BiWaze® Clear System Reimbursement Education

Carmen Anderson
Reimbursement & Market Access

abm® RESPIRATORY CARE

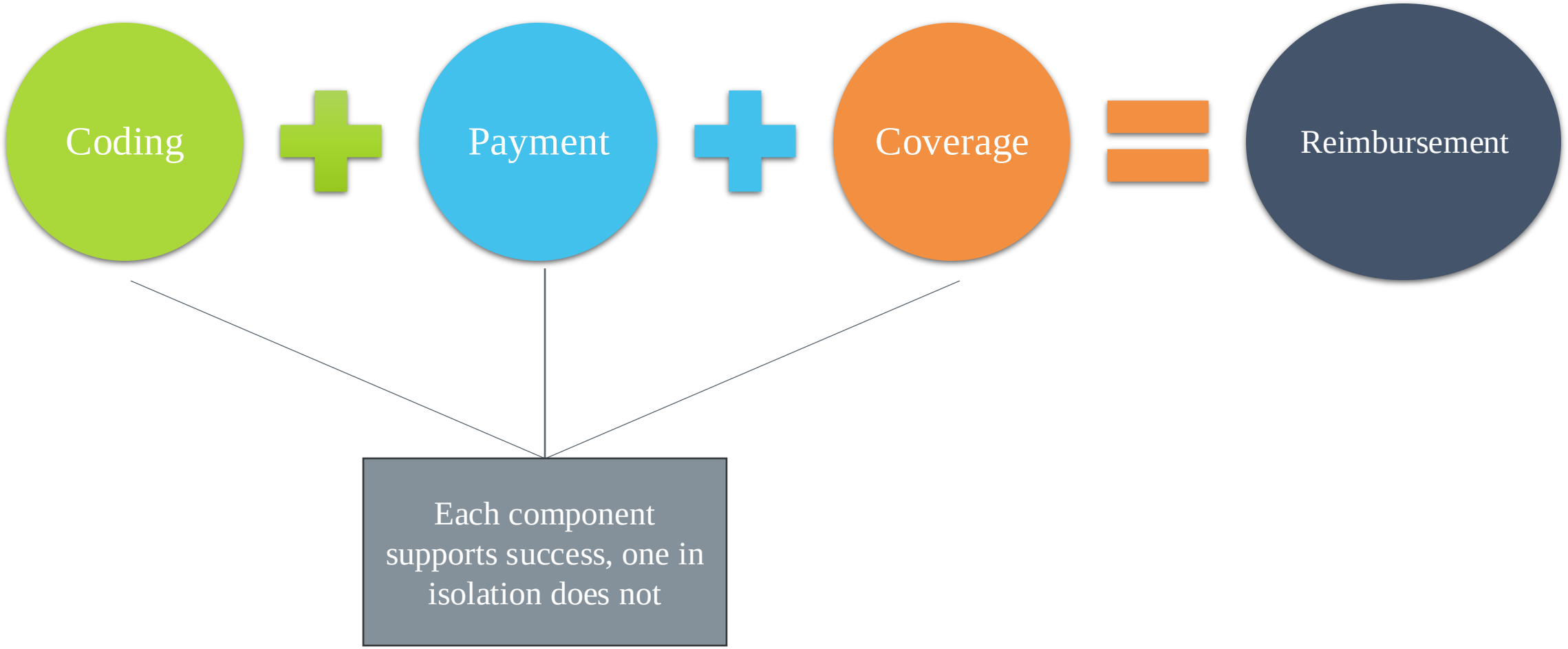
Disclaimer

The information provided in this presentation is intended solely for general educational purposes and does not constitute professional advice. For specific medical, legal, or financial matters related to market access, reimbursement, or regulatory compliance, please consult a qualified professional. Do not disregard or delay seeking professional advice based on the information presented here. The presenter and hosting company assumes no responsibility for actions taken based on the content of this educational presentation.

