

**Contractor Name**

Wisconsin Physicians Service (WPS)

**Contractor Number**

00951, 00952, 00953, 00954  
05101, 05201, 05301, 05401  
05102, 05202, 05302, 05402, 52280

**Contractor Type**

Carrier  
Fiscal Intermediary (FI)  
MAC – A  
MAC - B

**LCD Database ID Number**

**LCD Version Number**

**LCD Title**

Corneal Pachymetry

**Contractor's Determination Number**

OPHTH-025

**AMA CPT/ ADA CDT Copyright Statement**

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**CMS National Coverage Policy**

42CFR410.32 Diagnostic tests may only be ordered by the treating physician (or other treating practitioner acting within the scope of their licenses and Medicare requirements)\* who will use the results in management of the beneficiary’s specific medical problem and diagnostic tests payable under the Physicians Fee Schedule must be furnished under the appropriate level of supervision by a physician.

**Primary Geographic Jurisdiction**

**Intermediary:** Alaska, Alabama, Arizona, Arkansas, California - Entire State, Colorado, Connecticut, Delaware, Florida, Georgia, Hawaii, Iowa,-Idaho, Illinois, Indiana, Kansas, Kentucky, Louisiana, Massachusetts, Maryland, Maine, Michigan, Minnesota, Missouri - Entire State, Mississippi, Montana, North Carolina, North Dakota, Nebraska, New Hampshire, New Jersey, New Mexico, Nevada, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, Vermont, Washington, Wisconsin, West Virginia, Wyoming, District of Columbia, American Samoa, Guam, Northern Mariana Islands, Virgin Islands

**Carrier:** Wisconsin, Illinois, Michigan, Minnesota

**MAC AB:** Iowa, Missouri, Nebraska, Kansas

## **Oversight Region**

Region I

Region V

Region VII

## **Original Determination Effective Date**

## **Revision Effective Date**

### **Indications and Limitations of Coverage and/or Medical Necessity**

Corneal Pachymetry (CP) is a measurement of the thickness of the cornea. Cornea thickness provides indirect measurement of physiological function of the cornea. The cornea is approximately 540 to 550 microns thick in the center area and 1,000 microns (one millimeter) thick in the periphery. The most common accepted technique for obtaining corneal pachymetric measurement is ultrasound biometry due to its availability, accuracy and cost effectiveness. CP can also be measured by optical low coherence reflectometry

The evaluation of corneal thickness is a well-established procedure for studying corneal function in a number of medical disease conditions. There must be documented indications in the patients' medical record to substantiate medical necessity for testing. These disease conditions can be categorized into four groups:

### **Indications for Corneal Pachymetry**

1. Disorders of endothelial cell function
2. Disorders of corneal thickness
3. Corneal transplantation
4. Ocular hypertension (OHT) and glaucoma

### **Groups 1, 2, and 3**

Indications for groups 1, 2 and 3:

- A. Management of corneal disease and corneal transplant surgery.

Limitations for groups 1, 2 and 3:

- A. Payment frequency will be no more the once every six month, bilaterally, as indicated by the medical records.

### **Group 4**

The utilization of CP in relation to OHT and glaucoma (Group 4) has been documented in recent studies demonstrating that intraocular pressure (IOP) measurements need to be adjusted for abnormally thick or thin corneas. The target IOP is lower for a thin cornea and higher for a thick cornea.

The decision to treat glaucoma or OHT with topical medications, systemic medications, laser surgery or intraocular surgery is made by the treating physician after analyzing:

Indications for group 4:

- A. Ocular factors (various ocular parameters e.g. IOP, corneal thickness, optic nerve assessment, visual field results) and
- B. General systemic factors including family history, age, anemia, systemic medication, diabetes, other vascular diseases, etc.

Limitations for group 4:

- A. CP payment frequency for isolated category 4 criteria would be once in a patients' lifetime, bilaterally, as documented in the medical record for any individual provider or provider billing group.
- B. In patients' who have had CP based on group 4 indications, and have subsequent corneal refractive surgery or transplant surgery, it may be medically appropriate to repeat the test.

**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.**

- 12x Hospital-inpatient or home health visits (Part B only)
- 13x Hospital-outpatient (HHA-A also) (under OPSS 13x must be used for ASC claims submitted for OPSS payment (eff.: 7/00)
- 18x Hospital-swing beds
- 21x SNF-inpatient, Part A
- 22x SNF- Inpatient or home health visits (Part B only)
- 23x SNF—outpatient (HHA-A also)
- 71x Clinic-rural health
- 73x Clinic-independent provider based FQHC (eff:10/91)
- 85x Special facility or ASC surgery-rural primary care hospital (eff: 10/94)

**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.**

**Note:** WPS has identified the Type of Bill (TOB) and Revenue Center (RC) codes applicable for use with the CPT/HCPCS codes included in this LCD. Providers are reminded that not all CPT/HCPCS codes listed can be billed with all TOB and/or RC codes listed. CPT/HCPCS codes are required to be billed with specific TOB and RC codes. Providers are encouraged to refer to the CMS *Internet-Only Manual (IOM)* Pub. 100-04 *Claims Processing Manual* for further guidance.

