FREQUENTLY ASKED QUESTIONS

REIMBURSEMENT for SnapshotNIR®

In an effort to provide the most comprehensive information available, we have compiled a list of Frequently Asked Questions (FAQ) to assist you with specific inquiries regarding reimbursement for our device. If you have further questions, please do not hesitate to reach out to us. The applicable contact information is listed the end of this communication.

Who can bill under the following circumstances?

What if the physician/provider is employed or is a contractor?

Employed physician / provider

Hospital Owned Facility-Inpatient or Outpatient:

The employer should bill for the interpretation of the SnapshotNIR images, CPT code 0640T for the first anatomic site, and 0859T for additional anatomic sites, with modifier "26" (0640T-26 & 0859T-26) denoting professional service (interpretation) portion only.

Office based practice or clinic:

If the test is performed in a practice setting, where the image acquisition and interpretation are both billed under the same tax ID (TIN), and the device is leased or owned by the practice, the employer may bill for both the image acquisition and the interpretation, CPT Code 0640T for the first anatomic site, and 0859T for additional anatomic sites.

Contractor:

If the contracted provider is responsible for billing for the services that they provide, then the interpretation of Snapshot$_{NIR}$™ images (CPT code 0640-26 for the first anatomic site, and 0859T-26 for additional anatomic sites) should be billed. If the contractor does not bill for the professional services rendered, the guidance above for the employed physician should be applied.

Does it matter who owns the device?

Yes.

If a test is performed in a facility or hospital setting, and the provider does *not* own the device, the facility should bill for the image acquisition, CPT/HCPCS code 0640T for the first anatomic site, and 0859T for additional anatomic sites with the modifier "TC" indicating technical component (0640T-TC & 0859T-TC), and the provider should bill for the interpretation (CPT code 0640T-26 & 0859T-26).

If a test is performed in a facility or hospital setting, and the provider *does* own the device, there must be a contract in place between the facility and the provider outlining an agreement to provide the service of acquiring $Snapshot_{NIR}$ images for the facility. This contract allows the provider to bill the "global" code or the code that represents both the image acquisition as well as the interpretation of that image.

If a test is performed in an office or physician owned outpatient facility, the global code (0640T) for the first anatomic site, and 0859T for additional anatomic sites may be used if both the image acquisition and the image interpretation are billed under the same tax ID (TIN) number.

Does it matter where the test was performed/image obtained?

Yes.

(Similar to the previous question)

If the image is obtained in a facility/hospital setting, the facility should bill for the image acquisition (CPT code(s) 0640T-TC & 0859T-TC, APC code 5732)

Provider should bill for the interpretation of the image (CPT code 0640T-26 & 0859T-26)

If SnapshotNIR is owned by the provider/provider practice, there should be a contract in place as described in the previous question, and the provider should bill for the global code (CPT code 0640T & 0859T)

Is it different with different payers / private & commercial insurance?

For professional billing:
Each Medicare MAC will determine the payment for professional services (0640T, 0859T & 0640T-26, 0859T-26) on a case-by-case basis.

Medicaid may provide coverage for services that have been approved for coverage by Medicare, however, that is not always the case with Category III CPT/HCPCS codes. Verifying coverage or requesting a pre-authorization from managed Medicaid payers may be prudent.

Commercial / private payers may cover services that are covered by Medicare. It may be prudent to obtain pre-authorization.

For facility billing:
Medicare should be billed utilizing the 0640T-TC & 0859T-TC code(s), APC code 5732.

Medicaid may provide coverage for services that have been approved for coverage by Medicare, however, that is not always the case with Category III CPT/HCPCS codes. Verifying coverage or requesting a pre-authorization from managed Medicaid payers may be prudent.

Commercial / private payers may cover services that are covered by Medicare. It may be prudent to obtain pre-authorization.

What type of documentation will be required?

Neither a National Coverage Determination (NCD), nor any Local Coverage Determinations (LCDs) have been issued outlining documentation requirements for 0640T, 0859T. What that means to us is that there are no definitive documentation requirements. Kent Imaging provides examples of sample documentation guidelines and templates that are available for download at www.kentimaging.com/reimbursement .

What needs to be captured in order to bill?

