Inspire Medical Systems

SLEEP SERVICES BILLING GUIDE | 2023

Inspire
Sleep Apnea Innovation

Inspire Medical Systems Sleep Services Billing Guide

This Sleep Services Billing Guide was developed to help providers correctly bill for Inspire Upper Airway Stimulation (UAS) Programming. This Guide provides background information on payer coverage for programming devices as well as proper coding and billing for Medicare and private payers. The contents are intended to augment the physician's current awareness of coding and coverage for implantable devices.

Inspire Medical Systems has made every effort to ensure that the information in this Guide is suitable, accurate, and appropriate to describe and code the services provided in the programming and management of patients undergoing a UAS implant procedure for obstructive sleep apnea. The sample codes displayed should be used to facilitate appropriate coding and should not be construed as recommendations or guidelines in establishing policy, physician services or procedures, physician practice, or standards of care.

For questions regarding reimbursement, please email reimbursement@inspiresleep.com.

Inspire Medical Systems Sleep Services Billing Guide

Device and Programming Description

Device

Inspire Upper Airway Stimulation (UAS) therapy is a neurostimulation system for the treatment of moderate to severe obstructive sleep apnea. The system detects breathing patterns while the patient is sleeping and stimulates the hypoglossal nerve (cranial nerve XII) to move the tongue and soft palate from obstructing the airway.

The system consists of three implantable components:

- Generator – Like all neurostimulators, the generator provides the electrical stimulation pulse.
- Stimulation Lead – The stimulation lead delivers the stimulation pulse to the hypoglossal nerve.
- Breathing Sensor Lead – The breathing sensor lead detects breathing patterns and relays this information to the generator.

Analysis and Programming Procedures

During electronic analysis of the implanted neurostimulator pulse generator/transmitter, settings such as electrode configuration, amplitude, pulse width, rate, start delay, burst, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters are analyzed. Documentation should include diagnostic analysis, including battery state, current program settings, and impedance of electrodes, as well as any event logs from the programming equipment and patient device interrogation, in the patient's medical record.

Programming includes adjusting parameters (eg, current, frequency, pulse width, and train duration, magnet mode, or sensing), as limited by, respiratory, obstructive apneas and/or swallowing problems. The physician or other qualified health care professional conducts multiple stimulation trials, adjusting the parameters until optimal therapeutic stimulation are achieved. Documentation should include diagnostic analysis including battery state, current program settings, and impedance of electrodes, as well as any event logs from the programming equipment and patient device interrogation, in the patient's medical record.

Coverage

FDA Approval

Inspire UAS therapy received PMA approval from the FDA on April 30, 2014. As of April 21, 2020, the FDA has approved an expanded range for Inspire therapy to include 18-21 year old patients.

Medicare Coverage

Medicare and other payers determine whether to cover the procedure or technology as a health benefit based on the published literature as well as business considerations. The first requirement is FDA approval.

> An FDA-regulated product must receive FDA approval or clearance (unless exempt from the FDA premarket review process) for at least one indication to be eligible for consideration of Medicare coverage (except in specific circumstances). However, FDA approval or clearance alone does not entitle that technology to Medicare coverage.
>
> 8.7.2013, Federal Register, Vol. 78, No. 152, page 48165

All Medicare Administrative Contractors (MACs) have developed positive Local Coverage Determinations for Inspire therapy. These policies extend coverage for the procedure or technology for certain diagnoses or in specific scenarios.

It is the responsibility of the provider to be aware of existing Medicare coverage policies before providing the service to Medicare beneficiaries. Please reference your local MAC for exact Medicare coverage criteria in your region.

Traditional Medicare does not require or allow prior authorization or prior approval for procedures. To limit the risk of Medicare non-coverage, physicians should contact their local MAC's Medical Director in advance. It's also important to note the following regarding Medicare coverage and sleep studies:

- Medicare follows the 4% desaturation rule for scoring sleep studies.
- Medicare criteria also requires that patients have a polysomnogram performed within 24 months of the initial Inspire consultation.
- Certain sleep study technologies do not separate mixed apneas from central and obstructive apneas which is important for Inspire procedures. Additionally, some technologies do not provide an accurate calculation of central and mixed apneas relative to total AHI, which is also an important factor in determining Inspire patient eligibility.

