Local Coverage Determination (LCD):
Computerized Corneal Topography (L34008)

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**LCD Information**

**Document Information**

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CMS National Coverage Policy Language quoted from Centers for Medicare and Medicaid Services (CMS), National Coverage Determinations (NCDs) and coverage provisions in interpretive manuals is italicized throughout the policy. NCDs and coverage provisions in interpretive manuals are not subject to the Local Coverage Determination (LCD) Review Process (42 CFR 405.860[b] and 42 CFR 426 [Subpart D]). In addition, an administrative law judge may not review an NCD. See Section 1869(f)(1)(A)(i) of the Social Security Act.

Unless otherwise specified, italicized text represents quotation from one or more of the following CMS sources:

Title XVIII of the Social Security Act (SSA):

Section 1862(a)(1)(A) excludes expenses incurred for items or services which are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.

Section 1833(e) prohibits Medicare payment for any claim which lacks the necessary information to process the claim.

Section 1862 (a)(10) excludes cosmetic surgery.

Code of Federal Regulations:

42 CFR Section 410.32, indicates that diagnostic tests may only be ordered by the treating physician (or other treating practitioner acting within the scope of his or her license and Medicare requirements) **who furnishes a consultation or treats a beneficiary for a specific medical problem and who uses the results in the management of the beneficiary’s specific medical problem.** Tests not ordered by the physician (or other qualified non-physician provider) who is treating the beneficiary are not reasonable and necessary (see Sec. 411.15(k)(1) of this chapter

CMS Publications:

CMS Publication 100-02, *Medicare Benefit Policy Manual*, Chapter 15:

80 Requirements for Diagnostic X-Ray, Diagnostic Laboratory, and Other Diagnostic Tests


80.7 Refractive Keratoplasty
80.7.1 Keratoplasty

Coverage Guidance

**Coverage Indications, Limitations, and/or Medical Necessity**

**Abstract:**

Corneal topography is a computer assisted diagnostic technique where 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 nearly accurate portrayal of the physical state of the cornea and for the detection of subtle corneal surface irregularity and astigmatism.

Keratoplasty that treats specific lesions of the cornea, such as phototherapeutic keratectomy that removes scar
tissue from the visual axis, deals with an abnormality of the eye and is not cosmetic surgery. Such cases may be covered under §1862(a)(1)(A) of the Act. (CMS Publication 100-03, Medicare National Coverage Determinations Manual, Part 1, Section 80.7.1) This local coverage determination discusses medically necessary indications and limitations for computerized corneal topography testing.

**Indications:**

Computerized corneal topography is considered medically necessary under any of the following conditions:

- 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.

**Limitations:**

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.

Corneal topography is a covered service for the above 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.

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.

Per CMS Pub 100-03, Chapter 1, Part 1, Section 80.7, Refractive keratoplasty is surgery to reshape the cornea of the eye to correct vision problems such as myopia (nearsightedness) and hyperopia (farsightedness). Refractive keratoplasty procedures include keratomileusis, in which the front of the cornea is removed, frozen, reshaped, and stitched back on the eye to correct either near or farsightedness; keratophakia, in which a reshaped donor cornea is inserted in the eye to correct farsightedness; and radial keratotomy, in which spoke-like slits are cut in the cornea to weaken and flatten the normally curved central portion to correct nearsightedness.

The correction of common refractive errors by eyeglasses, contact lenses or other prosthetic devices is specifically excluded from coverage. The use of radial keratotomy and/or keratoplasty (Refractive Surgeries) for the purpose of refractive error compensation is considered a substitute or alternative to eye glasses or contact lenses which are specifically excluded by §1862 (a)(7) of the Act (except in certain cases in connection with cataract surgery). In addition, many in the medical community consider such procedures cosmetic surgery which is excluded by §1862 (a)(10) of the Act. Therefore, radial keratotomy and keratoplasty (Refractive Surgeries) to treat refractive defects are not covered.

