



DETAILED WRITTEN ORDER

Homecare Dimensions

Document #: 09.DWO.HCD.11b
Effective: 09/15/2009

Rev.: B

Title: **Suction Pumps**
E0600, E2000

Page #: 1 of 2

Initial Date of Medical Necessity: _____

Patient Name: _____ Medicare #: _____

Address: _____ City: _____ ST: _____ Zip: _____

Phone #: _____ Cell #: _____ DOB: _____

Email: _____ Length of Need: _____ (99 = Lifetime)

Diagnosis Code: _____

Medical records: The patient's medical record, **to be supplied with this order**, must contain sufficient documentation of the patient's medical condition to substantiate the necessity for the type and quantity of items ordered and for the frequency of use or replacement (if applicable).

Equipment Ordered: Suction pump and accessories are billed using the specific codes listed in the Local Coverage Determination.

ORDERED	CODE	DETAILED DESCRIPTION OF ORDERED ITEMS
	E0600	Respiratory suction pump, home model, portable or stationary, electric
	E2000	Gastric suction pump, home model, portable or stationary, electric
	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

Treating Physician Signature: _____ Date: _____

Treating Physician Name: _____ NPI: _____

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Indications and Limitations of Coverage and/or Medical Necessity

For any item to be covered by Medicare, it must 1) be eligible for a defined Medicare benefit category, 2) be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, and 3) meet all other applicable Medicare 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.

Basic Coverage Criteria for Suction Pumps: The Medical Records documenting that the patient has difficulty raising and clearing secretions secondary to **ONE** of the following:

- Cancer or surgery of the throat or mouth; **or**
- Dysfunction of the swallowing muscle; **or**
- Unconsciousness or obtunded state; **or**
- Tracheostomy.

Claims for Sterile Saline Solution (A4216, A4217): The saline is being used to clear a suction catheter after tracheostomy suctioning. (Sterile saline is not covered for oropharyngeal suctioning.)

When ordering A4605, A4624 for patients with a tracheostomy, ICD-9 code V44.0 or V55.0 must be entered in the diagnostic code line.

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