Arkansas Department of Human Services
Division of Medical Services
Donaghey Plaza South
P.O. Box 1437
Little Rock, Arkansas 72203-1437
Internet Website: www.medicaid.state.ar.us
Telephone (501) 682-8292 TDD (501) 682-6789 or 1-877-708-8191
FAX (501) 682-1197

TO: **Arkansas Medicaid Health Care Providers – Ventilator Equipment**

DATE: **August 1, 2005**

SUBJECT: **PROPOSED - Provider Manual Update Transmittal #52**

REMOVE		**INSERT**	
Section	**Date**	**Section**	**Date**
201.000	10-13-03	201.000	8-1-05
213.000 – 219.000	10-13-03	213.000 – 218.000	8-1-05
241.000 – 242.100	Dates vary	241.000 – 242.100	8-1-05
242.300 – 242.310	10-13-03	242.300 – 242.310	8-1-05

Explanation of Updates

Section 201.000 has been revised to include information that any person or entity that has been excluded or debarred under any state or federal law, regulation or rule is not eligible to enroll or remain enrolled as a Medicaid provider. Information has also been added to notify providers that of the timeframes involved in reporting renewal documentation for licenses.

Section 213.000 has been included to add information that a pulmonary physician should provide services regarding coverage for ventilator equipment.

Section 214.000 has been revised and titled “Types of Ventilators Covered.” Information previously located in the section has been transferred to the newly created section 214.100.

Section 214.100 has been created. Text previously found in section 214.000 has been transferred to the new section. Information clarifying ventilator equipment and renewals of services has been added. Typographical errors have been corrected in the section.

Section 214.200 has been created. Text and the title “Coverage of Negative Pressure Ventilator Equipment” previously found in section 215.000 have been transferred to the new section.

Section 214.300 has been created to notify providers that effective for dates of service on and after August 1, 2005, the LTV-950 portable ventilator will be covered by Arkansas Medicaid. Criteria and documentation for usage is explained.

Section 216.000 has been revised and titled “Rental of Used Equipment”. Text from section 217.000 has been transferred to the section.

Section 217.000 has been revised and titled “Coverage of Private Duty Nursing Services for Ventilator-Dependent Beneficiaries”. Text previously located in section 218.000 has been transferred to this section.

Section 218.000 has been revised and titled “Coverage of Respiratory Therapy Services”. Text previously located in section 219.000 has been transferred to this section.

“The Department of Human Services is in compliance with Titles VI and VII of the Civil Rights Act.”

Section 219.000 has been deleted.

Sections 241.000 and 242.000 have been included. Obsolete information has been removed from the sections.

Section 242.100 has been revised. Effective for dates of service on and after August 1, 2005, procedure code **E0463**, which is used for the LTV-950 ventilator, is covered by the Arkansas Medicaid Program. The national description for procedure code **E0450** has been added, typographical errors have been corrected and obsolete information has been removed from the section.

Sections 242.300 and 242.310 have been included to correct typographical errors and to remove obsolete information from the sections.

Paper versions of this update transmittal have updated pages attached to file in your provider manual. See Section I for instructions on updating the paper version of the manual. For electronic versions, these changes will be automatically incorporated.

If you need this material in an alternative format, such as large print, please contact our Americans with Disabilities Act Coordinator at (501) 682-6789 or 1-877-708-8191. Both telephone numbers are voice and TDD.

If you have questions regarding this transmittal, please contact the EDS Provider Assistance Center at 1-800-457-4454 (toll free) within Arkansas or locally and out of state at (501) 376-2211.

Arkansas Medicaid provider manuals (including update transmittals), official notices and remittance advice (RA) messages are available for downloading from the Arkansas Medicaid website: www.medicaid.state.ar.us.

Thank you for your participation in the Arkansas Medicaid Program.

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Roy Jeffus, Director

SECTION II – VENTILATOR EQUIPMENT

CONTENTS

201.000 Arkansas Medicaid Participation Requirements for Providers of Ventilator Equipment 8-1-05

Providers of ventilator equipment must meet the following criteria in order to be eligible for participation in the Arkansas Medicaid Program:

A. The provider must have a registered respiratory therapist on staff who is licensed to practice in the State of Arkansas. A current copy of the respiratory therapist's license must accompany the provider application and Medicaid contract. Subsequent licensure must be provided when issued.

