Non-tracheal suction catheters (A4628) are reasonable and necessary for suctioning in the oropharynx. The oropharynx is not sterile, therefore the catheter can be reused if properly cleansed and/or disinfected. More than three catheters (A4628) per week will be denied as not reasonable and necessary for oropharyngeal suctioning.

A7047 is not used to remove secretions for the covered indications described above. Claims for A7047 will be denied as not reasonable and necessary.

Sterile water/saline solution (A4216, A4217) is covered when used to clear a suction catheter after tracheostomy suctioning. Sterile water/saline will be denied as not reasonable and necessary when used for oropharyngeal suctioning.

WOUND SUCTION

Use of suction on wounds (A9272, K0743) is only appropriate in those clinical scenarios where the quantity of exudate exceeds the capacity of conservative measures such as surgical dressings and wound fillers to contain it. However, wound suction to remove exudate can be accomplished with the use of non-covered disposable, suction devices (A9272) or with covered DME devices (K0743). When a non-covered alternative exists (A9272), it is not reasonable or necessary to use a covered DME item (K0743). Therefore, when K0743 is billed it will be denied as not reasonable and necessary.

Wound suction pumps and their associated supplies, which have not been specifically designated as being qualified to use HCPCS code K0743 via written instructions from the Pricing, Data Analysis and Coding (PDAC) Contractor will be denied as not reasonable and necessary.

Supplies (dressings, tubing, etc.) are covered and are separately payable when they are medically necessary and used with a medically necessary K0743 pump. Supplies used with DME that is denied as not reasonable and necessary will also be denied as not reasonable and necessary.

HCPCS CODES:

Group 1 Codes:

HCPCS	Description
A4216	STERILE WATER, SALINE AND/OR DEXTROSE, DILUENT/FLUSH, 10 ML
A4217	STERILE WATER/SALINE, 500 ML
A4605	TRACHEAL SUCTION CATHETER, CLOSED SYSTEM, EACH
A4624	TRACHEAL SUCTION CATHETER, ANY TYPE OTHER THAN CLOSED SYSTEM, EACH
A4628	OROPHARYNGEAL SUCTION CATHETER, EACH
A7000	CANISTER, DISPOSABLE, USED WITH SUCTION PUMP, EACH
A7001	CANISTER, NON-DISPOSABLE, USED WITH SUCTION PUMP, EACH
A7002	TUBING, USED WITH SUCTION PUMP, EACH
A7047	ORAL INTERFACE USED WITH RESPIRATORY SUCTION PUMP, EACH
A9272	WOUND SUCTION, DISPOSABLE, INCLUDES DRESSING, ALL ACCESSORIES AND COMPONENTS, ANY TYPE, EACH
E0600	RESPIRATORY SUCTION PUMP, HOME MODEL, PORTABLE OR STATIONARY, ELECTRIC
E2000	GASTRIC SUCTION PUMP, HOME MODEL, PORTABLE OR STATIONARY, ELECTRIC
K0743	SUCTION PUMP, HOME MODEL, PORTABLE, FOR USE ON WOUNDS
K0744	ABSORPTIVE WOUND DRESSING FOR USE WITH SUCTION PUMP, HOME MODEL, PORTABLE, PAD SIZE 16 SQUARE INCHES OR LESS
K0745	ABSORPTIVE WOUND DRESSING FOR USE WITH SUCTION PUMP, HOME MODEL, PORTABLE, PAD SIZE MORE THAN 16 SQUARE INCHES BUT LESS THAN OR EQUAL TO 48 SQUARE INCHES
K0746	ABSORPTIVE WOUND DRESSING FOR USE WITH SUCTION PUMP, HOME MODEL, PORTABLE, PAD SIZE

Supplies used with DME that is denied as not reasonable and necessary will also be denied as not reasonable and necessary.

