



REIMBURSEMENT GUIDE

Anterior Segment OCT

This guide is intended to provide coding and billing information valid from **December 1, 2011**. Reimbursement codes and billing practices change over time. All information is subject to the descriptions and disclaimers contained in this guide.



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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 system is available in various models with different combinations of imaging modalities as listed in Table 1 below. The SPECTRALIS Anterior Segment Module (ASM) enables any SPECTRALIS OCT model to capture and view anterior segment OCT images, including images of the cornea, anterior chamber angles, sclera, and other structures.

Table 1 - SPECTRALIS Imaging Modalities

	HRA+OCT	FA+OCT	HRA	OCT ^{PLUS} with BluePeak	OCT ^{PLUS}	OCT with BluePeak	OCT
Optical coherence tomography	✓	✓		✓	✓	✓	✓
Infrared imaging	✓	✓	✓	✓	✓	✓	✓
Fluorescein angiography	✓	✓	✓				
ICG angiography	✓		✓				
Iris angiography	✓	✓	✓				
External photography	✓	✓	✓	✓	✓	✓	✓
BluePeak blue laser autofluorescence	✓	✓	✓	✓		✓	
Red-free photography	✓	✓	✓				
Fundus photography	✓	✓	✓	✓	✓	✓	✓

This reimbursement guide is intended to:

- Provide an overview of the current coverage, coding, and billing landscape for ophthalmologic applications of OCT using the SPECTRALIS Anterior Segment Module (ASM); and
- Equip health care providers with the information and tools to 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 denies 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.

1

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.

Anterior Segment Optical Coherence Tomography (OCT)

Medicare Coverage

There is no single national coverage policy for ophthalmologic applications of anterior segment OCT. However, some Medicare contractors have published Local Coverage Determinations (LCDs) stipulating various patient diagnoses that would justify coverage of this technology.

As of December 2011, the following Medicare contractors have published LCDs on anterior segment OCT:

- CGS Administrators (ID)
- First Coast Service Options (FL, PR, VI)
- Highmark Medicare Services (DE, DC, MD, NJ, PA)
- National Heritage Insurance Company (ME, MA, NH, RI, VT)
- Palmetto GBA (SC, NC, VA, WV)

To determine if anterior segment OCT would be covered for a particular condition, please refer to your local Medicare contractor’s LCD to identify if there are any covered International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) diagnosis codes that would appropriately describe the patient’s specific condition. If so, utilization of OCT for this indication may then be covered under the existing policy. It is the health care provider’s responsibility to report the ICD-9-CM diagnosis code(s) that most accurately describe(s) the patient’s disease state.

Table 2. Steps to Determine Medicare Coverage for Anterior Segment OCT

1	Go to the Centers for Medicare & Medicaid Services (CMS) website at http://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx to access the Medicare Coverage Database.
2	Search for the LCD relevant to your state or geographic area, using “92132” as the CPT/HCPCS code criteria.
3	Within the relevant LCD, locate the list of “ICD-9 codes that support medical necessity” and identify if there are any diagnosis codes that match the patient’s specific condition. If so, your local Medicare contractor will likely cover anterior segment OCT for that particular patient.

In the absence of an LCD for anterior segment OCT, Medicare will cover the procedure according to the medical necessity of an individual case. It is recommended that health care providers document the following in the patient’s medical record as evidence to support coverage: the patient’s condition, medical history, and reason for the service. Specific documentation guidelines are typically included in each LCD. If you require additional guidance on documentation requirements for anterior segment OCT in the absence of an LCD, please contact your local Medicare contractor.

Private Payer Coverage

Several private payers, including Aetna, Anthem Blue Cross, and Blue Cross Blue Shield of Florida, have published non-coverage policies for anterior segment OCT, which they consider “experimental and investigational” due to a belief that its clinical value has not yet been established in the published literature. In the event of a claim denial, health care providers can opt to file an appeal with the payer. Success in overturning denials will then be dependent on justifying the medical necessity of the procedure in each individual case. For more information on submitting appeals, please refer to Chapter 4: *Appeals*.

On the other hand, some private payers do not have published coverage policies for anterior segment OCT. 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.

As coverage guidelines vary by payer, please refer to individual private payer policies to determine the conditions for coverage of anterior segment OCT in each case.

ICD-9-CM Diagnosis Codes Supporting Medical Necessity

Table 3 includes some, but not necessarily all, of the common ICD-9-CM diagnosis codes for ophthalmic disorders that may justify coverage of anterior segment OCT.