B. The provider must complete a provider application (form DMS-652), a Medicaid contract (form DMS-653) and a request for Taxpayer Identification Number and Certification (Form W-9). **View or print a provider application (form DMS-652), a Medicaid contract (form DMS-653) and a Taxpayer Identification Number and Certification (Form W-9).**

C. The Arkansas Medicaid Program must approve the provider application (form DMS-652) and Medicaid contract (form DMS-653) as a condition of participation in the Arkansas Medicaid Program. Persons and entities that are excluded or debarred under any state or federal law, regulation or rule are not eligible to enroll, or to remain enrolled, as Medicaid providers.

D. Renewal documents must be forwarded to Provider Enrollment within thirty days of issuance. If the renewal document(s) have not been received within this timeframe, the provider will have an additional and final thirty days to comply.

E. Failure to timely submit verification of license and certification renewals will result in termination of enrollment in the Arkansas Medicaid Program.

Providers who have agreements with Medicaid to provide other services to Medicaid recipients must have a separate provider application and Medicaid contract to provide ventilator equipment. A separate provider number is assigned.

213.000 Coverage of Ventilator Equipment 8-1-05

Ventilator equipment is covered for an eligible recipient who:

A. Is medically dependent on a ventilator for life support at least 6 hours per day;

B. Has been medically dependent for at least 20 consecutive days as an inpatient. The continuous stay may be in any one or more of the following facilities: hospital, nursing facility or intermediate care facility for the mentally retarded;

C. But for the availability of the respiratory care services (ventilator equipment), would require respiratory care on an inpatient basis for which Medicaid would pay;

D. Has adequate social support services to be cared for at home;

E. Wishes to be cared for at home and

F. Receives services under the direction of a pulmonary physician who is familiar with the technical and medical components of home ventilator support and has medically determined that in-home care is safe and feasible for the individual.

214.000 Types of Ventilator Equipment Covered 8-1-05

214.100 Medical Criteria and Guidelines for Coverage of Positive Pressure Ventilator Equipment 8-1-05

The following medical criteria and guidelines are utilized in evaluation coverage of positive pressure ventilator equipment with invasive interface:

A. Selection of patient

1. Failure of aggressive weaning attempts is determined by a pulmonary physician.
2. Maximal treatment of underlying disease, airway obstruction and/or complications as determined by a pulmonary physician.
3. Stable medical condition with routine medical regimen established, e.g., oral meds, no IVs, stable ABGs.

B. Specific factors to be assessed

1. Medical
   a. Adequate weaning trial
   b. Stable ventilator status
   c. Stable arterial blood gases
   d. All reversible factors addressed, e.g., bronchospasm, increased lung fluids, infection, etc.
   e. Renewals require continued care by physician with the last physical examination occurring within one year by the pulmonologist. Documentation of the pulmonary examination is required within twelve months of the beginning date of renewal.
2. Family resources
   a. Members
   b. Primary care provider

c. Ability of family to provide care

d. Need for skilled nursing care

e. Motivation of patient and/or family

3. Home environment

a. Adequate space

b. Electricity

c. Water

d. Availability of respiratory equipment

e. Building codes and/or limitations

f. Emergency communication system

4. Nursing home environment

a. Nursing facility

b. Adequate personnel available

c. Personnel trained in ventilator use and emergency care for ventilator patient

214.200 Coverage of Negative Pressure Ventilator Equipment 8-1-05

Coverage of negative pressure ventilator equipment is considered on a case-by-case basis. The request must be accompanied by supporting documentation from a qualified pulmonary physician.

NOTE: A negative pressure ventilator should not be billed for a positive pressure ventilator being used to administer respiratory assistance via a nasal and/or oral mask interface.

214.300 Coverage of LTV-950 Portable Ventilator 8-1-05

A. Medical criteria for coverage of LTV-950 portable ventilator

1. The patient must be a newborn that has never been discharged from the hospital since birth.

2. The patient must be ventilator dependent.

3. The patient must weigh only between 3 and 25 kilograms.

4. The patient's discharge from a hospital has been delayed due to respiratory failure requiring use of the LTV-950 ventilator.

B. The request for the LTV-950 ventilator must have been the result of an EPSDT screening. The evaluation by the pulmonary physician must accompany the EPSDT screening.

C. Required documentation

Documentation must be written, signed and dated by the pulmonologist.

