REIMBURSEMENT GUIDE
BluePeak™ Blue Laser Autofluorescence Imaging

This guide is intended to provide coding and billing information valid from May 23, 2013. Reimbursement codes and billing practices change over time. All information is subject to the descriptions and disclaimers contained in this guide.
SPECTRALIS, BluePeak, and MultiColor are trademarks of Heidelberg Engineering, Inc., or Heidelberg Engineering GmbH. © 2013 Heidelberg Engineering, Inc. All rights reserved. 2551-002

CPT and all CPT codes are copyrighted by the American Medical Association with all rights and privileges reserved.

This document should not be considered a replacement for published Medicare regulations.
## Table of Contents

Introduction: The SPECTRALIS® Imaging System .................................................. 4

Overview of BluePeak™ Blue Laser Fundus Autofluorescence Imaging .......... 5

1: Coverage ............................................................................................................. 6
   - Medicare Coverage ....................................................................................... 6
   - Private Payer Coverage .............................................................................. 6
   - Potential ICD-9-CM Diagnosis Codes Supporting Medical Necessity .......... 7

2: Coding and Billing .............................................................................................. 8
   - Billing for Laser Fundus Autofluorescence .................................................. 9
     - Using Modifiers ....................................................................................... 9
   - Documentation Guidelines ......................................................................... 10

3: Reimbursement .................................................................................................. 11
   - Medicare Physician Payments .................................................................... 12
   - Private Payer Physician Payments ............................................................. 12

4: Appeals .............................................................................................................. 13
   - Managing Claim Denials ............................................................................ 14
   - Appealing Denials ..................................................................................... 14
     - Verify the Payer’s Appeals Process ......................................................... 14
     - Prepare an Appeal Letter ....................................................................... 14
     - Assemble the Appeal Packet .................................................................. 15
     - Submit the Appeal Packet ..................................................................... 15

Appendix .................................................................................................................. 16
   - A: Sample Claim Form for Laser Fundus Autofluorescence Imaging .......... 16
   - B: Sample Appeal Letter ......................................................................... 17
Introduction: The SPECTRALIS® Imaging System

The SPECTRALIS imaging system is a multi-modality platform that provides high resolution imaging of the retina and other ocular structures to facilitate disease diagnosis and monitoring. The SPECTRALIS imaging system is available in various models with different combinations of imaging modalities as listed in Table 1 below.

Table 1. SPECTRALIS Imaging Modalities

<table>
<thead>
<tr>
<th></th>
<th>HRA+OCT</th>
<th>FA+OCT</th>
<th>HRA</th>
<th>OCTPLUS</th>
<th>OCT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Optical coherence tomography</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Infrared imaging</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Fluorescein angiography</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>ICG angiography</td>
<td></td>
<td></td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Iris angiography</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>External photography</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>BluePeak™ laser autofluorescence</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>option</td>
<td>option</td>
</tr>
<tr>
<td>Red-free laser photography</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MultiColor™ laser photography</td>
<td>option</td>
<td>option</td>
<td>option</td>
<td>option</td>
<td>option</td>
</tr>
</tbody>
</table>

This reimbursement guide is intended to:

- Provide an overview of the current coverage, coding, and billing landscape for ophthalmologic applications of BluePeak™ blue laser fundus autofluorescence imaging using the SPECTRALIS imaging system; and
- Equip health care providers with the information and tools to needed obtain reimbursement from Medicare and other third-party payers for these services.

Disclaimer

The information provided in this guide contains general reimbursement information only and is not legal advice nor is it advice about how to code, complete, or submit any particular claim for payment. The information provided represents Heidelberg Engineering's understanding of current reimbursement policies. It is the health care provider’s responsibility to determine appropriate codes, charges, and modifiers, and submit bills for the services consistent with the patient’s insurer requirements. Third-party payers may have different policies and coding requirements. Such policies can change over time. Heidelberg Engineering disclaims any responsibility for claims submitted by health care providers. Health care providers should check and verify current policies and requirements with the payer for any particular patient that will be using the SPECTRALIS imaging system.
Overview of BluePeak™ Blue Laser Fundus Autofluorescence Imaging

BluePeak blue laser fundus autofluorescence imaging is a noninvasive technique for mapping lipofuscin distribution in the retinal pigment epithelium (RPE). BluePeak maps reflect metabolic activity in the retina. To create a BluePeak image, the SPECTRALIS imaging system illuminates retinal tissue with a specific wavelength (488 nm) which excites naturally occurring fluorophores (primarily lipofuscin). In response, the lipofuscin emits light across a broad range (480-800nm) with maximal emission at 600-640 nm. The emitted light is detected by the SPECTRALIS imaging system and the BluePeak fundus autofluorescence (FAF) map is created.

