



CARL ZEISS MEDITEC

2009 REIMBURSEMENT GUIDE

GDx™



Scanning Laser Polarimeter

INTRODUCTION

This billing guide is intended to provide information to eye care professionals on appropriate coding, coverage, and payment for procedures performed with Carl Zeiss Meditec's GDx™ Scanning Laser Polarimeter. The 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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COVERAGE

Overview

Often in insurer policies, the GDx and similar technologies are collectively identified as scanning computerized ophthalmic diagnostic imaging procedures or SCODI. The information contained within this guide will focus on appropriate third-party payer billing for SCODI procedures to evaluate glaucoma when performed in the physician office setting.

Payers will cover procedures that are considered reasonable and medically necessary. Medicare, Medicaid, and private payers will typically provide coverage for SCODI procedures for the diagnosis and management of glaucoma; however, each payer will have its own set of clinical criteria to warrant coverage.

Local Medicare carriers typically provide detailed coverage guidelines in the form of local coverage determinations (LCD) or supplemental coverage articles which may be found online. It is recommended that providers contact Medicaid and private insurance companies directly to understand their coverage guidelines for SCODI procedures.

Medicare and most private payers do not restrict coverage according to the provider type. As long as an ophthalmologist or optometrist is fully licensed to perform the procedure, he or she is eligible to receive reimbursement. However, Medicaid agencies have been known to place such limitations on optometrists. Since Medicaid coverage policies vary among states, please contact your local Medicaid agency for pertinent information.

Frequency Limitations

Generally, insurers provide coverage for SCODI procedures when used to evaluate glaucoma one to two times per year. We see many Medicare carriers outline frequency limitations based on the severity of disease. For example, “glaucoma suspects” or those with “pre-glaucoma” may undergo diagnostic imaging once per year; whereas those with “moderate glaucoma damage” are allowed to undergo imaging up to twice per year.

Please note that frequency limitations will vary among insurers. Please contact your patient’s insurer directly to understand how frequently you may perform SCODI procedures within a year.

Coverage Limitations

The National Correct Coding Initiative (CCI) edits identify fundus photography (CPT code 92250) as mutually exclusive when performed with SCODI. Providers are likely to be paid for the fundus photo instead of SCODI if both procedures are performed on the same day.

Furthermore, some local Medicare carriers have established their own local restrictions limiting performance of visual field testing, ophthalmoscopy, and contact B-scan on the same day as SCODI. Please refer to your local Medicare policy to understand such restrictions with your Medicare carrier.

BILLING GUIDELINES

Using CPT Code 92135 and Modifiers

Procedures performed with the GDx are identified by the following Current Procedural Terminology¹ (CPT) code:

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

Although most private payers will accept CPT code 92135, they may have additional coding requirements. It is the responsibility of the provider to submit claims with the appropriate codes as outlined by a patient's insurer.

Payment arrangements will vary according to payer, payer type, location, and patient plan. In the physician office and freestanding facility setting, Medicare carriers pay for procedures performed with the GDx according to the National Physician Fee Schedule. The table below outlines Medicare's current national unadjusted fee schedule (as of January 2009) for participating providers.

CPT Code	Modifier	Description	Fee Schedule Amount*
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.

Modifiers for professional or 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.

If your practice owns the GDx to perform diagnostic tests, claims would be coded using the code for the global service, since your practice would perform both the technical part (taking measurements) 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.

Eye care providers may choose to coordinate with other providers, such as mobile diagnostic testing facilities, to provide GDx examinations. Since there are many legal issues associated with this arrangement, it is recommended that eye care providers adhere to the "Payment to Physician or Other Supplier for Purchased Diagnostic Tests - Claims Submitted to Carriers" guidelines outlined in the Medicare Claims Processing Manual p. 57 section 30.2.9 <http://www.cms.hhs.gov/manuals/downloads/clm104c01.pdf>. It is recommended that you speak directly with payers to understand their coding and coverage guidelines for these arrangements.

¹ 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.

Unilateral and bilateral modifiers

CPT code 92135 is a unilateral code, representing imaging performed on one eye. Therefore, the following modifiers may be applicable to identify performance of GDx procedures on one or both eyes. Please check with your patient's insurer to determine which coding method is most appropriate.

