



CARL ZEISS MEDITEC

# **2009 REIMBURSEMENT GUIDE**

## **Stratus OCT™ and Cirrus™ HD-OCT**



### **Scanning Computerized Ophthalmic Diagnostic Imaging**

## **INTRODUCTION**

This billing guide is intended to provide information to eye care professionals on appropriate coding, coverage, and payment for computerized ophthalmic diagnostic imaging procedures performed with Carl Zeiss Meditec's Stratus OCT™ and Cirrus™ HD-OCT. The coding, coverage, and payment information contained in this guide is gathered from various resources and is subject to change.

Carl Zeiss Meditec cannot guarantee success in obtaining third-party insurance payments. It is the responsibility of the provider to determine and submit appropriate codes, charges, and modifiers for the services being rendered. Providers should contact insurers directly for specific information on policies for scanning computerized ophthalmic diagnostic imaging.

## **QUESTIONS**

If you have any questions or concerns regarding this guide, please contact Cheri Ritter, Manager of Practice Development and Ophthalmic Coding Specialist at (858) 716-0697.

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## OVERVIEW OF MEDICARE BILLING IN THE PHYSICIAN OFFICE SETTING

### COVERAGE

Most Medicare carriers allow use of the Stratus OCT and the Cirrus HD-OCT for the diagnosis and management of glaucoma. However, insurance coverage for the diagnosis and management of non-glaucoma indications (e.g., retinal pathology) may vary from insurer to insurer.

#### Medicare

For Medicare patients, your local Medicare may have specific clinical criteria defining patients for whom ophthalmic diagnostic imaging will be covered. In some cases, specific diagnostic criteria can be found in Medicare Local Coverage Determinations (LCDs), or other coverage policies issued by the patient's insurer.

#### Medicaid and Private Insurance

Most private plans and state Medicaid programs cover medically necessary procedures performed in the physician office, freestanding facility, and outpatient setting. Patient coverage policies will vary by payer; therefore, it is recommended that you check with the individual insurer or your state Medicaid program to determine coverage for scanning computerized ophthalmic diagnostic imaging tests.

### CODING

Procedures performed with the Stratus OCT or Cirrus HD-OCT are identified by the following Current Procedural Terminology<sup>1</sup> (CPT) code:

92135	Scanning computerized ophthalmic diagnostic imaging, posterior segment, (eg, scanning laser) with interpretation and report, unilateral
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#### Professional and Technical Components

Certain procedures are a combination of a professional component and a technical component. The professional component accounts for supervision of a procedure and the interpretation of results by the physician. The technical component refers to the actual taking of the image, the equipment, and technology involved. To report the component parts of a diagnostic procedure, use appropriate modifiers. The global service for the code indicates both the technical and professional components.

No modifier	Global service
26	Professional component
TC	Technical component

If your practice owns and performs a diagnostic tests with the Stratus OCT or Cirrus HD-OCT, claims would be coded using the code for the global service, since your practice would perform both the technical part (taking measurements and incurring associated overhead) and the professional part (physician supervision and interpretation). Practices that do not maintain equipment cannot bill for the technical component since the equipment is inherent to the technical component. The physician can, however, provide and bill for the professional component without billing for the technical.

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<sup>1</sup> All Current Procedural Terminology (CPT) five-digit numeric codes, descriptions, numeric modifiers, instructions, guidelines, and other material are Copyright 2009 American Medical Association. All rights reserved.

## Modifiers

In addition to technical and professional components, the following modifiers may be applicable on claims for scanning computerized ophthalmic diagnostic imaging procedures using the Stratus OCT or the Cirrus HD-OCT:

- RT Right side. Used to identify procedures performed on the right side of the body.
- LT Left side. Used to identify procedures performed on the left side of the body.
- 50 Bilateral procedure. Bilateral procedures that are performed at the same operative session should be identified by adding the modifier 50 to the appropriate procedure code. Report such procedures as a single line item with a unit of 1.

When coding for two procedures, one performed on each eye, different billing approaches may be used as described below:

- Bill 92135 as a single line item with a unit of two
- Bill 92135-50 as a single line item with a unit of one
- Bill 92135-RT and 92135-LT each as a single line item with a unit of one

Check with your local Medicare carrier to determine which method is most appropriate for your area.

