

Flowrest® Reimbursement Fact Sheet

Healthcare Common Procedure Coding System (HCPCS) for Flowrest®

Since the Flowrest® is a new device and does not fit into any existing **Healthcare Common Procedure Coding System (HCPCS)** code, Vapotherm will submit an application to CMS. CMS HCPCS Workgroup will make a decision to either create a new code or a revise an existing code. **Before an application is submitted however, the product has to have been on the market for at least 3 months.**

HCPCS and Claims Filings

The HCPCS Level II Code Set is one of the standard code sets used to identify and bill for products and supplies such as durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS). Within CMS there is a CMS HCPCS Workgroup which is an internal workgroup comprised of representatives of the major components of CMS, as well as other consultants from pertinent Federal agencies. National permanent HCPCS level II codes are maintained within this work group.

When submitting claims, suppliers are required to use a HCPCS code to identify the items they are billing. The descriptor that is assigned to a code represents the definition of the items and services that can be billed using that code.

In the case of Flowrest®, since there is not an existing code, code E1399 - miscellaneous/not otherwise classified – should be used.

Miscellaneous Codes

Miscellaneous codes are used when a supplier is submitting a bill for an item or service and there is no existing national code that adequately describes the item or service being billed. **The importance of miscellaneous codes is that they allow suppliers to begin billing immediately for a service or item as soon as it is allowed to be marketed by the Food and Drug Administration (FDA) even though there is no distinct code that describes the service or item.** A miscellaneous code can be used during the period of time a request for a new code is being considered under the HCPCS review process.

The absence of a specific code for a distinct category of products does not affect a supplier's ability to submit claims to private or public insurers and does not affect patient access to products.

For each claim that is submitted using a miscellaneous code, the claim is manually reviewed. When submitting claims, the item or service being billed must be clearly described and pricing information must be provided along with documentation to explain why the item or service is needed by the beneficiary.

How does a supplier make patients aware of the cost and their potential responsibility for payment for the Flowrest®?

Because of the uncertainty of reimbursement when billing with a miscellaneous code, suppliers should consider the use of an Advance Beneficiary Notice (ABN). According to CMS, ABNs are not required for care that is statutorily excluded or for services for which no Medicare benefit category exists. However, in these situations, health care providers can issue an ABN voluntarily. Health care providers report HCPCS Level II modifiers to distinguish between voluntary and required ABNs. Additional information regarding the use of ABNs can be found at: http://www.cms.gov/BNI/02_ABN.asp.

Addressing Patient Concerns About Costs

Normally, CMS sets the billing methodology for DME equipment. In this case though, there is no before knowledge of how or if CMS will pay for the Flowrest®. Before CMS makes a decision, the supplier can bill the patient as a purchase or rental. In either case, informing patients about costs of equipment and supplies is an important step when accepting a referral.

Please direct comments and questions about billing and reimbursement to homecare@vtherm.com.