VersantHealth™

Policy Name	Clinical Policy – Corneal Topography
Policy Number	1314.00
Department	Clinical Product & Strategy
Subcategory	Medical Management
Original Approval Date	02/06/2018
Current MPC/CCO Approval Date	01/03/2024
Current Effective Date	04/01/2024

Company Entities Supported (Select All that Apply)
X_Superior Vision Benefit Management
X_Superior Vision Services
X_Superior Vision of New Jersey, Inc.
X_Block Vision of Texas, Inc. d/b/a Superior Vision of Texas
X_Davis Vision
(Collectively referred to as 'Versant Health' or 'the Company')

ACRONYM	
CT	Corneal Topography

PURPOSE

To provide the medical necessity criteria to support the indication(s) for corneal topography and to render medical necessity determinations. Applicable procedure codes are also defined.

POLICY

A. BACKGROUND

Corneal topography (CT), also known as photokeratoscopy or video keratography, is a non-invasive imaging technique for mapping the surface curvature of the cornea particularly when astigmatism is present.

B. Medically Necessary

1. Corneal Topography (CT) is medically necessary when the information garnered from an eye exam is insufficient to assess the patient's condition, as in the following conditions:
   a. bullous keratopathy,
   b. clinically significant irregular corneal astigmatism,
   c. complications of transplanted cornea,
   d. corneal dystrophies,
   e. keratoconus or pellucid marginal degeneration,
   f. monocular diplopia,
   g. post-surgical or post-traumatic astigmatism,
   h. Pterygium and/or corneal ectasia that cause visual impairment.

2. Repeat CT is only allowed when a change in vision is reported due to one of the covered conditions.

3. CT is appropriate as an adjunct to the fitting of medically necessary contact lenses.

C. Not Medically Necessary

Corneal topography may not be medically necessary when:

1. it is performed as baseline documentation of a healthy eye such as during an evaluation for refractive surgery or as preventive medicine to screen for potential disease; or,
2. it is used on an eye without signs, symptoms, serious ophthalmic disease, ocular abnormalities, or contributory medical history; or,
3. it is used prior to cataract surgery when there is no indication of corneal disease,
4. it is used to confirm a diagnosis that has already been determined; or,
5. it is used to determine the need for corneal refractive surgery; or,
6. it is used to refine the selection of an astigmatism-correcting or presbyopia-correcting intraocular lens or another non-covered procedure; or,
7. it is without a documented medical rationale in the medical record.

D. Documentation

Medical necessity must be supported by adequate and complete documentation in the patient's medical record that describes the procedure and the medical rationale for it as in the requirements above. All medical record items must be available upon request to initiate or sustain previous payments. For any retrospective review, a full operative report is needed.

Every page of the record must be legible and include appropriate patient identification information (e.g., complete name, date(s) of service). Services provided/ordered must be authenticated by the physician, in a handwritten or electronic signature. Stamped signatures are not acceptable.

Corneal Topography requires an interpretation and report which includes:

1. Physician's order for CT with medical rationale
2. Date performed
3. Reliability of the CT (Do not bill a CT of dubious value.)

4. Patient cooperation
5. CT findings
6. Comparison of results from previous tests
7. Assessment, diagnosis
8. Impact on treatment, prognosis

E. Procedural Detail

CPT Code	
92025	Computerized corneal topography, unilateral or bilateral, with interpretation and report. (Do not report 92025 in conjunction with CPT codes 65710 corneal transplant – 65771 Radial keratotomy).
Invalid Modifiers	
Anatomical Modifiers	RT, LT, 50, E1, E2, E3, E4,
EM Modifiers	24, 25, 57, 95
Surgical Modifiers	AS, 80, 81, 82, 22, 52, 54, 55, 58, 62, 76, 77, 78, 79

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RELATED POLICIES AND PROCEDURES	
1304	OCT/SCODI

DOCUMENT HISTORY		
Approval Date	***Revisions***	***Effective Date***
02/06/2018	Initial Policy	02/06/2018
03/13/2019	Annual review; no criteria changes	03/13/2019
02/19/2020	Annual review; no criteria changes	04/01/2020
01/06/2021	Annual review; no criteria changes	04/01/2021
01/05/2022	Annual review; no criteria changes	04/01/2022
01/04/2023	Annual review; no criteria changes	04/01/2023
09/20/2023	Administrative review for CMS 2024 final rule Medicare Part C equity: no changes.	n/a
01/03/2024	Clarify indication for medically necessary contact lens fitting.	04/01/2024

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