## REIMBURSEMENT

In the physician office and freestanding facility, Medicare carriers will pay for scanning computerized ophthalmic diagnostic imaging procedures based on the National Physician Fee Schedule. The following table outlines Medicare's national unadjusted fee schedule effective January 1, 2000. Please check your local carrier for the allowable payment specific to your area.

CPT code	Modifier	Description	Total Unadjusted Allowable Payment*
92135		Scanning computerized ophthalmic diagnostic imaging, posterior segment, (eg, scanning laser) with interpretation and report, unilateral	\$42.20
92135	TC	- Technical component	\$24.16
92135	26	- Professional component	\$18.03

\* Fees listed are 2009 Medicare National Averages. Check with your local carrier for allowable payments specific to your area.

## DIAGNOSIS CODES

When submitting claims for Stratus OCT or Cirrus HD-OCT procedures, providers should record patient diagnosis to the greatest level of specificity. The following table is a list of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) codes that may be used to support the medical necessity for scanning computerized ophthalmic diagnostic imaging. Please check your local medical policy to determine which diagnosis codes are covered by your Medicare carrier.

115.02 Histoplasma capsulatum retinitis	362.14 Retinal microaneurysms NOS	362.64 Senile reticular degeneration of retina
190.60 Malignant neoplasm of choroid	362.15 Telangiectasia	362.65 Secondary pigmentary degeneration of retina
224.60 Benign neoplasm of choroid	362.16 Neovascularization NOS	362.66 Secondary vitreoretinal degeneration
228.03 Hemangioma of retina	362.17 Other intraretinal microvascular abnormalities	362.70 Hereditary retinal dystrophy, unspecified
361.00 Retinal detachment w retinal defect, unspecified	362.18 Retinal vasculities	362.71 Retinal dystrophy in systemic or cerebroretinal lipidoses
361.01 A recent retinal detachment, partial, w single defects	362.31 Central retinal artery or branch occlusion	362.72 In other systemic disorders and syndromes
361.02 Partial, w multiple defects	362.32 Arterial branch occlusion	362.73 Vitreoretinal dystrophies
361.03 Partial, w giant tear	362.35 Vein occlusion	362.74 Pigmentary retinal dystrophy
364.04 Partial, w retina dialysis	362.36 Venous tributary (branch) occlusion of retina	362.75 Other dystrophies
361.05 Total or subtotal	362.37 Venous engorgement of retina	362.76 Dystrophies primarily involving the sensory retina
361.06 Old retinal detachment, partial	362.40 Retinal layer separation, unspecified	362.77 Retinal dystrophies primarily involving bruch's membrane
361.07 Total or subtotal	362.41 Central serous retinopathy	362.81 Retinal hemorrhage
361.10 Retinoschisis, unspecified	362.42 Serous detachment of retinal pigment epithelium	362.82 Exudates and deposits
361.11 Flat retinoschisis	362.43 Hemorrhagic detachment of retinal pigment epithelium	362.83 Edema
361.12 Bullous retinoschisis	362.44 Hemorrhagic detachment of retinal pigment epithelium	362.85 Retinal nerve fiber bundle defects
361.13 Primary retinal cysts	362.50 Macular degeneration (senile) of retina, unspecified	363.00 Focal chorioretinitis, unspecified
361.14 Secondary retinal cysts	362.51 Nonexudative senile macular degeneration of retina	363.01 Focal choroiditis and chorioretinitis, juxtapapillary
361.19 Other retinoschisis and retinal cysts	362.52 Exudative senile macular degeneration of retina	363.03 Of other posterior pole
361.20 Serous retinal detachment	362.53 Cystoid macular degeneration of retina	363.04 Peripheral;
361.81 Traction detachment of retina	362.54 Macula cyst, hole or pseudohole of retina	363.05 Juxtapapillary
362.01 Background or proliferative diabetic	362.55 Toxic maculopathy of retina	363.06 Macular or paramacular
362.02 Retinopathy	362.56 Macular puckering of retina	363.07 Of other posterior pole
362.03 Nonproliferative diabetic retinopathy nos	362.60 Peripheral retinal degeneration, specified	363.08 Peripheral
362.04 Mild nonproliferative diabetic retinopathy	362.61 Paving stone degeneration of retina	363.10 Disseminated chorioretinitis, unspecified
362.05 Moderate nonproliferative diabetic retinopathy	362.62 Microcystoid degeneration of retina	363.11 Disseminated choroiditis and chorioretinitis, posterior pole
362.06 Severe nonproliferative diabetic retinopathy	362.63 Lattice degeneration of retina	363.12 Peripheral
362.07 Diabetic macular edema		363.13 Generalized
362.10 Background retinopathy, unspecified		363.14 Metastatic
362.11 Hypertensive retinopathy		
362.12 Exudative retinopathy		
362.13 Changes in vascular appearance of retina		