A pulmonologist may co-sign a primary care physician (PCP) letter of medical necessity.

A pulmonary evaluation must contain documentation of caregiver training.

Prior authorization for use of the LTV-950 must be submitted to the Utilization Review Section. Form DMS-679, titled Medical Equipment Request for Prior Authorization and Prescription, must be completed. **View or print form DMS-679 and instructions for**

completion. See section 222.000 for complete instructions for completion of a prior authorization request.

215.000 Exclusions 8-1-05

Ventilator equipment will not be authorized for use by a recipient in a boarding home, residential care facility or any other type of institution not defined as the place of residence.

216.000 Rental of Used Equipment 8-1-05

Rental of "used equipment" is covered. If used equipment is provided, the supplier must offer a limited warranty that provides the following:

A. Guarantee that the used equipment is in good working order and has no defects in workmanship or material.

B. If the equipment fails within half the period of time specified by the manufacturer's warranty for new equipment, the supplier will pay for the replacement (including labor costs) of faulty parts or will replace the item of equipment with another.

217.000 Coverage of Private Duty Nursing Services for Ventilator-Dependent Beneficiaries 8-1-05

Private duty nursing services may be covered for Medicaid-eligible ventilator-dependent beneficiaries when determined medically necessary and prescribed by a physician. Prior authorization is required. The request for prior authorization must originate with the provider of private duty nursing services. See the Private Duty Nursing Program Manual for complete information and instructions.

218.000 Coverage of Respiratory Therapy Services 8-1-05

The Arkansas Medicaid Program covers respiratory care services for ventilator-dependent Medicaid beneficiaries under 21 years of age in the Child Health Services (EPSDT) Program. These services require prior authorization. The prior authorization request must specify the frequency of the therapist's visits as prescribed. Refer to section 240.000 of this manual for the procedure codes and billing instructions.

241.000 Introduction to Billing 8-1-05

Ventilator equipment providers use the CMS-1500 form to bill the Arkansas Medicaid Program on paper for services provided to eligible Medicaid beneficiaries. Each claim may contain charges for only one beneficiary.

Section III of this manual contains information about Provider Electronic Solutions (PES) and other available options for electronic claim submission.

242.000 CMS-1500 Billing Procedures 8-1-05

242.100 Ventilator Equipment and Supplies Procedure Codes 8-1-05

Procedure codes must be billed either electronically or on paper with the modifiers indicated. Additionally, when billed on paper, procedure codes must be billed with a type of service (TOS) code "6" for individuals under age 21 or TOS code "9" for individuals of all ages.

Prior authorization requirements are shown under the heading PA.

[1] Code may only be billed for a ventilator patient in his or her home. The code is not covered for a ventilator patient in a nursing facility.

[2] Bill only for TOS 6.

* Prior authorization is not required when another insurance pays at least 50% of the Medicaid maximum allowable reimbursement amount.

⁂(…) This symbol, along with text in parentheses, indicates the Arkansas Medicaid description of the product.

Procedure Code	Modifier(s)	Description	PA	Max. Units	Payment Method
A4483		Nasal prosthesis	No	N/A	Purchase
E0250[1]		Hospital bed, fixed height, with any type side rails, with mattress	Yes*	1 per day (1 day = 1 unit)	Capped Rental
E0255[1]		Hospital bed, variable height, hi-lo, with any type side rails, with mattress	Yes*	1 per day (1 day = 1 unit)	Capped Rental
E0260[1]		Hospital bed, semi-electric (head and foot adjustment), with any type side rails, without mattress	Yes*	1 per day (1 day = 1 unit)	Capped Rental
E0424[1]		Stationary compressed gaseous oxygen system, rental; includes container, contents, regulator flowmeter, humidifier, nebulizer, cannula or mask, and tubing	Yes*	1 per day (1 day = 1 unit)	Rental Only

