FIRST COAST SERVICE OPTIONS
MAC - PART B
LOCAL COVERAGE DETERMINATION

LCD Database ID Number
L33810

Contractor Name
First Coast Service Options, Inc.

Contractor Number
09102 – Florida
09202 – Puerto Rico
09302 – Virgin Islands

Contractor Type
MAC – Part B

LCD Title
Computerized Corneal Topography

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CMS National Coverage Policy
Language quoted from CMS National Coverage Determinations (NCDs) and coverage provisions in interpretive manuals are italicized throughout the Local Coverage Determination (LCD). NCDs and coverage provisions in interpretive manuals are not subject to the LCD Review Process (42 CFR 405.860[b] and 42 CFR 426 [Subpart D]). In addition, an administrative law judge may not review an NCD. See §1869(f)(1)(A)(i) of the Social Security Act.

Unless otherwise specified, italicized text represents quotation from one or more of the following CMS sources:

CMS Manual System, Pub. 100-03, Medicare National Coverage Determinations Manual, Chapter 1, Section 80.7

Primary Geographic Jurisdiction
Florida
Puerto Rico/Virgin Islands
Computerized Corneal Topography Part B

Oversight Region

Region 1

Original Determination Effective Date

10/01/2015

Original Determination Ending Date

N/A

Revision Effective Date

08/08/2016

Revision Ending Date

08/07/2016

Indications and Limitations of Coverage and/or Medical Necessity

Computerized Corneal Topography (also known as computer-assisted video keratography (CAVK) and corneal mapping is a computer assisted diagnostic imaging technique in which a special instrument projects a series of light rings on the cornea, creating a color coded map of the corneal surface as well as a cross-section profile. This service is used to provide a detailed map or chart of the physical features and shape of the anterior surface of the cornea. This permits a more accurate portrayal of the physical state of the cornea and the subtle detection of corneal surface irregularity and astigmatism.

Keratoplasty that treats specific lesions of the cornea, such as phototherapeutic keratectomy that removes scar tissue from the visual field, deals with an abnormality of the eye and is not cosmetic surgery. Such cases may be covered under §1862(a)(1)(A) of the Act (CMS Pub 100-03, Chapter 1, Part I, Section 80.7.1).

Computerized Corneal Topography will be considered medically necessary under any of the following conditions:

- pre-operatively for evaluation of irregular astigmatism prior to cataract surgery
- monocular diplopia
- bullous keratopathy
- post surgical or post traumatic astigmatism, measuring at a minimum of 3.5 diopters;
- post penetrating keratoplasty surgery;
- post surgical or post traumatic irregular astigmatism;
- corneal dystrophy;
- complications of transplanted cornea;
- post traumatic corneal scarring;
- keratoconus; and/or
- pterygium and/or corneal ectasia that cause visual impairment.

Limitations

Corneal topography will only be allowed for a pre-operative cataract patient if documentation supports that the patient has irregular astigmatism

Corneal topography is to be billed only when the diagnosis of monocular diplopia is thought to be caused by a corneal irregularity.
Computerized Corneal Topography Part B

Corneal Topography is a covered service for the above indications when medically reasonable and necessary only if the results will assist in defining further treatment. It is not covered for routine follow-up testing.

Repeat testing is only indicated if a change of vision is reported in connection with one of the above listed conditions.

Services performed for screening purposes or in the absence of associated signs, symptoms, illness or injury as indicated above, will be denied as non-covered.

Corneal Topography will be non-covered if performed pre- or post-operatively in relation to a non-covered procedure, i.e., radial keratotomy.

_Per CMS Pub 100-03, Chapter 1, Part 1, Section 80.7, Refractive keratoplasty is surgery to reshape the cornea of the eye to correct vision problems such as myopia (nearsightedness) and hyperopia (farsightedness). Refractive keratoplasty procedures include keratomileusis, in which the front of the cornea is removed, frozen, reshaped, and stitched back on the eye to correct either near or farsightedness; keratophakia, in which a reshaped donor cornea is inserted in the eye to correct farsightedness; and radial keratotomy, in which spoke-like slits are cut in the cornea to weaken and flatten the normally curved central portion to correct nearsightedness.

The correction of common refractive errors by eyeglasses, contact lenses or other prosthetic devices is specifically excluded from coverage. The use of radial keratotomy and/or keratoplasty (Refractive Surgeries) for the purpose of refractive error compensation is considered a substitute or alternative to eyeglasses or contact lenses which are specifically excluded by §1862 (a)(7) of the Act (except in certain cases in connection with cataract surgery). In addition, many in the medical community consider such procedures cosmetic surgery which is excluded by §§1862 (a)(10) of the Act. Therefore, radial keratotomy and keratoplasty (Refractive Surgeries) to treat refractive defects are not covered.