- RT Right eye is imaged
- LT Left eye is imaged
- 50 Bilateral procedure – both eyes are imaged during the same session. Report such procedures as a single line item with a unit of 1.

Advance Beneficiary Notice

If you do not believe Medicare will provide coverage for GDx procedures (for example, when frequency limitations have been met, or Medicare does not pay for imaging of the patient's condition) you will need to notify the patient *prior to the exam* that they are financially responsible for the GDx procedure.

In addition, Medicare requires that you supply patients with an advance beneficiary notice (ABN). When completing the ABN, you must include the reason for a possible denial before the patient signs. Do not issue a blank ABN. For more information, use the attached link to the Medicare Claims Processing Manual and scroll to section 40.3 <http://www.cms.hhs.gov/manuals/downloads/clm104c30.pdf>

In addition to the ABN form, you must submit a claim to Medicare with CPT code 92135 and one of the modifiers included below.

- GA Service is expected to be denied as not reasonable and necessary and patient's signed ABN is on file
- GZ Service is expected to be denied as not reasonable and necessary, ABN was provided to patient, but signature was not obtained

If the patient refuses to sign an ABN, the patient is still liable for the service if it is not paid for by Medicare. In this situation, it is recommended that providers get a staff member to witness that the patient would not sign the ABN, note patient's objections, and include this in the patient's records.

Diagnosis Codes

It is important to include a patient's diagnosis to the greatest level of specificity when seeking reimbursement for SCODI procedures. The following table is a reference of International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) codes that may be used to support the medical necessity for GDx procedures.

Please note that not all Medicare, Medicaid, and private insurers will cover the conditions outlined in this table. Please check with each insurer to determine which diagnosis codes will be covered when submitting claims for SCODI procedures.

365.00 – 365.04	Borderline glaucoma (glaucoma suspect)
365.10 – 365.15	Open-angle glaucoma
365.20 – 365.24	Primary angle-closure glaucoma
365.31 – 365.32	Corticosteroid-induced glaucoma
365.41 – 365.44	Glaucoma associated with congenital anomalies, dystrophies, and systemic syndromes

365.51 – 365.59	Glaucoma associated with disorders of the lens
365.60 – 365.65	Glaucoma associated with other ocular disorders
365.81 – 365.89	Other specified forms of glaucoma
365.90	Unspecified glaucoma
743.20 – 743.22	Buphthalmos

Purchased Services

In some instances, a physician may not own or lease a GDx. The physician may “purchase” the examination from another Medicare provider and bill the total component (technical and professional) to Medicare using his or her own provider number. To submit a claim to Medicare for the purchased service, Item 20 of the CMS-1500 claim form must be checked “yes”. This indicates that the entity that performed the diagnostic test is different from the entity billing for the service. Item 20 must also indicate the amount paid to “purchase” the test. Item 32 must contain the provider’s name, PIN, address, and zip code. If multiple tests are purchased, each test must be submitted on a separate claim form. For more details, use the attached link to the Medicare Claims Processing Manual and scroll to section 30.2.

<http://www.cms.hhs.gov/manuals/downloads/clm104c01.pdf>

Concurrent Care

Situations may arise in which more than one eye care provider is needed to manage a patient’s condition. In these cases, a physician may perform GDx procedures on the condition that the services are not duplicated by the other physicians charged with the patient’s care. Please note that coverage for these procedures is still subject to local carrier coverage guidelines.

Medicare carriers may request clarification of a concurrent care situation if the role of each physician involved is not clear. Therefore it is strongly recommended that eye care providers agree upon and document each physician’s role with respect to a particular patient’s care prior to proceeding with a GDx exam. For more details, use the attached link to the Medicare Claims Processing Manual and search for “concurrent”. <http://www.cms.hhs.gov/manuals/downloads/clm104c12.pdf>

Documentation

Proper documentation is critical to avoid denial of claims and post-payment audits. Medical record documentation (e.g. office/progress notes) maintained by the performing provider must indicate the medical necessity of the SCODI exam. Since CPT code 92135 is considered a unilateral service, the documentation must demonstrate medical need for the performance of the test for each eye.