Please consult your billing and coding staff to confirm Medicare guidelines have been met.

Note: Medicare Advantage plans are managed by commercial payers but are still required to follow Medicare coverage determinations. Those payers may require prior authorization for Medicare Advantage patients.

Private Payer Coverage

Private payers also require FDA approval. Once approved, coverage is determined according to the framework of each patient's specific plan, rather than on a geographic basis like Medicare.

Unlike traditional Medicare, private payers may require prior authorization for the polysomnogram or programming. Before scheduling a patient's PSG, the specific insurance requirements for sleep studies should be verified and authorized if required.

Reimbursement Denials

Private payers and Medicare can sometimes deny submitted claims. See Appendix A for information on the Medicare appeal process. For private payer denials, physicians can contact Inspire Medical Systems for support. When doing so, it is helpful to provide the payer's denial letter or the Explanation of Benefits outlining the reasons for denial.

Coding

Diagnosis Codes

Inspire Upper Airway Stimulation (UAS) therapy is used to treat a subset of patients with moderate to severe Obstructive Sleep Apnea (OSA) (apnea-hypopnea index [AHI] of greater than or equal to 15 and less than or equal to 65).

Diagnosis coding for routine UAS interrogation and reprogramming may involve the following code:

ICD-10-CM Diagnosis Code	Code Description
Z45.42	Encounter for adjustment and management of neurostimulator
G47.33	Obstructive sleep apnea (adult) (pediatric)

Qualifying Polysomnogram or Home Sleep Test

It is recommended that patients undergo a qualifying polysomnogram (PSG) or home sleep test (HST) if they have not received one within 24 months prior to consultation for Inspire. CPT® coding for the PSG/HST may involve the following codes:

CPT® Procedure Code	Code Description	RVU			Example
		Work	Fac	Non-Fac	
95810	In-lab Polysomnogram	2.50	3.47	18.50	In-lab sleep study
95800	Home sleep test, unattended, Type III (Commercial)	.85	1.19	4.45	Watchpat
95801	Home sleep test, unattended, Type IV (Commercial)	.85	1.19	2.77	ResMed ApneaLink w/ Oximetry
95806	Home sleep test, unattended, Type III (Commercial)	.93	1.29	2.74	ResMed ApneaLink Air and ApneaLink Plus
G0398	Home sleep test, Type II (Medicare and select commercial insurers)	Carrier priced			---
G0399	Home sleep test, Type III (Medicare and select commercial insurers)	Carrier priced			ResMed ApneaLink Air and ApneaLink Plus
G0400	Home sleep test, Type IV (Medicare and select commercial insurers)	Carrier priced			Watchpat, Resmed ApneaLink w/ Oximetry

Activation: Daytime Clinic Visit

Typically 30 days after the Inspire implant, the patient will visit the sleep lab to have the device activated. CPT® coding for the activation may include the following code:

CPT® Procedure Code	Code Description	RVU			Service
		Work	Fac	Non-Fac	
95976	Electronic analysis of implanted neurostimulator pulse generator/transmitter (eg, contact group[s], interleaving, amplitude, pulse width, frequency [Hz], on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with simple cranial nerve neurostimulator pulse generator/transmitter programming by physician or other qualified health care professional	.73	1.15	1.18	Device analysis and simple programming

Simple programming consists of three or fewer parameter adjustments. If four or more parameters were adjusted, use 95977.

It is common for E/M visits to be billed along with activation. In order to bill, E/M criteria must be separate and identifiable from the activation. If billing an E/M visit alongside activation, see modifier-25 to use with the E/M CPT® code.

Post-Activation Check-in

It is common for the physician to reach out to the patient ~10 days post-activation to confirm that the device is working correctly. Please consult with your billing and coding staff as to what codes best fit the work performed. CPT® coding for the post-activation check-in call may include the following codes:

CPT® Procedure Code	Code Description	RVU			Service
		Work	Fac	Non-Fac	
99441-99443[2]	Phone call **check-in** between provider and patient[1]	.70-1.92	1.03-2.86	1.66-3.77	Audio-only E/M
G2012[3]	**Brief check-in** via telephone or other device to determine if office visit is needed, 5-10 min of medical discussion [1]	.25	.37	.42	Virtual Check-in
G2252[3]	**Brief check-in** via telephone or other device to determine if office visit is needed[1], 11-20 min of medical discussion	.50	.75	.79	Virtual Check-in
99421-99423	Provider-patient communication utilizing **online portal**[1]	.25-.80	.38-1.19	.44-1.39	E-Visit

1. Expected to be initiated by patient, but practitioner can educate patient on availability of these services prior to patient initiation
2. Append modifier-95 for audio only E/M services. This is subject to change post-PHE.
3. Cannot be related to E/M within previous 7 days.
Payment rate may change after the PHE has ended.