Agenda

- Reimbursement Overview
- HCPCS Public Meeting Recap
- Preparing to Submit Claims
- Next Steps
- Questions

Insurance Pathway



HCPCS Codes

Healthcare Common Procedure Coding System

Level II Codes are applied for during bi-annual cycles

- January (B1) application = May public meeting
- July (B2) application = November public meeting

B1 2024 Preliminary Determination & Meeting

- Analysis and comparison of existing codes (E0482, E0483, E0570, A7030)
- Physical, mechanical, and electrical components
- Function and intended use, additional aspects and features

Final Determination

- Establish new HCPCS Codes E0469 “Lung expansion airway clearance, continuous high frequency oscillation, and nebulization device” & A7021 “Supplies and accessories for lung expansion airway clearance, continuous high frequency oscillation, and nebulization device (e.g., handset, nebulizer kit, biofilter)” go into effect **10/1/2024**

Payment

HCPCS Code	CMS Recommendation
E0469	The Medicare payment amount used a fee schedule for comparable items in accordance with regulations at 42 CFR 414.238. The final payment determination for HCPCS Level II code E0469 is calculated using the following formula: E0469= E0483 + ((E0482/2) *10/60) + (E0570*10/60). The 2024 average non-rural capped rental fee schedule amount for HCPCS Level II code E0469 will be approximately **$1,505.16 for months 1 through 3 and approximately $1,128.90 for months 4 through 13**.
A7021	The final payment determination for HCPCS Level II code A7021 is calculated using the following formula: A7021 = A7030 + A7003 + A7004 + A7037 + A7039. The average 2024 non-rural purchase fee schedule amount for new code A7021 will be approximately **$137.34**.

