Inspire Medical Systems

HOSPITAL/ASC BILLING GUIDE | 2024

Inspire

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Inspire Medical Systems Hospital Billing Guide

This Hospital Billing Guide was developed to help centers correctly bill for Inspire Hypoglossal Nerve Stimulation (HGNS) therapy. This Guide provides background information on payer coverage for implantable devices as well as proper coding and billing for Medicare and private payers. The contents are intended to augment the hospital'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 care and management of patients undergoing a HGNS implant procedure for obstructive sleep apnea (OSA). 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 Hospital Billing Guide

Device and Procedure Description

Device

Inspire Hypoglossal Nerve Stimulation (HGNS) 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.

Upper Airway Examination Coding

Drug-induced sleep endoscopy (DISE) is a commonly required diagnostic procedure for evaluating palatal collapse for Hypoglossal Nerve Stimulation. During the procedure, artificial sleep is induced by midazolam and/or propofol, and the pharyngeal collapse patterns are visualized using a flexible fiberoptic nasopharyngoscope. The level (palate, oropharynx, tongue base, hypopharynx/epiglottis), the direction (anteroposterior, concentric, lateral), and the degree of collapse (none, partial, or complete) are examined.

Implant Procedure

The generator is placed in a subcutaneous pocket created via blunt dissection, typically in the upper chest. Following surgical exposure, the stimulation lead is placed in the upper neck with the cuff wrapped around the hypoglossal nerve. It is tunneled subcutaneously to the upper chest and connected to the generator. The breathing sensor lead is placed into the plane between the external and internal intercostal muscles and connected to the generator. The system is programmed and periodically interrogated and re-programmed to meet the patient's needs.

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 Determination policies for Inspire. These policies extend coverage for the procedure or technology for certain diagnoses or specific scenarios.

It is the responsibility of the provider to be aware of existing Medicare coverage policies before providing 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, hospitals should contact their local MAC's Medical Director in advance. Hospitals may also contact Inspire Medical Systems for support in this process.

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.

Also, unlike traditional Medicare, private payers often require prior authorization for an elective procedure such as HGNS implantation. Before scheduling a patient's HGNS procedure, the hospital can contact Inspire Medical Systems' Prior Authorization support team for assistance with prior authorizations. Proceeding without a required prior authorization may result in a denial and non-payment. Prior authorization is also a good time to check for the payer's billing requirements specific to implantable devices.

Reimbursement Denials

Private payers sometimes deny prior authorizations or submitted claims. Medicare may also deny a submitted claim. Hospitals may wish to appeal these denials. See Appendix A for information on the Medicare appeal process. For private payer denials, hospitals 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.

Upper Airway Examination Coding

Diagnosis Codes

Diagnosis coding for endoscopic evaluation of the upper airway may involve the following code:

ICD-10-CM Diagnosis Code	Code Description
G47.33	Obstructive sleep apnea (adult) (pediatric)

Procedure Codes

Pre-operative anatomical assessment of the upper airway is required for all Inspire patients. The procedure most often performed is a drug-induced sleep endoscopy (DISE), which is an evaluation of the upper airway after pharmacologic induction of unconscious sedation. The following code may be used for a drug-induced sleep endoscopic examination.

CPT®[1] Procedure Code	Code Description
42975	Drug-induced sleep endoscopy, with dynamic evaluation of velum, pharynx, tongue base, and larynx for evaluation of sleep disordered breathing, flexible, diagnostic

(Do not report 42975 in conjunction with 31231, unless performed for a separate condition [ie, other than sleep-disordered breathing] and using a separate endoscope)

(Do not report 42975 in conjunction with 31575, 92511)

APC Codes

As mentioned above, for hospital outpatient payments, Medicare assigns each CPT® code to a specific APC. Each APC has a fixed payment amount which includes the cost of any devices. The Upper Airway Examination Coding procedures map to the following APCs:

CPT® Procedure Code	APC	Code Description	SI
42975	5153	Level 3 Airway Endoscopy	J1

2024 APCs as published in CMS 1786-FC Addendum B. Nov 2023

Implant 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 HGNS implantation may involve the following code:

ICD-10-CM Diagnosis Code	Code Description
G47.33	Obstructive sleep apnea (adult) (pediatric)