Procedure Code	Modifier(s)	Description	PA	Max. Units	Payment Method
E0430[1]		Portable gaseous oxygen system, purchase; includes regulator, flowmeter, humidifier, cannula or mask, and tubing	Yes*	1 per day (1 day = 1 unit)	Rental Only
E0435[1]		Portable liquid oxygen system, purchase; includes portable container, supply reservoir, flowmeter, humidifier, contents gauge, cannula or mask, tubing, and refill adapter	Yes*	1 per day (1 day = 1 unit)	Rental Only
E0439[1]		Stationary liquid oxygen system, rental; includes container, contents, regulator, flowmeter, humidifier, nebulizer, cannula or mask, and tubing	Yes*	1 per day (1 day = 1 unit)	Rental Only
E0450		⁂(New equipment) Volume control ventilator without pressure support mode, may include pressure control mode, used with invasive interface, e.g., tracheostomy tube	Yes	1 per day (1 day = 1 unit)	Rental Only
E0450[1]	UB	⁂(Positive pressure ventilator supplies - Includes suction catheter kits, trach kits, trach tubes, sterile water and all respiratory care supplies) Volume control ventilator, may include pressure control mode, used with invasive interface, e.g., tracheostomy tube	Yes	1 per day (1 day = 1 unit)	Purchase
E0450	UE	⁂(Used equipment) Volume control ventilator without pressure support mode, may include pressure control mode, used with invasive interface, e.g., tracheostomy tube	Yes	1 per day (1 day = 1 unit)	Rental Only

Procedure Code	Modifier(s)	Description	PA	Max. Units	Payment Method
E0463		⁂(LTV-950) Pressure support ventilator with volume control mode, may include pressure control mode, used with invasive interface, e.g., tracheostomy tube	Yes	1 per day	Capped Rental
E0500		IPPB machine, all types, with built-in nebulization; manual or automatic valves; internal or external power source	Yes	1 per day	Rental Only
E0570[1]		Nebulizer with compressor	Yes*	1 per day (1 day = 1 unit)	Purchase Only
E0600[1]		Respiratory suction pump, home model, portable or stationary, electric	No	1 per day (1 day = 1 unit)	Rental Only
E0600[1]	U1	Suction pump, home model, portable (used equipment)	Yes	1 per day (1 day = 1 unit)	Rental Only
E1390		Oxygen concentrator, single delivery port, capable of delivering 85 percent or greater oxygen concentration at the prescribed flow rate	Yes*	1 per day	Rental Only
G0237[2] G0238[2]	EP, UA EP, UA	Respiratory therapy services for ventilator-dependent patients	Yes	Frequency of visits as prescribed	N/A

242.300 Billing Instructions – Paper Only 8-1-05

EDS offers providers several options for electronic billing. Therefore, claims submitted on paper are paid once per month. The only claims exempt from this process are those that require attachments or manual pricing.

To bill for ventilator equipment services, use form CMS-1500. **View a CMS-1500 sample form**.

The billing instructions must be read and carefully adhered to so that EDS can efficiently process claims. Accuracy, completeness and clarity are important. Claims cannot be processed if applicable information is not supplied or is illegible. Claims should be typed whenever possible. Follow the instructions below to complete the CMS-1500 claim form.

Completed claim forms should be forwarded to the EDS Claims Department. **View or print EDS Claims Department contact information**.

NOTE: A provider rendering services without verifying eligibility for each date of service does so at the risk of not being reimbursed for the services.

242.310 Completion of CMS-1500 Claim Form 8-1-05

Field Name and Number		Instructions for Completion
1.	Type of Coverage	This field is not required for Medicaid.
1a.	Insured's I.D. Number	Enter the patient's 10-digit Medicaid identification number.
2.	Patient's Name	Enter the patient's last name and first name.
3.	Patient's Birth Date	Enter the patient's date of birth in MM/DD/YY format as it appears on the Medicaid identification card.
	Sex	Check "M" for male or "F" for female.
4.	Insured's Name	Required if there is insurance affecting this claim. Enter the insured's last name, first name and middle initial.
5.	Patient's Address	Optional entry. Enter the patient's full mailing address, including street number and name (post office box or RFD), city name, state name and ZIP code.
6.	Patient Relationship to Insured	Check the appropriate box indicating the patient's relationship to the insured if there is insurance affecting this claim.
7.	Insured's Address	Required if insured's address is different from the patient's address.
8.	Patient Status	This field is not required for Medicaid.
9.	Other Insured's Name	If patient has other insurance coverage as indicated in Field 11D, enter the other insured's last name, first name and middle initial.
	a. Other Insured's Policy or Group Number	Enter the policy or group number of the other insured.
	b. Other Insured's Date of Birth	This field is not required for Medicaid.
	Sex	This field is not required for Medicaid.

