Glaucoma Local Coverage Determinations

Corneal Pachymetry

L32410  J11 (WV, VA, NC, SC); L28142  J6 (WI, IL, MN); L28142  JK (CT, MA, ME, NH, NY, RI, VT); L31834  J15 (KY, OH)

Indications and Limitations of Coverage and/or Medical Necessity
Medicare will consider corneal pachymetry to be medically necessary and reasonable when performed to determine the amount of endothelial trauma sustained during surgery, assessment of the health of the cornea pre-operatively in Fuch's dystrophy, post ocular trauma and for the assessment of corneal thickness or (in suspected glaucoma) following the diagnosis of increased intraocular pressure prior to the initiation of a treatment regimen for glaucoma. It is expected that a service for a corneal thickness measurement following the diagnosis of increased intraocular pressure will be performed once in a lifetime per provider, unless there has been interval corneal trauma or surgery. The lifetime limit ONLY applies for the glaucoma measurement and not for the other indications listed for this service.

CPT Code 76514
ICD-9 Codes that Support Medical Necessity: See LCDs for complete list; 364.22, 364.77, 365.00-365.9

Posterior Segment Imaging (Extended Ophthalmoscopy and Fundus Photography)

L32953  J11 (WV, VA, NC, SC)

Fundus photography
Fundus Photography is not covered for routine screening.
In general, fundus photography is considered medically necessary only when it would assist in:
1. monitoring potential progression of the disease process; or
2. guidance in evaluating the need for or response to a specific treatment or intervention.
In other words, medically necessary for fundus photography should guide a clinical decision.
Therefore, baseline photos to document a condition that is reasonably expected to be static and/or not require future treatment would not be medically necessary, while such photos to provide a means of comparison to detect, for example, potential progression of diabetic retinopathy, advanced non-neovascular (dry) macular degeneration with "suspicious" areas, or a nevus or other tumor could be medically necessary.
Repeat fundus photography should only be performed at clinically reasonable intervals (i.e., consistent with a noted change on examination or after sufficient time has elapsed for progression or for a treatment to have reasonably had an impact).
Specific to this policy, fundus photography to guide a given treatment or intervention (vs. monitoring for progression) e.g., photos used to guide the placement of macular laser treatment or to monitor the response to intraocular vascular endothelial growth factor (VEGF)agents should only be ordered by the physician who actually performs the treatment or intervention.

Extended ophthalmoscopy
An extended ophthalmoscopy may be considered medically reasonable and necessary for the following conditions (This List Is Not Exhaustive):
- Sudden visual loss or transient visual loss
- Blunt injury to the eye or adnexa
Disorders of the vitreous body (i.e., vitreous hemorrhage or posterior vitreous detachment) - spots before the eyes (floaters) and flashing lights (photopsia) can be signs/symptoms of these disorders
Posterior scleritis - signs and symptoms may include severe pain and inflammation, proptosis, limited ocular movements, and a loss of a portion of the visual field
Glaucoma or is a glaucoma suspect - this may be evidenced by increased intraocular pressure or progressive cupping of the optic nerve

CPT/HCPCS Codes: 92225, 92226, 92227, 92228, 92250
ICD-9 Codes that Support Medical Necessity: See LCD for complete list; 250.00-250.03, 250.50-250.53, 365.00-365.89, 368.11-368.16, 368.40, 377.10-377.54

Documentation Requirements:
Fundus Photography: The performance of extended ophthalmoscopy or fundus photography for specific conditions may be performed if reasonable and necessary to make clinical decisions in the treatment of the condition.
The patient's medical record must contain documentation that fully supports the medical necessity for fundus photography as it is covered by Medicare. This documentation includes, but is not limited to, relevant medical history, physical examination, and results of pertinent diagnostic tests or procedures.
A copy of the fundus photographs must be retained in the patient's medical records. An interpretation and report of the test must also be included, in addition to the photographs themselves. The medical record should also document whether the pupil was dilated for the procedure.
Extended Ophthalmoscopy: Documentation in the patient's medical record for a diagnosis of glaucoma must include all of the following:
Optic nerve abnormalities should be documented in a separate drawing from ANY in the retina, and should meet the above size requirements. For example: cupping, disc rim, pallor and slope, any pathology surrounding the optic nerve

L25466 J6 (WI, IL, MN); L25466 JK (CT, MA, ME, NH, NY, RI, VT); L31842 J15 (KY, OH)

Fundus photography
Photographs and an interpretation and report of the test may also be necessary to plan treatment for a disease process.
Fundus photography may be used for the diagnosis of conditions such as macular degeneration, retinal neoplasms, choroid disturbances and diabetic retinopathy, glaucoma, multiple sclerosis or other central nervous system anomalies.

