The following information is a general overview of coverage for scanning computerized ophthalmic diagnostic imaging using Stratus OCT and Cirrus HD-OCT by Carl Zeiss Meditec. The coding, coverage, and payment information contained in this guide is gathered from various resources and is subject to change. Carl Zeiss Meditec cannot guarantee success in obtaining third-party insurance payments. Third-party payment for medical products and services is affected by numerous factors. It is the responsibility of the provider to determine and submit appropriate codes, charges, and modifiers for the services being rendered. Providers should contact their third-party payers for specific information on their coding, coverage, and payment policies.

If you have any questions or concerns regarding this billing guide, please contact Senior Practice Building Specialist, Cheri Ritter, at (858) 716-0697.

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Appendix: Stratus OCT and Cirrus HD-OCT Medicare Part B Quick Reference Guide
COVERAGE FOR STRATUS OCT/CIRRUS HD-OCT

Medicare

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

For Medicare patients, your local Medicare carrier or fiscal intermediary may have specific clinical criteria defining patients for whom ophthalmic diagnostic imaging will be covered. In some cases, specific diagnostic criteria can be found in Medicare Local Coverage Determinations (LCDs), or other coverage policies issued by the patient’s insurer. The table in the Appendix provides a brief summary of Medicare LCDs which apply to the Stratus OCT and Cirrus HD-OCT procedures.

When submitting claims for Stratus OCT or Cirrus HD-OCT procedures, providers should record patient diagnosis to the greatest level of specificity. The following page 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 scanning computerized ophthalmic diagnostic imaging.

Medicaid and Private Insurance

Coverage

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

Coding

On claims to private insurers and Medicaid programs, procedures performed with the Stratus OCT and the Cirrus HD-OCT can be coded using the following Current Procedural Terminology (CPT) code1:

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

This same CPT code can be used when filing claims for patients who have Medicare as a primary insurance and Medicaid as a secondary insurance. To check coding requirements for an individual plan, it is recommended that providers contact the private insurance plan or the state Medicaid agency directly.

Reimbursement

Private insurance and Medicaid payment arrangements vary considerably between patients and plans. It is best to contact the insurer directly to check on the reimbursement policy specific to that payer.

---

1 All Current Procedural Terminology (CPT) five-digit numeric codes, descriptions, numeric modifiers, instructions, guidelines, and other material are copyright 2008 American Medical Association; all rights reserved.
Please check your local medical policy to determine which diagnosis codes are covered by your Medicare carrier or fiscal intermediary.
Coding

Medicare requires that providers submit claims with ICD-9-CM patient diagnosis codes and CPT codes.

*Diagnosis Codes*

Please see Page 4 of this billing guide.

*Procedure Codes*

Procedural coding requirements for the use of the Stratus OCT and Cirrus HD-OCT can vary from carrier to carrier. Medicare carriers may allow the following CPT code for scanning computerized ophthalmic diagnostic imaging procedures using the Stratus OCT or the Cirrus HD-OCT:

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

Again, checking with your local carrier for the appropriate code will help you with accuracy when submitting a claim.

Reimbursement

In the physician office and freestanding facility, Medicare carriers will pay for scanning computerized ophthalmic diagnostic imaging procedures based on the National Physician Fee Schedule. The following table outlines Medicare’s national unadjusted fee schedule effective January 1, 2008. Please check your local carrier for the allowable payment specific to your area.

<table>
<thead>
<tr>
<th>CPT code</th>
<th>Modifier</th>
<th>Description</th>
<th>Total Unadjusted Allowable Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>92135</td>
<td></td>
<td>Scanning computerized ophthalmic diagnostic imaging, posterior segment, (eg, scanning laser) with interpretation and report, unilateral</td>
<td>$42.66</td>
</tr>
<tr>
<td>92135</td>
<td>TC</td>
<td>- Technical component</td>
<td>$25.52</td>
</tr>
<tr>
<td>92135</td>
<td>26</td>
<td>- Professional component</td>
<td>$17.14</td>
</tr>
</tbody>
</table>
Professional and Technical Components