In the BluePeak maps, normal background FAF levels indicate normal photoreceptor outer segment turnover. Increased signal indicates RPE dysfunction. Decreased signal indicates a loss of photoreceptors.

BluePeak maps are useful for identifying otherwise difficult to diagnose pathologies, such as:

- Optic nerve head (ONH) drusen
- Stargardt’s disease
- Distinguishing pattern dystrophy from choroidal neovascularization (CNV)
- Geographic atrophy (GA) quantification
- Distinguishing between regressed drusen and focal GA
- Quantifying RPE loss in neovascular age-related macular degeneration (NV AMD)
- Identifying RPE damage in central serous retinopathy (CSR)
- Confirming presence of RPE damage associated with drusen.

In addition, BluePeak imaging is often used to assess the health of the RPE in patients at risk of developing age-related macular degeneration (AMD). It is also used as an aid to assessing effectiveness of prescribed vitamin therapies for AMD prevention and treatment.
Coverage

Coverage refers to whether a product or service would be reimbursed by a payer, and the conditions or restrictions under which it would be paid.

In general, payers provide coverage for services when they are medically reasonable and necessary for the treatment or diagnosis of illness or injury. In most cases, statements and conditions of coverage for a particular service are communicated in coverage policies that each payer develops according to their own methods and criteria. As coverage policies typically vary by payer, health care providers are strongly encouraged to contact individual payers as needed to verify whether a service is covered, as well as any coverage guidelines or restrictions that may be in place.

Medicare Coverage

At this time, there are no national coverage determinations (NCDs) or local coverage determinations (LCDs) for ophthalmic applications of laser fundus autofluorescence imaging.

In the absence of any NCDs or LCDs for laser fundus autofluorescence imaging, Medicare will cover the procedure according to the medical necessity of each individual case. It is recommended that health care providers document a patient’s condition, medical history, and reason for the service as evidence to support coverage.

If you require additional guidance on documentation requirements for laser fundus autofluorescence imaging in the absence of an LCD, please contact your local Medicare contractor.

Private Payer Coverage

Most private payers do not have published coverage policies for laser fundus autofluorescence imaging. For these payers, coverage will be based on determinations of medical necessity on a case-by-case basis. Health care providers should document in the patient’s medical record their condition, medical history, and reason for the service as evidence to support coverage.

In the absence of published coverage policies for laser fundus autofluorescence imaging, health care providers should report the ICD-9-CM diagnosis code(s) that most accurately describe(s) the patient’s specific condition, and provide supporting documentation to demonstrate the medical necessity of the service.

As with any new technology or service/procedure, claim denials are likely and should be expected in these early stages of clinical adoption. In the event of a claim denial for laser fundus autofluorescence imaging, first review the Explanation of Benefits (EOB) sent by the payer to identify the specific reason for denial. If the claim was denied due to a lack of medical necessity, health care providers should consider filing an appeal to overturn the denial.

For more information on how to navigate the claims appeal process, please refer to Chapter 4: Appeals.
### Potential ICD-9-CM Diagnosis Codes Supporting Medical Necessity

Table 2 below identifies some ICD-9-CM diagnosis codes for ophthalmic disorders that MAY justify coverage of laser fundus autofluorescence imaging.

Not all of the codes in this list apply to all payers. In the absence of published coverage policies for laser fundus autofluorescence imaging, please contact individual payers as needed to identify covered indications for this procedure, if any.

It is ultimately the health care provider's responsibility to report the ICD-9-CM diagnosis code(s) that most accurately describe the patient's condition.