Extended ophthalmoscopy
An extended ophthalmoscopy may be considered medically reasonable and necessary for the following conditions (This List Is Not Exhaustive):
- Sudden visual loss or transient visual loss
- Disorders of the vitreous body (i.e., vitreous hemorrhage or posterior vitreous detachment) - spots before the eyes (floaters) and flashing lights (photopsia) can be signs/symptoms of these disorders
- Posterior scleritis - signs and symptoms may include severe pain and inflammation, proptosis, limited ocular movements, and a loss of a portion of the visual field
- Glaucoma or is a glaucoma suspect - this may be evidenced by increased intraocular pressure or progressive cupping of the optic nerve

Extended ophthalmoscopy of a fellow eye without signs or symptoms or new abnormalities on general ophthalmoscopic exam will be denied as not medically necessary. Repeated extended ophthalmoscopy at each visit without change in signs, symptoms or condition may be denied as not medically necessary.

CPT/HCPCS Codes: 92225; 92226; 92227; 92228; 92250
ICD-9 Codes that Support Medical Necessity: See LCDs for complete list; 250.50-250.53, 365.00-365.9, 368.11-368.16

Documentation Requirements
Fundus photography: is usually medically necessary no more than two times per year.
Extended Ophthalmoscopy - Documentation in the patient’s medical record for a diagnosis of glaucoma (ICD-9-CM codes 365.00-365.9) must include all of the following:

- A separate detailed drawing of the optic nerve along with an interpretation that affects the plan of treatment,
- Documentation of cupping, disc rim, pallor, and slope,
- Documentation of any surrounding pathology around the optic nerve.

Conditions coded with other ICD-9-CM codes in the range 360.0-365.9, may require up to six (6) extended ophthalmoscopic examinations per eye, per year

**Fundus Photography**

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

Medicare will cover fundus photography if accompanied by fluorescein dye angiography when used to evaluate abnormalities or degeneration of the macula, the peripheral retina or the posterior pole. Fundus photography may be covered as a stand-alone procedure, without fluorescein dye angiography, following recently performed non-surgical or surgical treatment for macular pathology.

Preglaucoma, borderline glaucoma and glaucoma are generally slow disease processes which can be followed by modalities other than fundus photography. Baseline studies will, however, be allowed when performed by the treating physician as part of initial glaucoma eye care. Either of two situations may apply:

- Intraocular pressures are clearly documented in the patient's medical record and are at or above 21mm Hg or there is a difference in cup/disc ratio between the two eyes of 20% or greater.
- Intraocular pressures are less then 22mm Hg and there is clear fundoscopic evidence of glaucomatous optic nerve damage (e.g., abnormal cup size, thinning or notching of the disc rim, progressive change, disc hemorrhage, nerve fiber layer defects).

In either instance, repeat studies by the same physician more than once per year would generally not be expected unless other clinical indications exist to justify the study.

Fundus photos may be of value in the documentation of rapidly evolving diabetic retinopathy. In the absence of prior treatment, studies would not generally be performed for this indication more frequently than every 6 months.

Fundus photography may be indicated to document abnormalities related to a disease process affecting the eye, or to follow the course of such disease.

**Limitations**

Fundus photography is considered medically reasonable and necessary when it is furnished by a qualified optometrist or ophthalmologist in the course of the evaluation and management of a retinal disorder or another condition that has affected the retina as outlined above. Therefore, the digital imaging systems for the detection and evaluation of diabetic retinopathy used to acquire retinal images through a dilated pupil with remote interpretation do not meet Medicare’s reasonableness and necessity criteria for fundus photography (CPT codes 92227 and 92228).

**Performing Fundus Photography and SCODI on the Same Day on the Same Eye**

Fundus photography (CPT code 92250) and scanning ophthalmic computerized diagnostic imaging (CPT code 92133 or 92134) are generally mutually exclusive of one another in that a provider would use one technique or the other to evaluate fundal disease. However, there are a limited number of clinical conditions where both techniques are medically reasonable and necessary on the ipsilateral eye. In these situations, both CPT codes may be reported appending modifier 59 or HCPCS modifier XU-unusual, non-overlapping service to CPT code 92250 (National Correct Coding Initiative Policy Manual, Chapter 11, Section G, Ophthalmology).

The physician is not precluded from performing fundus photography and posterior segment SCODI on the same eye on the same day under appropriate circumstances (i.e., when each service is necessary to evaluate and treat the patient.

FCSO Medicare will consider fundus photography and posterior segment SCODI medically reasonable and necessary when performed on the same eye on the same day. Please see LCD for additional information.

**CPT/HCPCS Codes:** 92250

**ICD-9 Codes that Support Medical Necessity:** No list

**Associated Information**
Medical record documentation maintained by the performing physician must indicate the medical necessity of the fundus photography and be available to Medicare upon request. Office records/progress notes must document the complaint, symptomatology, or reason necessitating the test and must include the examination results/findings.

Photo documentation may be one of the following types: reproducible, slides, prints, digital photography, computerized analysis, or stereo photos.

Medical record documentation must clearly indicate rationale which supports the medical necessity for performing fundus photography and posterior segment SCODI on the same day on the same eye. Documentation should also reflect how the test results were used in the patient’s plan of care.