**Other Comments:**

For claims submitted to the Part A MAC: this coverage determination also applies within states outside the primary geographic jurisdiction with facilities that have nominated CGS Administrators, LLC. to process their claims.
Bill type codes only apply to providers who bill these services to the Part A MAC. Bill type codes do not apply to physicians, other professionals and suppliers who bill these services to the carrier or Part B MAC.

For dates of service on or after April 1, 2010, bill type 77X should be used to report FQHC services.

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.

Coding Information

Bill Type Codes:

Contractors may specify Bill Types to help providers identify those Bill Types typically used to report this service. Absence of a Bill Type does not guarantee that the policy does not apply to that Bill Type. Complete absence of all Bill Types indicates that coverage is not influenced by Bill Type and the policy should be assumed to apply equally to all claims.

011x Hospital Inpatient (Including Medicare Part A)
012x Hospital Inpatient (Medicare Part B only)
013x Hospital Outpatient
071x Clinic - Rural Health
073x Clinic - Freestanding
077x Clinic - Federally Qualified Health Center (FQHC)
085x Critical Access Hospital

Revenue Codes:

Contractors may specify Revenue Codes to help providers identify those Revenue Codes typically used to report this service. In most instances Revenue Codes are purely advisory. Unless specified in the policy, services reported under other Revenue Codes are equally subject to this coverage determination. Complete absence of all Revenue Codes indicates that coverage is not influenced by Revenue Code and the policy should be assumed to apply equally to all Revenue Codes.

Revenue codes only apply to providers who bill these services to the Part A MAC. Revenue codes do not apply to physicians, other professionals and suppliers who bill these services to the carrier or Part B MAC.

Please note that not all revenue codes apply to every type of bill code. Providers are encouraged to refer to the FISS revenue code file for allowable bill types. Similarly, not all revenue codes apply to each CPT/HCPCS code. Providers are encouraged to refer to the FISS HCPCS file for allowable revenue codes.

All revenue codes billed on the inpatient claim for the dates of service in question may be subject to review.

0360 Operating Room Services - General Classification
0409 Other Imaging Services - Other Imaging Services
0450 Emergency Room - General Classification
0510 Clinic - General Classification
0519 Clinic - Other Clinic
0520 Freestanding Clinic - General Classification
0521 Freestanding Clinic - Clinic Visit by Member to RHC/FQHC
0523 Freestanding Clinic - Family Practice Clinic
0529 Freestanding Clinic - Other Freestanding Clinic
0761 Specialty Services - Treatment Room
0920 Other Diagnostic Services - General Classification
0929 Other Diagnostic Services - Other Diagnostic Service
0960 Professional Fees - General Classification
COMPUTERIZED CORNEAL TOPOGRAPHY, UNILATERAL OR BILATERAL, WITH INTERPRETATION AND REPORT

ICD-10 Codes that Support Medical Necessity

**Group 1 Paragraph:** It is the responsibility of the provider to code to the highest level specified in the ICD-10-CM. The correct use of an ICD-10-CM code listed below does not assure coverage of a service. The service must be reasonable and necessary in the specific case and must meet the criteria specified in this determination.