Not all of the codes in this list may apply to a given payer. Please refer to individual Medicare LCDs and private payer coverage policies to identify the appropriate list of covered diagnoses, if any, for a specific payer. 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 3. ICD-9-CM Diagnosis Codes Commonly Covered for Anterior Segment OCT

ICD-9-CM Code	Code Description
190.0	MALIGNANT NEOPLASM OF EYEBALL EXCEPT CONJUNCTIVA CORNEA RETINA AND CHOROID
190.4	MALIGNANT NEOPLASM OF CORNEA
224.0	BENIGN NEOPLASM OF EYEBALL EXCEPT CONJUNCTIVA CORNEA RETINA AND CHOROID
224.3	BENIGN NEOPLASM OF CONJUNCTIVA
224.4	BENIGN NEOPLASM OF CORNEA
224.6	BENIGN NEOPLASM OF CHOROID
224.8	BENIGN NEOPLASM OF OTHER SPECIFIED PARTS OF EYE
364.51 - 364.59	ESSENTIAL OR PROGRESSIVE IRIS ATROPHY - OTHER IRIS ATROPHY
364.60 - 364.64	IDIOPATHIC CYSTS OF IRIS AND CILIARY BODY - EXUDATIVE CYST OF PARS PLANA
364.70 - 364.77	ADHESIONS OF IRIS UNSPECIFIED - RECESSION OF CHAMBER ANGLE OF EYE
364.81 - 364.89	FLOPPY IRIS SYNDROME - OTHER DISORDERS OF IRIS AND CILIARY BODY
365.02	ANATOMICAL NARROW ANGLE BORDERLINE GLAUCOMA
365.06	PRIMARY ANGLE CLOSURE WITHOUT GLAUCOMA DAMAGE
365.20 - 365.24	PRIMARY ANGLE-CLOSURE GLAUCOMA UNSPECIFIED - RESIDUAL STAGE OF ANGLE-CLOSURE GLAUCOMA
365.41 - 365.44	GLAUCOMA ASSOCIATED WITH CHAMBER ANGLE ANOMALIES - GLAUCOMA ASSOCIATED WITH SYSTEMIC SYNDROMES
365.51 - 365.59	PHACOLYTIC GLAUCOMA - GLAUCOMA ASSOCIATED WITH OTHER LENS DISORDERS
365.60 - 365.65	GLAUCOMA ASSOCIATED WITH UNSPECIFIED OCULAR DISORDER - GLAUCOMA ASSOCIATED WITH OCULAR TRAUMA
365.81 - 365.89	HYPERSECRETION GLAUCOMA - OTHER SPECIFIED GLAUCOMA
370.04	HYPOPYON ULCER
370.05	MYCOTIC CORNEAL ULCER
370.06	PERFORATED CORNEAL ULCER
371.00 - 371.05	CORNEAL OPACITY UNSPECIFIED - PHTHISICAL CORNEA
371.20 - 371.24	CORNEAL EDEMA UNSPECIFIED - CORNEAL EDEMA DUE TO WEARING OF CONTACT LENSES
371.71	CORNEAL ECTASIA
371.72	DESCEMETOCELE
371.73	CORNEAL STAPHYLOMA
372.40 - 372.45	PTERYGIUM UNSPECIFIED - RECURRENT PTERYGIUM
379.31	APHAKIA
379.32	SUBLUXATION OF LENS
379.33	ANTERIOR DISLOCATION OF LENS
379.39	OTHER DISORDERS OF LENS

2

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 are 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^{®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.

¹ CPT is a registered trademark of the American Medical Association. © 2011 AMA. All rights reserved.

Billing for Anterior Segment OCT

Effective January 1, 2011, there are three distinct CPT codes available to report OCT imaging. Two of the codes (92133 and 92134) describe *posterior* imaging and are not discussed in this guide. There is one distinct CPT code available to report anterior segment OCT imaging:

92132 **Scanning computerized ophthalmic diagnostic imaging, anterior segment, with interpretation and report, unilateral or bilateral**

All of the existing OCT codes (92132 – 92134) are intended to report unilateral OR bilateral procedures. This means that for each code, only one unit should be reported for a single patient encounter, regardless of whether the procedure is performed on one or both eyes.

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. Proper use of modifiers is necessary for accurate billing, and it is the responsibility of the health care provider to determine which modifier(s), if any, may be applicable in a given scenario.

Table 4 below lists some of the common modifiers that may apply to anterior segment OCT.