It would not be considered medically reasonable and necessary to perform fundus photography and posterior segment SCODI on the same day on the same eye to provide additional confirmatory information for a diagnosis or treatment which has already been determined.

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.

**L29242 JN (FL)**

**Ophthalmoscopy**

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

Extended ophthalmoscopy codes are reserved for the meticulous evaluation of the eye in detailed documentation of a severe ophthalmologic problem needing continued follow-up, which cannot be sufficiently evaluated by photography.

Medicare will consider ophthalmoscopy (CPT Codes 92225, 92226) to be medically reasonable and necessary if any one of the following circumstances is present: (extensive list.....refer to LCD for complete details)

**CPT/HCPCS Codes:** 92225; 92226

**ICD-9 Codes that Support Medical Necessity:** See LCD for complete list; 250.50-250.53, 365.00-365.9, 368.11-368.15

**Documentation Requirements**

Medical record documentation (eg, office/progress notes) maintained by the ordering/referring physician must indicate the medical necessity of the extended ophthalmoscopy exam. The medical records must include the following:

- The complaint or symptomatology necessitating the extended ophthalmoscopy exam
- Notation that the eye examined was dilated and the drug used
- The method of examination (eg, lens, instrument used)
- A detailed drawing of the retina showing anatomy in the patient as seen at time of examination, including the pathology found and a legible narrative report of the findings

An assessment of the change from previous examinations when performing follow-up services (92226) Documentation in the medical record for a diagnosis of glaucoma (ICD-9 Code 365.00-365.9) must include all of the following:

- a detailed drawing of the optic nerve,
- documentation of cupping, disc rim, pallor, and slope, and
- documentation of any surrounding pathology around the optic nerve.

### Scanning Computerized Ophthalmic Diagnostic Imaging (SCODI)

**J34187 J6 (WI, IL, MN); J34187 JK (CT, MA, ME, NH, NY, RI, VT)**

Posterior segment optical coherence tomography (OCT) is considered to be reasonable and necessary to:

- Diagnose and manage medically and surgically retinal and neuro-ophthalmic diseases which involve changes in the optic nerve, subretinal and intraretinal changes, vitreo-retinal relationships and changes in the nerve fiber layer.
- Diagnose early glaucoma and monitor glaucoma treatment
- Differentiate causes of other optic nerve disorders when a diagnosis is in doubt.
• Diagnose and manage the patient’s condition when visual field results are insufficient; or when reliable visual field testing cannot be performed, due to visual, physical, mental, or age constraints.
• Differentiate when a discrepancy exists between the clinical appearance of the optic nerve and the visual fields
• Detect further loss of optic nerve or retinal nerve fiber layer changes in the presence of advanced optic nerve damage and advanced visual field loss.
• Follow glaucoma suspects.

CPT/HCPCS Codes: 92133
ICD-9 Codes that Support Medical Necessity: See LCD for complete list; 364.22, 365.00-365.9, 368.40-368.45,377.14-377.16

L31897 J15 (KY, OH)
The following codes would generally not be necessary with SCODI. When needed the same day, documentation must justify the procedures.
• 92250 - Fundus photography with interpretation and report
• 92225 - Ophthalmoscopy, extended with retinal drawing (e.g., for retinal detachment, melanoma) with interpretation and report; initial
• 92226 - Subsequent ophthalmoscopy
• 76512 - B-scan (with or without superimposed non-quantitative A-scan)

Glaucoma may be diagnosed as mild, moderate, or severe and SCODI can be utilized as documented below.

Glaucoma Suspect or Mild Damage
SCODI can be used to follow pre-glaucoma patients or those with “mild” damage and who would demonstrate any or all of the following:

Visual Field
• no detectable VF defect;
• "mild" generalized reduction in retinal sensitivity;
• "mild" constriction of isopters;
• nasal step peripheral to 20 degrees; and/or
• small relative defects of the Bjerrum area, peripheral to 9 degrees.

Optic Nerve
• symmetric or vertically elongated cup enlargement; neural rim intact, rim: disc ratio> 0.2; cup:disc ratio <0.8;
• focal notch; rim:disc ratio > 0.2; cup:disc ratio <0.8
• no definite pathologic cupping; and/or
• previously observed disc hemorrhage.

Moderate Glaucomatous Damage
In patients with moderate glaucomatous damage, alternating the use of SCODI and visual field tests within correct time intervals will be considered appropriate, and may increase the sensitivity of detecting glaucomatous damage. Performance of SCODI and visual field tests on the same day, or separated by a short period of time (within three [3] months) is usually not considered medically necessary. However, there may be instances in which each test is needed to determine the patient’s status and thus, treatment. The contractor expects use of both tests on the same day or during short intervals will be the exception rather than the rule. Examples in which each test could be medically necessary include situations in which the clinical examination suggests progression of the glaucoma, yet the visual fields do not show new deficits. SCODI could be used to determine whether there is a change in the nerve fiber loss. Similarly, if the clinical examination showed progression and SCODI was unchanged, the visual field testing might be medically necessary to ascertain whether there is a functional loss of vision. If each test is performed on the same day or within short intervals, the medically necessary rationale must be present in the medical record.
Patients with moderate glaucomatous damage would demonstrate any or all of the following:

Visual Field
"moderate" generalized reduction in retinal sensitivity;
"moderate" constriction of isopters absolute defects to within 9 degrees of fixation; and/or
temporal wedge.