For Medicare there is a dual diagnosis requirement. Coverage for hypoglossal nerve stimulation procedures on patients who meet coverage criteria must include both a primary ICD-10-CM diagnosis code indicating the reason for the procedure and a secondary ICD-10-CM diagnosis code indicating the Body Mass Index (BMI) is less than 35 kg/m^2. as set forth in the LCD Covered Indications. The Local Medicare Administrative Contractors' (MACs) billing articles for HGNS require reporting a primary diagnosis code of OSA and a secondary diagnosis code from Group below, for coverage:

ICD-10-CM Diagnosis Code	Code Description
Z68.1	Body mass index [BMI] 19.9 or less, adult
Z68.20	Body mass index [BMI] 20.0-20.9, adult
Z68.21	Body mass index [BMI] 21.0-21.9, adult
Z68.22	Body mass index [BMI] 22.0-22.9, adult
Z68.23	Body mass index [BMI] 23.0-23.9, adult
Z68.24	Body mass index [BMI] 24.0-24.9, adult
Z68.25	Body mass index [BMI] 25.0-25.9, adult
Z68.26	Body mass index [BMI] 26.0-26.9, adult
Z68.27	Body mass index [BMI] 27.0-27.9, adult
Z68.28	Body mass index [BMI] 28.0-28.9, adult
Z68.29	Body mass index [BMI] 29.0-29.9, adult
Z68.30	Body mass index [BMI] 30.0-30.9, adult
Z68.31	Body mass index [BMI] 31.0-31.9, adult
Z68.32	Body mass index [BMI] 32.0-32.9, adult
Z68.33	Body mass index [BMI] 33.0-33.9, adult
Z68.34	Body mass index [BMI] 34.0-34.9, adult

Hospital Outpatient Codes – Implant Procedure

CPT® Procedure Codes

Hospitals report outpatient procedures using CPT codes. Procedures involving HGNS may involve the following code:

CPT® Procedure Code	Code Description	Components
64582	Open implantation of hypoglossal nerve neurostimulator array, pulse generator, and distal respiratory sensor electrode or electrode array	Generator, Stimulation Lead and Breathing Sensor Lead

APC

For hospital outpatient payments, Medicare assigns each CPT® code to a specific Ambulatory Payment Classification (APC). Each APC has a fixed payment amount which includes the cost of any devices. The HGNS implantation procedure may involve the following APCs:

CPT® Code	APC Code	APC Description	SI
64582	5465	Level 5 Neurostimulator and Related Procedures	J1

2024 APCs as published in CMS 1786-FC Addendum B. Nov 2023.

HCPCS II Device Codes

CPT® codes are assigned for the HGNS implant procedure. HCPCS II codes are assigned to identify the device itself.

Outpatient

Coding for the HGNS device may involve the HCPCS II codes listed below. Some payers may contract on C-codes while others may contract on L-codes.

ASC

For Medicare cases performed in an ASC setting, it is not recommended to include separate line items for HCPCS Level II codes. Instead, payment is bundled under the primary procedure code. Commercial insurances may still require C or L codes be included on claims.

HCPCS II Code	Code Description
C1767	Generator, neurostimulator (implantable), non-rechargeable
C1778	Lead, neurostimulator (implantable)
C1787	Patient programmer, neurostimulator
L8688	Implantable neurostimulator pulse generator, dual array, non-rechargeable, includes extension
L8680	Implantable neurostimulator electrode, each

In an outpatient facility, Medicare uses code C1778 for both the stimulation lead and the breathing sensor lead. Some payers may use L8680 for both. Prior authorization is a good time to check for private payer's device-coding requirements.