Table 4. Common Modifiers for Anterior Segment OCT

Modifier	Explanation
-RT	Right eye is imaged
-LT	Left eye is imaged
-59	Distinct procedural service – to identify procedures, other than E/M services, that are not normally reported together, but are appropriate under the clinical circumstances
-TC	Technical component – when billing for ONLY the actual taking of the image, the equipment, and the technology
-26	Professional component – when billing for ONLY the analysis and interpretation of the image obtained

Because CPT 92132 describes both unilateral *and* bilateral procedures:

1. If anterior segment OCT is performed on **both** eyes, bill 92132 as a single line item with a unit count of one.
2. If anterior segment OCT is performed on **one** eye, bill 92132 as a single line item with a unit count of one, and append the –RT or –LT modifier to indicate which eye was imaged.

In the event that only the technical or professional component of anterior segment OCT is performed, health care providers can bill for the service by appending the -TC or -26 modifier, respectively, to CPT 92132.

To view a sample claim form for anterior segment OCT imaging, see Appendix A.

Please note that the sample claim forms provided in this reimbursement guide are 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 anterior segment OCT. 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.

The specific documentation guidelines for anterior segment OCT will vary by payer, but some common requirements include:

- Relevant patient medical history, including progress notes supporting the ICD-9-CM diagnosis code(s) selected (e.g., description of patient complaints or symptoms)
- Copy of the test results and computer analysis of the data
- Documentation of how test results were used in the patient's plan of care
- Relevant prior diagnostic testing and completed report(s), including any previous OCT results when appropriate

Please refer to individual Medicare LCDs or private payer coverage policies to verify documentation requirements for a particular payer. In the absence of LCDs or coverage policies for anterior segment OCT, please contact the payer directly to obtain additional guidance.

National Correct Coding Initiative (NCCI) Edits

Medicare's NCCI edits identify procedure code pairs that cannot be billed together for the same patient on the same date of service because it would be medically unlikely or unnecessary to do so. The goal of these edits is to prevent improper payment when incorrect code combinations are reported.

While these edits are maintained by CMS and used by Medicare, private payers typically have similar coding edits in their claims processing systems. Please note that the following information is specific to Medicare policy; health care providers should contact individual private payers as needed to confirm their correct coding guidelines for anterior segment OCT imaging.

CPT 92132 + 92133 OR 92134

Under current NCCI edits, OCT of the anterior segment and OCT of the posterior segment (optic nerve/92133 or retina/92134) cannot be billed together for the same patient on the same date of service. In the event that these codes are billed together for the same patient encounter, only CPT 92133 or 92134 would be paid; CPT 92132 would be denied.

However, in certain situations where it may be medically necessary to perform both anterior segment OCT and posterior segment OCT during the same patient encounter, both procedures may be paid if an appropriate modifier is appended and supported by additional clinical documentation.

CPT 92132 + 92250

At the time of publication of this reimbursement guide, there are no NCCI edits that would prevent both CPT 92132 and 92250 (fundus imaging) from being billed together for the same patient encounter. However, health care providers should be prepared to provide documentation justifying the medical necessity of performing both procedures in the same session if requested by the payer.

CPT 92132 + 92499

Some payers such as Trailblazer (Medicare) may require infrared/red-free fundus imaging to be billed using CPT 92499 instead of 92250. In this case, while there are no NCCI edits specifically for the code pairs consisting of CPT 92132 and 92499, the presence of the unlisted code 92499 on the claim form would likely trigger manual review of the claim by the payer. Therefore, if both CPT codes are billed together for the same patient encounter, it would be up to the discretion of the payer to determine whether one or both codes can be paid.

For more information on the comprehensive set of NCCI edits for OCT imaging, please refer to the CMS website at <http://www.cms.gov/NationalCorrectCodInitEd/>.

3

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

Current calendar year (CY) 2011 MPFS payment rates for anterior segment OCT imaging are provided below in Table 5. Keep in mind that while these rates represent national base payments, actual reimbursement amounts will vary by location due to adjustments for geographic differences.

Table 5. 2011 Medicare Physician Payment Rates for Anterior Segment OCT

CPT Code	Code Descriptor	Component	2011 Medicare Physician Fee Schedule
92132	Scanning computerized ophthalmic diagnostic imaging, anterior segment, with interpretation and report, unilateral or bilateral	Global*	\$36.35
		TC [†]	\$15.29
		26 [‡]	\$21.07

[†] TC – Technical component

[‡] 26 – Professional component

* Global – Sum of technical and professional components

The “unilateral or bilateral” status of the CPT code for anterior segment OCT has significant implications for provider reimbursement. Since only one unit of CPT 92132 can be billed for unilateral or bilateral OCT, this means that a physician would receive the same payment amount regardless of whether the procedure is performed on one or both eyes.