**Optic Nerve**
- enlarged optic nerve cup with neural rim remaining but sloped or pale;
- focal notches with rim:disc ratio > 0.1 but < 0.2; cup:disc ratio > 0.8 but < 0.9; and/or
- prominent lamina cribrosa.

**Advanced Glaucomatous Damage**
Scanning computerized ophthalmic diagnostic imaging is not considered medically reasonable and necessary for patients with "advanced" glaucomatous damage. Instead, visual field testing should be performed. (Late in the course of glaucoma, when the nerve fiber layer has been extensively damaged, visual fields are more likely to detect small changes than scanning computerized ophthalmic diagnostic imaging). Patients with "advanced" glaucomatous damage would demonstrate any or all of the following:

**Visual Field**
- "severe" generalized reduction in retinal sensitivity;
- "severe" constriction of isopters (i.e., 14e <10 degrees);
- absolute defects to within 3 degrees of fixation;
- loss of central acuity; and/or
- temporal island remains.

**Optic Nerve**
- diffuse enlargement of optic nerve cup; rim:disc ratio<0.1; cup:disc ratio > 0.9; and/or
- wipe out of all or a portion of the neuroretinal rim.

Patients being treated with hydroxychloroquine (Plaquenil) should receive a baseline examination within the first year of initiating treatment. In patients with no additional risk factors, follow up annual screening is recommended after five years.

**CPT/HCPCS Codes:** 92133

**ICD-9 Codes that Support Medical Necessity:** See LCD for complete list; 364.22, 364.53, 364.73-364.74, 364.77, 365.00-365.9, 368.40-368.45, 377.00-377.41

CPT code 92133 will be considered medically necessary one (1) time per year for patients with “mild” damage. CPT code 92133 will be considered medically necessary usually only for one (1) or two (2) tests of either SCODI or visual fields per year for patients with “moderate” damage. If visual field testing and SCODI are used on the same day or within a three (3) month interval, the medically necessary rationale must be included in the record. Only one (1) of each test would usually be considered medically necessary per year. CPT code 92133 would rarely be necessary or beneficial with patients who have “advanced” damage. It would be rarely necessary to perform more than four (4) visual field tests a year for these patients.

**L29276 JN (FL)**

**Indications and Limitations of Coverage and/or Medical Necessity**
Posterior segment SCODI will be considered medically reasonable and necessary under the following circumstances:
1. The patient presents with “mild” glaucomatous damage or “suspect glaucoma” as demonstrated by any of the following:
   - Intraocular pressure 22mmHg as measured by applanation;
   - Symmetric or vertically elongated cup enlargement, neural rim intact, cup/disc ratio > 0.4;
   - Diffuse or focal narrowing or notching of disc rim, especially at inferior or superior poles;
   - Diffuse or localized abnormalities of the retinal nerve fiber layer, especially at the inferior or superior poles;
   - Nerve fiber layer disc hemorrhage;
   - Asymmetrical appearance of the optic disc or rim between fellow eyes that suggests loss of neural tissue;
   - Nasal step peripheral to 20 degrees or small paracentral or arcuate scotoma; or
Mild constriction of visual field isopters.

Because of the slow disease progression of patients with “suspect glaucoma” or those with “mild”


glaucomatous damage, the use of scanning computerized ophthalmic diagnostic imaging at a frequency of >

1/year is not expected.

2. The patient presents with “moderate” glaucomatous damage as demonstrated by any of the following:

- Enlarged optic cup with neural rim remaining but sloped or pale, cup to disc ratio > 0.5 but < 0.8;
- Definite focal notch with thinning of the neural rim; or
- Definite glaucomatous visual field defect (e.g., arcuate defect, nasal step, paracentral scotoma, or
general depression.

Patients with “moderate damage” may be followed with scanning computerized ophthalmic diagnostic imaging and/or visual fields. One or two tests of either per year may be appropriate. If both scanning computerized ophthalmic diagnostic imaging and visual field tests are used, only one of each test would be considered medically necessary, as these tests provide duplicative information.

Scanning computerized ophthalmic diagnostic imaging is not considered medically reasonable and necessary for patients with “advanced” glaucomatous damage. Instead, visual field testing should be performed. (Late in the course of glaucoma, when the nerve fiber layer has been extensively damaged, visual fields are more likely to detect small changes than scanning computerized ophthalmic diagnostic imaging).