- 032x Radiology diagnostic-general classification
- 034x Nuclear medicine-general classification
- 035x Computed tomographic (CT) scan-general classification
- 040x Other imaging services-general classification
- 061x Magnetic resonance technology (MRT)- general classification

**CPT/HCPCS Codes**

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

**Does the CPT 30% Rule Apply**

No

**ICD-9 Codes that Support Medical Necessity**

*Note: ICD-9 codes must be coded to the highest level of specificity.*

**Group 1 Indications**

Disorders of Endothelial Cell Function

371.20-371.23, 371.57, 371.58

**Group 2 Indications**

Disorders of Corneal Thickness

370.00-370.06, 371.03, 371.48, 371.60-371.62, 371.70-371.72

**Group 3 Indications**

Corneal Transplant 996.51, 996.80

**Group 4 Indications**

Ocular Hypertension (OHT) and Glaucoma

365.00-365.04, 365.10-365.15, 365.20-365.24, 365.31-365.32, 365.41-365.44, 365.51-365.59, 365.60-365.65, 365.81-365.89, 365.9

**Diagnoses that Support Medical Necessity**

Any listed above

**ICD-9 Codes that DO NOT Support Medical Necessity**

Any Not listed above

**Diagnoses that DO NOT Support Medical Necessity**

Any Not listed above

**Documentation Requirements**

1. Physician Services and diagnostic tests must be submitted with an ICD-9 code to support medical necessity and must be coded to the greatest level of accuracy and highest level of digit completeness. This means the precise ICD-9 code that most fully explains the narrative description of the diagnosis contained in the medical record or test interpretation and report including the 4<sup>th</sup> or 5<sup>th</sup> digit subclassification for that diagnosis category. The ICD-9 code based on the results of the diagnostic test should be reported as the primary diagnosis. If the diagnostic test results are normal or inconclusive the ICD-9 code representing the sign, symptom, illness or injury prompting the ordering of the test should be reported as the primary diagnosis. In the absence of signs, symptoms, illness or injury a screening ICD-9 should be reported, and payment will be denied. Ref. CMS Pub.100-04 Ch. 23 §§10.1-10.1.7
2. The patient's medical records should be legible, contain the relevant medical history and physical findings conforming to the criteria stated in the "Indication and Limitations of Coverage and/or Medical Necessity" section of this policy. Records must be made available to the Contractor on request.

**Utilization Guidelines**

The utilization of CP for Group 1, 2, and 3 will be no more than once every six months, bilaterally, as indicated by the medical records. (Refer to Indications and Limitations of Coverage and/or Medical Necessity section)

The utilization of CP Group 4 criteria would be once in patients' lifetime, bilaterally, as documented in the medical record. In patients' who have subsequent corneal refractive surgery or transplant surgery, it may be appropriate to repeat the test if medically indicated, based on the group 4 criteria. (Refer to Indications and Limitations of Coverage and/or Medical Necessity section)

More frequent CP may be approved when submitted with documentation describing the medical circumstance relating to the patient's condition explaining the need for more frequent services.

This service is considered a bilateral service and will, therefore, be paid once whether one or both eyes are tested.

CP measurement is not considered medically reasonable and necessary when performed prior to routine cataract surgery unless corneal disease is documented.

For routine glaucoma screening see CMS Pub100-02 Ch. §280.1 and CMS Pub.100-04 Ch.18 §§70-70.3.

If there is evidence of corneal endothelial dysfunction prior to cataract surgery, and the purpose of corneal pachymetry is to aid in the decision whether to perform a combined corneal transplant plus cataract surgery or cataract surgery alone, corneal pachymetry may be medically reasonable and necessary.

#### **Other Comments**

The "Coding Guidelines" and the "Reasons for Denial" have been removed from this policy. The information has been placed in a companion article.

An asterisk (\*) indicates a revision to that section of the policy.

This policy does not reflect the sole opinion of the contractor or Contractor Medical Director. Although the final decision rests with the contractor, this policy was developed in cooperation with advisory groups, which includes representatives from Ophthalmology.