#### Table 2. Potential ICD-9-CM Diagnosis Codes Justifying Coverage of Laser Fundus Autofluorescence Imaging

<table>
<thead>
<tr>
<th>ICD-9-CM Code</th>
<th>Code Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>362.57</td>
<td>Drusen (degenerative) of retina</td>
</tr>
<tr>
<td>362.75</td>
<td>Other dystrophies primarily involving the sensory retina</td>
</tr>
<tr>
<td>362.70</td>
<td>Hereditary retinal dystrophy unspecified</td>
</tr>
<tr>
<td>362.16</td>
<td>Retinal neovascularization NOS, Neovascularization: choroidal, subretinal</td>
</tr>
<tr>
<td>363.57</td>
<td>Other diffuse or generalized dystrophy of choroid total</td>
</tr>
<tr>
<td>363.54</td>
<td>Central choroidal atrophy total</td>
</tr>
<tr>
<td>362.52</td>
<td>Exudative senile macular degeneration of retina</td>
</tr>
<tr>
<td>362.41</td>
<td>Central serous retinopathy</td>
</tr>
<tr>
<td>362.51</td>
<td>Nonexudative senile macular degeneration of retina</td>
</tr>
<tr>
<td>362.50</td>
<td>Macular degeneration (senile) of retina unspecified</td>
</tr>
<tr>
<td>362.71</td>
<td>Retinal dystrophy in systemic or cerebroretinal lipidoses</td>
</tr>
<tr>
<td>362.72</td>
<td>Retinal dystrophy in other systemic disorders and syndromes</td>
</tr>
<tr>
<td>362.73</td>
<td>Vitreoretinal dystrophies</td>
</tr>
<tr>
<td>362.74</td>
<td>Pigmentary retinal dystrophy</td>
</tr>
<tr>
<td>362.76</td>
<td>Dystrophies primarily involving the retinal pigment epithelium</td>
</tr>
<tr>
<td>362.77</td>
<td>Retinal dystrophies primarily involving bruch's membrane</td>
</tr>
<tr>
<td>362.53</td>
<td>Cystoid macular degeneration of retina</td>
</tr>
<tr>
<td>362.54</td>
<td>Macular cyst hole or pseudohole of retina</td>
</tr>
<tr>
<td>362.55</td>
<td>Toxic maculopathy of retina</td>
</tr>
<tr>
<td>362.56</td>
<td>Macular puckering of retina</td>
</tr>
<tr>
<td>362.40</td>
<td>Retinal layer separation unspecified</td>
</tr>
<tr>
<td>364.41</td>
<td>Central serous retinopathy</td>
</tr>
<tr>
<td>366.42</td>
<td>Serous detach of retinal pigment epithelium</td>
</tr>
<tr>
<td>368.43</td>
<td>Hemorrhagic detach of retinal pigment epithelium</td>
</tr>
</tbody>
</table>
Coding and Billing

Coding refers to the standardized numeric and alpha-numeric systems that are used to identify specific items and procedures furnished to a patient.

Billing refers to the submission of these codes on claim forms for adjudication by the payer and subsequent reimbursement to the provider.

There is a variety of coding systems currently in use. When billing third-party payers for an episode of care, health care providers prepare claim forms by listing codes that report the patient’s condition (ICD-9-CM diagnosis codes), procedures performed (Current Procedural Terminology (CPT\textsuperscript{1}) codes), and items furnished (Healthcare Common Procedure Coding System (HCPCS) codes).

Although these coding systems are nationally recognized and employed, in some cases coding guidelines may vary by payer. Therefore, health care providers are strongly encouraged to contact individual payers as needed to verify their specific coding guidelines for a particular service.

\textsuperscript{1} CPT is a registered trademark of the American Medical Association. © 2013 AMA. All rights reserved.
Billing for Laser Fundus Autofluorescence Imaging

At this time, there is no unique CPT code for laser fundus autofluorescence imaging. In the absence of a specific code that accurately describes this procedure, it is most appropriately billed with the following CPT code:

92499  
*Unlisted ophthalmological service or procedure*

Because unlisted codes such as CPT 92499 are intended to report services that are not otherwise described by more specific CPT codes, health care providers will also need to provide a brief description of the procedure on the claim form in order for the payer to identify the service being billed (e.g., “Laser fundus autofluorescence imaging”). This description should be entered in Field 19 in the CMS-1500 claim form.