There are no "requirements" that have been published regarding documentation. We would recommend that the following points be addressed in the documentation:

Reason for testing along with applicable underlying diagnosis (some examples listed below):

- Assessment of micro circulation, oxygenation, and or perfusion to wound and peri-wound, flap, graft or other anatomic site at start of care and subsequent visits to document trends of healing or change the plan of care
- Assessment to determine medical necessity for debridement and adequacy of debridement to take a chronic wound from the inflammatory stage back to the acute phase
- HBO Qualification or prospective evaluation to determine if HBO is effective or if patient requires a vascular intervention
- To assess adequate wound bed preparation for advanced therapies such as cellular tissue products
- Assess the need for a vascular intervention
- Assess micro circulation for 4-6 weeks post vascular reconstruction
- Screening for Peripheral Arterial Disease.
- Screening for potential Deep Tissue Injury.

Sites Imaged:

- Describe in detail the anatomical location and number the site(s) where the images were taken.
- If this is a subsequent image on the same site, describe changes noted from previous images.
- Include description of all applicable locations in the image (i.e. for wounds, wound bed and peri-wound, for DTI assessment, center of at-risk area and surrounding tissues).
- Include other applicable site information (i.e., excessive edema, rubor, inflammation)

  NOTE: *when describing the characteristics of the site, other sections of the medical record may be referenced: "Image of L posterior lower extremity ulcer was obtained. A full description of this site may be found in the wound assessment portion of the patient record under "wound #1".*

Image Interpretation:

- Address areas of concern i.e., “lower left quadrant of the wound shows diminished microcirculation as evidenced by …” or “left lower extremity shows significantly lower StO2 than does the right lower extremity, indicating that the risk for critical, limb threatening ischemia is greater in the left lower extremity.
- Address areas of change if a subsequent image i.e., “significant improvement in microcirculation and oxygenation post 5 HBO treatments as evidenced by….”

Plan:

Explain in detail how the results of the study will impact the plan of care (see examples below):

- “We will send this patient for vascular consult. He/she may need surgical intervention based upon the diminished microcirculation noted in wound #1, which in my experience would not support wound healing…”
- “We will begin a trial of HBO therapy for (diagnosis code), noting how the results of the imaging have shown diminished oxygenation/microcirculation, but an adequate response to an oxygen challenge examination with the Snapshot$_{NIR}$ and or increased oxygenation saturation as results of effective HBO therapy.”
- “Graft is showing a decrease in oxygenation at 4 hours post operatively. Will monitor for one hour, and if no improvement or worsening of the microcirculation will send to HBO for graft/flap salvage.”

Can I still use the miscellaneous codes?

No.

The NCCI (National Correct Coding Initiative) states that the most accurate and detailed codes be utilized to describe the care given to patients. Since we now have codes that are specific to Snapshot$_{NIR}$, it is no longer permissible to use any other codes to describe the use of the device. Knowingly using codes that are less descriptive of the services provided can be interpreted as deliberate misrepresentation and potentially be considered fraudulent by payers.

How often can it be billed?

There are no restrictions on the number of times that Snapshot$_{NIR}$ can be billed other than:

- Imaging is per anatomic site, so the code 0640T, 0640-TC or 0640-26 should be billed for first anatomic location. Additional sites should be billed once per site, utilizing the code 0859T, 0859T-TC OR 0859T-26, regardless of the number of images performed of each site (i.e. to bill for four (4) images, 0640T should be reported once, and 0859T should be reported with a quantity of three (3).
- Each site is to be billed separately, there is no restriction on the number of sites that can be billed per session per patient.

- Multiple procedure discounting may be applied for multiple images taken on the same date of service. Medicare does not reimburse for more than one image per date of service, regardless of the number of anatomic locations imaged.
- The "Global" concept does not apply, so there is no required "wait time" between sessions.

Compliance tip: *While the global concept does not apply, testing daily on a single patient, or billing for more than one session on the same date of service may raise a red flag. If there are clinical reasons that require an unusually high frequency of testing (i.e. acute flap / graft failure assessment or acute peripheral arterial occlusion) please document the need for multiple tests in detail in the medical record.*

Can I bill for each anatomic site imaged on the same patient?

Yes, every service provided to the patient should be billed. Multiple procedures performed on the same date of service may be discounted or bundled into one payment. See question #5

Can I bill multiple images on the same wound in one visit?

