Inspire Medical Systems

Hospital Billing Guide 2020

Inspire
Sleep Apnea Innovation

Inspire Medical Systems Hospital Billing Guide

This Hospital Billing Guide was developed to help centers correctly bill for Inspire Upper Airway Stimulation (UAS) 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 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 call the Inspire Reimbursement Hotline at 1-833-897-0939 or email questions to reimbursement@inspiresleep.com.

Inspire Medical Systems Hospital Billing Guide

Device and Procedure 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.

Upper Airway Examination Coding

DISE (Drug Induced Sleep Endoscopy) is a required diagnostic procedure for evaluating palatial 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. Occasionally, a physician may choose to examine the upper airway while the patient is awake using local anesthesia.

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 via incision into the plane between the external and internal intercostal muscles in the lower chest. It is tunneled subcutaneously and connected 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.

Programming includes adjusting parameters (e.g., current, frequency, pulse width, train duration, magnet mode, or sensing), based on respiratory obstructive apneas and/or swallowing difficulties. The physician or other qualified health care professional conducts multiple stimulation trials, adjusting the parameters until optimal therapeutic stimulation are achieved.

Coverage

FDA Approval

Inspire UAS therapy received PMA approval from the FDA on April 30, 2014.

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

Although not required, Medicare may develop national or local coverage policies specific to the procedure or technology. These policies may extend coverage for the procedure or technology for certain diagnoses or specific scenarios, or they may identify the procedure or technology as generally non-covered. At this time, there is no Medicare national coverage policy on UAS, however some Medicare Administrative Contractors (MACs) have released policies and guidelines for UAS on the local or regional level.

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. 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 UAS implantation. Before scheduling a patient's UAS procedure, the hospital can contact Inspire Medical Systems' Prior Authorization program to determine the availability of coverage. Proceeding without a required prior authorization typically results 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 sometime deny prior authorizations or a submitted claim. 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)

This code includes obstructive sleep apnea hypopnea.

Procedure Codes

Pre-operative anatomical assessment of the upper airway is required for all Inspire patients. The procedure most performed is a Drug Induced Sleep Endoscopy (DISE), which is an evaluation of the upper airway after pharmacologic induction of unconscious sedation. Occasionally a physician may choose to examine the upper airway while the patient is awake using local anesthesia. The following codes can be used for either asleep or awake endoscopic examinations.

CPT®[1] Procedure Code	Code Description	Service
92511	Nasopharyngoscopy with endoscope (separate procedure)	Asleep or awake, nasal approach
92502	Otolaryngologic examination under general anesthesia*	Asleep only
31575	Laryngoscopy, flexible fiberoptic; diagnostic	Asleep or awake, nasal or oral approach

* Cannot be reported with 31575 (Correct Coding Initiative (CCI) edits) If CPT® 31575 is billed with 92511, most extensive procedure edit applies.

[1] CPT Copyright 2017 American Medical Association. All rights reserved. CPT® is a registered trademark of the American Medical Association. Applicable FARS/DFARS Restrictions Apply to Government Use. Fee schedules, relative value units, conversion factors and/or related components are not assigned by the AMA, are not part of CPT, and the AMA is not recommending their use. The AMA does not directly or indirectly practice medicine or dispense medical services. The AMA assumes no liability for data contained or not contained herein.

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
92511	5151	Level 1 Airway Endoscopy	T
92502	5162	Level 2 ENT Procedures	T
31575	5151	Level 1 Airway Endoscopy	T

APC is assigned ‘Status T’, meaning the procedure is paid at a reduced rate when performed with other procedures during the same visit. The “T” procedure with the highest relative weight will not be discounted. The remaining “T” procedure(s) will be subject to a multiple procedure discount (50%).

Implant 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 UAS implantation may involve the following code:

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

This code includes obstructive sleep apnea hypopnea.

