

Policy: MP199

Section: Medical Benefit Policy

Subject: Corneal Pachymetry

I. Policy: Corneal Pachymetry

II. Purpose/Objective:

To provide a policy of coverage regarding Corneal Pachymetry

III. Responsibility:

- A. Medical Directors
- B. Medical Management

IV. Required Definitions

1. Attachment – a supporting document that is developed and maintained by the policy writer or department requiring/authoring the policy.
2. Exhibit – a supporting document developed and maintained in a department other than the department requiring/authoring the policy.
3. Devised – the date the policy was implemented.
4. Revised – the date of every revision to the policy, including typographical and grammatical changes.
5. Reviewed – the date documenting the annual review if the policy has no revisions necessary.

V. Additional Definitions

Medical Necessity or Medically Necessary means Covered Services rendered by a Health Care Provider that the Plan determines are:

- a. appropriate for the symptoms and diagnosis or treatment of the Member's condition, illness, disease or injury;
- b. provided for the diagnosis, and the direct care and treatment of the Member's condition, illness disease or injury;
- c. in accordance with current standards of good medical treatment practiced by the general medical community.
- d. not primarily for the convenience of the Member, or the Member's Health Care Provider; and
- e. the most appropriate source or level of service that can safely be provided to the Member. When applied to hospitalization, this further means that the Member requires acute care as an inpatient due to the nature of the services rendered or the Member's condition, and the Member cannot receive safe or adequate care as an outpatient.

Medicaid Business Segment

Medical Necessity shall mean a service or benefit that is compensable under the Medical Assistance Program and if it meets any one of the following standards:

- (i) The service or benefit will, or is reasonably expected to, prevent the onset of an illness, condition or disability.
- (ii) The service or benefit will, or is reasonably expected to, reduce or ameliorate the physical, mental or development effects of an illness, condition, injury or disability.
- (iii) The service or benefit will assist the Member to achieve or maintain maximum functional

capacity in performing daily activities, taking into account both the functional capacity of the Member and those functional capacities that are appropriate for members of the same age.

DESCRIPTION:

Corneal pachymetry is the measurement of central corneal thickness by either ultrasound or optical biometry.

INDICATIONS:

Corneal pachymetry may be considered medically necessary for the following conditions:

- To assist in the diagnosis of corneal thinning disorders; or
- To assess disease progression in disorders of endothelial dysfunction; or
- To aid in the early diagnosis and treatment of corneal transplant rejection; or
- To determine the response to treatment of corneal transplant rejection; or
- To determine the influence of corneal thickness on intraocular pressure measurements (greater than 24 mm/Hg) in both suspected and established glaucoma; or
- To assist in selection of appropriate cataract surgical techniques for members with prior intraocular surgery or established corneal diseases

LIMITATIONS:

Corneal pachymetry testing for the evaluation of glaucoma is considered medically necessary once per lifetime.

Repeat corneal pachymetry testing for diseases and injury is considered medically necessary when performed no more frequently than once every six months.

EXCLUSIONS:

There is insufficient evidence in the available published, peer-reviewed medical literature to support the use of corneal pachymetry outside of the established indications. Corneal pachymetry is considered experimental, investigational or unproven and is **NOT COVERED** in the following scenarios:

- Pre-operative evaluation of cataract surgery in the absence of documented corneal disease
- As a screening test for glaucoma in the absence of signs or symptoms of glaucoma or increased intraocular pressure

The use of corneal pachymetry associated with the pre-operative evaluation for surgical refractive error correction is **NOT COVERED**.

Note: A complete description of the process by which a given technology or service is evaluated and determined to be experimental, investigational or unproven is outlined in MP 15 - Experimental Investigational or Unproven Services or Treatment.

CODING ASSOCIATED WITH: Corneal Pachymetry

The following codes are included below for informational purposes and may not be all inclusive. Inclusion of a procedure or device code(s) does not constitute or imply coverage nor does it imply or guarantee provider reimbursement. Coverage is determined by the member specific benefit plan document and any applicable laws regarding coverage of specific services. Please note that per Medicare coverage rules, only specific CPT/HCPCS Codes may be covered for the Medicare Business Segment. Please consult the CMS website at www.cms.gov or the local Medicare Administrative Carrier (MAC) for more information on Medicare coverage and coding requirements.

76514 Ophthalmic ultrasound, diagnostic, corneal pachymetry, unilateral or bilateral (determination of corneal thickness)

Current Procedural Terminology (CPT®) © American Medical Association: Chicago, IL

LINE OF BUSINESS:

Eligibility and contract specific benefits, limitations and/or exclusions will apply. Coverage statements found in the line of business specific benefit document will supersede this policy. For Medicare, applicable LCD's and NCD's will supersede this policy. For PA Medicaid Business segment, this policy applies as written.

REFERENCES:

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Ayala, M, Strandas R. Accuracy of optical coherence tomography (OCT) in pachymetry for glaucoma patients. BMC Ophthalmology 2015; 15:124

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This policy will be revised as necessary and reviewed no less than annually.

Devised: 03/2007

Revised:

Reviewed: 3/08, 3/09, 3/10, 5/11, 5/12, 5/13, 5/14, 5/15, 5/16, 4/17, 4/18, 4/19, 4/20