No. Each anatomic site should be billed with an image quantity of 1, regardless of the number of images obtained. If more than one anatomic site is billed, additional images should be billed with 0859T and a quantity that reflects the number of ADDITIONAL anatomic sites imaged.

Do the second and third sites get paid less?

Typically, additional anatomic sites are discounted or are bundled into the payment for the first anatomic site. In other words, imaging additional anatomic sites does not qualify for any additional reimbursement, or additional images may be discounted depending on individual payer coverage and payment policies.

How often can I image each anatomic site?

Each site may be imaged as many times as clinically indicated; however, the reimbursement is per site and only one payment will be made per date of service per patient, regardless of how many images are taken, or multiple images will be discounted depending upon specific payer and plan coverage and payment policies.

What do I bill for the global?

The "global" code or all-inclusive codes of 0640T & 0859T should be billed only by a physician practice that owns the SnapshotNIR.

Facilities cannot bill for the 0640T or 0859T because it includes professional services. Facilities cannot bill for professional services. [There is one rare exception for Critical Access Hospitals who have chosen to be reimbursed for professional services. If that is the case, please reach out to our reimbursement team for guidance.]

Kent Imaging is unable to provide information or guidance on what to charge for professional or facility charges. That is a decision that should be made exclusively by the provider practice or the facility.

Can I use this on every patient to help validate that my treatment method is or is not working?

The SnapshotNIR is a valuable tool that may assist a provider to evaluate the progress or (lack thereof) of patients.

The frequency of imaging should be determined solely by the professional judgement of the provider who is caring for each individual patient. If the provider feels that the information provided by the Snapshot$_{NIR}$ images is valuable at each visit, there is no reason that the images should not be obtained.

Additional documentation may be requested for submitting charges for three or more sites per date of service.

It says approved on a case-by-case per MAC for professional billing. What if I do not get paid?

If there are denials, or any other issues with payment for SnapshotNIR, please contact the Kent Imaging reimbursement team. We will be happy to assist you with claim resubmissions or appeals. The contact information is listed at the end of this document. We cannot guarantee payment, however, we will do our best to assist you with the submission of the most accurate and complete information available to substantiate the utilization of the SnapshotNIR.

Why use this CPT code when it is a "temporary" code, that may not get paid?

According to the NCCI (National Correct Coding Initiative) documents, only the most accurate codes that most closely describe the services provided to the patient may be used, regardless of payment status.

It is considered unlawful to not report and bill for services provided, regardless of payment status.

It is essential to report the utilization of SnapshotNIR with the newly effective codes of 0640T, 0859T with modifier utilization as appropriate. CMS evaluates the level of utilization of the procedure for future reimbursement decisions. If the providers who are seeing beneficiaries of federally funded health plans are not reporting the utilization of SnapshotNIR, they will see no need for future reimbursement, or increases in reimbursement. The utilization of the temporary codes allows CMS to see that providers find value in the device, and that it should become part

of the permanent CPT/HCPCS listing, as well as be considered a high priority for reimbursement consideration.

What is the CPT / HCPCS Code 0860T?

CPT/HCPCS code 0860T is defined as: Noncontact near-infrared spectroscopy (e.g., for the measurement of deoxyhemoglobin, oxyhemoglobin, land ratio of tissues oxygenation), for screening for peripheral arterial disease, including provocative maneuvers, image acquisition, interpretation, and report, one or both lower extremities.

- 0860T is considered a “screening” code, which means that it is NOT covered or reimbursed by Medicare.
- 0860T describes either one or both extremities, thus there are NO associated additional anatomic site codes.
- Global Reporting (both image acquisition and interpretation): 0860T.
- Image acquisition only (facility): 0860T-TC
- Image interpretation only (professional only, typically in a hospital or hospital owned facility): 0860T-26.
- Kent Imaging is working diligently to obtain the required clinical studies necessary to transition from a screening code (typically non-reimbursable) to a diagnostic code (typically reimbursable).

FURTHER QUESTIONS?
Reach out to the Kent Imaging Reimbursement Team

Toll-free Hotline: 1-833-SEE-KENT (1-833-733-5368)
Email: reimbursement@kentimaging.com
Additional resources: https://www.kentimaging.com/reimbursement