The interpretation may be written directly on the printout or elsewhere for the clinical record, although it should be readily identifiable as the test interpretation and not part of the exam. The following data should be reported:

- a. Technician comments
(the first four are all automatically displayed on the printout)
 - i. “GDx Nerve Fiber Analysis” OU, OD or OS
 - ii. Date performed
 - iii. Operator name
 - iv. Reliability score
 - v. Patient understanding and cooperation
- b. Physician interpretation
 - i. Test results
 - ii. Implications
 - iii. Impact on treatment/prognosis
 - iv. Ordering physician signature and date

Medicare carriers will likely request documentation of medical necessity when the procedure performed exceeds the frequency limitations or does not meet the coverage criteria set forth by the payer. In these cases, it may be advisable to include a modified letter of appeal detailing the applications of the device to further support coverage for the procedure. See page13 for a sample appeal letter.

Supervision

According to Medicare guidelines, general supervision is required for SCODI procedures. This means the procedure is furnished under the physician’s overall direction and control, but the physician’s presence is not required during the performance of the procedure.

CLAIM DENIALS

When an insurer denies a claim, it generally sends a letter or a note listing the reason(s) for the denial. Inaccurate coding, misspelling, or missing information are often reasons for claim rejection. In such cases, a claim should be corrected and resubmitted.

Insurers 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, one or more of the following must be submitted to the insurer:

- Letter of medical necessity: The insurer may consider payment on a case-by-base basis if you submit a letter explaining why the patient should undergo SCODI using the GDx. Be advised, however, that submitting a letter of medical necessity does not guarantee payment. See page13 for a sample appeal letter.
- Clinical information on the GDx: The insurance company may need information explaining the use of GDx scanning laser polarimetry for patients with certain pathology. This documentation may include peer-reviewed journals and product information.

Insurers’ policies may vary with respect to coverage of the GDx for any given patient indication. Therefore, you should check the specific payer policy for coverage of SCODI procedures.

Furthermore, some insurers have explicit guidelines on how to pursue an appeal. For example, the Medicare appeals process includes roughly 5 rounds of appeals as detailed below:

Appeal level	Time limit for filing request	Monetary threshold to be met
1. Redetermination	120 days from the initial date of the notice of the initial determination	None
2. Hearing officer (HO) hearing	6 months from the date of redetermination	At least \$100 remains in controversy
3. Administrative Law Judge (ALJ) Hearing	Filed within 60 days of receipt of HO hearing decision	At least \$100 remains in controversy
4. Departmental Appeals Board (DAB) Review	Filed within 60 days of receipt of ALJ hearing decision/dismissal	None
5. Federal Court Review	Filed within 60 days of receipt of DAB decision or declination of review by DAB	At least \$1,050 remains in controversy

Since payer appeals processes will vary, it is recommended that patients and providers contact their insurer directly to understand how to pursue the appeals process.

FREQUENTLY ASKED QUESTIONS

Q: Do private insurers provide coverage for SCODI procedures?

Most private health plans will provide coverage for SCODI exams when considered reasonable and medically necessary. Each payer will have specific definitions as to the conditions that support medical necessity. It is recommended that eye care providers contact the patient's insurer to understand these guidelines. However, typically, a patient's vision plan (i.e., Vision Service Plan) will not provide coverage for SCODI procedures.

Q: I have a GDx VCC with Screening. Does Medicare, Medicaid, or private insurers provide coverage for the Screening Mode?

Medicare does provide a glaucoma screening benefit for eligible beneficiaries. However, this exam is limited to (1) dilated eye examination with an intraocular pressure measurement; and (2) a direct ophthalmoscopy examination, or a slit-lamp biomicroscopic examination; this benefit does not include diagnostic evaluation with the GDx.

However, use of the GDx Screening Mode might identify pathology, thereby documenting the need for a full GDx exam which often is paid for by insurers. If a physician does decide to charge for the screening test, the fee will not be covered by insurers and must be paid as an out of pocket expense by the patient. For further information on screening, please refer to the CZMI 2009 Screening Reimbursement Guide.