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/m2. as set forth in the LCD Covered Indications. Report a primary diagnosis code of OSA and a secondary diagnosis code from Group below:

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 UAS may involve the following codes:

CPT® Procedure Code	Code Description	Component
64568	Incision for implantation of cranial nerve (eg, vagus nerve) neurostimulator electrode array and pulse generator	Generator and stimulation lead
+ 0466T	Insertion of chest wall respiratory sensor electrode or electrode array, including connection to a pulse generator (List separately in addition to code for primary procedure) (Use 0466T in conjunction with 64568)	Breathing sensor lead

Note that a regular Category I CPT® code is assigned for the placement of the generator and the stimulation lead. Because UAS stimulates the hypoglossal nerve, the system qualifies as a cranial nerve neurostimulator. The breathing sensor lead is a distinct component and is represented by Category III CPT® code +0466T. As indicated by the + symbol, this is an add-on code and cannot be assigned by itself. Code +0466T for the breathing sensor lead must always be assigned together with code 64568 for the generator and stimulation 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 UAS implantation procedure may involve the following APCs:

CPT® Code	APC Code	APC Description	SI
64568	5464	Level 4 Neurostimulator and Related Procedures	J1
+0466T	—	—	N

The Status Indicator (SI) of J1 denotes a complexity-adjusted procedure with which other procedures with a Status Indicator J1 may be complexity adjusted. Refer to CMS CY2020 OPPS 1717-FR Addendum J for complexity adjustments. Procedures with Status Indicator N are packaged into the payment for other procedures reported on the same hospital outpatient claim. Therefore, the payment for primary code 64568 is calculated to include the adjunctive procedure (i.e. 0466T) as well as the cost of all devices, drugs and ancillary services for which separate payment is not made.

Although some code combinations are eligible for an APC "complexity adjustment" that increases payment to the next level, the combination of 64568 and +0466T does not qualify for an APC complexity adjustment.

HCPCS II Device Codes

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

Coding for the UAS device may involve the following HCPCS II codes. In general, C-codes are used for billing Medicare and L-codes are used for billing private payers, although some private payers may also accept C-codes.

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
L8681	Patient programmer (external) for use with implantable programmable neurostimulator pulse generator, replacement only

On an outpatient basis, 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.

Hospital Inpatient Codes – Implant Procedure

ICD-10-PCS Procedure Codes

ICD-10-PCS codes are used by hospitals to report inpatient procedures. Each major component of the procedure is coded separately. Procedures involving the UAS implant procedure may involve the following codes:

ICD-10-PCS Procedure Code	Code Description	Component
0JH60DZ	Insertion of multiple array stimulator generator into chest subcutaneous tissue and fascia, open approach	Generator
00HE0MZ	Insertion of neurostimulator lead into cranial nerve, open approach	Stimulation lead
0KHX0YZ	Insertion of other device into upper muscle, open approach	Breathing sensor lead

See Appendix B for the code tables from which these specific codes were constructed.

The sixth character of an ICD-10-PCS code is the device value. A device value for the stimulation lead is available in code table 0KH but is not appropriate for the breathing sensor lead. In ICD-10-PCS, a sensing lead for a phrenic neurostimulator is assigned to the device value for a monitoring device and, by inference, the UAS breathing sensor lead should also use the value for a monitoring device. However, because the value for a monitoring device is not available in code table 0KH, the default value Y - Other Device is assigned. See Appendix B for code table 0KH which displays this.

MS-DRG Codes

Medicare uses MS-DRG codes to reimburse hospitals for inpatient admissions. Each inpatient stay is assigned to a specific diagnosis-related group (DRG) based on the ICD-10-CM diagnosis codes and ICD-10-PCS procedure codes. Only one MS-DRG is assigned for each inpatient stay, regardless of the number of procedures performed. When more than one procedure is coded, DRG assignment is based on the highest-ranked code. Each MS-DRG has a fixed payment amount which includes the cost of any devices.

The UAS implant procedure for obstructive sleep apnea may involve the following DRGs:

DRG Code	DRG Description
040	Peripheral/Cranial Nerve and Other Nervous System Procedures W/MCC
041	Peripheral/Cranial Nerve and Other Nervous System Procedures W/CC or Peripheral Neurostimulator
042	Peripheral/Cranial Nerve and Other Nervous System Procedures WO/CC/MCC

The distinction between DRG 040, 041 and 042 is the presence or absence of secondary diagnosis codes designated by Medicare as MCCs or CCs. MCC refers to secondary diagnosis codes designated as major complications or comorbidities. CC refers to secondary diagnosis codes designated as other (non-major) complications or comorbidities. A DRG defined as W CC/MCC means that at least one of the secondary diagnosis codes is a CC or an MCC. If none of the secondary diagnosis codes is a CC or MCC, then the DRG WO CC/MCC is assigned.