Revision, Removal, and Replacement Procedure Coding

CPT® Procedure Codes

In addition to implantation, the HGNS device may require revision, removal, or replacement at some time during its life cycle. Hospital outpatient procedures may involve the following codes:

CPT® Procedure Code	Code Description	Components
61886	Insertion or replacement of cranial neurostimulator pulse generator or receiver, direct or inductive coupling; with connection to 2 or more electrode arrays	Generator
61888	Revision or removal of cranial neurostimulator pulse generator or receiver	Generator
64583*	Revision or replacement of hypoglossal nerve neurostimulator array and distal respiratory sensor electrode or electrode array, including connection to an existing generator	Stimulation Lead and Breathing Sensor Lead
64584**	Removal of hypoglossal nerve neurostimulator array, pulse generator, and distal respiratory sensor electrode or electrode array	Generator, Stimulation Lead, and Breathing Sensor Lead

*If only one lead is being revised or replaced, it is recommended to append modifier 74 to 64583

**If only a portion of the device is being removed (ie: stimulation lead, breathing sensor lead, or generator), it is recommended to append modifier 74 to 64584

APC Codes

As mentioned above, for hospital outpatient payments, Medicare assigns each CPT® code to a specific APC. Each APC has a fixed payment amount which includes the cost of any devices. The HGNS revision, removal, or replacement procedures map to the following APCs:

CPT® Code	APC Code	APC Description	SI
61886	5465	Level 5 Neurostimulator and Related Procedures	J1
61888	5463	Level 2 Neurostimulator and Related Procedures	J1
64583	5463	Level 2 Neurostimulator and Related Procedures	J1
64584	5432	Level 2 Nerve Procedures	Q2

2024 APCs as published in CMS 1786-FC Addendum B. Nov 2023.

The Status Indicator (SI) of J1 shows primary codes for which all other procedures performed at the same encounter are considered adjunctive and not paid separately. Status Indicator Q2 means that these codes are packaged and not paid separately when reported with another code with Status Indicator T.

Analysis and Programming Coding

The HGNS device may also require periodic Analysis and Programming.

Analysis and Programming Diagnosis Coding

Diagnosis coding for routine HGNS Analysis and Programming 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)

Polysomnogram Procedure Coding

The HGNS device may require programming during an in-lab sleep study. The appropriate polysomnogram (PSG) code to be used in conjunction with device programming is:

CPT Procedure Code	Code Description	Service
95810	Polysomnography; age 6 years or older, sleep staging with 4 or more additional parameters of sleep, attended by a technologist	Polysomnogram performed during programming

CPT Procedure Code	Code Description	Service
95970	Electronic analysis of implanted neurostimulator pulse generator/ transmitter (e.g., 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 Analysis *only, without* programming (not at the time of generator implantation)
95976	Electronic analysis of implanted neurostimulator pulse generator/ transmitter (e.g., 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 Analysis and *simple* programming (not at the time of generator implantation)
95977	Electronic analysis of implanted neurostimulator pulse generator/ transmitter (e.g., 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 Analysis and *complex* programming (not at the time of generator implantation)

Code 95970 is not assigned for device analysis 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 of the parameters listed. Complex programming refers to changing four or more parameters.

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

APC Codes

The HGNS Analysis and Programming codes map to the following APCs:

CPT® Code	APC Code	APC Description	SI
95810	5724	Level 4 Diagnostic Tests and Related Services	S
95970	5734	Level 4 Minor Procedures	Q1
95976	5741	Level 1 Electronic Analysis of Devices	S
95977	5742	Level 2 Electronic Analysis of Devices	S

2024 APCs as published in CMS 1786-FC Addendum B. Nov 2023.

Status Indicator S means that the code is always paid at 100% of the rate even when submitted with other higher-ranked codes. Status Indicator Q1 means the code is packaged when billed on the same date of service with any other code with a status indicator of S, T, V, or X.

Billing Requirements

Hospital Outpatient Billing – Implant Procedure

Medicare has specific instructions for submitting hospital outpatient claims related to implantable devices. Hospitals are strongly encouraged to separately bill devices using a device category C-code or other appropriate HCPCS code for implantable devices, along with the charge for the device. Complete and accurate reporting of the codes and charges for implanted devices is critical to ensure the relative weights for the services are accurate. This will ensure proper payments to hospitals for the procedures that use implanted devices.

Pub. 100-04 Medicare Claims Processing Centers for Medicare & Medicaid Services (CMS) Transmittal 132 Date: March 30, 2004

This means for Medicare claims, device charges on the UB-04 listed under Column 47 - Total Charges that are on the same line as a C-Code and an acceptable revenue code are billed correctly, accurately capturing the charges for use in future payment rate calculations.