Q: I am an optometrist and want to perform GDx procedures. Do insurers develop different coverage guidelines for optometrists and ophthalmologists?

Medicare and many private insurers do not limit coverage for SCODI procedures based on provider type. If the provider is fully licensed to perform a procedure, they are equally eligible to receive coverage and reimbursement for that procedure. Certain Medicaid agencies do limit coverage for SCODI procedures to ophthalmologists alone. If optometrists are seeking coverage, they may need to follow certain appeals processes to obtain Medicaid reimbursement for SCODI procedures. It is recommended that optometrists contact their state Medicaid agency for additional details on possible coverage restrictions.

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 submit an appeal to the insurer requesting coverage. Oftentimes, this will require a written request outlining the reason(s) the procedure was considered medically necessary. Furthermore, many insurance companies provide guidelines on how providers should appeal a claim denial. Please contact your insurer to understand how an appeal may be filed with each insurer.

Q: Can I perform other diagnostic imaging procedures on the same day as a GDx exam?

National Medicare Correct Coding Initiative (CCI) edits indicate that fundus photography (CPT code 92250) procedures are considered mutually exclusive when performed on the same day as SCODI procedures. The provider can expect only to be paid for fundus photography if submitted on the same day as SCODI. Additionally, some local Medicare carriers have issued local restrictions limiting performance of visual field exams, extended ophthalmoscopy, and/or contact B-scans on the same day as SCODI. Please refer to your local SCODI Medicare policy for guidelines specific to your Medicare carrier.

Q: How many times per year can I perform GDx procedures on each patient?

Frequency guidelines will vary by each insurer. Generally, we see that insurers provide coverage for SCODI procedures one to two times per year. It is recommended that you contact your patient's insurance company directly to understand guidelines specific to her or his benefit.

Q: Does the eye care provider need to be present while the GDx test is administered?

General supervision is required when administering a GDx exam. This means that the procedure is furnished under the physician's overall direction and control, but the physician's presence is not required during the performance of the procedure.

Q: What do I do if the patient wants to pay out of pocket, and submits a claim to the insurance company directly?

Some insurers will allow patients to request payment/reimbursement from their insurance company after they have paid out-of-pocket for medical care. The healthcare provider is required to provide the patient with an itemized bill including a list of procedures that was performed, diagnosis codes, and charges. The patient is then required to complete a claim form, attach the itemized bill, and submit it to their insurer for payment. Patients and providers are advised to contact their insurance company directly to ensure that they are following the appropriate procedures and guidelines when the patient chooses to submit claims to the insurer.

Q: How do I get on a panel for a managed care organization?

A managed care panel identifies a group of providers—physicians, hospitals, pharmacists, others—authorized by a managed-care plan to care for the plan's enrollees. Every managed care organization is going to have its own criteria and contractual arrangements for panel members. Providers are advised to contact the insurer's provider relations department and ask for plan paperwork. This paperwork will spell out empanelment criteria and other relevant information.

Q: Once an optometrist who does not have glaucoma treatment, DPA or TPA certification refers a glaucoma patient to an ophthalmologist for treatment, can s/he continue performing GDx examinations and billing the patient's medical insurance?

According to Medicare's Benefit Policy Manual, "concurrent care exists where more than one physician renders services more extensive than consultative services during a period of time. The reasonable and necessary services of each physician rendering concurrent care could be covered where each is required to play an active role in the patient's treatment."

"Once it is determined that the patient requires the active services of more than one physician, the individual services must be examined for medical necessity, just as where a single physician provides the care."

See <http://www.cms.hhs.gov/manuals/downloads/clm104c12.pdf> for further details.

SAMPLE ADVANCE BENEFICIARY NOTICE

(A) Notifier(s):

(B) Patient Name:

(C) Identification Number:

ADVANCE BENEFICIARY NOTICE OF NONCOVERAGE (ABN)

NOTE: If Medicare doesn't pay for (D) _____ below, you may have to pay.

Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the (D) _____ below.

(D) _____	(E) Reason Medicare May Not Pay:	(F) Estimated Cost:

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the (D) _____ listed above.