Revision, Removal, and Replacement Procedure Coding

CPT® Procedure Codes

In addition to implantation, the UAS 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	Component
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
64569	Revision or replacement of cranial nerve (e.g., vagus nerve) neurostimulator electrode array, including connection to existing pulse generator	Stimulation lead
64570	Removal of cranial nerve neurostimulator electrode array and pulse generator	Generator and Stimulation lead
64585	Revision or removal of peripheral neurostimulator electrode array	Stimulation lead
0467T	Revision or replacement of chest wall respiratory sensor electrode or electrode array, including connection to existing pulse generator	Breathing sensor lead
0468T	Removal of chest wall respiratory sensor electrode or electrode array	Breathing sensor lead

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 UAS revision, removal, or replacement procedures map to the following APCs:

CPT® Code	APC Code	APC Description	SI
61886	5464	Level 4 Neurostimulator and Related Procedures	J1
61888	5462	Level 2 Neurostimulator and Related Procedures	J1
64569	5462	Level 2 Neurostimulator and Related Procedures	J1
64570	5432	Level 2 Nerve Procedures	Q
64585	5461	Level 1 Neurostimulator and Related Procedures	J1
0467T	5461	Level 1 Neurostimulator and Related Procedures	J1
0468T	5461	Level 1 Neurostimulator and Related Procedures	J1

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. Four of the codes have dual Status Indicators. Status Indicator Q2 means that these codes are packaged and not paid separately when reported with another code with Status Indicator T. In other scenarios, these codes take on the second Status Indicator and may be separately payable. Status Indicator T means that the code is subject to 50% reduction in payment in certain circumstances when submitted with another higher-ranked code.

Analysis and Programming Coding

The UAS device may also require periodic Analysis and Programming.

Analysis and Programming Diagnosis Coding

Diagnosis coding for routine UAS Analysis and Programming may involve the following code:

ICD-10-CM Diagnosis Code	Code Description
G47.33	Obstructive sleep apnea (adult), (pediatric)
Z45.42	Encounter for adjustment and management of neuropacemaker (brain) (peripheral nerve) (spinal cord)

Polysomnogram Procedure Coding

The UAS device requires programming during an in-lab sleep study. The appropriate polysomnogram 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.

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

APC Codes

The UAS 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

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 UAS 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 UAS can be found on page 14.

Alternately, device charges listed in Column 47 on the same line of the UB-04 as CPT code 64568, 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 includes:

- 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.

Hospital Inpatient Billing – Implant Procedure

Medicare instructions for submitting hospital-inpatient claims related to implantable devices utilize the same revenue codes reported above, as well as Column 47 for device charges. C-codes for the devices are not used for inpatient billing. Further, a CPT® code for the procedure is not posted to revenue code 0360. Instead, ICD-10-PCS codes are posted to FL 74 at the bottom of the UB-04. An example of an inpatient UB-04 using this billing method for UAS can be found on page 15.

Note: The revenue codes shown on the examples are just that: examples. In general, providers should report their charges under the revenue code that will result in the charges being assigned to the same cost center to which the cost of those services are assigned in the cost report.

2020 APCs as published in CMS 1717-FR Addendum A . Nov 2019.

Hospital Outpatient UB-04 Billing Example

1	2	3a PAT. CNTL. #	
		b. MED. REC. #	131
		5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM 01012020 THROUGH 01012020

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

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18	19	20	21	CONDITION CODES 22	23	24	25	26	27	28	29 ACDT STATE	30
		01012020																		

31 OCCURRENCE CODE	DATE	33 OCCURRENCE CODE	DATE	35 OCCURRENCE SPAN CODE	FROM	THROUGH	36 OCCURRENCE SPAN CODE	FROM	THROUGH	37

38	39 VALUE CODES CODE	AMOUNT		41 VALUE CODES CODE	AMOUNT
Jane Patient 1776 American Way Hometown HS 12345	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
0130	EKG			#	$XXXXX XX		
0250	PHARMACY			#	$XXXXX XX		
0258	IV SOLUTIONS			#	$XXXXX XX		
0270	MED.SURG SUPPLIES			#	$XXXXX XX		
0270	**OTHER SUPPLIES AND DEVICES**	**C1787**	**01012020**	**1**	**$XXXXX XX**		
0278	**OTHER DEVICE/IMPLANT**	**C1767**	**01012020**	**1**	**$XXXXX XX**		
0278	**OTHER DEVICE/IMPLANT**	**C1778**	**01012020**	**1**	**$XXXXX XX**		
0300	LABORATORY			#	$XXXXX XX		
0360	**OPERATING ROOM**	**64568**	**01012020**	**1**	**$XXXXX XX**		
0360	**OPERATING ROOM**	**0466T**	**01012020**	**1**	**$XXXXX XX**		
0370	ANESTHESIA			#	$XXXXX XX		
0710	RECOVERY ROOM			#	$XXXXX XX		
0001	TOTAL			#	$XXXXX XX		
	PAGE ____ OF ____	***CREATION DATE***		**TOTALS**			