#### **Sources of Information and Basis for Decision**

Brandt J., Beiser J., Kass M., et al. (2001). Central corneal thickness in ocular hypertension treatment study (OHTS). *Ophthalmology Vol. 108* 1779-1788

Doughty M., Zaman M., (2000). Human corneal thickness and its impact on intraocular pressure measures; A review and meta-analysis approach. *Surv Ophthalmology, Vol. 44* 367-408 (March-April)

Gordon, M., Beiser J., Brandt J., et al. (2002) The ocular hypertension treatment study. *Arch Ophthalmology, Vol. 120* (June)

Herndon L., et al. (1997) Central corneal thickness in normal glaucomatous and ocular hypertensive eyes." *Arch. Ophthalmology, Vol. 115* (Sept.)

Oh K., Weil L., et al (1998). Corneal thickness in Fuch's dystrophy with and without epithelial edema." *Eye Vol. 12* (Pt 2) 282-4

Parrish R., (2002) What clinicians can learn from OHTS. *Review of Ophthalmology* (Sept.)

Other Contractor Policies

**Advisory Committee Meeting Notes**

Meeting Date:

Wisconsin: 09/25/2009

Illinois: 09/16/2009

Michigan: 09/08/2009

Minnesota: 09/24/2009

Iowa, Kansas, 10/08/2009

Missouri,

Nebraska

**Start Date of Comment Period**

10/08/2009

**End Date of Comment Period**

11/23/2009

**Start Date of Notice Period**

(Published)

**Revision History Number/Explanation**

**Last Reviewed On**

**Related Documents**

[Corneal Pachymetry; Coding and Billing Guidelines](#)

**Does this LCD contain a "Least Costly Alternative" Provision?**

No

## Coding and Billing Guidelines

### Article Title

Corneal Pachymetry: Coding and Billing Guidelines

### Article Effective Date

### AMA CPT/ ADA CDT Copyright Statement

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### Article Text

This article contains the coding guidelines and reasons for denial of Corneal Pachymetry services. This article should be used in combination with the Corneal Pachymetry OPHTH-025 LCD.

### Coverage Topic

Diagnostic Tests and Xrays

### Coding Information

1. List the appropriate procedure code for the service performed, include any necessary modifiers.
2. List the appropriate ICD-9 code that best supports the medical necessity for the service. ICD-9 code(s) must be present on all Physicians Service claims and must be coded to the highest degree of accuracy and digit level completeness.
3. Procedure codes 76514 and 0025T is classified a bilateral procedure, the bilateral adjustment does not apply, the Physicians Fee Schedule amount represents payment for **both** eyes. The procedure should be reported on a single claim line **without** the 50 or RT/LT modifiers. In the event that the procedure is performed on only one eye per DOS the procedure may be reported with a 52 modifier – (reduced service) and a reduction to the physician’s usual charge.
4. When billing for services, requested by the beneficiary for denial, that are statutorily excluded by Medicare (i.e. screening), report a screening ICD-9 code (V80.2) and the GY modifier (items or services statutorily excluded or does not meet the definition of any Medicare benefit). A Notice of Exclusion from Medicare Benefits (NEMB) may be used with services excluded from Medicare benefits. See [www.cms.hhs.gov/BNI](http://www.cms.hhs.gov/BNI)
5. When billing for services, requested by the beneficiary for denial, that would be considered **not** reasonable and necessary, report an ICD-9 code that best describes the patients condition and the GA modifier (waiver of liability on file) if an ABN signed by the beneficiary is on file or the GZ modifier (items or services expected to be denied as not reasonable) when a signed ABN for this service is not on file.

### Other Information

#### Denial Summary

The following situation will result in the denial of initially billed CP services or in some cases as a result of a postpayment review

Corneal pachymetry will always be denied when it is used in clinical decision-making associated with refractive surgery. Refractive surgery is a statutorily excluded service [Social Security Act 1861(a)(7)-Cosmetic surgery

Title XVIII of the Social Security Act section 1862 (a)(1)(A). This section allows coverage and payment of those services that are considered to be medically reasonable and necessary.

1. Claims submitted without an ICD-9 code that support medical necessity would be denied as not medically necessary.
2. Services billed at excessive frequency will be denied as not medically necessary
3. CP measurement performed on a routine basis prior to uncomplicated cataract surgery will be denied as not medically necessary

Title XVIII of the Social Security Act section 1862 (a)(7). This section excludes routine physical examinations and services

1. Screening tests, in the absence of associated signs, symptoms, illness or injury will be denied as non-covered

Title XVIII of the Social Security Act section 1833 (e). This section prohibits Medicare payment for any claim which lacks the necessary information to process the claim.

1. Physician's services submitted without an ICD-9 code, or not coded to the greatest degree of accuracy and digit level completeness will be denied as unprocessable.

**Notes**

An asterisk (\*) indicates a revision to that section of the article.

**Other Versions**

**Original Effective Date**

**Publication Date**

**Effective Date/Number/Explanation**