POLICY EDUCATION TOPICS

CORRECT CODING AND COVERAGE OF VENTILATORS – REVISED MAY 2016

Joint DME MAC Publication

This article has been revised to reflect clarifications on coding and coverage requirements for ventilators in the FSS payment category and to remove ventilator codes that were retired effective 1/1/2016.

Ventilator technology has evolved to the point where it is possible to have a single device capable of operating in numerous modes, from basic continuous positive pressure (CPAP and bi-level PAP) to traditional pressure and volume ventilator modes. This creates the possibility that one piece of equipment may be able to replace numerous and different pieces of equipment. Equipment with multifunction capability creates the possibility of errors in claims submitted for these items. This article will discuss the application of Medicare proper coding and payment rules for ventilators.

HCPCS Coding

Effective for claims with DOS on or after 1/1/2016, all products classified as ventilators must be billed using one of the following HCPCS codes:

- E0465 – Home ventilator, any type, used with invasive interface, (e.g., tracheostomy tube)
- E0466 – Home ventilator, any type, used with noninvasive interface, (e.g., mask, chest shell)

Products previously assigned to HCPCS codes E0450 and E0463 must use HCPCS code E0465. Products previously assigned to HCPCS codes E0460, E0461 and E0464 must use HCPCS code E0466. The PDAC will update the product classification listing in a future update.

Suppliers are reminded that the payment policy requirements for the FSS payment category prohibits FSS payment for devices used to deliver continuous and/or intermittent positive airway pressure, regardless of the illness treated by the device. (Social Security Act 1834[a][3][A]) This means that products currently classified as HCPCS code E0465 or E0466 when used to provide CPAP or bi-level PAP (with or without backup rate) therapy, regardless of the underlying medical condition, may not be paid in the FSS payment category. General principles of correct coding require that products assigned to a specific HCPCS code only be billed using the assigned code. Thus, using the HCPCS codes for CPAP (E0601) or bi-level PAP (E0470,

E0471) devices for a ventilator (E0465, E0466) used to provide CPAP or bi-level PAP therapy is incorrect coding. Claims for ventilators billed using the CPAP or bi-level PAP device HCPCS codes will be denied as incorrect coding.

Suppliers are encouraged to be sure that the correct category of product is provided and billed to avoid errors in HCPCS coding.

Coverage

Items may only be covered based upon the R&N criteria applicable to the product. The Centers for Medicare & Medicaid Services (CMS) Internet-Only Manual (IOM) publication 100-03, *Medicare National Coverage Determinations (NCD) Manual*, Chapter 1, Part 4, Section 280.1 stipulates that ventilators are covered for the following conditions:

[N]euromuscular diseases, thoracic restrictive diseases, and chronic respiratory failure consequent to chronic obstructive pulmonary disease.

These ventilator-related disease groups overlap conditions described in the respiratory assist devices (RAD) LCD used to determine coverage for bi-level PAP devices. Each of these disease categories are conditions where the specific presentation of the disease can vary from patient to patient. For conditions such as these, the specific treatment plan for any individual patient will vary as well. Choice of an appropriate treatment plan, including the determination to use a ventilator vs. a bi-level PAP device, is made based upon the specifics of each individual beneficiary's medical condition. In the event of a claim review, there must be sufficient detailed information in the medical record to justify the treatment selected.

Upgrades

An upgrade is defined as an item that goes beyond what is medically necessary under Medicare's coverage requirements. In some cases, CMS policy that allows for billing of upgrade modifiers can be used when providing an item or service that is considered beyond what is medically necessary. This is **not** applicable to ventilators in the situations described above.

Although the use of a ventilator to treat any of the conditions contained in the PAP or RAD LCDs is considered "more than is medically necessary", the upgrade billing provisions may not be used to provide a ventilator for conditions described in the PAP or RAD LCDs. CPAP and bi-level PAP items are in the Capped Rental payment category while ventilators are in the FSS payment category. Upgrade billing across different payment categories is not possible. Claims for items billed for upgrade across different payment categories will be rejected as unprocessable.

Payment Category

Ventilators are classified in the FSS payment category. FSS items are those for which there must be frequent and substantial servicing in order to avoid risk to the patient's

health (Social Security Act Section1834[a][3][A]). The monthly rental payment for items in this pricing category is all-inclusive meaning there is no separate payment by Medicare for any options, accessories or supplies used with a ventilator. In addition, all necessary maintenance, servicing, repairs and replacement are also included in the monthly rental. Claims for these items and/or services will be denied as unbundling.

Coverage of Second Ventilator

Medicare does not cover spare or back-up equipment. Claims for backup equipment will be denied as not reasonable and necessary – same/similar equipment.

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 beneficiary. 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 medical purpose that is determined by the beneficiary's medical needs.

The following are examples of situations in which a beneficiary would qualify for both a primary ventilator and a secondary ventilator:

- 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 ventilator (e.g. positive pressure ventilator 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 two 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.

Refer to the PAP and RAD LCDs and related policy articles and to the DME MAC supplier manuals for additional information on coverage, coding and documentation of these items.

For questions about correct coding, contact the PDAC Contact Center at 877-735-1326 during the hours of 8:30 a.m. to 4:00 p.m. CT, Monday through Friday, or email the PDAC by completing PDAC Contact Form located on the PDAC website .

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