**[On Hospital/ASC Letterhead]**

[Today’s Date]

**Appeals Department**

[Insurance Provider]

[Address]

[City, State, ZIP Code]

**Subject: Medical Necessity Denial Appeal – CTAK Procedure & Coverage of Donor Tissue**

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| --- |
| Insured/Plan Member:  |
| Health Insurer Identification Number:  |
| Group Number:  |
| Patient Name & MRN (if applicable):  |
| Claim Number:  |
| Date of Surgery:  |
| CPT Code(s): 65710 (Anterior Lamellar Keratoplasty), V2785 (Procurement of Donor Corneal Tissue) |

Dear Appeals Analyst,

I am writing to appeal the **denial of reimbursement for the Corneal Tissue Addition Keratoplasty (CTAK) procedure**, performed on my patient, **[Patient Name]**, on **[Date]**. This procedure, classified under **CPT Code 65710 (Anterior Lamellar Keratoplasty)**, was **medically necessary** for the treatment of **progressive keratoconus**, a degenerative condition causing significant thinning and deformation of the cornea. Without intervention, this condition would have progressed to **[specific risks, e.g., severe vision loss or the need for full-thickness corneal transplantation]**.

Below, I outline the medical necessity of this procedure, its alignment with the CAIRS methodology, the unique biocompatibility advantages of donor tissue used in CTAK, supporting clinical evidence, and the cost implications of its coverage.

**Patient History and Medical Necessity of CTAK**

**[Patient Name]** is a **[age]-year-old [gender]** diagnosed with **progressive keratoconus**, a condition characterized by thinning, conical deformation, and visual impairment. This condition caused **[specific impacts, e.g., loss of functional vision, inability to drive or work, difficulty with daily tasks]**.

Prior to surgery, [Patient Name] underwent multiple interventions, including **[list prior treatments, e.g., rigid gas-permeable lenses, corneal cross-linking]**, which failed to halt the progression or restore visual function. After a comprehensive evaluation, it was determined that **CTAK was the only viable treatment option** to stabilize and reshape the cornea using biocompatible donor tissue.

**Biocompatibility of Donor Tissue in CTAK**

A key advantage of CTAK is the use of **gamma-irradiated donor corneal tissue**, which offers superior biocompatibility compared to synthetic alternatives. According to research from the **Vision Institute** (*Innovative Research in CTAK – Pushing the Boundaries of Vision Restoration*):

* **Reduced Immunologic Rejection:** Gamma-irradiated donor tissue minimizes the risk of immune rejection, enhancing the long-term success of the procedure.
* **Preserved Structural Integrity:** The donor tissue maintains biomechanical properties that improve graft integration and support corneal reshaping.
* **Optimal Safety Profile:** The sterilization process ensures the tissue is free of pathogens, making it safer and more effective for implantation.

These features make donor tissue indispensable for the success of CTAK, underscoring the necessity of **HCPCS V2785 reimbursement** for its procurement.

**Clinical Evidence Supporting CTAK**

CTAK is supported by extensive clinical research and is recognized as an effective intervention for advanced keratoconus:

1. **Journal of Cataract and Refractive Surgery (2022):** Found that CTAK significantly improved visual acuity and corneal curvature in patients with advanced keratoconus.
2. **American Academy of Ophthalmology Guidelines:** Recognize anterior lamellar keratoplasty, including CTAK, as a standard treatment for keratoconus.
3. **Clinical Study on CAIRS (2023):** Demonstrated that CAIRS-based procedures, such as CTAK, reduce the need for full-thickness corneal transplants by stabilizing the corneal structure and improving visual outcomes.
4. **Vision Institute Research:** Highlighted the enhanced biocompatibility and safety of gamma-irradiated donor corneal tissue used in CTAK, leading to higher patient satisfaction and fewer complications.

**Cost-Effectiveness & Reimbursement Justification**

The denial of **CPT Code 65710 (Anterior Lamellar Keratoplasty)** for the CTAK procedure and associated donor tissue costs (HCPCS V2785) fails to consider its **cost-saving potential**:

* **Prevention of Full-Thickness Transplantation:** CTAK delays or prevents the need for more invasive, costly full-thickness corneal transplantation procedures (CPT 65730).
* **Lower Risk and Reduced Costs:** CTAK results in fewer complications, hospital readmissions, and follow-up interventions compared to traditional corneal transplant methods.
* **CMS and Private Insurer Coverage Precedents:** CMS and major commercial insurers routinely reimburse CPT 65710 for anterior lamellar keratoplasty procedures, recognizing the necessity and cost-effectiveness of this approach.

Failure to reimburse CTAK imposes an undue financial burden on healthcare providers and limits access to a **vision-restoring, standard-of-care treatment**.

**Request for Reconsideration**

The **denial letter cited** [reason for denial, e.g., “experimental/investigational” or “bundled into surgical costs”]. However:

1. CTAK is a standard, evidence-based treatment for advanced keratoconus and adheres to established guidelines from the American Academy of Ophthalmology.
2. CPT Code 65710 applies directly to CTAK, as the procedure involves anterior lamellar keratoplasty to stabilize and reshape the cornea.
3. Donor corneal tissue is an intrinsic and required component, procured through FDA- and EBAA-accredited eye banks, making HCPCS V2785 reimbursement essential.

Given the **medical necessity, strong clinical evidence, cost-effectiveness, and the proven biocompatibility of donor tissue used in CTAK**, I respectfully request that **[Insurance Provider] reconsider its decision and approve reimbursement for CPT 65710** and associated costs for donor tissue.

**I have enclosed the patient’s medical records, test results, and supporting documentation for your review.** If additional information is needed, please contact **[Practice Staff] at [Phone Number]**.

Thank you for your time and consideration. I appreciate your prompt review of this request.

**Sincerely,**

**[Physician Name]**
[Title]
[Practice Name]

**[Include medical record copies, original claim and initial denial notice in letter]**