Coverage

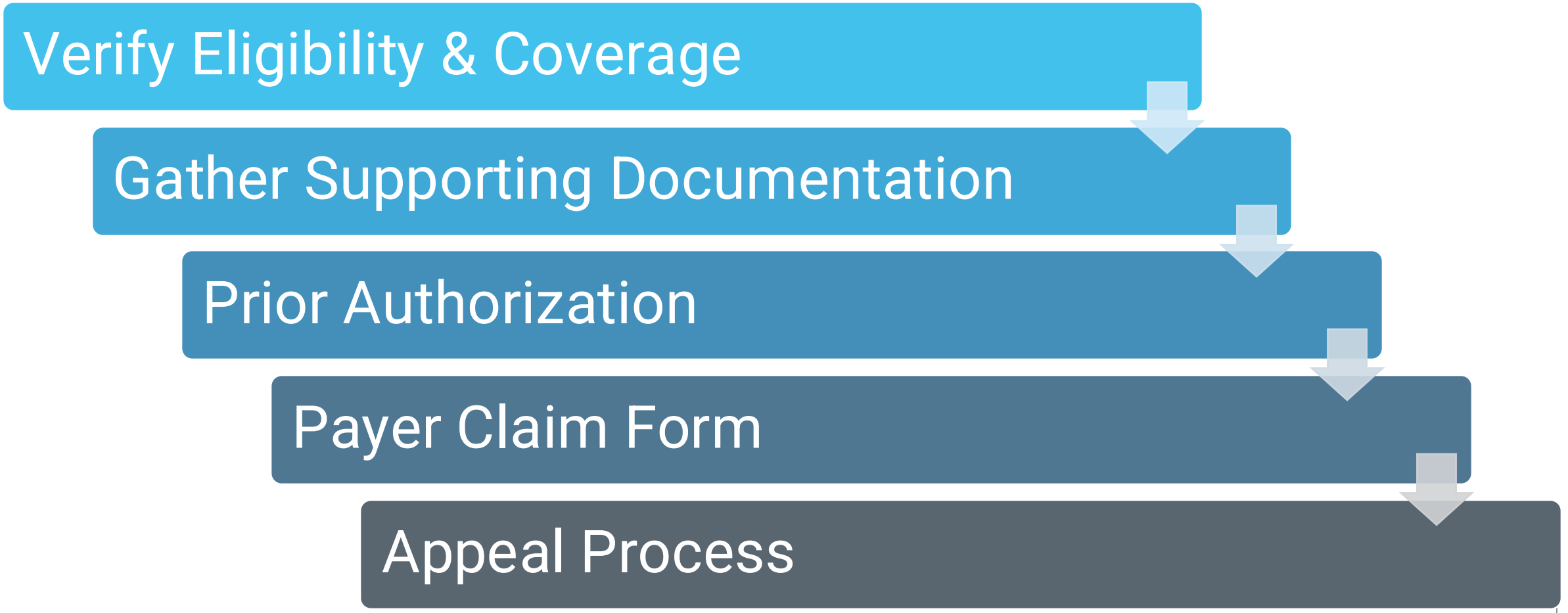
To Be Determined

- Medicare coverage is limited to items and services that are reasonable and necessary for the diagnosis or treatment of an illness or injury

- Pathways for determining what is “reasonable and necessary” :
  - National Coverage Determination (NCD)
  - Local Coverage Determination (LCD)
  - Claim Determination in the Absence of a Medical Policy

Preparing to Submit Claims

Process Overview



Documentation Requirements

Physician Prescription

- Medicare Standard Written Order Requirements

Clinical Documentation

- Patient History
- Prior Treatment & Outcomes
- Clinical Assessment

Proof of Delivery

- Delivery directly to the beneficiary or authorized representative
- Delivery via shipping or delivery service
- Delivery of items to a nursing facility on behalf of the beneficiary

Standard Written Order (SWO)

- Beneficiary's name or Medicare Beneficiary Identifier (MBI)
- Order Date
- General description of the item
    - The description can be either a general description (e.g., wheelchair or hospital bed), a HCPCS code, a HCPCS code narrative, or a brand name/model number
    - For equipment - In addition to the description of the base item, the SWO may include all concurrently ordered options, accessories or additional features that are separately billed or require an upgraded code (List each separately).
    - For supplies - In addition to the description of the base item, the DMEPOS order/prescription may include all concurrently ordered supplies that are separately billed (List each separately)
- Quantity to be dispensed, if applicable
- Treating Practitioner Name or National Provider Identifier (NPI)
- Treating practitioner's signature

Scan the QR code to see full details

Clinical Documentation

Patient History

- Relevant ICD-10 codes

Prior Treatment & Outcomes

- Previous attempts with other standard therapies (e.g., MIE, PEP, chest physiotherapy) and if/why they failed to mobilize retained secretions

Clinical Assessment

- Objective evidence of pulmonary dysfunction such spirometry results or a documented history of excessive mucus production or poor airway clearance. Include rationale for why high-frequency oscillation and nebulization are required for effective treatment and why the patient is unable to use less intensive therapies effectively.

Scan the QR code to see a detailed list of ICD-10 codes

Proof of Delivery (POD)

The Date of Service (DOS) shall be the Date of Delivery.

42 CFR 424.57(c)(12) requires suppliers to maintain POD documentation, as well as claims documentation, in their files for 7 years (starting from the DOS).

Method 1	Delivery directly to the beneficiary or authorized representative
Method 2	Delivery via shipping or delivery service
Method 3	Delivery of items to a nursing facility on behalf of the beneficiary

Scan the QR code to see full details

How to Avoid 3 Common Pitfalls

Insufficient Documentation

- Gather and review all necessary medical documentation and justifications for the device prior to submission of the claim.
- Supplier prepared statements and physician attestations (i.e., LMNs) by themselves do not provide sufficient documentation of medical necessity, even if signed by the ordering physician.
- Medical information intended to demonstrate compliance with coverage criteria may be included on a prescription but must be corroborated by information contained in the medical record.

Incorrect Coding

- Double-check that you are using the correct ICD-10, and modifiers to prevent claim denials.

Failure to Obtain Prior Authorization

- For private payers, obtain prior-authorization when required or pre-determination when available to avoid denials.

Denials & Appeals

- If denied, review the appeal process and timeline for the specific health plan, each one is different.
- Be prepared to provide supporting documentation such as medical records and the ABMRC Clinical Value Dossier.

Questions?

PRTN-1585539264-980 Rev. 1.0 FEB-2025 ENG

For further information about this product or a service, visit our webpage: www.abmrc.com or call customer service: 1-877-ABM-RC01 (877-226-7201)