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

No modifier  Global service
26  Professional component
TC  Technical component

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

Modifiers

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

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

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

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

Check with your local Medicare carrier to determine which method is most appropriate for your area.
SAMPLE CMS-1500 CLAIM FORM

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE 08/05

1. MEDICARE | MEDICAID | TRICARE | CHAMPVA | GROUP | FEDERAL

(Medicare #) | (Medicaid #) | (Tricare #) | (Champva #) | (Group #) | (Federal #)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)
   Doe, John

3. PATIENT'S DATE OF BIRTH
   04 25 20

4. PATIENT'S GENDER
   M

5. PATIENT'S ADDRESS (No., Street)
   1245 Virginia Street

6. PATIENT'S RELATIONSHIP TO INSURED
   Self

7. PATIENT'S RESIDENTIAL ADDRESS (Street)
   1245 Virginia Street

8. PATIENT'S STATE
   AS

9. PATIENT'S ZIP CODE
   01010

10. PATIENT'S TELEPHONE (Include Area Code)
    555-1234

11. INSURED'S NAME (Last Name, First Name, Middle Initial)
    Doe, John

12. INSURED'S DATE OF BIRTH
    04 25 20

13. INSURED'S GENDER
    M

14. INSURED'S ADDRESS (Street)
    1245 Virginia Street

15. INSURED'S CITY
    Anytown

16. INSURED'S STATE
    AS

17. INSURED'S ZIP CODE
    01010

18. INSURED'S TELEPHONE (Include Area Code)
    555-1234

19. EMPLOYER'S NAME
    Dr. Jane Smith

20. EMPLOYER'S TELEPHONE (Include Area Code)
    555-1234

21. EMPLOYER'S ADDRESS (Street)
    1245 Virginia Street

22. EMPLOYER'S CITY
    Anytown

23. EMPLOYER'S STATE
    AS

24. EMPLOYER'S ZIP CODE
    01010

25. EMPLOYER'S TELEPHONE (Include Area Code)
    555-1234

DIAGNOSIS OR NATURE

1. Code for the patient diagnosis
   CPT code for Stratus OCT, Cirrus HD-OCT or other appropriate code

2. Date of Service
   01 08 01 01 08

3. Procedure Code
   92135

4. Service
   modifier

5. Service
   92135

6. Federal Tax ID Number
   0330333

7. Patient's Account Number
   99-9999

8. Signature of Physician or Supplier
   (I certify that the statements on the reverse apply to this bill and are made a part thereof)

9. Service Facility Location Information
   Freestanding Center
   15 Elm Street
   Anytown, AS 01010
   (203) 555-4321

10. Date
    a.

11. Date
    b.

12. Date
    a.

13. Date
    b.

* Check with your local medical review policy to determine which coding practice is most appropriate.
Coding

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

Diagnosis Codes

Please see Page 4 of this billing guide.

Revenue Codes

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

- 510 Clinic, general classification
- 920 Other diagnostic services

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

Procedure Codes

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

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

Reimbursement

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

The following table outlines 2008 HOPPS reimbursement effective January 1, 2008:

<table>
<thead>
<tr>
<th>CPT code</th>
<th>APC Description</th>
<th>HOPD2 Status</th>
<th>APC</th>
<th>Minimum Unadjusted Copayment</th>
<th>Medicare Payment</th>
<th>Total Unadjusted Allowable Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>92135</td>
<td>Level 1 Eye Tests and Treatments</td>
<td>$3</td>
<td>230</td>
<td>$7.52</td>
<td>$30.08</td>
<td>$37.60</td>
</tr>
</tbody>
</table>

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

3 Status indicator $: Significant procedure, not discounted when multiple procedures are performed.
<table>
<thead>
<tr>
<th>Item</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>7/25/1920</td>
<td>Date of Service</td>
</tr>
<tr>
<td>John Doe</td>
<td>Patient Name</td>
</tr>
<tr>
<td>1245 Virginia Street, Anytown, AS, 01010</td>
<td>Patient Address</td>
</tr>
</tbody>
</table>

The CPT code for the Stratus OCT and Cirrus HD-OCT maps to APC 230.