363.15 Pigment	365.51 Phacolytic glaucoma
363.20 Chorioretinitis, unspecified	365.52 Pseudoexfoliation glaucoma
363.21 Pars planitis	365.64 Glaucoma associated w tumors or cysts
363.22 Harada's disease	365.65 Glaucoma associated w ocular trauma
363.40 Choroidal degeneration, unspecified	365.81 Hypersecretion glaucoma
363.41 Senile atrophy of choroid	365.82 Glaucoma w increased episcleral venous pressure
363.42 Diffuse secondary atrophy of choroid	365.89 Other specified glaucoma
363.43 Angioid streaks of choroid	365.90 Unspecified glaucoma
363.63 Choroidal rupture	368.40 Visual field defect, unspecified
363.70 Choroidal detachment, unspecified	368.41 Scotoma involving central area
363.71 Serous choroidal detachment	368.42 Scotoma of blind spot area
363.72 Hemorrhagic choroidal detachment	368.43 Sector or arcuate defects
364.22 Glaucomatocyclitic crises	368.44 Other localized visual field defect
364.53 Pigmentary iris degeneration	368.45 Generalized contraction or constriction
364.73 Goniosynechiae	377.00 Papilledema, unspecified
364.74 Pupillary membranes	377.01 Papilledema associated w increased intracranial pressure
364.77 Recession of chamber angle	377.02 Papilledema associated w decreased ocular pressure
365.00 Preglaucoma, unspecified	377.03 Papilledema associated w retinal disorder
365.01 Open angle glaucoma w borderline findings	377.04 Foster-Kennedy syndrome
365.02 Anatomical narrow angle glaucoma	377.90 Unspecified disorder of optic nerve or visual pathways
365.03 Glaucoma, steroid responders	743.20 Buphthalmos, unspecified
365.04 Glaucoma, ocular hypertension	743.21 Simple buphthalmos
365.10 Open-angle glaucoma, unspecified	743.22 Buphthalmos associated w other ocular anomalies
365.11 Primary open angle glaucoma	
365.12 Low tension glaucoma	
365.13 Pigmentary glaucoma	
365.14 Glaucoma of childhood	
365.15 Residual stage of open angle glaucoma	
365.20 Primary angle-closure glaucoma	
365.21 Intermittent angle-closure glaucoma	
365.22 Glaucomatous stage	
365.23 Chronic angle-closure glaucoma	
365.21 Intermittent angle-closure glaucoma	
365.31 Glaucomatous stage	
365.32 Residual stage	
365.42 Glaucoma associated w anomalies of iris	
365.41 Glaucoma associated w chamber angle anomalies	
365.44 Glaucoma associated w other anterior segment anomalies	

