Corneal Hysteresis Measurement

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Effective Date	6/1992
Next Review Date	2/2024
Coverage Policy	Medical 265
Version	4

All requests for authorization for the services described by this medical policy will be reviewed per Early and Periodic Screening, Diagnostic and Treatment (EPSDT) guidelines. These services may be authorized under individual consideration for Medicaid members under the age of 21-years if the services are judged to be medically necessary to correct or ameliorate the member's condition. Department of Medical Assistance Services (DMAS), Supplement B - EPSDT (Early and Periodic Screening, Diagnosis and Treatment) Manual.*.

Purpose:

This policy addresses the medical necessity of Corneal Hysteresis Measurement.

Description & Definitions:

Corneal hysteresis measurement is the testing of the cornea to assess glaucoma risk.

Criteria:

Corneal Hysteresis Measurement is considered not medically necessary for any indication.

Coding:

Medically necessary with criteria:

Coding	Description
	None

Considered Not Medically Necessary:

Coding	Description
0198T	Measurement of ocular blood flow by repetitive intraocular pressure sampling, with interpretation and report.

92145	Corneal hysteresis determination, by air impulse stimulation, unilateral or bilateral, with interpretation and report.

U.S. Food and Drug Administration (FDA) - approved only products only.

Document History:

Revised Dates:

- 2020: January
- 2016: February
- 2015: March
- 2014: February
- 2012: March, April, May
- 2010: February
- 2009: February
- 2008: May
- 2005: October
- 1998: February, October
- 1994: February

Reviewed Dates:

- 2023: February
- 2022: February
- 2021: February
- 2020: February
- 2018: November
- 2017: December
- 2015: February
- 2013: February
- 2012: February
- 2011: February
- 2007: December
- 2004: October
- 2003: October, November
- 2002: October
- 2001: November
- 2000: November
- 1999: November
- 1996: February

Effective Date:

- June 1992

References:

Including but not limited to: Specialty Association Guidelines; Government Regulations; Winifred S. Hayes, Inc; UpToDate; Literature Review; Specialty Advisors; National Coverage Determination (NCD); Local Coverage Determination (LCD).

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Ocular Response Analyzer - Code of Federal Regulations Title 21 886.1930 Tonometer and accessories. (2022, Jul 20). Retrieved Dec 12, 2022, from FDA: https://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfCFR/CFRSearch.cfm?fr=886.1930&SearchTerm=886%2E1930

Special Notes: *

This medical policy express Sentara Health Plan's determination of medically necessity of services, and they are based upon a review of currently available clinical information. These policies are used when no specific guidelines for coverage are provided by the Department of Medical Assistance Services of Virginia (DMAS). Medical Policies may be superseded by state Medicaid Plan guidelines. Medical policies are not a substitute for clinical judgment or for any prior authorization requirements of the health plan. These policies are not an explanation of benefits.

Medical policies can be highly technical and complex and are provided here for informational purposes. These medical policies are intended for use by health care professionals. The medical policies do not constitute medical advice or medical care. Treating health care professionals are solely responsible for diagnosis, treatment and medical advice. Sentara Health Plan members should discuss the information in the medical policies with their treating health care professionals. Medical technology is constantly evolving and these medical policies are subject to change without notice, although Sentara Health Plan will notify providers as required in advance of changes that could have a negative impact on benefits.

The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) covers services, products, or procedures for children, if those items are determined to be medically necessary to "correct or ameliorate" (make better) a defect, physical or mental illness, or condition (health problem) identified through routine medical screening or examination, regardless of whether coverage for the same service or support is an optional or limited service under the state plan. Children enrolled in the FAMIS Program are not eligible for all EPSDT treatment services. All requests for authorization for the services described by this medical policy will be reviewed per EPSDT guidelines. These services may be authorized under individual consideration for Medicaid members under the age of 21-years if the services are judged to by medically necessary to correct or ameliorate the member's condition. *Department of Medical Assistance Services (DMAS), Supplement B - EPSDT (Early and Periodic Screening, Diagnosis and Treatment) Manual.*

Keywords:

SHP Corneal Hysteresis Measurement, SHP Medical 265, glaucoma, keratoconus, contact lenses, cornea