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. Please check your service contracts with individual private payers or contact each payer directly to verify the applicable reimbursement methodologies and/or amounts for anterior segment OCT.

4

Appeals

An appeal is a request by the patient or provider for the payer to review a denied claim or service and consider overturning the denial and reimbursing the claim or service.

When a claim is submitted to a payer, the payer will either approve the claim for payment or deny it. In general, 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 anterior segment OCT imaging performed using the SPECTRALIS, 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

If you decide to appeal a denied claim, it is important to note that individual payers have different appeals processes. Therefore, 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

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.

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>.

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. The documentation listed below is an example of the other types of information that may be submitted to support an appeal for anterior segment OCT imaging performed on the SPECTRALIS:

- Physician order for the service
- Patient's medical history relevant to the indicated diagnosis
- OCT test results
- 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.

Appendix A

Sample CMS-1500 Claim Form for Unilateral or Bilateral Anterior Segment OCT

1500
HEALTH INSURANCE CLAIM FORM
 APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

PICA PICA

1. MEDICARE <input type="checkbox"/> (Medicare #) MEDICAID <input type="checkbox"/> (Medicaid #) TRICARE CHAMPUS <input type="checkbox"/> (Sponsor's SSN) CHAMPVA <input type="checkbox"/> (Member ID#) GROUP HEALTH PLAN <input type="checkbox"/> (SSN or ID) FECA BLK LUNG <input type="checkbox"/> (SSN) OTHER <input type="checkbox"/> (ID)	1a. INSURED'S I.D. NUMBER (For Program in Item 1)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) DOE, JOHN		3. PATIENT'S BIRTH DATE MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>
5. PATIENT'S ADDRESS (No., Street) 123 MAIN ST CITY ANYTOWN STATE CA ZIP CODE 12345 TELEPHONE (Include Area Code) (123) 555-1234		4. INSURED'S NAME (Last Name, First Name, Middle Initial)
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) CITY STATE ZIP CODE TELEPHONE (Include Area Code)
8. PATIENT STATUS Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/> Employed <input type="checkbox"/> Full-Time Student <input type="checkbox"/> Part-Time Student <input type="checkbox"/>		8. PATIENT'S BIRTH DATE MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input type="checkbox"/> b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> PLACE (State) _____ c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> 10d. RESERVED FOR LOCAL USE
11. INSURED'S POLICY GROUP OR FECA NUMBER		11. INSURED'S POLICY GROUP OR FECA NUMBER
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 _____		12. PATIENT'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
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY PITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY TO MM DD YY
19. RESERVED FOR LOCAL USE		21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relat) 1. 365.06
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY B. PLACE OF SERVICE C. CPT/HCPCS D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E. DIAGNOSIS POINTER F. CHARGES G. DAYS OR UNITS H. EFFECT Family Plan I. ID. QUAL J. RENDERING PROVIDER ID. #		21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relat) 2. _____
1 12 01 11 92132 365.06 1 NPI		21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relat) 3. _____
2 12 01 11 92132 365.06 1 NPI		21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relat) 4. _____
3 12 01 11 92132 365.06 1 NPI		21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relat) 5. _____
4 12 01 11 92132 365.06 1 NPI		21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relat) 6. _____
5 12 01 11 92132 365.06 1 NPI		21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relat) 6. _____
6 12 01 11 92132 365.06 1 NPI		21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relat) 6. _____
25. FEDERAL TAX I.D. NUMBER SSN EIN 26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES <input type="checkbox"/> NO <input type="checkbox"/> 28. TOTAL CHARGE \$ 29. AMOUNT PAID \$ 30. BALANCE DUE \$		21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relat) 6. _____
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.) SIGNED _____ DATE _____		33. BILLING PROVIDER INFO & PH # ()
a. NPI b. _____		a. NPI b. _____

NUCC Instruction Manual available at: www.nucc.org APPROVED OMB-0938-0999 FORM CMS-1500 (08-05)

Enter the appropriate ICD-9-CM diagnosis code that describes the patient's condition that necessitates the procedure (Example shown)

Unit count of 1 (for unilateral or bilateral imaging)

CPT code for anterior segment OCT

CPT and all CPT codes are copyrighted by the
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This document should not be considered a replacement for published Medicare regulations.

For more information, call 800-931-2230 or visit www.HeidelbergEngineering.com



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