The most appropriate revenue code for HGNS is 0278, Medical/Surgical Supplies: Other Implants. This revenue code was developed to separate high-cost implants from low-cost supplies, which improves charge consistency when creating revenue-code-specific cost-to-charge ratios. Charges for the procedure to implant the device are shown in revenue code 0360, Operating Room Services. An example of an outpatient UB-04 using this billing method for HGNS can be found on page 11.

Alternately, device charges listed in Column 47 on the same line of the UB-04 as CPT code 64582, using revenue code 0360, Operating Room Services, are also acceptable and support future payment-rate calculations. A review of EOBs shows various private payers accepting each of these approaches. It is recommended that hospitals request any specific device-billing requirements when working with Inspire Medical Systems to obtain prior authorization from a private payer.

Billing that does *not* support appropriate cost capture and will lead to undervalued future payments include:

- Incorrectly listing the device on the UB-04 as a non-covered charge (Column 48)
- Using an undesignated revenue code
- Failing to markup the device in keeping with the hospital's applicable cost-to-charge ratio

The latter may occur with revenue code 0360, which can include service charges and a mix of low-cost and high-cost supplies.

ASC Billing – Implant Procedure

For commercial claims requiring the addition of HCPCS level II codes, the most appropriate revenue code for HGNS is 0278, Medical/Surgical Supplies: Other Implants. Charges for the procedure to implant the device are shown in revenue code 0490, Ambulatory Surgical Care. An example of an ASC claim using this billing method for HGNS can be found on page 12.

2024 Outpatient Facility - UB-04 Medicare Billing Example

1	2	3a PAT. CNTL #		4 TYPE OF BILL
		b. MED. REC. #		111
		5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM: 01012024 THROUGH: 01012024	7

8 PATIENT NAME	a Jane Patient	9 PATIENT ADDRESS	a
b		b	c d e

10 BIRTHDATE	11 SEX	ADMISSION 12 DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	CONDITION CODES 18 19 20 21 22 23 24 25 26 27 28	29 ACDT STATE	30
		01012024								

31 OCCURRENCE CODE / DATE	32 OCCURRENCE CODE / DATE	33 OCCURRENCE CODE / DATE	34 OCCURRENCE CODE / DATE	35 OCCURRENCE SPAN CODE / FROM / THROUGH	36 OCCURRENCE SPAN CODE / FROM / THROUGH	37

38

Jane Patient
1776 American Way
Hometown HS 12345

	39 VALUE CODES CODE / AMOUNT	40 VALUE CODES CODE / AMOUNT	41 VALUE CODES CODE / AMOUNT
a			
b			
c			
d			

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49	
1	0120	R&B - SEMI PRIVATE			#	$XXXXX XX			1
2	0130	EKG			#	$XXXXX XX			2
3	0250	PHARMACY			#	$XXXXX XX			3
4	0258	IV SOLUTIONS			#	$XXXXX XX			4
5	0270	MED. SURG SUPPLIES			#	$XXXXX XX			5
6	0270	OTHER SUPPLIES AND DEVICES	C1787	01012024	1	$XXXXX XX			6
7	0278	OTHER DEVICE/IMPLANT	C1767	01012024	1	$XXXXX XX			7
8	0278	OTHER DEVICE/IMPLANT	C1778	01012024	2	$XXXXX XX			8
9	0300	LABORATORY			#	$XXXXX XX			9
10	0360	OPERATING ROOM	64582	01012024	1	$XXXXX XX			10
11	0370	ANESTHIA			#	$XXXXX XX			11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22	0001	TOTAL			#	$XXXXX XX			22
23		PAGE ____ OF ____	CREATION DATE		TOTALS				23

	50 PAYER NAME	51 HEALTH PLAN ID	52 REL. INFO	53 ASG. BEN.	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56 NPI		
A							57		A
B							OTHER		B
C							PRV ID		C

	58 INSURED'S NAME	59 P. REL	60 INSURED'S UNIQUE ID	61 GROUP NAME	62 INSURANCE GROUP NO.	
A						A
B						B
C						C

	63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME	
A	ABC987654321			A
B				B
C				C