**SAMPLE 1500 CLAIM FORM FOR REPORTING STRATUS OCT OR CIRRUS HD-OCT WITH 92135**

1500

**HEALTH INSURANCE CLAIM FORM**

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA										PICA																													
1. MEDICARE MEDICAID TRICARE CHAMPVA GROUP HEALTH PLAN FECA BLK LUNG OTHER (Medicare #) (Medicaid #) (Sponsor's SSN) (Member ID#) (SSN or ID) (SSN) (ID)										1a. INSURED'S I.D. NUMBER (For Program in Item 1) 000-01-0000																													
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) Doe, John										3. PATIENT'S BIRTH DATE SEX MM DD YY M X F 04 25 20 M X F																													
5. PATIENT'S ADDRESS (No., Street) 1245 Virginia Street										6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other																													
CITY Any Town					STATE AZ					7. INSURED'S ADDRESS (No., Street) 1245 Virginia Street					CITY STATE Any Town AZ																								
ZIP CODE 01010					TELEPHONE (Include Area Code) (203) 555-1234					8. PATIENT STATUS Single Married Other Employed Full-Time Student Part-Time Student					ZIP CODE TELEPHONE (Include Area Code) 01010 (203) 555-1234																								
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										10. IS PATIENT'S CONDITION RELATED TO:										11. INSURED'S POLICY GROUP OR FECA NUMBER																			
a. OTHER INSURED'S POLICY OR GROUP NUMBER										a. EMPLOYMENT? (Current or Previous) YES NO										a. INSURED'S DATE OF BIRTH SEX MM DD YY M F																			
b. OTHER INSURED'S DATE OF BIRTH SEX MM DD YY M F										b. AUTO ACCIDENT? PLACE (State) YES NO										b. EMPLOYER'S NAME OR SCHOOL NAME																			
c. EMPLOYER'S NAME OR SCHOOL NAME										c. OTHER ACCIDENT? YES NO										c. INSURANCE PLAN NAME OR PROGRAM NAME																			
d. INSURANCE PLAN NAME OR PROGRAM NAME										10d. RESERVED FOR LOCAL USE										d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, return to and complete item 9 a-d.																			
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. on file SIGNED DATE																				13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED																			
14. DATE OF CURRENT ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP) MM DD YY										15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY										16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY																			
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE Dr. Jane Smith										17a. 12-4356 A										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY																			
19. RESERVED FOR LOCAL USE										17b. NPI										20. OUTSIDE LAB? \$ CHARGES YES NO																			
21. DIAGNOSIS OR NATURE 1. 365.11										22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.										23. PRIOR AUTHORIZATION NUMBER																			
24. A. DATE(S) OF SERVICE From To B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPDS MODIFIER E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. EP/SBT Family Plan I. ID. OF J. RENDERING PROVIDER										25. FEDERAL TAX I.D. NUMBER SSN EIN 0330333										26. PATIENT'S ACCOUNT NO. 99-9998																			
1 01 01 09 01 01 09 92135 1 xxx xx 2										28. TOTAL CHARGE \$ xxxx xx										29. AMOUNT PAID \$																			
2 01 01 09 01 01 09 92135 modifier 1 xxx xx 1 NPI										30. BALANCE DUE \$										31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) on file SIGNED DATE																			
3 01 01 09 01 01 09 92135 modifier 1 xxx xx 1 NPI										32. SERVICE FACILITY LOCATION INFORMATION a. NPI b.										33. BILLING PROVIDER INFO & PH # Freestanding Center 15 Elm Street Any Town, AZ 01010 (203) 555-4321																			
4										5										6																			

Code for the patient diagnosis

CPT code for Stratus OCT, Cirrus HD-OCT or other appropriate code

Indicate 2 units when performed on both eyes during the same visit\*

Indicate here one of the following modifiers:  
• -50  
• -RT  
• -LT

Indicate 1 unit when using these modifiers\*

\* Check with your local carrier determination (LCD) to determine which coding practice is most appropriate.

## OVERVIEW OF MEDICARE BILLING IN THE HOSPITAL OUTPATIENT SETTING

### Coding

On all hospital outpatient claims, providers must include appropriate procedure codes. Report charges using American Hospital Association (AHA) revenue codes and report patient diagnosis using ICD-9-CM diagnosis codes.

The appropriate CPT code must be listed next to the AHA revenue code under which the charge for the procedure appears. The ophthalmic diagnostic imaging CPT code is:

92135 Scanning computerized ophthalmic diagnostic imaging, posterior segment, (eg, scanning laser) with interpretation and report, unilateral

### Diagnosis Codes

Please see Page 5-6 of this billing guide for the listing of appropriate diagnosis codes.

### Revenue Codes

Charges for scanning computerized ophthalmic diagnostic imaging using the Stratus OCT and the Cirrus HD-OCT should appear under one of the following AHA revenue codes:

510 Clinic, general classification  
920 Other diagnostic services

Individual hospital billing practices may vary. Please check with your local carrier to determine which AHA revenue code is most appropriate.

