Medical Coverage Policy | Optical Coherence Tomography of the Anterior Eye Segment

EFFECTIVE DATE: 01|01|2017
POLICY LAST REVIEWED: 04|03|2024

OVERVIEW
This policy relates only to the anterior eye segment and not the posterior segment, which is a covered service.

Optical coherence tomography (OCT) is a non-invasive, high-resolution imaging method that can be used to visualize ocular structures. OCT of the anterior segment is being evaluated as a non-invasive diagnostic and screening tool for detecting angle-closure glaucoma, for presurgical evaluation, surgical guidance, and for assessing complications following surgical procedures. It is also being studied as a tool to evaluate the pathologic processes of dry eye syndrome, tumors, uveitis, and infections.

This policy is applicable to Commercial Products only. For Medicare Advantage Plans, see Related Policies section.

MEDICAL CRITERIA
Not applicable

PRIOR AUTHORIZATION
Not applicable

POLICY STATEMENT
Commercial Products
Scanning computerized ophthalmic (e.g., OCT) imaging of the anterior eye segment is not medically necessary as the evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

COVERAGE
Benefits may vary between groups and contracts. Please refer to the appropriate Benefit Booklet, Evidence of Coverage or Subscriber Agreement for applicable not medically necessary benefits/coverage.

BACKGROUND
Optical Coherence Tomography
Optical coherence tomography (OCT) is a noninvasive, high-resolution imaging method that can be used to visualize ocular structures. OCT creates an image of light reflected from the ocular structures. In this technique, a reflected light beam interacts with a reference light beam. The coherent (positive) interference between the 2 beams (reflected and reference) is measured by an interferometer, allowing construction of an image of the ocular structures. This method allows cross-sectional imaging at a resolution of 6 to 25 µm.

The Stratus OCT, which uses a 0.8-µm wavelength light source, was designed to evaluate the optic nerve head, retinal nerve fiber layer, and retinal thickness in the posterior segment. The Zeiss Visante OCT and anterior chamber (AC) Cornea OCT use a 1.3-µm wavelength light source designed specifically for imaging the anterior eye segment. Light of this wavelength penetrates the sclera, permitting high-resolution cross-sectional imaging of the AC angle and ciliary body. The light is, however, typically blocked by pigment, preventing exploration behind the iris. Ultrahigh resolution OCT can achieve a spatial resolution of 1.3 µm, allowing imaging and measurement of corneal layers.

An early application of OCT technology was the evaluation of the cornea before and after refractive surgery. Because this noninvasive procedure can be conducted by a technician, it has been proposed that this device may provide a rapid diagnostic and screening tool for detecting angle-closure glaucoma.

Other Diagnostic Tools

OCT of the anterior eye segment is being evaluated as a noninvasive diagnostic and screening tool with a number of potential applications. One proposed use of anterior segment OCT is to determine whether there is a narrowing of the AC angle, which could lead to angle-closure glaucoma. Another general area of potential use is as a pre- and postsurgical evaluation tool for of AC procedures. This could include assessment of corneal thickness and opacity, calculation of intraocular lens power, guiding surgery, imaging intracorneal ring segments, and assessing complications following surgical procedures such as blockage of glaucoma tubes or detachment of Descemet membrane following endothelial keratoplasty. A third general category of use is to image pathologic processes such as dry eye syndrome, tumors, noninfectious uveitis, and infections. It is proposed that anterior segment (AS) OCT provides better images than slit-lamp biomicroscopy/gonioscopy and ultrasound biomicroscopy due to higher resolution; in addition, AS OCT does not require probe placement under topical anesthesia.

Alternative methods of evaluating the AC are slit-lamp biomicroscopy or ultrasound biomicroscopy. Slitlamp biomicroscopy is typically used to evaluate the AC; however, the chamber angle can only be examined with specialized lenses, the most common being the gonioscopic mirror. In this procedure, a gonio lens is applied to the surface of the cornea, which may result in distortion of the globe. Ultrasonography may also be used for imaging the anterior eye segment. Ultrasonography uses high-frequency mechanical pulses (10-20 MHz) to build a AC chamber depth, lens thickness, and axial length. Ultrasound scanning across the eye creates a 2-dimensional image of the ocular structures. It has a resolution of 100 μm but only moderately high intraobserver and low interobserver reproducibility. Ultrasound biomicroscopy (»50 MHz) has a resolution of 30 to 50 μm. As with slit-lamp biomicroscopy with a gonioscopic mirror, this technique requires placement of a probe under topical anesthesia.

