KENT IMAGING

2024 CPT / HCPCS Codes

Effective 01/01/2024

CPT CODE	LONG DESCRIPTOR	OPPS SI	OPPS APC	PAYMENT*	PROFESSIONAL	LOCATION
0640T	Non-contact near-infrared spectroscopy (e.g., for the measurement of deoxyhemoglobin, oxyhemoglobin, and ratio of tissue oxygenation), other than for screening for peripheral arterial disease, image acquisition, interpretation, and report; first anatomic site.	T	5732 Paid under OPPS; separate APC payment PBD/HOPD Site of service 22 MUST use modifier TC	OPPS National: $38.26 Co Pay: $7.66	0640T 0640T-26	11-Office 32-Nursing Facility 12-Home 13-Assisted Living 19-Off campus Hospital Facility 21-Inpatient Hospital 22-Outpatient Hospital 31-Skilled Nursing
0859T	Non-contact near-infrared spectroscopy (e.g., for the measurement of deoxyhemoglobin, oxyhemoglobin, and ratio of tissue oxygenation), other than for screening for peripheral arterial disease, image acquisition, interpretation, and report; each additional anatomic site (List separately in addition to the code for primary procedure.)	N	PBD/HOPD Site of service 22 MUST use modifier TC	No Separate Payment available	0859T 0859T-26	11-Office 32-Nursing Facility 12-Home 13-Assisted Living 19-Off campus Hospital Facility 21-Inpatient Hospital 22-Outpatient Hospital 31-Skilled Nursing
0860T	Non-contact near-infrared spectroscopy (e.g., for the measurement of deoxyhemoglobin, oxyhemoglobin, and ratio of tissue oxygenation), for screening for peripheral arterial disease, including provocative maneuvers, image acquisition, interpretation, and report, one or both lower extremities.	E1	PBD/HOPD Site of service 22 MUST use modifier TC	No Separate Payment available	0860T 0860T-26	11-Office 32-Nursing Facility 12-Home 13-Assisted Living 19-Off campus Hospital Facility 21-Inpatient Hospital 22-Outpatient Hospital 31-Skilled Nursing

* Payment amounts are obtained from the published CY 2024 Final OPPS Rule (CY 2024 Final OPPS Rule), and refer **only to traditional Medicare payments for outpatient hospital procedures.**

Reminder: It is essential that the most specific and detailed CPT®/HCPCS codes be utilized, and that every service performed is coded, in order to maintain compliance with coding and billing requirements.

References:

- OPPS: Outpatient Prospective Payment System
  - Medicare payment for outpatient services provided in hospitals is based on set rates under Medicare Part B. The system for payment, known as the Outpatient Prospective Payment System (OPPS) is used when paying for services such as X-rays, emergency department visits, and partial hospitalization services in hospital outpatient departments.

- APC: Ambulatory Payment Classification
  - APCs, or "Ambulatory Payment Classifications," are the government's method of paying facilities for outpatient services for the Medicare program.
  - Procedures that are reimbursed under the OPPS system are assigned to an APC group. Each APC group is assigned a specific reimbursement amount.

- PBD: Provider Based Department
  - An outpatient department of a hospital that meets the "provider based" requirements set fourth by CMS. (Federal Regulation-Provider Based Requirements)

- HOPD: Hospital based Outpatient Department
  - Same as PBD or Provider Based Department

- SI: OPPS Payment Status Indicators
  - Status Indicators provide specific guidance to MACs and providers on the specific payment policies and rules from CMS.

    - OPPS Payment Status Indicators and Guides:
      - **T**: Procedure or service subject to multiple procedure discounting, separately payable
        - 0640T may be billed only once per patient per date of service, additional anatomic sites are to be billed under code 0859T.
      - **N:** Items or services packaged into APC rates
        - 0859T (additional anatomic site(s)) is considered to be part of the 5732 APC payment for 0640T and is not separately reimbursed by Medicare.
      - **E1:** Items, codes, and services not covered by any Medicare outpatient benefit category; statutorily excluded; not reasonable and necessary.
        - 0860T is considered to be a "screening" for PAD, rather than a diagnostic test for PAD. CMS considers screening tests to be "not reasonable and necessary" for reimbursement.
        - Kent Imaging is working diligently to complete the necessary clinical trials required to obtain a diagnostic designation for 0860T
        - It is necessary to accurately submit claims for all services performed. 0860T may be added to claims, with the understanding that there may be no reimbursement for the services performed. The modifier "GA" may be added to the claim line.

Professional Claim Submission:

Modifier 26-Professional component used for interpretation ONLY.

Category III CPT® codes may not be posted within published MAC fee schedules, as it is up to the individual MAC to determine coverage and payment for these codes. WPS and First Coast did publish reimbursement rates for 0640T. Those fee schedules may be found at:

WPS (WPS Physician Fee Schedule)
First Coast (First Coast Physician Fee Schedule)