### Reimbursement

In hospital outpatient facilities, ophthalmic diagnostic imaging procedures are subject to Medicare's Hospital Outpatient Prospective Payment System (HOPPS) which groups drugs and services into ambulatory payment classifications (APCs). The HOPPS provides a fixed, bundled payment for hospital outpatient procedures or services that group into an APC. The system determines only the hospital payment and does not affect payment to physicians who perform services in the hospital outpatient setting. Payment to physicians for their professional services is determined under the physician fee schedule.

The following table outlines 2009 HOPPS reimbursement effective January 1, 2009:

CPT code	APC Description	HOPD <sup>2</sup> Status	APC	Minimum Unadjusted Copayment	Medicare Payment	Total Unadjusted Allowable Payment
92135	Level 1 Eye Tests and Treatments	S <sup>3</sup>	230	\$8.54	\$34.14	\$42.68

<sup>2</sup> Hospital Outpatient Department (HOPD) Payment Status indicators state whether a service is payable under the HOPPS or another payment system and also whether particular HOPPS policies apply to the code.

<sup>3</sup> Status indicator S: Significant procedure, not discounted when multiple procedures are performed.



## REASONS FOR CLAIM DELAYS AND DENIALS

When a payer denies a claim, generally a letter or note is sent that lists the reason(s) for the denial. Inaccurate coding, misspellings, and missing information often are the reason for claims rejections. In such cases, claims should be corrected and resubmitted.

Payers also may request clarification about the use of a procedure or request that the physician document the medical necessity of the procedure. When a claim is returned for this kind of information, you may need to submit one or more of the following to the insurer:

- Letter of medical necessity: the insurer may consider payment on a case-by-case base if you submit a letter explaining why the patient should undergo scanning computerized ophthalmic diagnostic imaging using the Stratus OCT or the Cirrus HD-OCT. Be advised, however, that submitting a letter of medical necessity does not guarantee payment. Please see the sample letter at the end of this billing guide.
- Clinical information on Stratus OCT or the Cirrus HD-OCT: the insurance company may need information explaining the use of these devices for patients with certain pathologies.

Insurer's policies may vary with respect to coverage of Stratus OCT and Cirrus HD-OCT for any given patient indication. Therefore, you should check the specific payer policy for coverage of scanning computerized ophthalmic diagnostic imaging.

## FREQUENTLY ASKED QUESTIONS

### **Q: How do I bill Medicare for scanning computerized ophthalmic diagnostic imaging when used in the physician's office?**

CPT code 92135 is most commonly used to bill for the use of Stratus OCT or the Cirrus HD-OCT in the physician office setting. Medicare's allowable amount for procedure code 92135 is listed in your carrier's physician fee schedule. The patient or his/her secondary insurer is responsible for the co-payment amount. Please check with your local carrier to determine appropriate coding.

### **Q: Can I bill Medicare for diagnostic images acquired by the Stratus OCT or the Cirrus HD-OCT with the CPT code 92250 (Fundus photography with interpretation and report)?**

Scanning computerized ophthalmic diagnostic imaging procedures are separate and distinct procedures from fundus photography procedures. The American Medical Association (AMA) has provided guidance indicating that it is not appropriate to report CPT code 92250 for scanning computerized ophthalmic diagnostic imaging procedures such as those performed by the Stratus OCT or Cirrus HD-OCT.<sup>4</sup> Providers are advised to report CPT code 92135 when billing for procedures performed with the Stratus OCT or the Cirrus HD-OCT.

### **Q: How do I bill Medicare for scanning computerized ophthalmic diagnostic imaging when used in the hospital outpatient department setting?**

Hospital outpatient facilities should use revenue code 510 or 920 and CPT code 92135 to bill for Stratus OCT and the Cirrus HD-OCT in this setting. Medicare reimbursement for hospital outpatient departments is based on the APC payment system. CPT code 92135 maps to APC 230 (Level I Eye Tests and Treatments).

### **Q: How often can I bill Medicare for scanning computerized ophthalmic diagnostic imaging for a patient?**

It is generally acceptable to bill 92135 one time per year for glaucoma suspects and two times per year for glaucoma patients. Retinal conditions vary by carrier. Carriers may request a letter of medical necessity or medical records as justification for a patient to undergo multiple scanning computerized ophthalmic diagnostic imaging procedures in one year. Physicians are advised to consult local coverage policies for specific frequency allowables.