### ICD-10 Codes that Support Medical Necessity

**Group 1 Codes:**

- **H11.001 - H11.003**: Unspecified pterygium of right eye - Unspecified pterygium of eye, bilateral
- **H11.011 - H11.013**: Amyloid pterygium of right eye - Amyloid pterygium of eye, bilateral
- **H11.021 - H11.023**: Central pterygium of right eye - Central pterygium of eye, bilateral
- **H11.031 - H11.033**: Double pterygium of right eye - Double pterygium of eye, bilateral
- **H11.041 - H11.043**: Peripheral pterygium, stationary, right eye - Peripheral pterygium, stationary, bilateral
- **H11.051 - H11.053**: Peripheral pterygium, progressive, right eye - Peripheral pterygium, progressive, bilateral
- **H11.061 - H11.063**: Recurrent pterygium of right eye - Recurrent pterygium of eye, bilateral
- **H16.051 - H16.053**: Moor's corneal ulcer, right eye - Moor's corneal ulcer, bilateral
- **H16.301 - H16.303**: Unspecified interstitial keratitis, right eye - Unspecified interstitial keratitis, bilateral
- **H16.321 - H16.323**: Diffuse interstitial keratitis, right eye - Diffuse interstitial keratitis, bilateral
- **H16.331 - H16.333**: Sclerosing keratitis, right eye - Sclerosing keratitis, bilateral
- **H17.9**: Unspecified corneal scar and opacity
- **H18.421 - H18.423**: Band keratopathy, right eye - Band keratopathy, bilateral
- **H18.451 - H18.453**: Nodular corneal degeneration, right eye - Nodular corneal degeneration, bilateral
- **H18.59**: Other hereditary corneal dystrophies
- **H18.601 - H18.603**: Keratoconus, unspecified, right eye - Keratoconus, unspecified, bilateral
- **H18.611 - H18.613**: Keratoconus, stable, right eye - Keratoconus, stable, bilateral
- **H18.621 - H18.623**: Keratoconus, unstable, right eye - Keratoconus, unstable, bilateral
- **H18.711 - H18.713**: Corneal ectasia, right eye - Corneal ectasia, bilateral
- **H52.211 - H52.213**: Irregular astigmatism, right eye - Irregular astigmatism, bilateral
- **H53.2**: Diplopia
- **T85.21XA**: Breakdown (mechanical) of intraocular lens, initial encounter
- **T85.22XA**: Displacement of intraocular lens, initial encounter
- **T85.318A**: Breakdown (mechanical) of other ocular prosthetic devices, implants and grafts, initial encounter
- **T85.328A**: Displacement of other ocular prosthetic devices, implants and grafts, initial encounter
- **T86.840**: Corneal transplant rejection
- **T86.841**: Corneal transplant failure
- **Z94.7**: Corneal transplant status
- **Z96.1**: Presence of intraocular lens
- **Z98.41**: Cataract extraction status, right eye
- **Z98.42**: Cataract extraction status, left eye
- **Z98.83**: Filtering (vitreous) bleb after glaucoma surgery status

**Group 1 Medical Necessity ICD-10 Codes Asterisk Explanation:** *Z96.1, Z98.41, and Z98.42 must be accompanied by ICD-10-CM code H52.211, H52.212, or H52.213.

ICD-10 Codes that DO NOT Support Medical Necessity N/A

ICD-10 Additional Information [Back to Top]
The patient's medical record must contain documentation that fully supports the medical necessity for services included within this LCD. (See "Indications and Limitations of Coverage.") This documentation includes, but is not limited to, relevant medical history, physical examination, and results of pertinent diagnostic tests or procedures. The patient's record must also include the computerized corneal topography results with examination and photo interpretation.

Not applicable

It is expected that these services 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.

Repeat testing is only indicated if a change in vision occurs. Corneal topography should not be reported with or during the post-operative period for corneal procedures, e.g., 65710, 65730, 65750, 65755, 65756, 65757 and 65770.

Sources of Information and Basis for Decision
This bibliography presents those sources that were obtained during the development of this policy. CGS Administrators, LLC. is not responsible for the continuing viability of Web site addresses listed below.


Other Medicare contractors’ local coverage determinations.

### Revision History Information

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| 10/01/2015 | R1 | Revision Effective: N/A | Other (revenue code description) |
| 10/01/2015 |     | Revision Explanation: Accepted revenue code description. | |

### Associated Documents

Attachments N/A

Related Local Coverage Documents N/A

Related National Coverage Documents N/A

Public Version(s) Updated on 02/01/2016 with effective dates 10/01/2015 - N/A Updated on 06/15/2015 with effective dates 10/01/2015 - N/A Updated on 03/14/2014 with effective dates 10/01/2015 - N/A

### Keywords

N/A Read the [LCD Disclaimer](#)