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

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

63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME
ABC987654321*		

66 DX																					68
	G47.33	**Z68.XX***																			

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

74 PRINCIPAL PROCEDURE CODE	DATE	b. OTHER PROCEDURE CODE	DATE	75	76 ATTENDING	NPI	QUAL	
					LAST		FIRST	
d. OTHER PROCEDURE CODE	DATE				77 OPERATING	NPI	QUAL	
					LAST		FIRST	

80 REMARKS	81CC a			78 OTHER	NPI	QUAL	
	b			LAST		FIRST	
	c			79 OTHER	NPI	QUAL	
	d			LAST		FIRST	

UB-04 CMS-1450 APPROVED OMB NO. THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

**** BMI Diagnosis code is required on Medicare claims***

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

Hospital Inpatient UB-04 Billing Example

1	2	3a PAT. CNTL #		
		b. MED. REC. #		111
		5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM	THROUGH 7
			01012020	01012020

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

10 BIRTHDATE	11 SEX	12 ADMISSION DATE	13 HR	14 TYPE	15 SRC	16 DHR	17 STAT	18	19	20	21	CONDITION CODES 22	23	24	25	26	27	28	29 ACDT STATE	30
		01012020																		

31 OCCURRENCE CODE	DATE	33 OCCURRENCE CODE	DATE	35 OCCURRENCE SPAN CODE	FROM	THROUGH	36 OCCURRENCE SPAN CODE	FROM	THROUGH	37

38	39 VALUE CODES CODE	AMOUNT		41 VALUE CODES CODE	AMOUNT
Jane Patient 1776 American Way Hometown HS 12345	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
0120	R&B - SEMI PRIVATE			#	$XXXXX XX		
0130	EKG			#	$XXXXX XX		
0250	PHARMACY			#	$XXXXX XX		
0258	IV SOLUTIONS			#	$XXXXX XX		
0270	MED. SURG SUPPLIES			#	$XXXXX XX		
0270	**OTHER SUPPLIES AND DEVICES**			**#**	**$XXXXX XX**		
0278	**OTHER DEVICE/IMPLANT**			**#**	**$XXXXX XX**		
0300	LABORATORY			#	$XXXXX XX		
0360	**OPERATING ROOM**			**#**	**$XXXXX XX**		
0370	ANESTHESIA			#	$XXXXX XX		
0710	RECOVERY ROOM			#	$XXXXX XX		
0001	TOTAL			#	$XXXXX XX		
	PAGE ____ OF ____	***CREATION DATE***		**TOTALS**			

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

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

63 TREATMENT AUTHORIZATION CODES	64 DOCUMENT CONTROL NUMBER	65 EMPLOYER NAME
ABC987654321*		

66 DX																				68
	G47.33	Z68.XX*																		
	I	J	K	L	M	N	O	P	Q											

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

74 PRINCIPAL PROCEDURE CODE	DATE	b. OTHER PROCEDURE CODE	DATE	75	76 ATTENDING	NPI	QUAL	
00HE0MZ	01012020	0JH60BZ	01012020		LAST		FIRST	
d. OTHER PROCEDURE CODE	DATE	0KHX0YZ	01012020		77 OPERATING	NPI	QUAL	
					LAST		FIRST	

80 REMARKS	81CC			78 OTHER	NPI	QUAL	
	a			LAST		FIRST	
	b			79 OTHER	NPI	QUAL	
	c			LAST		FIRST	
	d						

UB-04 CMS-1450 APPROVED OMB NO. THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

**** BMI Diagnosis code is required on Medicare claims***

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

Disclaimers

Inspire Medical Systems has authorized the completion of this Guide for the benefit of hospitals 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.

