2025

Sleep Services Billing Guide

Inspire Medical Systems

Inspire®

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Inspire Medical Systems, Inc. (Inspire) developed this material to provide general information about payer coverage and coding for Inspire Upper Airway Stimulation (UAS). It is intended for illustrative purposes only, and is not intended to be construed as legal, clinical or reimbursement advice, or a guarantee of reimbursement coverage or payment.

Inspire makes no express or implied warranty or guarantee that the coding or other information in this material is current, complete, or error-free. As always, providers are ultimately responsible for coding and understanding and complying with existing Medicare coverage policies and any other coverage requirements established by third party payers, including, without limitation, any provider specialty requirements. Providers should verify policies with payers, and consult with their reimbursement specialists, financial advisors or legal counsel for questions and issues regarding coding, coverage, and all other reimbursement matters.

For questions regarding reimbursement of Inspire UAS, please email reimbursement@inspiresleep.com.

Important Safety Information

Inspire is not for everyone. It is a surgically implanted system that is intended to treat obstructive sleep apnea in patients who are not effectively treated by, or able to tolerate CPAP. Talk to your patients about risks, benefits and expectations associated with Inspire. Risks associated with the surgical implant procedure may include infection and temporary tongue weakness. In rare cases tongue paresis and atrophy may occur. Some patients may require post implant adjustments to the system's settings in order to improve effectiveness and ease any initial discomfort they may experience. Important safety information and product manuals can be found at inspiresleep.com/safety-information/ or call 1-844-OSA-HELP.

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Device and Programming Description

Device

Inspire Hypoglossal Nerve Stimulation (HGNS) therapy is a neurostimulation system for the treatment of moderate to severe obstructive sleep apnea (OSA). 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.

Analysis and Programming Procedures

During electronic analysis and programming of the implanted neurostimulator, settings are analyzed and adjusted. Whenever programming is performed, it is essential that physicians individually name and document the specific parameters changed for coding purposes. Common settings may include:

Stimulation Settings

- Amplitude
- Patient Control Lower Limit
- Patient Control Upper Limit
- Start Delay
- Pause Time
- Therapy Duration
- Pulse Width
- Rate
- Electrode Configuration

Sensing Settings

- Exhalation Sensitivity
- Exhalation Threshold
- Invert
- Inhalation Sensitivity
- Inhalation Threshold
- Hard Off Period
- Soft Off Period
- Max Stim Time

Coverage

FDA Approval

Inspire HGNS 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. On June 8, 2023, the FDA expanded the Apnea-Hypopnea Index (AHI) range to greater than or equal to 15 and less than or equal to 100. The warning label for BMI also increased from 32 to 40.

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. 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 Hypoglossal Nerve Stimulation (HGNS) 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 100).

Diagnosis coding for routine HGNS 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)

CPT® Codes

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® Code	Code Description	RVU			Example
		Work	Fac	Non-Fac	
95810	In-lab Polysomnogram	2.50	3.47	18.81	In-lab sleep study
95800	Home sleep test, unattended, Type III (Commercial)	.85	1.15	3.85	Watchpat
95801	Home sleep test, unattended, Type IV (Commercial)	.85	1.20	2.92	ResMed ApneaLink w/ Oximetry
95806	Home sleep test, unattended, Type III (Commercial)	.93	1.29	2.88	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 one of the following codes:

CPT® 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	1.11	1.13
95977	Device analysis and complex programming	.97	1.49	1.51

Simple programming consists of three or fewer parameter adjustments. Complex programming consists of four or more parameter adjustments.

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

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.

Polysomnogram (performed during programming)

The HGNS device may require programming during an in-lab sleep study. Please refer above for programming CPT® codes.

CPT® coding for the PSG may include the following code:

CPT® 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*	18.81	Polysomnogram performed during programming

*Modifier 26: RVU's for Professional Component of PSG only

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. Please see page 6 for applicable CPT® codes.

Sleep Studies:

If medically necessary, the sleep physician may order sleep tests every 6-12 months to confirm the device is *working correctly. Please see page 6 for applicable CPT® codes.*

Office Visits:

Routine office visits may be performed to ensure patients are appropriately responding to therapy. In 2024 there was a new code established by CMS[1] that accounts for additional work associated with treating complex conditions.

G2211- *Visit complexity inherent to evaluation and management associated with medical care services that serve as the continuing focal point for all needed health care services and/or with medical care services that are part of ongoing care related to a patient's single, serious condition or a complex condition.* (add-on code, list separately in addition to office/outpatient evaluation and management visit, new or established). **Do not bill G2211 when the E/M service is reported with a modifier 25**. Please check with commercial carriers for reimbursement.

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

1. G2211 CMS Final Rule article link: https://www.cms.gov/newsroom/fact-sheets/calendar-year-cy-2024-medicare-physician-fee-schedule-final-rule