The patient with “advanced” glaucomatous damage would demonstrate any of the following:

- Diffuse enlargement of optic nerve cup, with cup to disc ratio > 0.8;
- Wipe-out of all or a portion of the neural retinal rim;
- Severe generalized constriction of isopters (i.e., Goldmann I4e, < 10 degrees of fixation);
- Absolute visual field defects to within 10 degrees of fixation;
- Severe generalized reduction of retinal sensitivity; or
- Loss of central visual acuity, with temporal island remaining.

In addition, scanning computerized ophthalmic diagnostic imaging is not considered medically reasonable and necessary when performed to provide additional confirmatory information regarding a diagnosis which has already been determined.

3. Monitoring patients for the development of chloroquine (CQ) and/or hydroxychloroquine (HCQ) retinopathy.

Patients being treated with CQ and/or HCQ should receive a baseline examination within the first year of
treatment and as an annual follow-up after five years of treatment. For higher-risk patients, annual testing may begin immediately (without a 5-year delay).

Limitations of Coverage for Posterior Segment SCODI

Performing Fundus Photography and SCODI on the Same Day on the Same Eye:

Fundus photography (CPT code 92250) and scanning ophthalmic computerized diagnostic imaging (CPT code 92133 or 92134) are generally mutually exclusive of one another in that a provider would use one technique or the other to evaluate fundal disease. However, there are a limited number of clinical conditions where both techniques are medically reasonable and necessary on the ipsilateral eye. In these situations, both CPT codes may be reported appending modifier 59, or HCPCS modifier XU-unusual, non-overlapping service to CPT code 92250 (National Correct Coding Initiative Policy Manual, Chapter 11, Section G, Ophthalmology).

The physician is not precluded from performing fundus photography and posterior segment SCODI on the same eye on the same day under appropriate circumstances (i.e., when each service is necessary to evaluate and treat the patient.

FCSO Medicare will consider fundus photography and posterior segment SCODI medically reasonable and necessary when performed on the same eye on the same day as outlined below.

Fundus photography and posterior segment SCODI are frequently used together for the following ICD-9-CM codes: Refer to extensive diagnosis list in LCD.

Indications of Coverage for Anterior Segment SCODI

FCSO Medicare will consider anterior segment SCODI medically reasonable and necessary for evaluation of specified forms of glaucoma and disorders of the cornea, iris and ciliary body.

CPT/HCPCS Codes: 92133

ICD-9 Codes that Support Medical Necessity: See LCD for complete list; 364.22, 364.53, 364.73-364.74, 364.77,365.00- 365.9, 368.40-368.45, 377.00-377.41

Documentations Requirements
• Medical record documentation (e.g., office/progress notes) maintained by the performing physician must indicate the medical necessity of the scanning computerized ophthalmic diagnostic imaging and be available to Medicare upon request.
• A copy of the test results, computer analysis of the data, and appropriate data storage for future comparison in follow-up exams is required.
• Medical record documentation must clearly indicate rationale which supports the medical necessity for performing the fundus photography and posterior segment SCODI on the same day on the same eye. Documentation should also reflect how the test results were used in the patient’s plan of care.
  ○ It would not be considered medically reasonable and necessary to perform fundus photography and posterior segment SCODI on the same day on the same eye to provide additional confirmatory information for a diagnosis or treatment which has already been determined.

L33590 JH (AR, CO, LA, MS, NM, OK, TX, IHS and Veterans Affairs); L27529 JL (DC, DE, MD, NJ, PA)
SCODI includes the following tests:
• Confocal Laser Scanning Ophthalmoscopy (topography)
• Scanning Laser Polarimetry, nerve fiber analyzer
• Optical Coherence Tomography (OCT)

**Indications**

**Glaucoma**
• Technological improvements have rendered SCODI as a valuable diagnostic tool in the diagnosis and treatment of glaucoma. These improvements enable discernment of changes of the nerve fiber even in advanced cases of glaucoma.
• It is expected that only two exams/eye/year would be required

**ICD-9 Codes that Support Medical Necessity:** See LCD for complete list; 364.22, 364.53, 364.73-364.74, 364.77, 365.00-365.9, 368.11, 368.14, 368.40-368.42, 368.43-368.45

L34143 JS (IA, KS, MO, NE); L34143 J8 (IN, MI)

**Anterior Segment Disorders**
SCODI may be used to examine the structures in the anterior segment structures of the eye. However, it is still seen as experimental/investigational except in the following:
Narrow angle, suspected narrow angle, and mixed narrow and open angle glaucoma

**Limitations**
The following codes/procedures would generally not be necessary with SCODI. When medically needed the same day, documentation must justify the procedures.
• 92250 - Fundus photography with interpretation and report
• 92225 - Ophthalmoscopy extended with retinal drawing (e.g. For retinal detachment, melanoma) with interpretation and report initial
• 92226 - Subsequent ophthalmoscopy
• 76512 - B-scan (with or without superimposed non-quantitative A-scan)

**ICD-9 Codes that Support Medical Necessity:** See LCD for complete list; 364.22, 364.53, 364.77, 365.00-365.9, 368.40-368.45, 377.00-377.04, 377.14-377.15