Polysomnogram (performed during programming)

The UAS device requires programming during an in-lab sleep study. CPT® coding for the PSG may include the following code:

CPT® Procedure Code	Code Description	RVU			Service
		Work	Fac	Non-Fac	
95810	Polysomnography; age 6 years or older, sleep staging with 4 or more additional parameters of sleep, attended by a technologist	2.50	3.47	18.15	Polysomnogram performed during programming

Analysis and Programming

The UAS device may also require interrogation and programming.

CPT® Procedure Code	Code Description	Service
95970	Electronic analysis of implanted neurostimulator pulse generator/ transmitter (eg, contact group(s), interleaving, amplitude, pulse width, frequency (Hz), on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with brain, cranial nerve, spinal cord, peripheral nerve, or sacral nerve neurostimulator pulse generator/ transmitter, without programming	Device interrogation *only*, without programming, subsequent visits only (not at the time of generator implantation)
95976	Electronic analysis of implanted neurostimulator pulse generator/ transmitter (eg, contact group(s), interleaving, amplitude, pulse width, frequency (Hz), on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with simple cranial nerve neurostimulator pulse generator/transmitter programming by physician or other qualified health care professional	Device interrogation and *simple* programming
95977	Electronic analysis of implanted neurostimulator pulse generator/ transmitter (eg, contact group(s), interleaving, amplitude, pulse width, frequency (Hz), on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with complex cranial nerve neurostimulator pulse generator/transmitter programming by physician or other qualified health care professional	Device interrogation and *complex* programming

Code 95970 is not assigned for device interrogation when performed at the time of generator implantation. CPT manual instructions state that code 95970 describes only "subsequent" electronic analysis of "a previously implanted" generator.

Code 95976 is defined for simple programming and code 95977 is defined for complex programming. Simple programming refers to changing three or fewer parameters. Complex programming refers to changing four or more parameters.

Whenever programming is performed, it is essential that physicians individually name and document the specific parameters changed for coding purposes.

Long Term Care Management

Analysis and Programming

If medically necessary, a patient may need to have the device analyzed or programmed at a time following the fine-tune sleep study. The work to perform this may involve the following CPT® codes:

CPT Procedure Code	Code Description	RVU		
		Work	Fac	Non-Fac
95970	Device Analysis *only*, without programming, subsequent visits *only* (not at time of generator implantation)	.35	.55	.56
95976	Device analysis and *simple programming*	.73	1.15	1.10
95977	Device analysis and *complex programming*	.97	1.54	1.56

Sleep Studies

If medically necessary, the sleep physician may order sleep tests every 6-12 months to confirm the device is working correctly. CPT® coding for the HSTs may include the following codes:

CPT® Procedure Code	Code Description	RVU			Example
		Work	Fac	Non-Fac	
95810	In-lab Polysomnography	2.50	3.47	18.15	In-lab sleep study
95800	Home sleep test, unattended, Type III (Commercial)	.85	1.19	4.45	Watchpat
95801	Home sleep test, unattended, Type IV (Commercial)	.85	1.19	2.77	ResMed ApneaLink w/ Oximetry
95806	Home sleep test, unattended, Type III (Commercial)	.93	1.29	2.74	ResMed ApneaLink Air and ApneaLink Plus
G0398	Home sleep test, Type II (Medicare and select commercial insurers)	Carrier priced			---
G0399	Home sleep test, Type III (Medicare and select commercial insurers)	Carrier priced			ResMed ApneaLink Air and ApneaLink Plus
G0400	Home sleep test, Type IV (Medicare and select commercial insurers)	Carrier priced			Watchpat, Resmed ApneaLink w/ Oximetry

Billing Requirements

Physician Billing

Medicare has specific instructions for submitting physician claims. Prior authorization is a good time to check for the payer's billing requirements specific to polysomnograms and programming.