Health care providers should also note that claims with unlisted codes may be marked by payers for manual review, and coverage subsequently determined on a case-by-case basis. Therefore, health care providers should be prepared to provide the payer with additional documentation justifying the medical necessity of the service.

For more information on the specific supporting documents that may be required, please refer to the section *Documentation Guidelines* later in this chapter.

Using Modifiers

CPT modifiers are two-letter or two-digit codes that may be appended to CPT codes on claim forms in order to convey additional information regarding the procedure(s) performed by the health care provider. For example, appending modifier –RT to a CPT code for an ophthalmic diagnostic procedure indicates that the right eye was imaged and appending modifier –LT indicates that the left eye was imaged.

These same modifiers (-RT and –LT) may also apply when using CPT 92499 to bill for laser fundus autofluorescence imaging:

- When billing for laser fundus autofluorescence imaging of the right eye only…
  - Append modifier –RT to one unit of CPT 92499
- When billing for laser fundus autofluorescence imaging of the left eye only…
  - Append modifier –LT to one unit of CPT 92499
- When billing for laser fundus autofluorescence imaging of both eyes (i.e., bilateral imaging)…
  - Append modifier –RT to one unit of CPT 92499, and append modifier –LT to one unit of 92499 as a separate line item

To view a sample claim form for bilateral laser fundus autofluorescence imaging, please refer to Appendix A.

*Please note that the sample claim form provided in this reimbursement guide is NOT inclusive of all applicable codes that may be reported for a single patient encounter. It is the responsibility of the health care provider to document and code appropriately for services performed at all times.*
**Documentation Guidelines**

Both Medicare and private payers generally require that health care providers maintain some form of documentation in the patient’s medical record to justify the medical necessity of ophthalmic imaging. Although payers may not instruct health care providers to submit the supporting documentation with every claim for these services, they may request this information at any time to facilitate a determination of medical necessity.

Because laser fundus autofluorescence imaging is billed with an unlisted code at this time, health care providers are encouraged to provide supporting documentation at the time of initial claim submission to minimize their chances of receiving a denial.

The specific documentation guidelines for laser fundus autofluorescence imaging may vary by payer, but some common requirements may include:

- Relevant patient medical history, including chart notes and other documentation supporting the ICD-9-CM diagnosis code(s) selected (e.g., description of patient complaints or symptoms)
- Relevant prior diagnostic testing and completed report(s), including any previous laser fundus autofluorescence images, when appropriate
- Copies of laser fundus autofluorescence image(s) taken, including the physician interpretation and report

For more information on the specific documentation that a payer may require to determine the medical necessity of laser fundus autofluorescence imaging, please contact individual payers directly.
Reimbursement

Reimbursement refers to the process by which health care providers are paid for the items and services furnished to a patient during an episode of care.

Under Medicare guidelines, physicians are reimbursed for their professional services according to the Medicare Physician Fee Schedule (MPFS), which aligns payment rates to individual CPT/HCPCS codes. In contrast, private payers may use a wide variety of reimbursement methodologies to pay physicians for the services provided to their beneficiaries, including fee-for-service, percent of billed charges, capitation, etc.

To ensure proper reimbursement, health care providers should document and code appropriately for services performed and/or items furnished at all times.

Reimbursement systems and rates are subject to change over time. Please check with individual payers as needed to obtain the most up-to-date payment information.
**Medicare Physician Payments**

Under Medicare, unlisted CPT codes do not have established national MPFS payment rates. Instead, physician payments are determined by local Medicare contractors on a case-by-case basis following manual review of the claims submitted.

Therefore, when billing for laser fundus autofluorescence imaging using CPT 92499, health care providers should submit documentation that describes and supports the medical necessity of the procedure in order to justify payment.

Please note that it is up to the health care provider to charge appropriately for the procedure(s) performed; Heidelberg Engineering cannot advise on charge amounts to be submitted to payers.

**Private Payer Physician Payments**

As mentioned at the beginning of this chapter, there are no standardized methodologies that private payers use to determine payment amounts for physician services.

However, similar to Medicare, claims submitted with unlisted codes are generally subject to manual review by private payers, and payment amounts subsequently determined on a case-by-case basis. Therefore, health care providers should be prepared to submit supporting documentation with each claim for laser fundus autofluorescence imaging to justify the charges submitted to the payer.