**Visual Field Testing**

L26367 J6 (WI, IL, MN); L26367 JK (CT, MA, ME, NH, NY, RI, VT); L31909 J15 (KY, OH); L29308 JN (FL); L31348 J5 (IA, KS, MO, NE); L31348 J8 (IN, MI)

**Indications and Limitations of Coverage and/or Medical Necessity**
Visual field examinations are considered medically necessary for the conditions listed below:
• The patient has a disorder of the eyelid(s) potentially affecting the visual field(s).
• The patient has a visual field defect detected on gross visual field testing (e.g., confrontational testing).
• The patient has a documented diagnosis of glaucoma.
It should be noted that the progression of, and effects of treatment on glaucoma can be monitored only through periodic visual field testing. The frequency of such examinations is dependent on changes in intraocular pressure (IOP), retinal damage and changes at the optic disc.

- The patient is suspected of having glaucoma; signs include increased intraocular pressure, asymmetric IOP measurements, notching or thinning of the neuroretinal rim, splinter hemorrhages and asymmetric appearance of the discs.
- The patient has a documented disorder of the optic nerve, the retina or the neurologic visual pathway.
- The patient has a recent intracranial hemorrhage, an intracranial mass or a recent increased intracranial pressure measurement (with or without visual symptoms).
- The patient has a recent occlusion / stenosis of cerebral or precerebral arteries.
- The patient has a history of a cerebral aneurysm, pituitary or occipital tumor potentially affecting the visual fields.
- The patient is being evaluated for buphthalmos, congenital anomalies of the posterior segment or congenital ptosis.
- The patient has a disorder of the orbit potentially affecting the visual field.
- The patient has sustained a significant eye injury.
- The patient has unexplained visual loss.
- The patient has a pale or swollen optic nerve on a recent examination.
- The patient is having new functional limitations which may be due to visual field loss (e.g., reports by family of patient bumping into objects). (change to e.g.,)
- The patient is taking a medication with a high risk of affecting the visual system (e.g., Plaquenil).
- The patient is being evaluated for macular degeneration, or has experienced central vision loss (< 20/70). (Repeated examinations for diagnosis of macular degeneration or central vision loss are not medically necessary unless changes in vision are documented, or to evaluate the results of a surgical intervention).

Limitations
Gross visual field testing (e.g., confrontation testing) is a part of general ophthalmological service and should not be reported separately.

CPT/HCPCS Codes: 92081; 92082; 92083
ICD-9 Codes that Support Medical Necessity: See LCD List for complete list; 250.50 - 250.53, 365.00 - 365.9

| Iridotomy by Laser Surgery |

L29207_JN (FL)
Indications and Limitations of Coverage and/or Medical Necessity
Medicare will consider iridotomy by laser surgery medically necessary and reasonable to treat acute, sub-acute, intermittent or chronic angle-closure glaucoma. Laser iridotomy can successfully eliminate the chance of acute or chronic angle-closure glaucoma in most cases. Additionally, when a patient is noted to have an occludable angle upon gonioscopic examination, even in the absence of symptoms, a peripheral iridotomy may be performed to prevent angle-closure glaucoma. When laser iridotomy is not possible (e.g., because patients are uncooperative or severe corneal edema persists), incisional iridectomy remains an effective alternative. Following iridotomy or iridectomy, further treatment may be required for elevated intraocular pressure (IOP) in the residual stage of angle-closure when drainage function has been compromised by the formation of adhesions between the iris and trabecular meshwork or by other damage to the trabecular meshwork. This procedure is not indicated for open angle glaucoma.

CPT/HCPCS Codes: 66761
ICD-9 Codes that Support Medical Necessity: 365.02, 365.06, 365.13, 365.20-365.24, 365.83
Documentation Requirements
The patient’s medical record must clearly show the medical necessity of performing the procedure including, but not limited to, the symptoms experienced by the patient, the intraocular pressure and the status of the angle as evaluated with gonioscopy.
Laser Trabeculoplasty

Indications and Limitations of Coverage and/or Medical Necessity
Medicare will consider Argon Laser Trabeculoplasty (ALT), Selective Laser Trabeculoplasty (SLT), and Diode Laser Trabeculoplasty (DLT) medically necessary and reasonable for the following indications:

- Primary treatment for open-angle glaucoma
- Primary open-angle glaucoma when the raised intraocular pressure is unresponsive to topical or oral medications.
- Primary open-angle glaucoma with normal pressure and evidence of optic nerve damage.

CPT/HCPCS Codes: 65855

ICD-9 Codes that Support Medical Necessity: 365.01, 365.04, 365.05, 365.10-365.15, 365.32, 365.52

Ophthalmological Diagnostic Services

Indications and Limitations of Coverage and/or Medical Necessity
Diagnostic ophthalmological services (92018-92499) rendered by a physician are covered services when medically necessary and reasonable for the patient's condition. Routine eye examinations for the purpose of prescribing, fitting, or changing eyeglasses or contact lens(es); eye refractions are non-covered.

