Overview

Computerized corneal topography utilizes video and computer-assisted technology to project light rings on the cornea and create a detailed map of the corneal surface. This diagnostic test is utilized to detect corneal irregularities for possible surgical correction of a visual defect.

Corneal topography provides accurate information about shape, curvature, and depth of the cornea. This approach, combined with other tests can assist in diagnosing conditions, such as keratoconus or postoperative complications of cataract surgery, or improve preoperative planning for corneal transplant or refractive surgery.

Policy

Fallon Health requires prior authorization for Corneal Topography. Medical records from the providers who have diagnosed or treated the symptoms prompting this request are also required.

The below diagnosis or clinical scenarios will be considered for coverage.

- Corneal Scarring
- Central Corneal ulcer
- Complications of a transplanted cornea
- Bullous keratopathy
- Pre and post penetrating keratoplasty
- Pterygium
- Preoperative evaluation for phototherapeutic keratectomy
- Fitting of a contact lens in relation to an ocular disease
- Diagnosing and monitoring disease progression in keratoconus or Terrien's marginal degeneration

Repeat testing must be supported by a justification of potential changes in the cornea and support that additional testing will impact the clinical outcome.

Exclusions

- Any use of Corneal Topography other than outlined above
- Corneal Topography performed in relation to an non-covered eye procedure (e.g. refractive surgery)
- Corneal Topography performed in relation to contact lens fitting
- Corneal Topography performed routinely prior to cataract surgery

Codes

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


Policy History

<table>
<thead>
<tr>
<th>Origination date:</th>
<th>01/01/2017</th>
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<tr>
<td>Approval(s):</td>
<td>Technology Assessment Committee: 01/25/2017 (new policy), 1/24/2018 (updated references), 01/23/2019 (annual review, no updates), 01/22/2020 (updated references)</td>
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Not all services mentioned in this policy are covered for all products or employer groups. Coverage is based upon the terms of a member’s particular benefit plan which may contain its own specific provisions for coverage and exclusions regardless of medical necessity. Please consult the product’s Evidence of Coverage for exclusions or other benefit limitations applicable to this service or supply. If there is any discrepancy between this policy and a member’s benefit plan, the provisions of the benefit plan will govern. However, applicable state mandates take precedence with respect to fully-insured plans and self-funded non-ERISA (e.g., government, school boards, church) plans. Unless otherwise specifically excluded, federal mandates will apply to all plans. For Medicare and Medicaid members, this policy will apply unless Medicare and Medicaid policies extend coverage beyond this policy.