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

(G) OPTIONS:

Check only one box. We cannot choose a box for you.

OPTION 1. I want the (D) _____ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

OPTION 2. I want the (D) _____ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. I cannot appeal if Medicare is not billed.

OPTION 3. I don't want the (D) _____ listed above. I understand with this choice I am not responsible for payment, and I cannot appeal to see if Medicare would pay.

(H) Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/TTY: 1-877-486-2048).

Signing below means that you have received and understand this notice. You also receive a copy.

(I) Signature:

(J) Date:

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

SAMPLE 1500 CLAIM FORM FOR REPORTING GDx WITH 92135

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

1500

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA <input type="checkbox"/> OTHER <input type="checkbox"/> <small>(Medicare #) (Medicaid #) (Sponsor's SSN) (Member ID#) (SSN or ID) (SSN) (ID)</small>										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 MM DD YY 04 25 20 M <input checked="" type="checkbox"/> F <input type="checkbox"/>					4. INSURED'S NAME (Last Name, First Name, Middle Initial)									
5. PATIENT'S ADDRESS (No., Street) 1245 Virginia Street					6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>					7. INSURED'S ADDRESS (No., Street) 1245 Virginia Street									
CITY Any Town			STATE AZ		8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>					CITY Any Town			STATE AZ						
ZIP CODE 01010		TELEPHONE (Include Area Code) (203) 555-1234			9. EMPLOYED <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>					ZIP CODE 01010			TELEPHONE (Include Area Code) (203) 555-1234						
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)					10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO					11. INSURED'S POLICY GROUP OR FECA NUMBER									
a. OTHER INSURED'S POLICY OR GROUP NUMBER					a. INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>					b. EMPLOYER'S NAME OR SCHOOL NAME									
b. OTHER INSURED'S DATE OF BIRTH MM DD YY M <input type="checkbox"/> F <input type="checkbox"/>					b. AUTO ACCIDENT?					c. INSURANCE PLAN NAME OR PROGRAM NAME									
c. EMPLOYER'S NAME OR SCHOOL NAME					c. OTHER ACCIDENT?					d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, return to and complete item 9 a-d.</i>									
d. INSURANCE PLAN NAME OR PROGRAM NAME					10d. RESERVED FOR LOCAL USE					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 _____ DATE _____									
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. 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 _____ DATE _____									
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 17b. NPI					18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY									
19. RESERVED FOR LOCAL USE										20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO									
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate to Items 1, 2, 3 or 4 to Item 24E by Line) 1. 365 11 ICD-9 code for diagnosis 2. _____ 3. _____ CPT code for GDx or other appropriate code 4. _____										22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.					23. PRIOR AUTHORIZATION NUMBER				
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY		B. PLACE OF SERVICE EMG		C. PROCEDURE (Explain Unus) CPT/HCPCS		D. DIAGNOSIS POINTER		E. \$ CHARGES		F. G. DAYS OF UNITS H. I. J.									
1 01 01 09 01 01 09		92135		1,2		00 00		2		Indicate 2 units when performed on both eyes during the same visit*									
OR										NPI									
3 01 01 09 01 01 09		92135		modifier		1,2		00 00		1		Indicate 1 unit when using these modifiers*							
5 _____ 6 _____										NPI									
25. FEDERAL TAX I.D. NUMBER 0330333					SSN EIN <input type="checkbox"/> <input type="checkbox"/>					26. PATIENT'S ACCOUNT NO. 99-9998									
28. TOTAL CHARGE \$ 00 00					29. AMOUNT PAID \$					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										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				
SIGNED _____ DATE _____					a. NPI b.					a. NPI b.									

NUCC Instruction Manual available at: www.nucc.org

APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)

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

SAMPLE LETTER OF MEDICAL NECESSITY / APPEAL LETTER

Date
Medical Director
Insurance Company
Address
RE: [PATIENT NAME]
ID Number
Date of Service

Dear _____:

I am writing in response to a recent denial of our claim(s) for scanning computerized ophthalmic diagnostic imaging (SCODI) performed in our office with the GDx. This letter will serve as a request for an appeal of your denial as well as provide additional information on which to base a favorable payment determination.