CPT/HCPCS Codes

92025  Computerized corneal topography, unilateral or bilateral, with interpretation and report

ICD-10 Codes that Support Medical Necessity

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
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<tbody>
<tr>
<td>H11.001-H11.069</td>
<td>Pterygium of eye</td>
</tr>
<tr>
<td>H11.141-H11.149</td>
<td>Conjunctival xerosis, unspecified</td>
</tr>
<tr>
<td>H11.811-H11.819</td>
<td>Pseudopterygium of conjunctiva right eye - Pseudopterygium of conjunctiva, unspecified eye</td>
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<tr>
<td>H17.89</td>
<td>Other corneal scars and opacities</td>
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<tr>
<td>H17.9</td>
<td>Unspecified corneal scar and opacity</td>
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<tr>
<td>H18.10-H18.13</td>
<td>Bullous keratopathy</td>
</tr>
<tr>
<td>H18.451-H18.469</td>
<td>Nodular or peripheral Corneal degeneration</td>
</tr>
<tr>
<td>H18.51</td>
<td>Endothelial corneal dystrophy</td>
</tr>
<tr>
<td>H18.52</td>
<td>Epithelial (juvenile) corneal dystrophy</td>
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<tr>
<td>H18.53</td>
<td>Granular corneal dystrophy</td>
</tr>
<tr>
<td>H18.54</td>
<td>Lattice corneal dystrophy</td>
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<tr>
<td>H18.55</td>
<td>Macular corneal dystrophy</td>
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<tr>
<td>H18.59</td>
<td>Other hereditary corneal dystrophies</td>
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<tr>
<td>H18.601-H18.629</td>
<td>Keratoconus</td>
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<tr>
<td>H18.711-H18.719</td>
<td>Corneal ectasia</td>
</tr>
<tr>
<td>H52.211-H52.219*</td>
<td>Irregular Astigmatism</td>
</tr>
<tr>
<td>H52.221-H52.229*</td>
<td>Regular astigmatism</td>
</tr>
<tr>
<td>H53.2</td>
<td>Diplopia</td>
</tr>
<tr>
<td>T85.318A-T85.318S</td>
<td>Breakdown (mechanical) of other ocular prosthetic devices, implants and grafts,</td>
</tr>
<tr>
<td>T85.328A-T85.328S</td>
<td>Displacement of other ocular prosthetic devices, implants and grafts</td>
</tr>
<tr>
<td>T85.398A-T85.398S</td>
<td>Other mechanical complication of other ocular prosthetic devices, implants and grafts</td>
</tr>
<tr>
<td>T86.840</td>
<td>Corneal transplant rejection</td>
</tr>
<tr>
<td>T86.841</td>
<td>Corneal transplant failure</td>
</tr>
<tr>
<td>T86.848</td>
<td>Other complications of corneal transplant</td>
</tr>
<tr>
<td>Z94.7*</td>
<td>Corneal transplant status</td>
</tr>
</tbody>
</table>
Computerized Corneal Topography Part B
Z98.41-Z98.49* Cataract extraction status
Z98.83* Filtering (vitreous) bleb after glaucoma surgery status

*ICD-10-CM codes H52.221-H52.229 must be accompanied by diagnosis code Z98.41-Z98.49 or Z98.83.

* Diagnosis codes Z94.7, Z98.41-Z98.49, and Z98.83 should not be billed as the primary diagnosis.

Diagnoses that Support Medical Necessity

N/A

ICD-10 Codes that DO NOT Support Medical Necessity

N/A

Diagnoses that DO NOT Support Medical Necessity

N/A

Associated Information

Documentation Requirements

Medical record documentation submitted by the ordering/referring physician must indicate the medical necessity for performing the procedure and the results derived from the corneal topography procedure. This information is usually found in the history and physical, office/progress notes and the computerized corneal topography imaging interpretation and report.

Utilization Guidelines

It is expected that these services would be performed as indicated by current medical literature and/or standards of practice. When services are performed in excess of established parameters, they may be subject to review for medical necessity.

Sources of Information and Basis for Decision

FCSO reference LCD number – L29140


Start Date of Comment Period
N/A

End Date of Comment Period
N/A

Start Date of Notice Period
04/01/2014

Revision History Number: R2
Revision Number: 2
Publication: August 2016 Connection
LCR B2016-015

Explanation of revision: The LCD was revised to add ICD-10-CM diagnosis codes H18.51, H18.52, H18.53, H18.54 and H18.55 and diagnosis range H11.811-H11.819 to the “ICD-10 Codes that Support Medical Necessity” section of the LCD. The effective date of this revision is for claims processed on or after 08/08/2016, for dates of service on or after 10/01/15.

Revision History Number: R1
Revision Number: 1
Publication: March 2016 Connection
LCR B2016-008

Explanation of revision: LCD revised to add additional ICD-10-CM diagnosis code T86.848 to the “ICD-10 Codes that Support Medical Necessity” section of the LCD. The effective date of this revision is for claims processed on or after 02/24/2016, for dates of service on or after 10/01/15.

Revision Number: Original

This LCD replaces all previous LCD versions (refer to “Sources of Information and Basis for Decision” section of the LCD) and publications on this subject to comply with ICD-10-CM based on Change Request 8112. The effective date of this LCD is based on date of service.

Related Documents
N/A

LCD Attachments
N/A