Reimbursement Fast Facts: Ventilators

Understanding Medicare coding and coverage for ventilators

Ventilators are medical devices that provide mechanical ventilation to assist with or replace patients' spontaneous breathing. Mechanical ventilation is often categorized based on the interface used, such as a tracheostomy tube for invasive ventilation or a mask for non-invasive ventilation.

Device	Description	HCPCS	2015 Medicare Reimbursement[1]
Home ventilator: Invasive	Home ventilator, any type, used with invasive interface (e.g. tracheostomy tube)	E0465	$1055.23–896.95 (monthly rate)
Home ventilator: Non-invasive	Home ventilator, any type, used with non-invasive interface (e.g. mask, chest shell)	E0466	$1055.23–896.95 (monthly rate)

Billing criteria for ventilators

Ventilators are covered by Medicare for the treatment of neuromuscular diseases, thoracic restrictive diseases and chronic respiratory failure consequent to chronic obstructive pulmonary disease.[2]

Ventilators are included in Medicare's "Frequently & Substantially Serviced" payment category.[3] Equipment in this payment category is paid on a monthly rental (RR) basis while the equipment is medically necessary. No payment is made by Medicare for the purchase of equipment, maintenance and servicing, or for the replacement of items in this category.[4] Due to the "Frequently & Substantially Serviced" payment category, no separate payment is allowed for ventilator accessories or supplies under the Medicare Program.[5]

Documentation to support the medical necessity of a ventilator may include:

- Valid physician's order
- Payable diagnosis
- Medical necessity documented in the medical record
- Ventilator settings
- Documentation describing the supplier's backup plan in case the primary ventilator breaks down
- Proof of delivery[6]

Documentation to support continued medical need must also be on file.

When should a ventilator be considered in place of a Respiratory Assist Device (RAD)?

Ventilators are covered for neuromuscular diseases, thoracic restrictive diseases and chronic respiratory failure consequent to chronic obstructive pulmonary disease (COPD).

Each of these disease categories are comprised of conditions that can vary from severe and life-threatening to less serious forms. These disease groups may appear to overlap conditions described in the Respiratory Assist Devices Local Coverage Determination (LCD), but they do not. Choice of an appropriate device (i.e. a ventilator vs. a bilevel PAP device) is made based upon the severity of the condition.

RADs may be applied to assist insufficient respiratory efforts in the treatment of conditions that may involve sleep-associated hypoventilation. It is distinguished from the invasive ventilation administered via a securely intubated airway, in a patient for whom interruption or failure of respiratory support leads to death.

The conditions described in the RAD LCD are not life-threatening conditions where interruption of respiratory support would quickly lead to serious harm or death. These policies describe clinical conditions that require intermittent and relatively short durations of respiratory support. Thus, a ventilator would not be eligible for reimbursement for any of the conditions described in the RAD LCD even though the ventilator equipment may have the capability of operating in a bilevel PAP mode.[2]

Q & A

Q: What additional items are typically supplied to ventilation patients?

Since ventilators are covered under the "Frequently & Substantially Serviced" payment category, bills for supplies and accessories are not separately allowed. However, other items may be medically necessary. Depending on the patient's condition, items like oxygen, nebulizers, suction machines and tracheostomy supplies may also be provided.[6] Please check with your payor to confirm coverage and billing details.

Q: Are humidifiers separately reimbursable?

No, under the "Frequently & Substantially Serviced" payment category, humidifiers are bundled into the ventilator reimbursement and are *not* separately billable. When a ventilator is purchased by the beneficiary or acquired before Medicare eligibility, separate reimbursement may be considered.[7]

Q: Is a face-to-face meeting required prior to writing a detailed written order for a ventilator?

Yes, ventilators are included in the list of DME items that require a face-to-face encounter examination with a beneficiary in the six (6) months prior to the written order.[8]

Q: Can a supplier bill for a positive airway pressure (PAP) device in addition to a ventilator?

If both a ventilator and a PAP device (E0601, E0470, E0471) are billed, the PAP device will be denied as not medically necessary.

Q: Can a supplier bill for a second ventilator or a backup ventilator?

It depends. Medicare does not pay separately for a backup ventilator. Medicare's payment for a ventilator under the "Frequently & Substantially Serviced" category includes payment for a backup ventilator if one is deemed necessary.

Although Medicare does not pay separately for backup equipment, Medicare *will* make a separate payment for a second piece of equipment if it is required to serve a different purpose determined based on the patient's medical needs.[9]

Examples of situations in which multiple items may be covered (not all-inclusive):

- A beneficiary requires one type of ventilator (e.g. a negative pressure ventilator with a chest shell) for part of the day and needs a different type of device (e.g. positive pressure RAD with a nasal mask) during the rest of the day.
- A beneficiary who is confined to a wheelchair requires a ventilator mounted on the wheelchair for use during the day, and needs another ventilator of the same type for use while in bed. Without both pieces of equipment, the beneficiary may be prone to certain medical complications, may not be able to achieve certain appropriate medical outcomes, or may not be able to use the medical equipment effectively.

Here's an example in which a second or other multiple piece of equipment would be considered a backup and therefore would not be covered (not all-inclusive):

- A ventilator-dependent beneficiary is confined to bed and a second ventilator of the same or similar type is provided at the bedside as a precaution in case of malfunction of the primary ventilator.

Q: What documentation can be used to prove continued medical need?

Any of the following may serve as documentation justifying continued medical need:

- A recent order by the treating physician for refills
- A recent change in prescription
- A properly completed Certificate of Medical Necessity (CMN) or DME Information Form (DIF) with an appropriate length of need specified
- Timely documentation in the beneficiary's medical record showing usage of the item

"Timely documentation" is defined as a record in the preceding twelve (12) months unless otherwise specified elsewhere in the policy.

Q: Does Medicare cover repairs or maintenance for ventilators?

Ventilators fall into the "Frequently & Substantially Serviced" payment category, and neither repairs nor maintenance and servicing are covered.

For more information on RADs, please reference:

- **ResMed's RAD Guidelines, PN 1010293**
- **ResMed's RAD Reimbursement Fast Facts, PN 1013495**
- **CMS' RAD LCD (L33800) effective date 10/1/2015**

1 The rates listed are based on the Medicare 2016 DMEPOS National Fee Schedule. Actual allowables vary by state. **2** Correct Coding and Coverage of Ventilators, Joint DME MAC Publication, revised December 3, 2015 **3** www.dmepdac.com DMECS Search for E0463 & E0464 **4** CGS MAC Supplier Manual: Chapter 5 **5** CGS DME MAC Supplier Manual: Chapter 5 **6** NGS Ventilator Computer Based Training DME – 0053, updated December 30, 2013 **7** Palmetto GBA DMERC Medicare Advisory Issue 37; Summer 2001 **8** MLN Matters® Number: MM8304; July 1, 2013 **9** CGS DMEPOS Supplier Manual: Chapter 3

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