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<sup>4</sup> American Medical Association; CPT Assistant; Mar 99: 10.

**Q: I would like to use the scanning computerized ophthalmic diagnostic imaging for the diagnosis and management of retinal pathology, but my carrier does not list retinal diagnosis codes in the list of acceptable ICD-9-CM codes. What can I do?**

If your Medicare carrier does not allow scanning computerized ophthalmic diagnostic imaging for the diagnosis and management of retinal pathology, you can submit a claim with a letter of medical necessity. This letter should indicate the clinical appropriateness for using scanning computerized ophthalmic diagnostic imaging for a patient with retinal disease.

Alternatively, providers can request policy additions or changes by going through your Medicare carrier's LCD reconsideration process. To locate information on how to go through this process, please contact your local Medicare carrier.

**Q: I submitted a claim for CPT 92135 with the modifier 50 appended to identify a bilateral procedure. However, the payer only reimbursed me for performing the procedure on one eye. What can I do?**

Each insurer may have specific guidelines for billing for the Stratus OCT and Cirrus OCT examinations bilaterally. Often times, insurers may instruct providers to report bilateral procedures using the –RT and –LT modifiers. Providers should check with the patient's insurer to verify the appropriate billing practice and relevant coverage guidelines

**Q: I submitted a claim to the patient's insurer, but was denied payment because the procedure is not covered. Is there anything I can do?**

If you believe the claim should have been paid, you may request additional consideration of coverage and submit an appeal to the insurer. Often, this will require a written statement detailing the reason(s) why the procedure was considered medically necessary. Insurance companies may have additional guidelines on how providers should appeal a denied claim.

**SAMPLE LETTER OF MEDICAL NECESSITY / APPEAL LETTER**

[Date]

[Name of Medical Director]

[Title]

[Name of Insurer]

[Address of Insurer]

[City, ST, Zip]

Re: [Patient's Name]  
[Patient's ID Number]

Dear [Name of Medical Director]:

This letter is in response to a recently denied claim for services provided to **[patient's name and claim number]**. The use of scanning computerized ophthalmic diagnostic imaging tests using the [insert device used {Stratus OCT or Cirrus HD-OCT}] is medically necessary. I would like to appeal this denial and am submitting this letter to provide my clinical rationale for using this imaging technique and information about this patient's medical history.

***[Be sure to include all additional information requested in the original claim denial.]***

**Patient's Diagnosis and Clinical Rationale for Selecting the Stratus OCT or the Cirrus HD-OCT for Disease Management**

The history of **[patient's diagnosis]** for **[patient's name]** is as follows: ***[insert information concerning the date and method of diagnosis and patient's complete history. Include a complete summary of all previous diagnosis or disease management tools and documentation of clinical improvements and failures. Also summarize the patient's clinical course since diagnosis using device used {either Stratus OCT or the Cirrus HD-OCT}].***

**Disease Management Rationale and Request for Coverage Approval**

Scanning computerized ophthalmic diagnostic imaging tests performed with the ***[insert device used {Stratus OCT or Cirrus HD-OCT}]*** are indicated for the diagnosis and management of glaucoma and certain retinal pathology. The ***[insert device used {Stratus OCT or Cirrus HD-OCT}]*** is a non-invasive, non-contact image creating technique. It produces high-resolution, longitudinal, cross-sectional tomographs of ocular structures to detect evidence of glaucomatous damage or subsurface retinal defects.

There are alternative methods to detecting and monitoring ocular pathology. However, in light of the patient's condition, it is my opinion that the ***[insert device used {Stratus OCT or Cirrus HD-OCT}]*** more accurately detects changes to the eye which helps in making appropriate clinical decisions for treatment and management of this patient's ***[insert patient's diagnosis]***.

I have enclosed a copy of the denied claim. I hope that this information is helpful to you in understanding the reasons why I have pursued use of scanning computerized ophthalmic diagnostic imaging for diagnosis and disease management. Use of the ***[insert device used {Stratus OCT or Cirrus HD-OCT}]*** was medically necessary, and my claim should be approved for payment. If you require any additional information, please contact me directly.

Sincerely,

[Physician's name]

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