The material referenced and provided is based on research of current Medicare reference sources. 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. We are providing you this information in an educational capacity with the understanding that we are not engaged in rendering legal, accounting or other professional services or advice. Note that applicable laws, rules and regulations may change. While we will use reasonable efforts to update this guide regularly, this guide should not be relied upon as a current or comprehensive statement of all applicable laws, rules and regulations.

Sources used for this quick guide include Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Coverage Issues Manual, Section 60-9; Medicare Home Health Agency Manual, Section 463; and the 2012 DMEPOS Fee Schedule.

The information in this quick guide is provided by our Healthcare Economics Department, which supports Respiratory and Monitoring Solutions products from Covidien. If you have questions or would like additional information, please call our toll-free reimbursement hotline at 1-877-278-7482 or contact us at CovidienReimbursement@ArgentaAdvisors.com.

### 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>Range of Medicare Allowable Amounts** 2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>A4618</td>
<td>Breathing circuits</td>
<td>$8.11 - $9.54</td>
</tr>
<tr>
<td>E0450</td>
<td>Volume control ventilator, without pressure support mode, may include pressure control mode, used with invasive interface. Example: Puritan Bennett™ LP Series portable ventilator</td>
<td>$871.49 - $1,025.28</td>
</tr>
<tr>
<td>E0461</td>
<td>Volume control ventilator, without pressure support mode, may include pressure control mode, used with non-invasive interface. Example: Puritan Bennett LP Series portable ventilator</td>
<td>$871.49 - $1,025.28</td>
</tr>
<tr>
<td>E0463</td>
<td>Pressure support ventilator with volume control mode, may include pressure control mode, used with invasive interface. Example: Puritan Bennett™ 540 and Achieva portable ventilators</td>
<td>$1,284.04 - $1,510.63</td>
</tr>
<tr>
<td>E0464</td>
<td>Pressure support ventilator with volume control mode, may include pressure control mode, used with non-invasive interface. Example: Puritan Bennett 540 and Achieva portable ventilators</td>
<td>$1,284.04 - $1,510.63</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.

**Medicare allowable amounts vary by geographic location.
WHAT IS THE MEDICARE PART B COVERAGE POLICY FOR VENTILATORS?

According to the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Coverage Issues Manual, Section 60-9, 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.”

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.

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.

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.