Computerized Corneal Topography

Policy Number: MM.12.005
Original Effective Date: 03/11/2008
Line(s) of Business: PPO; HMO; QUEST Integration
Current Effective Date: 02/27/2015
Section: Other/Miscellaneous
Place(s) of Service: Outpatient

I. Description
Corneal topography and computerized corneal topography provide measurements of curvature of the cornea. This technology can be used for the diagnosis and follow-up of keratoconus, difficult contact lens fits, subtle detection of corneal irregularity and astigmatism and pre- and postoperative assessment of the cornea.

Computerized corneal topography (computer assisted video keratography and corneal mapping) creates graphic displays and high-resolution color-coded maps of the corneal surface as well as a cross-section profile.

II. Criteria/Guidelines
Computerized corneal topography is covered (subject to Limitations/ Exclusions and Administrative Guidelines) when one of the following criteria is met:
A. Pre and post penetrating keratoplasty
B. Irregular astigmatism associated with post-operative eye surgery status
C. Corneal dystrophy, bullous keratopathy and complications of transplanted cornea
D. Post traumatic, infectious, or inflammatory corneal scarring
E. Keratoconus
F. High postoperative surgically induced regular or irregular astigmatism of greater than three diopters
G. Pterygium which induces more than one diopter of corneal astigmatism or induces irregular corneal astigmatism

III. Limitations
A. Corneal topography is not covered for the following indications because it is not known to be effective in improving health outcomes:
   1. Postoperative cataract except where there is documented evidence that the patient has irregular astigmatism resulting from the operation
   2. Post kerato-refractive surgery
   3. Regular astigmatism not associated with postoperative eye surgery
B. Repeat testing will only be considered if a change in vision is reported in relation to the conditions listed in this policy.
C. The use of corneal topography for screening is not a covered benefit.
D. This service includes testing of both eyes and should not be billed separately.

IV. Administrative Guidelines
Precertification is not required. Documentation supporting the medical necessity should be legible, maintained in the patient's medical record and must be made available to HMSA upon request. HMSA reserves the right to perform retrospective review using the above criteria to validate if services rendered met payment determination criteria.

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<th>HCPCS Code</th>
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<td>92025</td>
<td>Computerized corneal topography, unilateral or bilateral, with interpretation &amp; report</td>
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V. Scientific Background
Computer assisted corneal topography provides qualitative and quantitative information about the corneal surface. It is used to obtain a detailed description of the shape of the cornea and may include subtle but clinically significant changes in the curvature of the cornea. Conventional techniques, such as keratometry may be adequate when the cornea is spherical but when the shape of the cornea is irregular, computer assisted corneal topography provides a better evaluation of the cornea.

Testing to determine accuracy in abnormal corneas is lacking as there is no standard to measure the human cornea but topography is showing usefulness in assessing changes in the cornea. As a diagnostic tool, corneal topography can be used to aid in monitoring and treating certain visual disorders. Patient selection is important and strides are being made to define that patient selection.

VI. Important Reminder
The purpose of this Medical Policy is to provide a guide to coverage. This Medical Policy is not intended to dictate to providers how to practice medicine. Nothing in this Medical Policy is intended to discourage or prohibit providing other medical advice or treatment deemed appropriate by the treating physician.

Benefit determinations are subject to applicable member contract language. To the extent there are any conflicts between these guidelines and the contract language, the contract language will control.

This Medical Policy has been developed through consideration of the medical necessity criteria under Hawaii's Patients' Bill of Rights and Responsibilities Act (Hawaii Revised Statutes §432E-1.4), generally accepted standards of medical practice and review of medical literature and government approval status. HMSA has determined that services not covered under this Medical Policy will not be medically necessary under Hawaii law in
most cases. If a treating physician disagrees with HMSA's determination as to medical necessity in a given case, the physician may request that HMSA reconsider the application of the medical necessity criteria to the case at issue in light of any supporting documentation.

VII. References
2. Blue Cross Blue Shield Association. Corneal Topography/Computer-Assisted Corneal Topography/Photokeratoscopy. 9.03.05. April 2014.