Priority Health	BILLING POLICY No. 098
MECHANICAL VENTILATION & LENGTH OF STAY	
Date of origin: June 19, 2025	**Review dates: None yet recorded**

APPLIES TO

- Commercial
- Medicare follows CMS unless otherwise specified
- Medicaid follows MDHHS unless otherwise specified

DEFINITION

Mechanical ventilation is using a machine to fully or partially breathe for a patient unable to do so effectively on their own.

The mechanical ventilation code reported by a facility must be consistent with the length of the inpatient stay.

MEDICAL POLICY

- Durable Medical Equipment (#91110)

POLICY SPECIFIC INFORMATION

Codes

Code	Description
5A1935Z	Respiratory ventilation, less than 24 consecutive hours
5A1945Z	Respiratory ventilation, 24-96 consecutive hours
5A1955Z	Respiratory ventilation, greater than 96 consecutive hours
5A09557	Assistance with respiratory ventilation, greater than 96 consecutive hours, continuous positive airway pressure
5A09558	Assistance with respiratory ventilation, greater than 96 consecutive hours, intermittent positive airway pressure
5A09559	Assistance with respiratory ventilation, greater than 96 consecutive hours, continuous negative airway pressure
5A0955A	Assistance with respiratory ventilation, greater than 96 consecutive hours, high flow/velocity cannula
5A0955B	Assistance with respiratory ventilation, greater than 96 consecutive hours, intermittent negative airway pressure

Documentation requirements

Complete and thorough documentation to substantiate the procedure performed is the responsibility of the provider. In addition, the provider should consult any specific documentation requirements that are necessary of any applicable defined guidelines.

Modifiers

Priority Health follows standard billing and coding guidelines which include CMS NCCI. Modifiers should be applied when applicable based on this guidance and only when supported by documentation.

Incorrect application of modifiers will result in denials. The modifier list below may not be an all-inclusive list. Learn more about modifier use in our Provider Manual.

Place of service

Coverage will be considered for services furnished in the appropriate setting to the patient's medical needs and condition. Authorization may be required. Get more information in our Provider Manual.

REFERENCES

- Medicare Claims Processing Manual Chapter 3 - Inpatient Hospital Billing (CMS)
- Pub 100-20 One-Time Notification (CMS)
- OIG Audit Finds Medicare Overpaid Hospitals an Estimated $79 Million for Enrollees Who Had Received Mechanical Ventilation (JDSPURRA)

DISCLAIMER

Priority Health's billing policies outline our guidelines to assist providers in accurate claim submissions and define reimbursement or coding requirements if the service is covered by a Priority Health member's benefit plan. The determination of visits, procedures, DME, supplies and other services or items for coverage under a member's benefit plan or authorization isn't being determined for reimbursement. Authorization requirements and medical necessity requirements appropriate to procedure, diagnosis and frequency are still required. We use Current Procedural Terminology (CPT), Centers for Medicare and Medicaid Services (CMS), Michigan Department of Health and Human Services (MDHHS) and other defined medical coding guidelines for coding accuracy.

An authorization isn't a guarantee of payment when proper billing and coding requirements or adherence to our policies aren't followed. Proper billing and submission guidelines must be followed. We require industry standard, compliant codes defined by CPT, HCPCS and revenue codes for all claim submissions. CPT, HCPCPS, revenue codes, etc., can be reported only when the service has been performed and fully documented in the medical record to the highest level of specificity. Failure to document for services rendered or items supplied will result in a denial. To validate billing and coding accuracy, payment integrity pre- or post-claim reviews may be performed to prevent fraud, waste and abuse. Unless otherwise detailed in the policy, our billing policies apply to both participating and non-participating providers and facilities.

If guidelines detailed in government program regulations, defined in policies and contractual requirements aren't followed, Priority Health may:

- Reject or deny the claim
- Recover or recoup claim payment

An authorization on file for an item or services doesn't supersede coding, billing or reimbursement requirements.

These policies may be superseded by mandates defined in provider contracts or state, federal or CMS contracts or requirements. We make every effort to update our policies in a timely manner to align to these requirements or contracts. If there's a delay in implementation of a policy or requirement defined by state or federal law, as well as contract language, we reserve the right to recoup and/or recover claim payments to the effective dates per our policy. We reserve the right to update policies when necessary. Our most current policy will be made available in our Provider Manual.

CHANGE / REVIEW HISTORY

Date	Revisions made