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

Enter CPT code and appropriate modifier.

Indicate 1 unit when using the -50 modifier.*

Insert code for patient diagnosis.

* Check with your local fiscal intermediary to determine the most appropriate coding for your area.
When a payer denies a claim, generally a letter or note is sent that lists the reason(s) for the denial. Inaccurate coding, misspellings, and missing information often are the reason for claims rejections. In such cases, claims should be corrected and resubmitted.

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

- **Letter of medical necessity**: The insurer may consider payment on a case-by-case base if you submit a letter explaining why the patient should undergo scanning computerized ophthalmic diagnostic imaging using the Stratus OCT or the Cirrus HD-OCT. Be advised, however, that submitting a letter of medical necessity does not guarantee payment. Please see page 12 of this billing guide for a sample letter.
- **Clinical information on Stratus OCT or the Cirrus HD-OCT**: The insurance company may need information explaining the use of these devices for patients with certain pathologies.

Insurers’ policies may vary with respect to coverage of Stratus OCT and Cirrus HD-OCT for any given patient indication. Therefore, you should check the specific payer policy for coverage of scanning computerized ophthalmic diagnostic imaging.
Q: How do I bill Medicare for scanning computerized ophthalmic diagnostic imaging when used in the physician’s office?

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

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

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

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

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

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

Please refer to the Appendix for more information on Medicare Part B carrier guidelines on the frequency of use. Carriers may request a letter of medical necessity or medical records as justification for a patient to undergo multiple scanning computerized ophthalmic diagnostic imaging procedures in one year.

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

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

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

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

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

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

If you believe the claim should have been paid, you may request additional consideration of coverage and submit an appeal to the insurer. Often, this will require a written statement detailing the reason(s) why the procedure was considered medically necessary. Insurance companies may have additional guidelines on how providers should appeal a denied claim. For further assistance, contact Carl Zeiss Meditec’s Senior Practice Building Specialist, Cheri Ritter, at (858) 716-0697.

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4 American Medical Association; CPT Assistant; Mar 99: 10.
[Date]

[Name of Medical Director]
[Title]
[Name of Insurer]
[Address of Insurer]
[City, ST, Zip]

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

Dear [Name of Medical Director]:

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

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

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

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

Disease Management Rationale and Request for Coverage Approval

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

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

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

Sincerely,

[Physician's name]
The table on the next page provides a brief summary of each Medicare Part B Local Coverage Determination that would apply to the Stratus OCT and the Cirrus HD-OCT. The table has been divided into the following columns:

<table>
<thead>
<tr>
<th>State</th>
<th>Each state is listed in alphabetical order. Please note that some states are covered by multiple carriers – in this case, the region for the listed carrier is found in parentheses next to the state name.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Carrier name</td>
<td>Medicare Part B carrier is indicated for each state/region.</td>
</tr>
<tr>
<td>LCD</td>
<td>Indicates whether carrier has an LCD for scanning computerized ophthalmic diagnostic imaging.</td>
</tr>
<tr>
<td>LCD name</td>
<td>Title of each LCD pertains to scanning computerized ophthalmic diagnostic imaging. Each carrier may use its own discretion when creating a title for an LCD. All Medicare carriers will not have the same policy name for the same procedure. For those carriers without a published policy for scanning computerized ophthalmic diagnostic imaging tests, a hyphen (--) has been used to indicate “no policy.”</td>
</tr>
<tr>
<td>Frequency of visits per year – glaucoma</td>
<td>Indicates how frequently providers can bill scanning computerized ophthalmic diagnostic imaging tests for glaucoma indications. Please check with your carrier for more detailed policy guidelines regarding frequency limitations.</td>
</tr>
<tr>
<td>Other frequency limitations per year</td>
<td>Indicates how frequently providers can bill scanning computerized ophthalmic diagnostic imaging tests for covered indications other than glaucoma. The relevant covered indications for which the listed limitations apply are given in parentheses. For those carriers who have not explicitly stated frequency of visits, “no mention” has been used to indicate this. Please check with your carrier for more detailed policy guidelines regarding frequency limitations.</td>
</tr>
</tbody>
</table>

