IMPORTANT NOTE ABOUT THIS REIMBURSEMENT POLICY

This policy is applicable to UnitedHealthcare Medicare Advantage Plans offered by UnitedHealthcare and its affiliates.

You are responsible for submission of accurate claims. This reimbursement policy is intended to ensure that you are reimbursed based on the code or codes that correctly describe the health care services provided. UnitedHealthcare reimbursement policies use Current Procedural Terminology (CPT®*), Centers for Medicare and Medicaid Services (CMS), or other coding guidelines. References to CPT or other sources are for definitional purposes only and do not imply any right to reimbursement.

This reimbursement policy applies to all health care services billed on CMS 1500 forms and, when specified, to those billed on UB04 forms (CMS 1450). Coding methodology, industry-standard reimbursement logic, regulatory requirements, benefits design and other factors are considered in developing reimbursement policy. This information is intended to serve only as a general resource regarding UnitedHealthcare’s reimbursement policy for the services described and is not intended to address every aspect of a reimbursement situation. Accordingly, UnitedHealthcare may use reasonable discretion in interpreting and applying this policy to health care services provided in a particular case. Further, the policy does not address all issues related to reimbursement for health care services provided to UnitedHealthcare enrollees. Other factors affecting reimbursement may supplement, modify or, in some cases, supersede this policy. These factors may include, but are not limited to: legislative mandates, the physician or other provider contracts, and/or the enrollee’s benefit coverage documents. Finally, this policy may not be implemented exactly the same way on the different electronic claims processing systems used by UnitedHealthcare due to programming or other constraints; however, UnitedHealthcare strives to minimize these variations.

UnitedHealthcare may modify this reimbursement policy at any time by publishing a new version of the policy on this Website. However, the information presented in this policy is accurate and current as of the date of publication.

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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.

Corneal Topography is indicated in the identification of deep or superficial corneal disorders/distortions causing irregular astigmatism and visual impairment. Results are used in assisting the physician in determining the appropriate surgical or medical treatment needed.

Reimbursement Guidelines

Corneal topography is a covered service for the following 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:

- pre-operative evaluation of irregular astigmatism for intraocular lens power determination with cataract surgery;
- monocular diplopia;
- diagnosis of early keratoconus;
- post-surgical or post-traumatic astigmatism, measuring at a minimum of 3.5 diopters;
- suspected irregular astigmatism based on retinoscopic streak or conventional keratometry;
- post-penetrating keratoplasty surgery;
- post-surgical or post-traumatic irregular astigmatism;
- certain corneal dystrophies;
- complications of transplanted cornea;
- post-traumatic corneal scarring; and/or
- pterygium and/or corneal ectasia that cause visual impairment

Corneal topography will only be allowed for a pre-operative cataract patient if documentation supports that the patient has irregular astigmatism. Its use for this purpose should be rare. Corneal topography is to be billed only when the diagnosis of monocular diplopia is thought to be caused by a corneal irregularity. 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 Medicare non-covered procedure, e.g., radial keratotomy.

Corneal Topography is indicated in the identification of deep or superficial corneal disorders/distortions causing irregular astigmatism and visual impairment. Results are used in assisting the physician in determining the appropriate surgical or medical treatment needed.

*It is expected that computerized corneal topography 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.

Diagnostic tests may only be ordered by the treating physician (or other treating practitioners acting within...
the scope of their licenses and Medicare requirements) who will use the results in the management of the beneficiary's specific medical problem and diagnostic tests payable under the Physicians Fee Schedule must be furnished under the appropriate level of supervision by the physician.

**Documentation Guidelines**

- The patient's medical records should be legible and contain the relevant history and physical findings conforming to the criteria stated in the "Indication and Limitations of Coverage and/or Medical Necessity" section above and must be made available to the Carrier on request. The patient's record should also include the computerized corneal topography results with examination and photo interpretation.

- Physicians' Services and diagnostic tests must be submitted with an ICD-9 code to support the medical necessity for the service and must be coded to the greatest level of accuracy and highest level of digit completeness. This means the precise ICD-9 code that fully explains the narrative description of the diagnosis contained in the medical record or the test interpretation and report including the 4th or 5th digit sub-classification for the diagnosis category. The ICD-9 code based on the results of the test should be the primary diagnosis. If the diagnostic test results are normal or inconclusive the ICD-9 code representing the sign, symptom, illness or injury prompting the ordering of the test should be reported as the primary diagnosis. In the absence of signs, symptoms, illness or injury a screening diagnosis should be reported, and payment will be denied.

- Limitation of liability and refund requirements apply when denials are likely, whether based on medical necessity or other coverage reasons. The provider/supplier must notify the beneficiary in writing, prior to rendering the service, if the provider/supplier is aware that the test, item or procedure may not be covered by Medicare. The limitation of liability and refund requirements do not apply when the test, item or procedure is statutorily excluded, has no Medicare benefit category or is rendered for screening purposes.

For outpatient settings other than CORFs, references to "physicians" throughout this policy include non-physicians, such as nurse practitioners, clinical nurse specialists and physician assistants. Such non-physician practitioners, with certain exceptions, may certify, order and establish the plan of care as authorized by State law. (See Sections 1861[s][2] and 1862[a][14] of Title XVIII of the Social Security Act; 42 CFR, Sections 410.74, 410.75, 410.76 and 419.22; 58 FR 18543, April 7, 2000.)

### CPT/HCPCS Codes

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<th>Code</th>
<th>Description</th>
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<tr>
<td>92025</td>
<td>Computerized corneal topography, unilateral or bilateral, with interpretation and report</td>
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#### Modifiers

- **LT** Left side (used to identify procedures performed on the left side of the body)
- **RT** Right side (used to identify procedures performed on the right side of the body)
- **50** Bilateral Procedure

#### References Included (but not limited to):

- **CMS LCD(s)**
- Numerous LCDs
- **UnitedHealthcare Medicare Advantage Coverage Summaries**
- Vision Services, Therapy and Rehabilitation
- **Others**
- Billing and Coding Guidelines: Billing and Coding Guidelines for Computerized Corneal Topography (OPHTH-014), WPS, CMS Website

#### History

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<td>09/09/2014</td>
<td>Removed liability modifier references</td>
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<tr>
<td>06/11/2014</td>
<td>Re-review presented to MRPC for approval</td>
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<tr>
<td>04/28/2014</td>
<td>Administrative updates</td>
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<tr>
<td>06/12/2013</td>
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<td>Policy presented to and approved by MRP Committee with an effective date of 12/01/2012</td>
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