CPT/HCPCS Codes: 92284; 92287

ICD-9 Codes that Support Medical Necessity: See LCD for complete list for each code; 92284: 365.20; 92287: 365.52, 365.63, 365.64, 365.82

Documentation Requirements
- Office Notes supplying documentation of complaint or symptomatology for visual disturbances and the affect on activities of daily living
- Diagnostic test results (The provider has a responsibility to maintain a record for post-payment audit)

Avastin

Indications and Limitations of Coverage and/or Medical Necessity
Based on published reports and widespread clinical use, there is compelling evidence of bevacizumab’s safety and efficacy for CNV in AMD and also in proliferative diabetic retinopathy, neovascular glaucoma, macular edema, retinal and iris neovascularizations and branch and central retinal vein occlusions, due to common VEGF-induced pathogenic pathways. The ophthalmology community is increasingly using intravitreal bevacizumab in the treatment of these conditions that have not responded to other accepted therapies.

Current literature indicates anticipated dosage is 1.25 mg (0.05ml) or less, on a yearly average of every 4 to 6 weeks, as needed, by aseptic intravitreal injection into affected eye. Treatment continues on a monthly basis until the abnormal neovascularization, vitreous hemorrhage, macular edema, subretinal fluid, and/or pigment epithelial detachment is resolved.

"Reasonable and necessary" services are "ordered and/or furnished by qualified personnel." Services will be considered medically reasonable and necessary only if performed by appropriately trained providers. Bevacizumab is contraindicated in patients with ocular or periocular infections or known hypersensitivity to bevacizumab or any of the inactive ingredients in bevacizumab.

CPT/HCPCS Codes: J3490; C9257

ICD-9 Codes that Support Medical Necessity: See LCD for complete list; 365.63

Documentation Requirements
Medical record documentation maintained by the performing ophthalmologist must include the following:
- The clinical indication/medical necessity for the bevacizumab injection and the frequency of its usage.
- The actual dosage of bevacizumab given, site of injection and route of administration.
- Test results to firmly establish diagnosis by fluorescein angiogram or optical coherence tomography (OCT), for individuals with proliferative diabetic retinopathy, diabetic macular edema, retinal neovascularization, central retinal vein occlusion, venous tributary (branch) occlusion, exudative macular degeneration, and retinal edema. Tests to confirm the established diagnosis are not required for rubeosis iridis, or in the case of a vitreous hemorrhage in which the neovascularization cannot be visualized.
- Indication that the patient has been provided appropriate informed consent regarding the benefits and risks of this therapy and off-label use of this drug.

L32013  J5 (IA, KS, MO, NE) L32013 J8 (IN, MI)
Drugs and Biologics (Non-chemotherapy)
An unlabeled use of a drug is a use that is not included as an indication on the drug's label as approved by the FDA. FDA approved drugs used for indications other than what is indicated on the official label may be covered under Medicare if the carrier determines the use to be medically accepted, taking into consideration the major drug compendia, authoritative medical literature and/or accepted standards of medical practice. An LCD reconsideration request with supporting documentation should be submitted via policycomments@wpsic.com to request off-label use of a drug.

Limitations:
The following guidelines identify three categories with specific examples of situations in which medications would not be reasonable and necessary according to accepted standards of medical practice:
- Medications given for a purpose other than the treatment of a particular condition, illness, or injury are not covered.
- Medication given by injection (parenterally) is not covered if standard medical practice indicates that the administration of the medication by mouth (orally) is effective and is an accepted or preferred method of administration. For example, the accepted standard of medical practice for the treatment of certain diseases is to initiate therapy with parenteral penicillin and to complete therapy with oral penicillin. Contractors exclude the entire charge for penicillin injections given after the initiation of therapy if oral penicillin is indicated unless there are special medical circumstances that justify additional injections.
- Medications administered for treatment of a disease and which exceed the frequency or duration of injections indicated by accepted standards of medical practice are not covered.
- If a medication is determined not to be reasonable and necessary for diagnosis or treatment of an illness or injury according to these guidelines, the entire charge (i.e., for both the drug and its administration) is not considered medically necessary.

This is not an all-inclusive list and will not be updated to include every newly FDA approved drug.

CPT/HCPCS Codes: J3590/C9257
ICD-9 Codes that Support Medical Necessity: See LCD for complete list; 365.63

**Glaucoma Treatment with Aqueous Drainage Device**

L32733  JH (AR, CO, LA, MS, NM, OK, TX, IHS and Veterans Affairs); L34355  JL (DC, DE, MD, NJ, PA)

Indications and Limitations of Coverage and/or Medical Necessity
Glaucoma consists of a group of disease, frequently characterized by raised intraocular pressure which affects the optic nerve. It is the second leading cause of blindness in the world. Therapy for glaucoma mainly consists of reducing the intraocular pressure by medical or surgical means. Historically, trabeculectomy (penetrating) has been considered the gold standard for surgical intervention. More recently a minimally penetrating glaucoma surgery has developed with the use of an aqueous drainage device. It is indicated in patients who are refractory to medical intervention (first line and second line drugs). This LCD is establishing coverage for such care.

