Computerized Corneal Topography

I. Policy

University Health Alliance (UHA) will reimburse for computerized corneal topography services when they are determined to be medically necessary and when they meet the medical criteria guidelines (subject to limitations and exclusions) indicated below.

II. Criteria/Guidelines

A. Computerized corneal topography is covered without prior authorization (subject to Limitations/Exclusions and Administrative Guidelines) only when one of the following criteria are met:

1. Pre and post penetrating keratoplasty
2. Irregular astigmatism associated with post-operative eye surgery status
3. Corneal dystrophy, bullous keratopathy, and complications of transplanted cornea
4. Post traumatic, infectious, or inflammatory corneal scarring
5. Keratoconus
6. High postoperative surgically induced regular or irregular astigmatism of greater than 3 diopters
7. Pterygium which induces more than 1 diopter of corneal astigmatism or induces irregular corneal astigmatism
8. Pre-operative medically necessary cataract surgery with a conventional (NON Premium IOL) in patient who previously had kerato-refractive surgery

B. NOTE:

This UHA payment policy is a guide to coverage, the need for prior authorization and other administrative directives. It is not meant to provide instruction in the practice of medicine and it should not deter a provider from expressing his/her judgment.

Even though this payment policy may indicate that a particular service or supply is considered covered, specific provider contract terms and/or members’ individual benefit plans may apply, and this policy is not a guarantee of payment. UHA reserves the right to apply this payment policy to all UHA companies and subsidiaries.

UHA understands that opinions about and approaches to clinical problems may vary. Questions concerning medical necessity (see Hawaii Revised Statutes §432E-1.4) are welcome. A provider may request that UHA reconsider the application of the medical necessity criteria in light of any supporting documentation.

III. Limitations/Exclusions

A. Corneal topography will not be covered for a postoperative cataract patient, except where there is documented evidence that the patient has irregular astigmatism resulting from the operation.

B. Corneal topography in follow-up of post or pre-operative kerato-refractive surgery (i.e., RK, PRK, Lasik, etc.) will not be covered.
C. Regular astigmatism not associated with postoperative eye surgery status is a refractive issue and will
not be covered.
D. Repeat testing will only be considered if a change in vision is reported in relation to the conditions listed
in this policy.
E. The use of corneal topography for screening is not a covered benefit.
F. This service includes testing of both eyes and should not be billed separately.

IV. Administrative Guidelines

A. Prior authorization is not required.
B. Documentation supporting the medical necessity should be legible, maintained in the patient's medical
record and must be made available to UHA upon request. UHA reserves the right to perform
retrospective review using the above criteria to validate if services rendered met payment determination
criteria and to ensure proper reimbursement is made.

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<tr>
<th>HCPCS Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>92025</td>
<td>Computerized corneal topography, unilateral or bilateral, with interpretation &amp; report</td>
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V. Policy History

Policy Number: MPP-0044-120301
Current Effective Date: 11/01/2017
Original Document Effective Date: 03/01/2012
Previous Revision Dates: 07/01/2013
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