Limitations:

1. Billing for quantities of supplies greater than those described in the policy as the usual maximum amounts must be supported by medical documentation which must be sent in. In the absence of documentation clearly explaining the medical necessity of the excess quantities, they will be considered not reasonable and necessary.
2. A gastric suction pump is covered when used in conjunction with a nasogastric tube.
3. Tubing (A7002) replacement is limited to one per month.
4. Canister, disposable (A7000) and non-disposable (A7001) replacement is limited to one per month for the disposable canister (A7000) and one per six months for the non-disposable canister (A7001).

Important Note:

Northwood's Medical Policies are developed to assist Northwood in administering plan benefits and determining whether a particular DMEPOS product or service is reasonable and necessary. Equipment that is used primarily and customarily for a non-medical purpose is not considered durable medical equipment.

Coverage determinations are made on a case-by-case basis and are subject to all of the terms, conditions, limitations, and exclusions of the member's contract including medical necessity requirements.

The conclusion that a DMEPOS product or service is reasonable and necessary does not constitute coverage. The member's contract defines which DMEPOS product or service is covered, excluded or limited. The policies provide for clearly written, reasonable and current criteria that have been approved by Northwood's Medical Director.

The clinical criteria and medical policies provide guidelines for determining the medical necessity for specific DMEPOS products or services. In all cases, final benefit determinations are based on the applicable contract language. To the extent there are any conflicts between medical policy guidelines and applicable contract language, the contract language prevails. Medical policy is not intended to override the policy that defines the member's benefits, nor is it intended to dictate to providers how to direct care. Northwood Medical policies shall not be interpreted to limit the benefits afforded to Medicare or Medicaid members by law and regulation and Northwood will use the applicable state requirements to determine required quantity limit guidelines.

Northwood's policies do not constitute medical advice. Northwood does not provide or recommend treatment to members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

References

Centers for Medicare and Medicaid Services, Medicare Coverage Database, National Coverage Documents; October 2015.

CGS Administrators, LLC. Jurisdiction B DME MAC, Suction Pumps. Local Coverage Determination No. L33612; revised date October 1, 2015.

Noridian Healthcare Solutions, LLC. Suction Pumps. Local Coverage Determination No. L33612. Durable Medical Equipment Medicare Administrative Carrier Jurisdiction A.; revised October 1, 2015.

Applicable URAC Standard

Core 8	Staff operational tools and support

Change/Authorization History

Revision Number	Date	Description of Change	Prepared / Reviewed by	Approved by	Review Date:
A	11-20-06	Initial Release	Rosanne Brugnoni	Ken Fasse	n/a
01	12-2008	Added to Sterile Saline Solution to coverage criteria	Susan Glomb	Ken Fasse	n/a
02		Annual Review – no additional changes	Susan Glomb	Ken Fasse	Dec.2008
03	12-22-09	Annual Review/ no changes	Susan Glomb	Ken Fasse	Dec.2009
04	12-03-10	Annual Review – No changes	Susan Glomb	Ken Fasse	Dec.2010
05	03-11-11	Replaced A4624 with A4628 in reference to re-use of catheter	Susan Glomb	Ken Fasse	
06	07-20-11	Added Important Note to all Medical Policies	Susan Glomb	Dr. B. Almasri	
07	11-10-11	Annual Review. Added References to Policy	Susan Glomb	Dr. B. Almasri	Nov. 2011
08	12-03-12	Annual review – no changes.	Susan Glomb	Dr. B. Almasri	Dec. 2012
09	12-18-13	Annual review. No changes.	Susan Glomb	Dr. B. Almasri	

10	12-1-14	Annual Review. No changes	Susan Glomb	Dr. B. Almasri	
11	12-11-15	Annual Review. Updated policy to include Medicare guidelines re: wound pumps A9272 and K0743. References updated	Susan Glomb	Dr. B. Almasri	
12	12-07-16	Annual Review. No Changes.	Lisa Wojno	Dr. B. Almasri	December 2016
13	12-13-17	Annual review. No changes.	Carol Dimech	Dr. C. Lerchin	December 2017
14	12-03-18	Annual Review. Updated Medicare references.	Lisa Wojno	Dr. C. Lerchin	December 2018