Medical Policy

Title: Scanning Computerized Ophthalmic Diagnostic Imaging Devices

**Professional**
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Current Effective Date: September 27, 2019

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DESCRIPTION
Several techniques have been developed to measure the thickness of the optic nerve/retinal nerve fiber layer (RNFL) as a method to diagnose and monitor glaucoma. Measurement of ocular blood flow is also being evaluated as a diagnostic and management tool for glaucoma.

OBJECTIVE
The objective of this policy is to assess whether methods that evaluate the optic nerve and nerve fiber layer or that evaluate retinal blood flow improve the net health outcome in individuals with glaucoma or who are suspected to have glaucoma.

BACKGROUND
Glaucoma
Glaucoma is a disease characterized by degeneration of the optic nerve (optic disc). Elevated intraocular pressure (IOP) has long been thought to be the primary etiology, but the relationship between IOP and optic nerve damage varies among patients, suggesting a multifactorial origin. For example, some patients with clearly elevated IOP will show no optic nerve damage, while others with marginal or no pressure elevation will, nonetheless, show optic nerve damage. The association between glaucoma and other vascular disorders such as diabetes or hypertension suggests vascular factors may play a role in glaucoma. Specifically, it has been hypothesized that reductions in blood flow to the optic nerve may contribute to the visual field defects associated with glaucoma.

Diagnosis and Management
A comprehensive ophthalmologic exam is required for the diagnosis of glaucoma, but no single test is adequate for establishing the diagnosis. A comprehensive ophthalmologic examination includes an examination of the optic nerve by fundoscopy, 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 IOP, is sufficient for a definitive diagnosis. However, some patients will show ophthalmologic evidence of glaucoma with normal IOPs. These cases of normal tension glaucoma (NTG) are considered to be a type of primary open-angle glaucoma (POAG). Angle-closure glaucoma is another type of glaucoma associated with an increase in IOP. The increased IOP in angle-closure glaucoma arises from a reduction in aqueous outflow from the eye due to a closed angle in the anterior chamber.

Conventional management of the patient with glaucoma principally involves drug therapy, to control elevated IOPs, and serial evaluation of the optic nerve to follow disease progression. Standard methods of evaluation include careful direct examination of the optic nerve using ophthalmoscopy or stereophotography, or evaluation of visual fields. There is interest in developing more objective, reproducible techniques both to document optic nerve damage and to detect early changes in the optic nerve and RNFL before the development of permanent visual field deficits. Specifically, evaluating changes in the thickness of the RNFL has been investigated as a technique to diagnose and monitor glaucoma. However, IOP reduction is not effective in decreasing disease progression in a significant number of patients, and in patients with NTG, there is never an increase in IOP. It has been proposed that vascular dysregulation is a significant cause of damage to the RNFL, and there is interest in measuring ocular blood flow as both a diagnostic and a management tool for glaucoma. Changes in blood flow to the retina and choroid may be particularly relevant for diagnosis and treatment of NTG. A variety of techniques have been developed, as described below.

Techniques to Evaluate the Optic Nerve and RNFL

Confocal Scanning Laser Ophthalmoscopy
Confocal scanning laser ophthalmoscopy (CSLO) is an image acquisition technique intended to improve the quality of the examination compared with standard ophthalmologic examination. A laser is scanned across the retina along with a detector system. Only a single spot on the retina is illuminated at any time, resulting in a high-contrast image of great reproducibility that can be used to estimate the thickness of the RNFL. In addition, this technique does not require maximal mydriasis, which may be a problem in patients with glaucoma. The Heidelberg Retinal Tomography is a commonly used technology.

Scanning Laser Polarimetry
The RNFL is birefringent, causing a change in the state of polarization of a laser beam as it passes. A 780-nm diode laser is used to illuminate the optic nerve. The polarization state of the light emerging from the eye is then evaluated and correlated with RNFL thickness. Unlike CSLO, SLP can directly measure the thickness of the RNFL. GDx is a common example of an SLP. GDx contains a normative database and statistical software package to allow comparison with age-matched normal subjects of the same ethnic origin. The advantages of this system are that images can be obtained without pupil dilation, and evaluation can be done in approximately 10 minutes. Current
instruments have added enhanced and variable corneal compensation technology to account for corneal polarization.

**Optical Coherence Tomography**
Optical coherence tomography (OCT) uses near-infrared light to provide direct cross-sectional measurement of the RNFL. The principles employed are similar to those used in B-mode ultrasound except light, not sound, is used to produce the 2-dimensional images. The light source can be directed into the eye through a conventional slit-lamp biomicroscope and focused onto the retina through a typical 78-diopter lens. This system requires dilation of the patient’s pupil. OCT is an example of this technology. OCT analysis software is being developed to include optic nerve head parameters with spectral domain OCT, analysis of macular parameters, and hemodynamic parameters with Doppler OCT and OCT angiography.

**Pulsatile Ocular Blood Flow**
The pulsatile variation in ocular pressure results from the flow of blood into the eye during cardiac systole. Pulsatile ocular blood flow can thus be detected by the continuous monitoring of IOP. The detected pressure pulse can then be converted into a volume measurement using the known relationship between ocular pressure and ocular volume. Pulsatile blood flow is primarily determined by the choroidal vessels, particularly relevant to patients with glaucoma, because the optic nerve is supplied in large part by choroidal circulation.

**Techniques to Measure Ocular Blood Flow**
A number of techniques have been developed to assess ocular blood flow. They include laser speckle flowgraphy, color Doppler imaging, Doppler Fourier domain OCT, laser Doppler velocimetry, confocal scanning laser Doppler flowmetry, and retinal functional imaging.¹

**Laser Speckle Flowgraphy**
Laser speckle is detected when a coherent light source such as laser light is dispersed from a diffusing surface such as retinal and choroidal vessels and the circulation of the optic nerve head. The varying patterns of light can be used to determine red blood cell velocity and retinal blood flow. However, due to differences in the tissue structure in different eyes, flux values cannot be used for comparisons between eyes. This limitation may be overcome by subtracting background choroidal blood flow results from the overall blood flow results in the region of interest.