Please note the following abbreviations:

<table>
<thead>
<tr>
<th>Policy Titles</th>
</tr>
</thead>
<tbody>
<tr>
<td>LCT</td>
</tr>
<tr>
<td>OCT</td>
</tr>
<tr>
<td>RNFLI</td>
</tr>
<tr>
<td>SCODI</td>
</tr>
<tr>
<td>SLGT</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Carrier Names</th>
</tr>
</thead>
<tbody>
<tr>
<td>GHI</td>
</tr>
<tr>
<td>NHIC</td>
</tr>
<tr>
<td>WPS</td>
</tr>
<tr>
<td>NGS</td>
</tr>
</tbody>
</table>

This Medicare Part B Quick Reference Guide is subject to change. Please check with your local Medicare Part B carrier to determine appropriate policy guidelines for use of the Stratus OCT and the Cirrus HD-OCT.
<table>
<thead>
<tr>
<th>State</th>
<th>Carrier name</th>
<th>LCD name</th>
<th>Frequency of visits per year - glaucoma</th>
<th>Other frequency limitations per year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alabama</td>
<td>Cahaba</td>
<td>OCT</td>
<td>1-2 times</td>
<td>No mention</td>
</tr>
<tr>
<td>Alaska</td>
<td>Noridian</td>
<td>No</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>Arizona</td>
<td>Noridian</td>
<td>No</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>Arkansas</td>
<td>Pinnacle</td>
<td>Yes</td>
<td>SCODI</td>
<td>1-2 times</td>
</tr>
<tr>
<td>California</td>
<td>NHIC</td>
<td>No</td>
<td>--</td>
<td>No mention</td>
</tr>
<tr>
<td>Colorado</td>
<td>Noridian</td>
<td>No</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>Connecticut</td>
<td>First Coast</td>
<td>Yes</td>
<td>SCODI</td>
<td>1-2 times</td>
</tr>
<tr>
<td>Delaware</td>
<td>TrailBlazer</td>
<td>Yes</td>
<td>LCT</td>
<td>1-2 times, 1-4 times (non-glaucoma)</td>
</tr>
<tr>
<td>DC</td>
<td>TrailBlazer</td>
<td>Yes</td>
<td>LCT</td>
<td>1-2 times, 1-4 times (non-glaucoma)</td>
</tr>
<tr>
<td>Florida</td>
<td>First Coast</td>
<td>Yes</td>
<td>SCODI</td>
<td>1-2 times</td>
</tr>
<tr>
<td>Georgia</td>
<td>Cahaba</td>
<td>Yes</td>
<td>OCT</td>
<td>1-2 times</td>
</tr>
<tr>
<td>Hawaii</td>
<td>Noridian</td>
<td>No</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>Idaho</td>
<td>Cigna</td>
<td>Yes</td>
<td>SCODI</td>
<td>1-2 times</td>
</tr>
<tr>
<td>Illinois</td>
<td>WPS</td>
<td>Yes</td>
<td>OCT</td>
<td>1-2 times</td>
</tr>
<tr>
<td>Indiana</td>
<td>NGS</td>
<td>No</td>
<td>--</td>
<td>No mention</td>
</tr>
<tr>
<td>Iowa</td>
<td>Noridian</td>
<td>No</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
<td>Kansas</td>
<td>Wheatlands Administrative Services</td>
<td>Yes</td>
<td>OCT</td>
<td>1-2 times</td>
</tr>
<tr>
<td>Kentucky</td>
<td>NGS</td>
<td>No</td>
<td>--</td>
<td>No mention</td>
</tr>
<tr>
<td>Louisiana</td>
<td>Pinnacle</td>
<td>Yes</td>
<td>SCODI</td>
<td>1-2 times</td>
</tr>
<tr>
<td>Maine</td>
<td>NHIC</td>
<td>Yes</td>
<td>SCODI</td>
<td>1-2 times, No mention</td>
</tr>
<tr>
<td>Maryland</td>
<td>TrailBlazer</td>
<td>Yes</td>
<td>LCT</td>
<td>1-2 times, 1-4 times (non-glaucoma)</td>
</tr>
<tr>
<td>Massachusetts</td>
<td>NHIC</td>
<td>Yes</td>
<td>SCODI</td>