Please check your service contracts with individual private payers or contact each payer directly to verify their reimbursement methodologies for unlisted codes.
An appeal is a request by the patient or provider for the payer to review a denied or low pay claim and consider overturning the denial and reimbursing the claim at an acceptable amount.

When a claim is submitted to a payer, the payer will either pay the claim (either at an acceptable or unacceptable amount) or deny it.

For low pay claims, if the health care provider believes that the claim was underpaid, payers typically allow for low pay claim appeals to be submitted.

For claim denials, claims may be denied for two reasons: technical billing errors or lack of documented medical necessity. Technical billing errors refer to administrative mistakes on the claim form, such as reporting the wrong number of units or forgetting to list the diagnosis code. On the other hand, medical necessity denials typically arise when the payer considers a technology to be experimental/investigational and therefore non-covered, or when they believe that there is a lack of supporting documentation that demonstrates the medical necessity of the service for the particular patient in question.

The appeals process allows health care providers to request reconsideration of a denied claim, with the ultimate goal of obtaining payment for the service billed. While the requirements and timelines for this process will vary for each individual payer, most payers offer at least two levels of appeal, with decisions made at the final level of appeal usually considered binding.
Managing Claim Denials

In the event that you receive a denied claim for laser fundus autofluorescence imaging performed using the SPECTRALIS imaging system, review the Explanation of Benefits (EOB) sent by the payer (or Medicare Summary Notice if the patient is a Medicare beneficiary) to identify the specific reason for denial.

- If the payer is requesting additional information in order to adjudicate the claim, submit the necessary documentation according to the payer’s instructions.
- If the claim was denied due to technical billing errors (e.g., incorrect modifier, missing diagnosis code), correct the claim form and resubmit to the payer for processing.
- If the claim was denied due to lack of medical necessity, consider filing an appeal according to the payer’s specific guidelines.

Appealing Denials

Verify the Payer’s Appeals Process

It is important to note that individual payers have different appeals processes. The first step in filing an appeal should be to contact the payer in question to verify their specific administrative requirements and timelines. Some payers may utilize a standard appeal form or require a written letter to initiate an appeal – it will be important to identify such factors before beginning the process.²

The following are some key questions to ask to obtain a complete picture of a payer’s appeals process:

- Does the appeal have to be filed by the patient or the health care provider?
- Is there a particular form that needs to be completed?
- How many levels of appeal are allowed?
- What is the administrative process at each level of appeal?
- What are the deadlines for requesting an appeal?
- Where and how should appeals be sent?
- What type of supporting documentation should be submitted for a medical necessity appeal?
- Who is the appropriate point of contact with whom to follow up on an appeal?
- When can a response on the appeal be expected?

Prepare an Appeal Letter

If the payer does not use a standard appeal form, draft an appeal letter summarizing why you believe the denied service should be covered for the patient.

The letter should specify the reason for appeal (as listed in the EOB or denial letter received from the payer) and clearly identify the medical necessity of the service provided within the context of each patient’s unique situation.

To view a sample appeal letter template for laser fundus autofluorescence imaging, please refer to Appendix B.

---

² The Medicare appeals process is standardized across all regional contractors. For more information, please visit the CMS website at [http://www.cms.hhs.gov/MLNProducts/downloads/MedicareAppealsprocess.pdf](http://www.cms.hhs.gov/MLNProducts/downloads/MedicareAppealsprocess.pdf).
Assemble the Appeal Packet

Aside from the appeal letter, appeal packets typically include additional supporting materials to document the medical necessity of the service provided.

One of the key components of an appeal packet is a letter of medical necessity signed by the ordering physician that clearly describes the condition(s) justifying the service provided to the patient. A sample letter of medical necessity for laser fundus autofluorescence imaging is provided in Appendix B of this reimbursement guide.