Physician Billing on the CMS-1500

Claim Form Item	Values	Notes
Item 21A	Diagnosis (primary)	Display the primary ICD-10-CM diagnosis codes (see page 6).
Item 21 B-L	Diagnosis (other)	Display ICD-10-CM diagnosis codes for the patient's secondary diagnoses.
Item 23	Prior Authorization Number	Display the payer's prior authorization number if required and obtained
Item 24D	Procedures, Services, or Supplies	Display the CPT code for each procedure or service rendered, with one CPT code in each line.
Item 24E	Diagnosis Pointer	Relate the services in 24 D to the diagnosis codes in 21 A-L

An example of physician billing for UAS programming can be found on page 10.

Fine Tune Sleep Study CMS-1500 2023 Billing Example

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare#)	MEDICAID (Medicaid#)	TRICARE (ID#/DoD#)	CHAMPVA (Member ID#)	GROUP HEALTH PLAN (ID#)	FECA BLK LUNG (ID#)	OTHER (ID#)	1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE MM DD YY / SEX M F	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
Patient Jane		Patient Jane
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
1776 American Way	Self [X] Spouse [ ] Child [ ] Other [ ]	1776 American Way
CITY: Hometown / STATE: HS	8. RESERVED FOR NUCC USE	CITY: Hometown / STATE: HS
ZIP CODE: 12345 / TELEPHONE (Include Area Code): ( )		ZIP CODE: 12345 / TELEPHONE (Include Area Code): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) YES NO	a. INSURED'S DATE OF BIRTH MM DD YY / SEX M F
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? YES NO PLACE (State)	b. OTHER CLAIM ID (Designated by NUCC)
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? YES NO	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.	15. OTHER DATE QUAL. MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. / 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? YES NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.		22. RESUBMISSION CODE / ORIGINAL REF. NO.
A. Z45.42 B. G47.33 C. D. E. F. G. H. I. J. K. L.		23. PRIOR AUTHORIZATION NUMBER ABC987654321

	24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	01 01 23	22		95810		A	xxxx xx			NPI	
2	01 01 23	22		95977		A	xxxx xx			NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO	28. TOTAL CHARGE $	29. AMOUNT PAID $	30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH # ( )
SIGNED DATE	a. NPI b.	a. NPI b.

NUCC Instruction Manual available at: www.nucc.org **PLEASE PRINT OR TYPE** APPROVED OMB-0938-1197 FORM 1500 (02-12)

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Please ensure the Prior Authorization number is included on every claim submitted to commercial insurance providers where prior authorization is required.

Disclaimers

Inspire Medical Systems has authorized the completion of this Guide for the benefit of physicians implanting Inspire UAS therapy. Readers of this Guide are advised that the contents of this publication are to be used as guidelines and are not to be construed as policies of Inspire Medical Systems.

Inspire Medical Systems specifically disclaims liability or responsibility for the results or consequences of any actions taken in reliance on the statements, opinions, or suggestions in this Guide.

Inspire Medical Systems makes no representations or warranties with respect to the contents of the Guide and disclaims any implied guarantee or warranty of fitness for any particular purpose. Inspire Medical Systems will not be liable to any individual or entity for any losses or damages that may be occasioned by the use of this Guide.

Appendix A: Medicare Appeal Process

Medicare Claims are typically processed within 30 days of submission.

- If denied – The physician must file a request for redetermination within 120 days from the date of receipt of the Remittance Advice.
- Please email reimbursement@inspiresleep.com for assistance with a denied claim or appeal template.
- Medicare requires a signature on each appeal--please sign the appeal letter and the redetermination form and send to the address provided with:
  - Copy of the EOB
  - Copy of the Polysomnogram
  - Copy of the programming notes

MACs generally issue a decision within 60 days of receipt of the request for redetermination.

- If denied – The physician must file a request for reconsideration within 180 days of receipt of the decision.
- Generally, a QIC sends a decision to all parties within 60 days of receipt of the request for reconsideration

For questions regarding reimbursement, please email reimbursement@inspiresleep.com.