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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.
- To receive a Physician Appeals Packet and/or with any questions you may have, please contact the Inspire Reimbursement Hotline at 833-897-0939 or reimbursement@inspiresleep.com.
- A templated Redetermination appeal is included in the packet for claims. Please contact the Inspire Reimbursement Hotline at 833-897-0939 or reimbursement@inspiresleep.com for a copy.
- 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
  - Clinical articles and coding information included in the packet

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.
- Again, a templated reconsideration appeal is included in the packet for claims.
- Medicare requires a signature on each appeal – please sign the appeal letter and reconsideration form and send to the address provided with:
  - Copy of the denial
  - Patient pre-op notes (PSG, DISE and surgical consult)
  - Copy of completed patient selection checklist
  - Op-notes

- Clinical articles and coding information included in the packet
- Generally, a QIC sends a decision to all parties within 60 days of receipt of the request for reconsideration

For questions regarding reimbursement, please call the Inspire Reimbursement Hotline at 1-833-897-0939 or email questions to reimbursement@inspiresleep.com.

Appendix B: ICD-10-PCS Code Tables

ICD-10-PCS Procedure Code	Code Description	Component
0JH60DZ	Insertion of multiple array stimulator generator into chest subcutaneous tissue and fascia, open approach	Generator
00HE0MZ	Insertion of neurostimulator lead into cranial nerve, open approach	Stimulation lead
0KHX0YZ	Insertion of other device into upper muscle, open approach	Breathing sensor lead

Code Table 0JH* - *for generator implantation*

Section	0	Medical and Surgical
Body System	J	Subcutaneous Tissue and Fascia
Operation	H	Insertion: Putting in a nonbiological appliance that monitors, assists, performs, or prevents a physiological function but does not physically take the place of a body part

Body Part	*Approach*	*Device*	*Qualifier*
6 Subcutaneous Tissue and Fascia, Chest 8 Subcutaneous Tissue and Fascia, Abdomen	0 Open 3 Percutaneous	0 Monitoring Device, Hemodynamic 2 Monitoring Device 4 Pacemaker, Single Chamber 5 Pacemaker, Single Chamber Rate Responsive 6 Pacemaker, Dual Chamber 7 Cardiac Resynchronization Pacemaker Pulse Generator 8 Defibrillator Generator 9 Cardiac Resynchronization Defibrillator Pulse Generator A Contractility Modulation Device B Stimulator Generator, Single Array C Stimulator Generator, Single Array Rechargeable D Stimulator Generator, Multiple Array E Stimulator Generator, Multiple Array Rechargeable H Contraceptive Device M Stimulator Generator N Tissue Expander P Cardiac Rhythm Related Device V Infusion Device, Pump W Vascular Access Device, Totally Implantable X Vascular Access Device, Tunneled	Z No Qualifier

*Code table excerpt

Table 00H - *for stimulation lead implantation*

Section	**0**	Medical and Surgical
Body System	**0**	Central Nervous System and Cranial Nerves
Operation	**H**	Insertion: Putting in a nonbiological appliance that monitors, assists, performs, or prevents a physiological function but does not physically take the place of a body part

Body Part	*Approach*	*Device*	*Qualifier*
0 Brain	**0** Open	**2** Monitoring Device **3** Infusion Device **4** Radioactive Element, Cesium-131 Collagen Implant **M** Neurostimulator Lead **Y** Other Device	**Z** No Qualifier
0 Brain	**3** Percutaneous **4** Percutaneous Endoscopic	**2** Monitoring Device **3** Infusion Device **M** Neurostimulator Lead **Y** Other Device	**Z** No Qualifier
6 Cerebral Ventricle **E** Cranial Nerve **U** Spinal Canal **V** Spinal Cord	**0** Open **3** Percutaneous **4** Percutaneous Endoscopic	**2** Monitoring Device **3** Infusion Device **M** Neurostimulator Lead **Y** Other Device	**Z** No Qualifier

Code Table 0KH - *for breathing sensor lead implantation*

Section	**0**	Medical and Surgical
Body System	**K**	Muscles
Operation	**H**	Insertion: Putting in a nonbiological appliance that monitors, assists, performs, or prevents a physiological function but does not physically take the place of a body part

Body Part	*Approach*	*Device*	*Qualifier*
X Upper Muscle **Y** Lower Muscle	**0** Open **3** Percutaneous **4** Percutaneous Endoscopic	**M** Stimulator Lead **Y** Other Device	**Z** No Qualifier