The documentation listed below is an example of the other types of information that may be submitted to support an appeal for laser fundus autofluorescence imaging performed on the SPECTRALIS imaging system:

- Physician order for the service
- Patient’s medical history relevant to the indicated diagnosis
- Copy of the laser fundus autofluorescence image(s)
- Physician interpretation and report of diagnostic results
- Relevant clinical literature

Submit the Appeal Packet

Once the appeal packet has been assembled, it should be submitted to the payer according to their specific guidelines. The following are some tips to ensure that your appeal is successfully submitted:

- Before sending, verify that the appeal packet is correctly addressed to the payer’s appeals department
- When possible, obtain a fax number for the payer’s appeals department and send a copy of all documents via fax as well
- Contact the payer’s appeals department one week after submission to confirm that your appeal was received; if not received by that time, check back periodically until confirmation is given

If you are not satisfied with the outcome of an appeal at a particular level, you may consider elevating the appeal to the next level (if available). Please be advised that the guidelines and timeframes for subsequent levels of appeal may be included in the decision letter provided by the payer. If this information is not readily available, contact the payer’s appeals department for further instructions.
Enter brief description of the procedure (example shown)

Enter the ICD-9-CM diagnosis code that describes the patient's condition (example shown)

Unit counts of 1

CPT code for unlisted ophthalmological service or procedure

Modifiers RT and LT appended to indicate bilateral imaging
Appendix B

Sample Appeal Letter for Laser Fundus Autofluorescence Imaging

[Date]

[Payer Name]
[Address]
[City, State, Zip code]

RE: Appeal of Denied Claim for Laser Fundus Autofluorescence Imaging (CPT 92499)

Beneficiary Name:
Date of Birth:
Subscriber ID Number:
Claim Number:
Claim Date of Service:

Dear Sir/Madam,

I am writing to appeal the denial for laser fundus autofluorescence (FAF) imaging that was performed for [Patient Name] on [Date of Service]. The following denial reason was listed on the attached Explanation of Benefits (EOB):

[List the reason for denial as listed on the EOB or denial letter from the payer]

I strongly believe that FAF was medically necessary for this patient and will further explain the reason why, which will include the patient’s diagnosis, medical history, and explanation of FAF imaging.

Clinical Background of FAF Imaging

A normal function of the retinal pigment epithelium (RPE) includes digesting waste products generated by photoreceptors. Lipofuscin, one of the metabolites in this process, accumulates naturally with age in RPE cells. Excessive accumulation of lipofuscin can lead to cellular toxicity and eventually cell death or atrophy, thus representing a common pathogenetic pathway in various degenerative retinal diseases such as age-related macular degeneration (AMD).

FAF signals are generated when lipofuscin in the RPE is exposed to a peak wavelength of blue light (488 nm), creating a metabolic map based on the presence or absence of lipofuscin. In this way, FAF allows areas of geographic atrophy (GA) or other dystrophy of the RPE to be identified, thus providing clinicians with a functional indicator of retinal health that cannot be obtained from other imaging methods such as laser fundus photography or fluorescein angiography.

Clinical Utility of FAF Imaging

The clinical utility of FAF is strongly supported by the published literature. Because lipofuscin accumulation plays a large role in manifestations of GA (a common phenotype of AMD), distinct FAF patterns may serve as prognostic determinants of GA progression in eyes with atrophic AMD.1,5 Other published studies have also demonstrated that FAF is clinically useful as a diagnostic tool for ophthalmologic diseases such as pseudoxanthoma elasticum and cystoid macular edema.6,7

Application of FAF for [Patient Name]

[Insert information about the patient’s medical history pertinent to the diagnosis necessitating FAF in this instance. Describe how FAF results were used to confirm a diagnosis or identify the progression of a disease, and how this information may have influenced subsequent treatment/management decisions for]
the patient. Consider including any patient’s complains or symptoms and any relevant prior diagnostic testing.] In summary, FAF imaging is reasonable and medically necessary for [Patient Name]'s condition and warrants coverage. Enclosed are documents supporting the medical necessity of the procedure for this patient, and below is a bibliography of relevant literature that demonstrate the clinical utility of FAF. Should you require more information on this case, please do not hesitate to contact me at [Physician Phone Number]. Thank you for your assistance.

Sincerely,

[Physician Signature]

[Physician Name]
[Practice Name]

Enclosed:

- Patient’s Explanation of Benefits
- Patient’s medical records
- Patient’s FAF image(s) and physician interpretation & report
- [List any other relevant supporting documentation that may be available]

Select FAF Literature References: