Corneal Topography

Guideline Number: MPG062.08
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Terms and Conditions

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Overview

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.

Indications

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. Coverage is limited to the following conditions which may not be all inclusive:

- Pre-operative evaluation of irregular astigmatism for intraocular lens power determination with cataract surgery
- Monocular diplopia
- Bullous keratopathy
- 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
- Pterygium and/or corneal ectasia that cause visual impairment

Limitations

- Corneal topography is not covered for routine follow-up testing.

- Corneal topography will only be allowed for a pre-operative cataract patient if documentation supports that the patient has irregular astigmatism.
- 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.

Applicable Codes

The following list(s) of procedure and/or diagnosis codes is provided for reference purposes only and may not be all inclusive. Listing of a code in this guideline does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

CPT Code	Description
92025	Computerized corneal topography, unilateral or bilateral, with interpretation and report

Modifier	Description
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

Diagnosis Code	Description
H11.001	Unspecified pterygium of right eye
H11.002	Unspecified pterygium of left eye
H11.003	Unspecified pterygium of eye, bilateral
H11.009	Unspecified pterygium of unspecified eye
H11.011	Amyloid pterygium of right eye
H11.012	Amyloid pterygium of left eye
H11.013	Amyloid pterygium of eye, bilateral
H11.019	Amyloid pterygium of unspecified eye
H11.021	Central pterygium of right eye
H11.022	Central pterygium of left eye
H11.023	Central pterygium of eye, bilateral
H11.029	Central pterygium of unspecified eye
H11.031	Double pterygium of right eye
H11.032	Double pterygium of left eye
H11.033	Double pterygium of eye, bilateral
H11.039	Double pterygium of unspecified eye
H11.041	Peripheral pterygium, stationary, right eye
H11.042	Peripheral pterygium, stationary, left eye
H11.043	Peripheral pterygium, stationary, bilateral
H11.049	Peripheral pterygium, stationary, unspecified eye

Diagnosis Code	Description
H11.051	Peripheral pterygium, progressive, right eye
H11.052	Peripheral pterygium, progressive, left eye
H11.053	Peripheral pterygium, progressive, bilateral
H11.059	Peripheral pterygium, progressive, unspecified eye
H11.061	Recurrent pterygium of right eye
H11.062	Recurrent pterygium of left eye
H11.063	Recurrent pterygium of eye, bilateral
H11.069	Recurrent pterygium of unspecified eye
H11.141	Conjunctival xerosis, unspecified, right eye
H11.142	Conjunctival xerosis, unspecified, left eye
H11.143	Conjunctival xerosis, unspecified, bilateral
H11.149	Conjunctival xerosis, unspecified, unspecified eye
H11.811	Pseudopterygium of conjunctiva, right eye
H11.812	Pseudopterygium of conjunctiva, left eye
H11.813	Pseudopterygium of conjunctiva, bilateral
H11.819	Pseudopterygium of conjunctiva, unspecified eye
H16.051	Mooren's corneal ulcer, right eye
H16.052	Mooren's corneal ulcer, left eye
H16.053	Mooren's corneal ulcer, bilateral
H16.301	Unspecified interstitial keratitis, right eye
H16.302	Unspecified interstitial keratitis, left eye
H16.303	Unspecified interstitial keratitis, bilateral
H16.321	Diffuse interstitial keratitis, right eye
H16.322	Diffuse interstitial keratitis, left eye
H16.323	Diffuse interstitial keratitis, bilateral
H16.331	Sclerosing keratitis, right eye
H16.332	Sclerosing keratitis, left eye
H16.333	Sclerosing keratitis, bilateral
H17.89	Other corneal scars and opacities
H17.9	Unspecified corneal scar and opacity
H18.10	Bullous keratopathy, unspecified eye
H18.11	Bullous keratopathy, right eye
H18.12	Bullous keratopathy, left eye
H18.13	Bullous keratopathy, bilateral
H18.421	Band keratopathy, right eye
H18.422	Band keratopathy, left eye
H18.423	Band keratopathy, bilateral
H18.451	Nodular corneal degeneration, right eye
H18.452	Nodular corneal degeneration, left eye
H18.453	Nodular corneal degeneration, bilateral
H18.459	Nodular corneal degeneration, unspecified eye
H18.461	Peripheral corneal degeneration, right eye

Diagnosis Code	Description
H18.462	Peripheral corneal degeneration, left eye
H18.463	Peripheral corneal degeneration, bilateral
H18.469	Peripheral corneal degeneration, unspecified eye
H18.51	Endothelial corneal dystrophy (Deleted 09/30/2020)
H18.511	Endothelial corneal dystrophy, right eye(Effective 10/01/2020)
H18.512	Endothelial corneal dystrophy, left eye(Effective 10/01/2020)
H18.513	Endothelial corneal dystrophy, bilateral(Effective 10/01/2020)
H18.52	Epithelial (juvenile) corneal dystrophy (Deleted 09/30/2020)
H18.521	Epithelial (juvenile) corneal dystrophy, right eye(Effective 10/01/2020)
H18.522	Epithelial (juvenile) corneal dystrophy, left eye(Effective 10/01/2020)
H18.523	Epithelial (juvenile) corneal dystrophy, bilateral(Effective 10/01/2020)
H18.53	Granular corneal dystrophy (Deleted 09/30/2020)
H18.531	Granular corneal dystrophy, right eye(Effective 10/01/2020)
H18.532	Granular corneal dystrophy, left eye(Effective 10/01/2020)
H18.533	Granular corneal dystrophy, bilateral(Effective 10/01/2020)
H18.54	Lattice corneal dystrophy (Deleted 09/30/2020)
H18.541	Lattice corneal dystrophy, right eye(Effective 10/01/2020)
H18.542	Lattice corneal dystrophy, left eye(Effective 10/01/2020)
H18.543	Lattice corneal dystrophy, bilateral(Effective 10/01/2020)
H18.55	Macular corneal dystrophy (Deleted 09/30/2020)
H18.551	Macular corneal dystrophy, right eye(Effective 10/01/2020)
H18.552	Macular corneal dystrophy, left eye(Effective 10/01/2020)
H18.553	Macular corneal dystrophy, bilateral(Effective 10/01/2020)
H18.59	Other hereditary corneal dystrophies (Deleted 09/30/2020)
H18.591	Other hereditary corneal dystrophies, right eye(Effective 10/01/2020)
H18.592	Other hereditary corneal dystrophies, left eye(Effective 10/01/2020)
H18.593	Other hereditary corneal dystrophies, bilateral(Effective 10/01/2020)
H18.601	Keratoconus, unspecified, right eye
H18.602	Keratoconus, unspecified, left eye
H18.603	Keratoconus, unspecified, bilateral
H18.609	Keratoconus, unspecified, unspecified eye
H18.611	Keratoconus, stable, right eye
H18.612	Keratoconus, stable, left eye
H18.613	Keratoconus, stable, bilateral
H18.619	Keratoconus, stable, unspecified eye
H18.621	Keratoconus, unstable, right eye
H18.622	Keratoconus, unstable, left eye
H18.623	Keratoconus, unstable, bilateral
H18.629	Keratoconus, unstable, unspecified eye
H18.711	Corneal ectasia, right eye
H18.712	Corneal ectasia, left eye
H18.713	Corneal ectasia, bilateral

Diagnosis Code	Description
H18.719	Corneal ectasia, unspecified eye
H52.211	Irregular astigmatism, right eye
H52.212	Irregular astigmatism, left eye
H52.213	Irregular astigmatism, bilateral
H52.219	Irregular astigmatism, unspecified eye
H52.221	Regular astigmatism, right eye
H52.222	Regular astigmatism, left eye
H52.223	Regular astigmatism, bilateral
H52.229	Regular astigmatism, unspecified eye
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
T85.318D	Breakdown (mechanical) of other ocular prosthetic devices, implants and grafts, subsequent encounter
T85.318S	Breakdown (mechanical) of other ocular prosthetic devices, implants and grafts, sequela
T85.328A	Displacement of other ocular prosthetic devices, implants and grafts, initial encounter
T85.328D	Displacement of other ocular prosthetic devices, implants and grafts, subsequent encounter
T85.328S	Displacement of other ocular prosthetic devices, implants and grafts, sequela
T85.398A	Other mechanical complication of other ocular prosthetic devices, implants and grafts, initial encounter
T85.398D	Other mechanical complication of other ocular prosthetic devices, implants and grafts, subsequent encounter
T85.398S	Other mechanical complication of other ocular prosthetic devices, implants and grafts, sequela
T86.840	Corneal transplant rejection
T86.841	Corneal transplant failure
T86.848	Other complications of corneal transplant
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
Z98.49	Cataract extraction status, unspecified eye
Z98.83	Filtering (vitreous) bleb after glaucoma surgery status

References

CMS Local Coverage Determinations (LCDs) and Articles

LCD	Article	Contractor	Medicare Part A	Medicare Part B
L33810 Computerized Corneal Topography	A57699 Billing and Coding: Computerized Corneal Topography	First Coast		FL, PR, VI
L34008 Computerized Corneal Topography	A56816 Billing and Coding: Computerized Corneal Topography	CGS	KY, OH	KY, OH

Other(s)

Billing and Coding Guidelines: Billing and Coding Guidelines for Computerized Corneal Topography (OPHTH-014), WPS, CMS Website

Guideline History/Revision Information

Revisions to this summary document do not in any way modify the requirement that services be provided and documented in accordance with the Medicare guidelines in effect on the date of service in question.

Date	Summary of Changes
04/01/2021	Template Update • Reformatted policy; transferred content to new template
10/14/2020	Applicable Codes • Removed ICD-10 diagnosis codes H18.519, H18.529, H18.539, H18.549, H18.559, and H18.599 Supporting Information • Archived previous policy version MPG062.07

Purpose

The Medicare Advantage Policy Guideline documents are generally used to support UnitedHealthcare Medicare Advantage claims processing activities and facilitate providers' submission of accurate claims for the specified services. The document can be used as a guide to help determine applicable:

- Medicare coding or billing requirements, and/or
- Medical necessity coverage guidelines; including documentation requirements.

UnitedHealthcare follows Medicare guidelines such as NCDs, LCDs, LCAs, and other Medicare manuals for the purposes of determining coverage. It is expected providers retain or have access to appropriate documentation when requested to support coverage. Please utilize the links in the References section below to view the Medicare source materials used to develop this resource document. This document is not a replacement for the Medicare source materials that outline Medicare coverage requirements. Where there is a conflict between this document and Medicare source materials, the Medicare source materials will apply.

Terms and Conditions

The Medicare Advantage Policy Guidelines are applicable to UnitedHealthcare Medicare Advantage Plans offered by UnitedHealthcare and its affiliates.

These Policy Guidelines are provided for informational purposes, and do not constitute medical advice. Treating physicians and healthcare providers are solely responsible for determining what care to provide to their patients. Members should always consult their physician before making any decisions about medical care.

Benefit coverage for health services is determined by the member specific benefit plan document* and applicable laws that may require coverage for a specific service. The member specific benefit plan document identifies which services are covered, which are excluded, and which are subject to limitations. In the event of a conflict, the member specific benefit plan document supersedes the Medicare Advantage Policy Guidelines.

Medicare Advantage Policy Guidelines are developed as needed, are regularly reviewed and updated, and are subject to change. They represent a portion of the resources used to support UnitedHealthcare coverage decision making. UnitedHealthcare may modify these Policy Guidelines at any time by publishing a new version of the policy on this website. Medicare source materials used to develop these guidelines include, but are not limited to, CMS National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), Medicare Benefit Policy Manual, Medicare Claims Processing Manual, Medicare Program Integrity Manual, Medicare Managed Care Manual, etc. The information presented in the Medicare Advantage Policy Guidelines is believed to be accurate and current as of the date of publication and is provided on an "AS IS"

basis. Where there is a conflict between this document and Medicare source materials, the Medicare source materials will apply.

You are responsible for submission of accurate claims. Medicare Advantage Policy Guidelines are intended to ensure that coverage decisions are made accurately based on the code or codes that correctly describe the health care services provided. UnitedHealthcare Medicare Advantage Policy Guidelines 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 or guarantee claims payment.

*For more information on a specific member's benefit coverage, please call the customer service number on the back of the member ID card or refer to the Administrative Guide.