What is the Medicare Part B Coverage Policy for Ventilators?

Medical equipment needed at home (e.g., portable ventilators) to treat Medicare beneficiary’s condition is covered under the durable medical equipment (DME) benefit, which is paid under supplementary medical insurance (Part B). DME is defined as equipment that:

- Can withstand repeated use,
- Primarily and customarily serves a medical purpose,
- Generally is not useful to a person without an illness or injury, and
- Is appropriate for use in the home.

According to The Centers for Medicare & Medicaid Services (CMS) National Coverage Determination Manual (Internet-Only Manual, Publ. 100-3) in Chapter 1, Part 4, Section 280.1, ventilators are “covered for treatment of neuromuscular diseases, thoracic restrictive diseases, and chronic respiratory failure consequent to chronic obstructive pulmonary disease. [This coverage] includes both positive and negative pressure types.”

Volume ventilators are included in Medicare’s “Frequently and Substantially Serviced” payment category. For items in this category, Medicare pays an ongoing monthly rental fee to the supplier as long as the device is deemed medically necessary.

What are the available Healthcare Common Procedure Coding System (HCPCS) codes and payment rates for Portable Ventilators?

<table>
<thead>
<tr>
<th>HCPCS CODE*</th>
<th>DESCRIPTION</th>
<th>2018 MEDICARE ALLOWABLE RANGE**</th>
</tr>
</thead>
<tbody>
<tr>
<td>A4618</td>
<td>Breathing circuits</td>
<td>$8.51 - $10.01</td>
</tr>
<tr>
<td>E0465</td>
<td>Home ventilator, any type, used with invasive interface, (e.g., tracheostomy tube)</td>
<td>$913.16 - $1,074.31</td>
</tr>
<tr>
<td>E0466</td>
<td>Home ventilator, any type, used with non-invasive interface, (e.g., mask, chest shell)</td>
<td>$913.16 - $1,074.31</td>
</tr>
</tbody>
</table>

*The existence of HCPCS codes does not guarantee coverage or payment for any device by any insurance carrier or Medicare. Medical necessity must be established by the patient’s physician in accordance with specific coverage policy guidelines.

**The Medicare allowable amounts may vary by geographic location and are the maximum amount paid to a provider by Medicare, less any patient copayments and deductibles. Geographic location allowables include patient cost-sharing (co-payments and any deductibles). These amounts are national averages and are not adjusted for geography.
How are Ventilator accessories covered?
Usual and necessary ventilator accessories include circuits, filters, batteries and humidifiers. Payers differ in coverage policies for accessories. Under the Medicare program, coverage for ventilator accessories is included in coverage for the ventilator, so no separate payment is made for ventilator accessories under the Medicare Program. Some non-Medicare payers may pay separately for ventilator accessories under prescribed conditions. Typically, maintenance and service are included in the monthly allowable rate. We recommend verification of specific coverage and payment policies with the specific payer.

What additional items can be billed separately?
Ventilator patients cared for in the home often require multiple types of equipment. Some examples of additional items often supplied to ventilator patients that may be billed separately include tracheostomy supplies (tubes, dressings, trach care kits, etc.), dressing supplies, oxygen, wheelchairs, suction machines, compressor nebulizer therapy equipment and medications, hospital beds and Hoyer lifts.

For more detailed coverage information please refer to CMS National Coverage Determination Manual (Internet-Only Manual, Publ. 100-3) in Chapter 1, Part 4, Section 280.1. The final decision of billing for any product or procedure must be made by the provider of care, considering the medical necessity of the services and supplies provided, the requirements of insurance carriers and any other third-party payers, and any local, state or federal laws that apply to the products and services rendered.

Will a second Ventilator be covered?
Many providers routinely supply both primary and secondary ventilators to ventilator-dependent patients in the home. There is no national Medicare guideline on claim submission for a second ventilator.

The Durable Medical Equipment Medicare Administrative Carriers (DME MAC) published instructions regarding coverage of “backup equipment,” which state that a backup ventilator of the same or similar type provided at the bedside as a precaution in case of malfunction of the primary ventilator would not be covered.

The publications specify:
“Backup equipment must be distinguished from multiple medically necessary items, which are defined as identical or similar devices, each of which meets a different medical need for the patient. Though Medicare does not pay separately for backup equipment, Medicare may make a separate payment for a second piece of equipment if it is required to serve a different purpose as determined by the patient’s medical needs. Examples of situations in which multiple equipment may be covered include:

1. A patient 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 ventilator (e.g., a positive pressure ventilator with a nasal mask) during the rest of the day.
2. A patient 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 patient 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.”

When billing for a second ventilator, suppliers are asked to enter the reason for medical necessity of the secondary ventilator in the NTE 2400 loop.

DME MACs differ regarding line-item entry of primary and secondary ventilators. Cigna Medicare, for example, asks that suppliers bill both ventilators on the same line with the number of services as two, and key the submitted amount for two as well (Autumn 2006 DMERC Medicare Advisory). Medicare NHIC asks for two claim lines to be submitted to identify the need for a secondary ventilator (DME MAC Jurisdiction A, 12/14/07 Educational Article).

Please check with your DME MAC to verify claims submission requirements for two qualifying ventilators on the same claim form.
REFERENCES:


2. Sources used for this quick guide include The Centers for Medicare & Medicaid Services (CMS) National Coverage Determination Manual (Internet-Only Manual, Publ. 100–3) in Chapter 1, Part 4, Section 280.1 and the 2018 DMEPOS Fee Schedule.