	c. Employer's Name or School Name	Enter the employer's name or school name.
	d. Insurance Plan Name or Program Name	Enter the name of the insurance company.
10.	Is Patient's Condition Related to:	
	a. Employment	Check "YES" if the patient's condition was employment related (current or previous). If the condition was not employment related, check "NO."
	b. Auto Accident	Check the appropriate box if the patient's condition was auto accident related. If "YES," enter the place (two-letter state postal abbreviation) where the accident took place. Check "NO" if not auto accident related.
	c. Other Accident	Check "YES" if the patient's condition was other accident related. Check "NO" if not other accident related.
10d.	Reserved for Local Use	This field is not required for Medicaid.
11.	Insured's Policy Group or FECA Number	Enter the insured's policy group or FECA number.
	a. Insured's Date of Birth	This field is not required for Medicaid.
	Sex	This field is not required for Medicaid.
	b. Employer's Name or School Name	Enter the insured's employer's name or school name.
	c. Insurance Plan Name or Program Name	Enter the name of the insurance company.
	d. Is There Another Health Benefit Plan?	Check the appropriate box indicating whether there is another health benefit plan.
12.	Patient's or Authorized Person's Signature	This field is not required for Medicaid.
13.	Insured's or Authorized Person's Signature	This field is not required for Medicaid.
14.	Date of Current: Illness Injury Pregnancy	Required only if medical care being billed is related to an accident. Enter the date of the accident.
15.	If Patient Has Had Same or Similar Illness, Give First Date	This field is not required for Medicaid.
16.	Dates Patient Unable to Work in Current Occupation	This field is not required for Medicaid.
17.	Name of Referring Physician or Other Source	Primary care physician (PCP) referral is not required for ventilator equipment services. If services are the result of a Child Health Services (EPSDT) screening/ referral, enter the referral source, including name and title.
17a.	I.D. Number of Referring Physician	Enter the 9-digit Medicaid provider number of the referring physician.
18.	Hospitalization Dates Related to Current Services	For services related to hospitalization, enter hospital admission and discharge dates in MM/DD/YY format.

19. Reserved for Local Use	Not applicable to the Ventilator Equipment Program.
20. Outside Lab?	This field is not required for Medicaid.
21. Diagnosis or Nature of Illness or Injury	Enter the diagnosis code from the ICD-9-CM. Up to four diagnoses may be listed. Arkansas Medicaid requires providers to comply with CMS diagnosis coding requirements found in the ICD-9-CM edition current for the claim dates of service.
22. Medicaid Resubmission Code	Reserved for future use.
Original Ref No.	Reserved for future use.
23. Prior Authorization Number	Enter the prior authorization number, if applicable.
24. A. Dates of Service	Enter the "from" and "to" dates of service, in MM/DD/YY format, for each billed service. 1. On a single claim detail (one charge on one line), bill only for services within a single calendar month. 2. Providers may bill, on the same claim detail, for two (2) or more *sequential* dates of service within the same calendar month when the provider furnished equal amounts of service on each day of the span.
B. Place of Service	Enter the appropriate place of service code. See section 242.200 for codes.
C. Type of Service	Enter the appropriate type of service code. See section 242.200 for codes.
D. Procedures, Services or Supplies	
CPT/HCPCS	Enter the correct CPT or HCPCS procedure code from section 242.100.
Modifier	Use applicable modifier.
E. Diagnosis Code	Enter a diagnosis code that corresponds to the diagnosis in Field 21. If preferred, simply enter the corresponding line number ("1," "2," "3," "4") from Field 21 on the appropriate line in Field 24E instead of reentering the actual corresponding diagnosis code. Enter only <u>one</u> diagnosis code or one diagnosis code line number on each line of the claim. If two or more diagnosis codes apply to a service, use the code most appropriate to that service. The diagnosis codes are found in the ICD-9-CM.
F. $ Charges	Enter the charge for the service. This charge should be the provider's usual charge to private clients. If more than one unit of service is being billed, enter the charge for the total number of units billed.
G. Days or Units	Enter the units (in whole numbers) of service rendered within the time frame indicated in Field 24A.
H. EPSDT/Family Plan	Enter "E" if services rendered were a result of a Child Health Services (EPSDT) screening/referral.
I. EMG	Emergency - This field is not required for Medicaid.
J. COB	Coordination of Benefit - This field is not required for Medicaid.