<td>1-2 times, No mention</td>
</tr>
<tr>
<td>Michigan</td>
<td>WPS</td>
<td>Yes</td>
<td>OCT</td>
<td>1-2 times</td>
</tr>
<tr>
<td>Minnesota</td>
<td>WPS</td>
<td>Yes</td>
<td>OCT</td>
<td>1-2 times</td>
</tr>
<tr>
<td>Mississippi</td>
<td>Cahaba</td>
<td>Yes</td>
<td>OCT</td>
<td>1-2 times</td>
</tr>
<tr>
<td>Missouri (E)</td>
<td>Pinnacle</td>
<td>Yes</td>
<td>SCODI</td>
<td>1-2 times</td>
</tr>
<tr>
<td>Missouri (W)</td>
<td>Wheatlands Administrative Services</td>
<td>Yes</td>
<td>OCT</td>
<td>1-2 times</td>
</tr>
<tr>
<td>Montana</td>
<td>Noridian</td>
<td>No</td>
<td>--</td>
<td>No mention</td>
</tr>
<tr>
<td>Nebraska</td>
<td>Wheatlands Administrative Services</td>
<td>Yes</td>
<td>OCT</td>
<td>1-2 times</td>
</tr>
<tr>
<td>Nevada</td>
<td>Noridian</td>
<td>No</td>
<td>--</td>
<td>No mention</td>
</tr>
<tr>
<td>New Hampshire</td>
<td>NHIC</td>
<td>Yes</td>
<td>SCODI</td>
<td>1-2 times</td>
</tr>
<tr>
<td>New Jersey</td>
<td>NGS</td>
<td>Yes</td>
<td>SCODI</td>
<td>1-2 times, 1-4 times (retinal disorders)</td>
</tr>
<tr>
<td>New Mexico</td>
<td>Pinnacle</td>
<td>Yes</td>
<td>SCODI</td>
<td>1-2 times</td>
</tr>
<tr>
<td>New York</td>
<td>HealthNow, NGS, GHI</td>
<td>Yes</td>
<td>SCODI</td>
<td>1-2 times, 1-4 times (retinal disorders)</td>
</tr>
<tr>
<td>North Carolina</td>
<td>Cigna</td>
<td>Yes</td>
<td>SLGT</td>
<td>1-2 times</td>
</tr>
<tr>
<td>North Dakota</td>
<td>Noridian</td>
<td>No</td>
<td>--</td>
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</tr>
<tr>
<td>Ohio</td>
<td>Palmetto</td>
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<td>--</td>
</tr>
<tr>
<td>Oklahoma</td>
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<td>1-2 times</td>
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<tr>
<td>Pennsylvania</td>
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<td>Yes</td>
<td>SCODI</td>
<td>1-2 times, In accordance w/ standards of practice (retinal disorders)</td>
</tr>
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<td>1-2 times</td>
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<tr>
<td>South Carolina</td>
<td>Palmetto</td>
<td>No</td>
<td>--</td>
<td>No mention</td>
</tr>
<tr>
<td>South Dakota</td>
<td>Noridian</td>
<td>No</td>
<td>--</td>
<td>--</td>
</tr>
<tr>
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<td>Yes</td>
<td>SLGT</td>
<td>1-2 times</td>
</tr>
<tr>
<td>Texas</td>
<td>TrailBlazer</td>
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<td>LCT</td>
<td>1-2 times, 1-4 times (non-glaucoma)</td>
</tr>
<tr>
<td>Utah</td>
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<td>1-2 times</td>
</tr>
<tr>
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<td>LCT</td>
<td>1-2 times, 1-4 times (non-glaucoma)</td>
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<tr>
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<td>OCT</td>
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Note: Information contained in the table is subject to change.