Description of GDx Technology

The GDx is a scanning laser polarimeter that uses polarized light to assess retinal nerve fiber layer (RNFL) thickness. The birefringent properties of the RNFL cause a measurable phase shift in the incident polarized light proportional to the tissue thickness. 16,384 data points are presented per eye. The measurements are compared to a large, multi-ethnic, age-stratified normative database. Both eyes are usually scanned in order to measure symmetry. The GDx's colorful, graphic printouts assist in educating patients about the importance of compliance.

Clinical Applications

Early detection can be imperative to preserve vision in glaucoma, and RNFL damage is one of the early manifestations of this disease. By the time the RNFL surrounding the optic nerve has changed sufficiently to be noticeable by other means, a significant amount of damage may already have occurred. It has been shown that GDx measurements can predict visual field loss¹. Sensitivity and specificity of the GDx for pre-perimetric glaucoma have been measured at 83% and 82%, respectively². The GDx offers a quantitative assessment of the RNFL that is equivalent or better to expert evaluation of red-free photography³, and is therefore far more precise than routine subjective clinical observation in general practice. Once glaucoma has been diagnosed, it is crucial to monitor change to evaluate treatment effectiveness. It has been found that patients with mild to moderate visual field loss may be better monitored with the GDx than with standard automated perimetry (SAP)⁴. The GDx is particularly suited for monitoring change because it is highly repeatable⁵ and results do not vary with changing operators⁶.

1 Mohammadi K, Bowd C, Weinreb RN et al. Retinal Nerve Fiber Layer Thickness Measurements with Scanning Laser Polarimetry Predict Visual Field Loss.

American Journal of Ophthalmology 2004;138:592-601.

2 Medeiros FA, Zangwill LM, Weinreb RN et al. Use of Progressive Glaucomatous Optic Disk Change as the Reference Standard for Evaluation of Diagnostic Tests in Glaucoma.

American Journal of Ophthalmology 2005; 139:1010-1018.

3 Medeiros, Zangwill, et al. Comparison of Scanning Laser Polarimetry using Variable Compensation and Retinal Nerve Fiber Layer Photography for Detection of Glaucoma.

Arch Ophthalmol. 2004;122:698-704.

4 Reus, NJ and Lemij, HG. The relationship between standard automated perimetry and GDx VCC measurements. Invest Ophthalmol Vis Sci. 2004 Mar;45(3):840-5.

5 Blumenthal, EZ and Frenkel, S. "Inter-Device reproducibility of the scanning laser polarimeter with variable cornea compensation." Eye. 2004 Jul 30.

6 Frenkel, Slonim, et al. "Operator learning effect and interoperator reproducibility of the scanning laser polarimeter with variable corneal compensation". Ophthalmology. 2005 Feb;112(2):257-61.

Reasonable Charge

The GDx system is a costly diagnostic tool. I believe my investment is justified because it provides better information on which to base management of glaucoma patients. The 2009 national Medicare Fee Schedule contains an allowed amount of \$42.20 per eye. I believe this is an equitable reimbursement amount.

Utilization Parameters

This test is indicated approximately as often as a visual field. For most patients with glaucoma, this occurs about one to two times per year.

CPT Code

Effective January 1, 2008, the American Medical Association published a CPT code for SCODI.
92135 – Scanning computerized ophthalmic diagnostic imaging, posterior segment, (eg, scanning laser) with interpretation and report, unilateral

Conclusion

SCODI with the GDx greatly enhances my ability to both detect and manage glaucoma. It adds accurate, objective, and reproducible new information that complements data obtained using other techniques such as visual field analysis, tonometry, gonioscopy and optic disc photography. Based on the time and effort required to perform the test, the initial cost of the equipment and the associated costs, a reasonable payment rate is \$88 for both eyes, based on the Medicare fee schedule. After reviewing this information, we hope that the denial previously issued will be reversed and our claim will be honored for reimbursement. If you have questions or need additional information to proceed with this request, please do not hesitate to contact our office.

Sincerely,
[PHYSICIAN NAME]

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