The Department of Vermont Health Access Medical Policy

Subject: Respiratory Suction Pump
Last Review: August 7, 2020*

*Please note: Most current content changes will be highlighted in yellow.

Description of Service or Procedure

A respiratory suction pump is an electrical aspirator designed for upper respiratory oral pharyngeal and tracheal suction and may be for use in the home. It is designed to remove respiratory secretions that cannot be managed by the beneficiary due to a compromised cough mechanism or artificial airway such as a tracheostomy or endotracheal tube.

Disclaimer

Coverage is limited to that outlined in Medicaid Rule or Health Care Administrative Rules that pertains to the member’s aid category. Prior Authorization (PA) is only valid if the member is eligible for the applicable item or service on the date of service.

Medicaid Rule


Medicaid Rules

7102.2 Prior Authorization Determination
7103 Medical Necessity

Coverage Position

An electrical suction device may be covered for beneficiaries:

- When this device is prescribed by a licensed medical provider, enrolled in the Vermont Medicaid program, operating within their scope of practice as described in their Vermont State Practice Act, who is knowledgeable in the use of suction devices and who provides medical care to the beneficiary AND
• When the clinical criteria below are met.

• Effective for dates of service on or after May 1, 2018 providers may bill for supplies up to the DVHA quantity limit during the rental period for: E0445, E0465, E0466, E0470, E0471, E0565, E0600, and E0601.

Coverage Criteria

A suction device may be covered for a beneficiary when the following criteria are met:
• Has a medical condition which impairs the raising and clearing of secretions (secondary to but are not limited to cancer of the mouth/throat, dysfunctional swallowing due to a neurological condition, tracheostomy, unconsciousness, or obtunded state) AND
• The individual and/or caregiver has successfully demonstrated, to a knowledgeable practitioner such as a home health or hospital nurse, the ability to use, manage, and clean the suction device to a skilled professional practitioner.

This is currently a Capped Rental item and is paid in 10 monthly installments.

Clinical guidelines for repeat service or procedure

• If the repair of the device is greater than 50% of the cost of replacement.
• Repeat service is limited to the guidelines above.

Type of service or procedure covered

Home respiratory suction device and related supplies and services. Medical supplies which are necessary to the functioning of the equipment are included in the rental and not to be billed in addition to the rental of the equipment.

References


This document has been classified as public information.