Priority Health	BILLING POLICY No. 153
Suction Pumps	
Date of origin: Sept 2025	**Review dates: None yet recorded**

APPLIES TO

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

DEFINITION

A medical suction pump, or aspirator, is a device designed to extract bodily fluids such as mucus, blood, or other secretions from a patient's airway or wounds. By creating a vacuum, it effectively clears these fluids, helping to keep airways open, reduce the risk of infection, and support the healing process.

MEDICAL POLICY

Durable Medical Equipment # 91110

BILLING POLICY

Durable Medical Equipment (DME) Place of Service (POS) No. 050

DME Refill Requirements billing policy No. 87

Miscellaneous Durable Medical Equipment No. 017

Durable Medical Equipment (DME) Repair and Replacement Billing Policy No. 108

Durable Medical Equipment (DME) Capped Rental Billing Policy No. 110

Negative Pressure Wound Therapy Pumps Billing policy No. 072

For Medicare

For indications that do not meet criteria of NCD, local LCD or specific medical policy a Pre-Service Organization Determination (PSOD) will need to be completed. Click here for additional details on PSOD.

POLICY SPECIFIC INFORMATION

Reimbursement rates

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

Billing details

- All items used in conjunction with any suction pump (i.e. A4605, A4624, A4216, A4217, etc.) are classified as durable medical equipment (DME) supplies.
    - When these items are provided to beneficiaries in nursing facilities (Place of Service 31 and 32), they are considered noncovered, as DME items are excluded from coverage in these settings.
- Disposable wound suction devices (A9270, A9272) and supplies are not covered as they do not meet Durable Medical Equipment requirements.
- A4605 and/or A4624
    - An appropriate diagnosis code indicating tracheostomy status must be included on the claim form.
- E0600, A7002, and A7047
    - A diagnosis code(s) supporting the medical necessity of these items must be documented on the claim form.
- When billing HCPCS codes with descriptions such as “miscellaneous,” “NOC,” “unlisted,” or “non-specified,” the following details must be included in loop 2400 (NTE02) of electronic claims or Item 19 of paper claims:

    - Item or service description
    - Manufacturer name
    - Product name and number
    - Supplier price list amount
    - Related HCPCS code (if applicable)

    Claims with miscellaneous HCPCS codes missing this information will be rejected and must be resubmitted with complete details.

Coding specifics

The procedure code list(s) provided below are intended for reference only and may not be exhaustive. The inclusion of a code within this policy does not determine whether the associated service is covered or non-covered. Coverage decisions are based on the member’s specific benefit plan and applicable regulatory requirements. The presence of a code does not imply eligibility for reimbursement or guarantee claim payment. Please consult additional policies and guidelines as they may also apply.

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: Oral and/or 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,

A9270: Noncovered item or service

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

K7044: Absorptive wound dressing for use with suction pump, home model, portable, pad size 16 sq in or less

K7045: Absorptive wound dressing for use with suction pump, home model, portable, pad size more than 16 sq in but less than or equal to 48 sq in

K7046: Absorptive wound dressing for use with suction pump, home model, portable, pad size greater than 48 sq in

Documentation requirements

Complete and thorough documentation to substantiate the procedure performed is the responsibility of the Provider. In addition, the Provider should consult any specific documentation requirements that are necessary of any applicable defined guidelines.

A valid prescription must be provided by the ordering physician or practitioner.

Medical records from the physician/practitioner must clearly support the medical necessity for a suction pump:

- **Gastric suction pumps (E2000):** Documentation must show the patient is unable to manage gastric secretions through normal gastrointestinal function.
- **Respiratory suction pumps (E0600):** Records must indicate difficulty clearing airway secretions due to conditions such as cancer, surgery, swallowing dysfunction, or tracheostomy.
- **Tracheal Suction Catheters (A4624):** Medical records must confirm the presence of a **tracheostomy** and document the need for a covered respiratory suction pump (E0600) to support the use of tracheal suction catheters.

This typically includes a detailed account of the patient's diagnosis, the clinical need for suction, and how the pump will help manage the condition. If the suction pump is intended for wound care, the documentation should explain why standard treatments—such as dressings or wound fillers—are inadequate.

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. Please see our provider manual page for modifier use here.

AU - Item furnished in conjunction with a urological, ostomy, or tracheostomy supply
EY – No physician or other licensed health care provider order for this item or service
RR - Rental
KH - First rental month
KI - Second and third rental months
KJ - Fourth to the thirteenth months

Please see DME modifiers & clinical edits on the Durable medical equipment (DME), Prosthetics and Orthotics page in the provider for more information.

Durable Medical Equipment (DME), Prosthetics and Orthotics

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. Click here for additional information.

REFERENCES

LCD - Suction Pumps (L33612)

Article - Suction Pumps - Policy Article (A52519)

Article - Standard Documentation Requirements for All Claims Submitted to DME MACs (A55426)

MLN4824456 – Medicare Provider Compliance Tips

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
Sept 2025	New Policy – Effective date Oct 16