	K. Reserved for Local Use	When billing for a clinic or group practice, enter the 9-digit Medicaid provider number of the performing provider in this field and enter the group provider number in Field 33 after "GRP#." When billing for an individual practitioner whose income is reported by 1099 under a Social Security number, DO NOT enter the provider number here. Enter the number in Field 33 after "GRP#."
25.	Federal Tax I.D. Number	This field is not required for Medicaid. This information is carried in the provider's Medicaid file. If it changes, please contact Provider Enrollment.
26.	Patient's Account No.	This is an optional entry that may be used for accounting purposes. Enter the patient's account number, if applicable. Up to 16 numeric or alphabetic characters will be accepted.
27.	Accept Assignment	This field is not required for Medicaid. Assignment is automatically accepted by the provider when billing Medicaid.
28.	Total Charge	Enter the total of Field 24F. This field should contain a sum of charges for all services indicated on the claim form. (See NOTE below Field 30.)
29.	Amount Paid	Enter the total amount of funds received from other sources. The source of payment should be indicated in Field 11 and/or Field 9. Do <u>not</u> enter any amount previously paid by Medicaid. (See NOTE below Field 30.)
30.	Balance Due	Enter the net charge. This amount is obtained by subtracting the amount received from other sources from the total charge. **NOTE: For Fields 28, 29 and 30, up to 26 lines may be billed per claim. To bill a continued claim, enter the page number of the continued claim here (e.g., page 1 of 3, page 2 of 3). On the last page of the claim, enter the total charges due.**
31.	Signature of Physician or Supplier, Including Degrees and Credentials	The provider or designated authorized individual must sign and date the claim certifying that the services were personally rendered by the provider or under the provider's direction. "Provider's signature" is defined as the provider's actual signature, a rubber stamp of the provider's signature, an automated signature, a typewritten signature or the signature of an individual authorized by the provider rendering the service. The name of a clinic or group is not acceptable.
32.	Name and Address of Facility Where Services Were Rendered (If Other Than Home or Office)	If other than home or office, enter the name and address, specifying the street, city, state and ZIP code of the facility where services were performed.
33.	Physician's/Supplier's Billing Name, Address, ZIP Code & Phone #	Enter the billing provider's name and complete address. Telephone number is requested but not required.
	PIN #	This field is not required for Medicaid.

GRP #	Clinic or Group Providers: Enter the 9-digit pay-to provider number in Field 33 after “GRP#” and the individual practitioner’s number in Field 24K. Individual Providers: Enter the 9-digit pay-to provider number in Field 33 after “GRP#.”

21. Ambulatory prenatal care for pregnant women furnished during a presumptive eligibility period by a qualified provider (in accordance with section 1920 of the Act.)

Reimbursement for these services is described in Attachment 4.19-B, e.g. outpatient hospital, physician services, etc.

22. Respiratory care services (in accordance with section 1920(e)(9)(A) through (C) of the Act).

a. See reimbursement methodology for respiratory therapy services for ventilator-dependent recipients under age 21 on Attachment 4.19-B, Page 1j.

b. Ventilator equipment - Reimbursement is based on the lower of the amount billed or the Title XIX maximum charge allowed.

The Title XIX maximum is based on the following:

(1) The positive pressure ventilator and accessories are based on the LP-6 manufacturer=s price (Aequitron Medical - October 1, 1986) for new equipment and 75% of the LP-6 manufacturer=s price (Aequitron Medical - October 1, 1986) for used equipment.

(2) The suction pump is based on Medicare=s rate in effect in August 1987 for new equipment. Used equipment is based on 75% of Medicare=s rate.

(3) The negative pressure ventilator and accessories are based on the manufacturer=s price plus 10% for the maintenance, delivery, set up, emergency call, 24/hr/day, 7 day/week availability.

(4) The oxygen concentrator, liquid oxygen, liquid oxygen walker and reservoir, hospital bed and nebulizer are based on the DME Fiscal Year 1981 Medicare median.

(5) The ventilator supplies are based on the manufacturer=s price.

The reimbursement methodology includes a provision for automatic adjustments based on fluctuations in the economy.

(c) Portable Ventilator Equipment – Reimbursement for a portable ventilator used in the care of small infants (3 to 25 kilos), is reimbursed at the lower of the amount billed or the current Medicare rate.