

Policy: MP207

Section: Medical Benefit Policy

Subject: Corneal Hysteresis

Applicable Lines of Business

Commercial	X	CHIP	X
Medicare	X	ACA	X
Medicaid	X		

I. Policy: Corneal Hysteresis

II. Purpose/Objective:

To provide a policy of coverage regarding Corneal Hysteresis

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

Medically Necessary — A service, item, procedure, or level of care that is necessary for the proper treatment or management of an illness, injury, or disability is one that:

- Will, or is reasonably expected to, prevent the onset of an illness, condition, injury or disability.
- Will, or is reasonably expected to, reduce or ameliorate the physical, mental or developmental effects of an illness, condition, injury or disability.
- 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 hysteresis is a measure of the viscous damping characteristics of the corneal tissue. It is calculated by deflecting the cornea with a rapid air pulse, and then using an advanced electro-optical system to obtain two intraocular pressure measurements. The difference between the values is defined as the corneal hysteresis.

EXCLUSIONS:

The Plan does **NOT** provide coverage for the use of *Corneal Hysteresis* because it is considered **experimental, investigational or unproven**. Although the device is FDA approved, there is insufficient evidence in the peer-reviewed published medical literature to establish its effectiveness on health outcomes when compared to established treatments or technologies

The Plan does **NOT** provide coverage for **Continuous monitoring of intraocular pressure** for 24 hours or longer in patients with glaucoma because it is considered **experimental, investigational or unproven**. There is insufficient evidence in the peer-reviewed published medical literature to draw conclusions that continuous monitoring of intraocular pressure improves health outcomes in patients with glaucoma.

Medicaid Business Segment:

Any requests for services, that do not meet criteria set in the PARP, may be evaluated on a case by case basis.

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:

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.

- 0329T** Monitoring of intraocular pressure for 24 hours or longer, unilateral or bilateral, with interpretation and report
- 0330T** Tear film imaging, unilateral or bilateral, with interpretation and report
- 92145** Corneal hysteresis determination, by air impulse stimulation, unilateral or bilateral, with interpretation and report

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 supercede this policy. For PA Medicaid Business segment, this policy applies as written.

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Chan E, Yeh K, Moghimi S, et al. Changes in corneal biomechanics and glaucomatous visual field loss. *J Glaucoma*. 2021 May 1;30(5):e246-e251.

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

Devised: 10/01/2007

Revised: 1/14

Reviewed: 10/08, 10/09, 9/10, 8/11, 8/12, 8/13, 1/15, 1/16, 1/17, 1/18, 1/19, 1/20, 1/21, 1/22, 1/23

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Coverage for experimental or investigational treatments, services and procedures is specifically excluded under the member's certificate with Geisinger Health Plan. Unproven services outside of an approved clinical trial are also specifically excluded under the member's certificate with Geisinger Health Plan. This policy does not expand coverage to services or items specifically excluded from coverage in the member's certificate with Geisinger Health Plan. Additional information can be found in MP015 Experimental, Investigational or Unproven Services.

Prior authorization and/or pre-certification requirements for services or items may apply. Pre-certification lists may be found in the member's contract specific benefit document. Prior authorization requirements can be found at <https://www.geisinger.org/health-plan/providers/ghp-clinical-policies>

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