66 DX									68
	G47.33	Z68.XX*							

69 ADMIT DX	70 PATIENT REASON DX	71 PPS CODE	72 ECI	73

74 PRINCIPAL PROCEDURE CODE	DATE	a. OTHER PROCEDURE CODE	DATE	b. OTHER PROCEDURE CODE	DATE	75
00HE0MZ	01/01/2024	0JH60BZ	01/01/2024	OKHXOYZ	01/01/2024	
c. OTHER PROCEDURE CODE	DATE	d. OTHER PROCEDURE CODE	DATE	e. OTHER PROCEDURE CODE	DATE	

	NPI	QUAL	
76 ATTENDING			
LAST		FIRST	
77 OPERATING			
LAST		FIRST	
78 OTHER			
LAST		FIRST	
79 OTHER			
LAST		FIRST	

80 REMARKS	81CC	
	a	
	b	
	c	
	d	

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

2024 ASC CMS-1500 Medicare 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): Patient Jane

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial): Patient Jane

5. PATIENT'S ADDRESS (No., Street): 1776 American Way

6. PATIENT RELATIONSHIP TO INSURED: Self ✓ Spouse Child Other

7. INSURED'S ADDRESS (No., Street): 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 MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

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.

A. G47.33 B. Z68.XX* C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

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	24			24		64582		AB	xxxx	xx		NPI	
2														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.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

CARR

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

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

**BMI Diagnosis code is required on Medicare claims*

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

Disclaimers

Inspire Medical Systems has authorized the completion of this Guide for the benefit of hospitals and ASCs implanting Inspire HGNS 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.

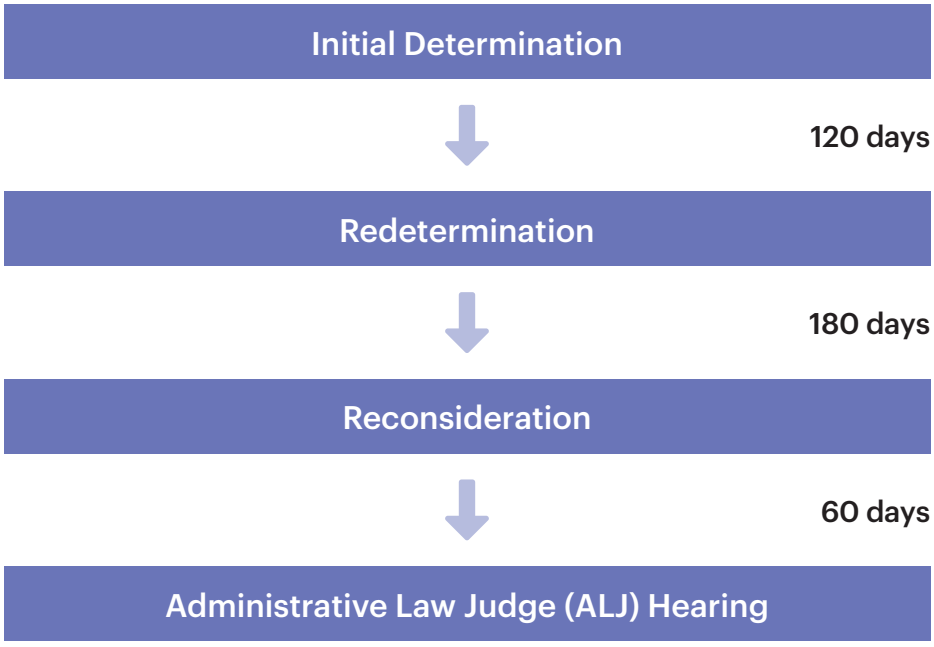
Inspire Medical Systems makes no representations or warranties with respect to the contents of the Guide and disclaims any implied guarantee or warranty of fitness for any particular purpose. Inspire Medical Systems will not be liable to any individual or entity for any losses or damages that may be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

Appendix A: Medicare Appeal Process

Medicare Claims are typically processed within 30 days of submission.

- 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 denial
  - Patient pre-op notes: polysomnography (PSG), drug induced sleep endoscopy (DISE) and surgical consult
  - Copy of completed patient selection checklist
  - Op-notes
  - Your local MAC coverage policy (reach out to reimbursement@inspiresleep.com for a copy)

Please see an overview of the Medicare appeals process below.



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