**Indications**
Open angle glaucoma
The Ex-PRESS mini-shunt (implantation via CPT 66183) is indicated for the reduction of intraocular pressure (IOP) in patients with glaucoma where medical and conventional surgical treatments have failed.

The iSTENT Trabecular Micro-Bypass stent is indicated for use in conjunction with cataract surgery for the reduction of IOP in adult subjects with mild to moderate open-angle glaucoma currently treated with ocular hypotensive medication.

Limitations
This test is covered only for services using FDA-approved devices.

CPT/HCPCS Code(s): 0191T; 0253T; 0376T; 66174; 66175; 66183

ICD-9 Codes that Support Medical Necessity: 365.10-365.15

Chemotherapy Drugs and their Adjuncts/ Off-Label Uses

L28576 J5 (IA, KS, MO, NE)
Indications and Limitations of Coverage and/or Medical Necessity
Coverage for medication is based on the patient’s condition, the appropriateness of the dose and route of administration, based on the clinical condition and the standard of medical practice regarding the effectiveness of the drug for the diagnosis and condition. The drug must be used according to the indication and protocol listed in the accepted compendia ratings listed below.

- Fluorouracil (5FU, Adrucil) 500 mg (J9190):
  glaucoma (365.10-365.9) for patients at high risk for filtering surgery failure.
- Mitomycin (Mutomycin) 5 mg (J9280) Use/See J7315 for ophthalmic use.

Documentation Requirements
The medical record should include the disease being treated with the name and dosage of the drug being administered. Medical Records should be made available upon Contractors request.

L25820 J6 (IL, MN, WI)
Drugs and Biologicals, Coverage of, for Label and Off-Label Uses
Indications and Limitations of Coverage and/or Medical Necessity
- An off-label/unlabeled use of a drug is defined as a use for a non-FDA approved indication, that is, one that is not listed on the drug’s official label/prescribing information.
- Providers may request that a drug be approved for off-label use by submitting this request in writing and including the data supporting its use. See LCD further information on written requests.
- National Government Services will use evidence-based clinical guidelines to determine medical necessity of the route of administration.

Documentation Requirements
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 medical record must include the following information:
• The name of the drug or biological administered;
• The route of administration;
• The dosage (e.g., mgs, mcgs, cc's or IU's);
• The duration of the administration (for CPT codes that are time based); and
• When modifier –JW is used to report that a portion of the drug or biological is discarded, from single use vials, the medical record must clearly document the amount administered and the amount wasted or discarded.

L32094 JN (FL)
Documentation Requirements
For a newly approved FDA drug and/or in the absence of a unique HCPCS code, the drug must be billed using the
appropriate unlisted drug code. The medical record must clearly support the medical necessity of any drug administered. When an unlisted HCPCS code is billed, the contractor will request documentation from the billing provider. Providers must submit the documentation that is requested in the development letter, which may include, but is not limited to relevant history and physical, any results of pertinent diagnostic tests or procedures, a physician’s order, the name of the drug or biological, the route of administration, the dosage (e.g., mgs, mcgs, cc’s or IU’s), the duration of the administration, and any wastage of the drug or biological. When a portion of the drug or biological is discarded, whether from a single or multi-use vial, the medical record must clearly document the amount administered and the amount wasted or discarded.

For drugs with unique HCPCS codes in the absence of a NCD, LCD or published article, the medical necessity must clearly be documented in the patient’s medical record and available to the contractor upon request. The documentation that would support medical necessity may be the same as outlined in the above paragraph.

Request for coverage for any off-label drug usage, the LCD reconsideration process as outlined in the Program Integrity Manual, Pub. 100-08, Chapter 13, Section 13.11 as well as on the FCSO website at http://medicare.fcsio.com/Coverage_Find_LCDs_and_NCDs/138575.asp, will be followed in determining the medical necessity for the off-label drug use. Documentation to support the request for coverage should include peer reviewed authoritative literature (full text copies), full copies of one or more of CMS approved compendia, supporting documentation for the dosage, administration, route, and frequency of administration. Also include the ICD-9 CM codes that would support the off-label indication being requested, as well as the administration schedules if different from the FDA approved drug label.

Over the next several years, CMS will consolidate ten A/B MAC workloads to form five consolidated A/B MAC workloads:

- Jurisdictions 2 and 3 will be combined to form A/B MAC Jurisdiction F; complete
- Jurisdictions 4 and 7 will be combined to form A/B MAC Jurisdiction H; complete
- Jurisdictions 14 and 13 will be combined to form A/B MAC Jurisdiction K; complete
- Jurisdictions 8 and 15 will be combined to form A/B MAC Jurisdiction I; and
- Jurisdictions 5 and 6 will be combined to form A/B MAC Jurisdiction G.

See the consolidated jurisdictions map link below.