Classification and Assessment of Glaucoma

Glaucoma is characterized by degeneration of the optic nerve. The classification of glaucoma as open-angle or angle-closure relies on assessment of the anterior segment anatomy, particularly that of the anterior chamber angle. Angle-closure glaucoma is characterized by obstruction of aqueous fluid drainage through the trabecular meshwork (the primary fluid egress site) from the eye's anterior chamber. The width of the angle is a factor affecting the drainage of aqueous humor. A wide unobstructed iridocorneal angle permits sufficient drainage of aqueous humor, whereas a narrow-angle may impede the drainage system and leave the patient susceptible to an increase in intraocular pressure and angle-closure glaucoma.

A comprehensive ophthalmologic examination for glaucoma includes assessment of the optic nerve and retinal nerve fiber layer (see evidence review 9.03.06 on imaging of the optic nerve with posterior segment optical coherence tomography, evaluation of visual fields, and measurement of ocular pressure). The presence of characteristic changes in the optic nerve or abnormalities in visual field, together with increased intraocular pressure, is sufficient for a definitive diagnosis of glaucoma.

For individuals who are being evaluated for angle-closure glaucoma who receive AS OCT, the evidence includes a systematic review, case series, and cohort studies. Relevant outcomes are test accuracy, symptoms, change in disease status, and morbid events. Current literature consists primarily of assessments of qualitative and quantitative imaging and detection capabilities. Ideally, a diagnostic test should be evaluated based on its diagnostic accuracy and clinical utility. Studies have shown that AS OCT detects more eyes with narrow or closed angles than gonioscopy, suggesting that the sensitivity of optical coherence tomography may be higher than that of gonioscopy. However, because of clinical follow-up and validation studies, it is not clear to what degree these additional cases are true-positives or false-positives and, therefore, the specificity and predictive values cannot be determined. The evaluation of diagnostic performance depends, therefore, on evidence that the additional eyes identified with narrow-angle by AS OCT are at higher risk for primary angle-closure glaucoma. Results from a study with mid-term follow-up have shown that some patients identified with angle-

closure on AS OCT will develop angle-closure on gonioscopy after several years, but that there may also be a large number of false-positive results. Longer-term studies are needed to determine whether eyes classified as closed-angle by AS OCT are at higher risk of developing primary angle-closure glaucoma. It is also not known whether early detection of angle-closure will improve outcomes in individuals who do not have symptoms of angle-closure. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

For individuals who are being evaluated for anterior eye surgery or postsurgical complications who receive AS OCT, the evidence includes case series. Relevant outcomes are test accuracy, symptoms, change in disease status, and morbid events. Use of AS OCT has been reported for presurgical evaluation, surgical guidance, and monitoring for postsurgical complications. There is some evidence that the high-resolution images provided by AS OCT are superior to results from slit-lamp examination or gonioscopy for some indications. However, current literature is very limited. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

For individuals who have anterior eye segment disease or pathology who receive AS OCT, the evidence includes case series. Relevant outcomes are test accuracy, symptoms, change in disease status, and morbid events. The evidence related to the use of AS OCT for AS disease or pathology (eg, dry eye syndrome, tumors, uveitis, infections) is limited, and does not support improvements in imaging compared with alternative diagnostic techniques. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

CODING

Commercial Products

The following code is considered not medically necessary:

92132 Scanning computerized ophthalmic diagnostic imaging, anterior segment, with interpretation and report, unilateral or bilateral

RELATED POLICIES

Medicare Advantage Plans National and Local Coverage Determinations
Measurement of Ocular Blood Flow for Glaucoma

PUBLISHED

Provider Update, June 2024
Provider Update, July 2023
Provider Update, August 2022
Provider Update, April 2021
Provider Update, April 2020

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