**Color Doppler**
Color Doppler imaging has also been investigated as a technique to measure the blood velocity in the retinal and choroidal arteries. This technique delivers ultrasound in pulsed Doppler mode with a transducer set on closed eyelids. The examination takes 30 to 40 minutes, and is most effective for the mean velocity of large ophthalmic vessels such as the ophthalmic artery, the central retinal artery, and the short posterior ciliary
arteries. However, total blood flow cannot be determined with this technique, and imaging is highly dependent on probe placement.

*Doppler Fourier Domain OCT*: Doppler Fourier domain OCT is a noncontact imaging technique that detects the intensity of the light scattered back from erythrocytes as they move in the vessels of the ocular tissue. This induces a frequency shift that represents the velocity of the blood in the ocular tissue.

*Laser Doppler Velocimetry*: Laser Doppler velocimetry compares the frequency of reflected laser light from a moving particle to stationary tissue.

*Confocal Scanning Laser Doppler Flowmetry*: Confocal scanning laser Doppler flowmetry combines laser Doppler flowmetry with confocal scanning laser tomography. Infrared laser light is used to scan the retina, and the frequency and amplitude of Doppler shifts are determined from the reflected light. Determinations of blood velocity and blood volume are used to compute the total blood flow and create a physical map of retinal flow values.

**REGULATORY STATUS**

A number of confocal scanning laser ophthalmoscopy, scanning laser polarimetry, and optical coherence tomography (OCT) devices have been cleared by the U.S. Food and Drug Administration (FDA) through the 510(k) process for imaging the posterior eye segment. For example, the RTVue XR OCT Avanti™ (Optovue) is an OCT system indicated for the in vivo imaging and measurement of the retina, retinal nerve fiber layer, and optic disc as a tool and aid in the diagnosis and management of retinal diseases by a clinician. The RTVue XR OCT Avanti™ with Normative Database is a quantitative tool for the comparison of retina, retinal nerve fiber layer, and optic disk measurements in the human eye to a database of known normal subjects. It is intended for use as a diagnostic device to aid in the detection and management of ocular diseases. In 2016, the RTVue XR OCT with Avanti™ with AngioVue™ Software was cleared by FDA through the 510(k) process (K153080) as an aid in the visualization of vascular structures of the retina and choroid. FDA product code: HLI, OBO.

In 2012, the iExaminer™ (Welch Allyn) received marketing clearance by FDA through the 510(k) process. The iExaminer consists of a hardware adapter and associated software (iPhone® App) to capture, store, send and retrieve images from the Welch Allyn PanOptic™ Ophthalmoscope using an iPhone®. FDA product code: HKI.
POLICY
A. Scanning Laser Ophthalmoscopy (SLO) test is allowable for the diagnosis and the monitoring of the optic nerve, retinal conditions and glaucoma. Testing may be allowed every year. If the testing is done more frequently than every year, consultant review will be required.

B. Optical Coherence Tomography (OCT) test is allowed for the diagnoses, listed below, monitoring for retinal conditions, and ocular toxicity secondary to high-risk medications (ie, chloroquine [Aralen], hydroxychloroquine [Plaquenil], Interferon alpha-2b, Amiodarone, tamoxifen citrate [Nolvadex], fingolimod [Gilenya], Seroquel).

Repeat testing:
1. If Exudative Age-Related Macular Degeneration (AMD):
   Repeat OCT will significantly help guide the need for retreatment (with photodynamic therapy [PDT] or intravitreal injection treatments) in conjunction with intravenous fluorescein angiography (IVF) / indocyanine green (ICG). Maximum of 8 per year linked to intravitreal injections.

2. If Macular Drusen:
   Repeat annually, only if subjective visual changes or suspicion of choroidal neovascularization: if more than 2 studies per year, then documentation is required

3. If Diabetic Macular Edema (DME):
   Maximum of 8 per year linked to intravitreal injections or laser treatment.

4. If Retinal Detachment (RD):
   Repeat pre-treatment and post-surgical at 2 months (maximum of 2).

5. If Epiretinal Membrane (ERM):
   Repeat pre-treatment and post-surgical (maximum of 4 per year) if with macular edema.

6. If Macular Hole:
   Repeat pre-treatment and post-treatment (maximum of 4 per year) in cases of partially closed hole.

7. If Cystoid Macular Edema:
   Repeat every 2 months during acute treatment.

8. If Branch Retinal Vein Occlusion (BRVO):
   Maximum of 8 per year linked to intravitreal injections.
9. If Central Retinal Vein Occlusion (CRVO):
   Maximum of 8 per year linked to intravitreal injections.

10. If Vitreomacular Traction / Adhesion:
    Maximum of 4 per year.

C. OCT is also allowed for diagnosing and monitoring glaucoma, nerve fiber layer,
    and optic nerve conditions. Testing may be allowed every year. If the testing is
done more frequently than every year, consultant review will be required.

**RATIONALE**
This policy has been updated regularly with searches of the MEDLINE database. The most
recent literature update was performed through January 8, 2018.

Evidence reviews assess whether a medical test is clinically useful. A useful test provides
information to make a clinical management decision that improves the net health outcome.
That is, the balance of benefits and harms is better when the test is used to manage the
condition than when another test or no test is used to manage the condition.

The first step in assessing a medical test is to formulate the clinical context and purpose of the
test. The test must be technically reliable, clinically valid, and clinically useful for that purpose.
Evidence reviews assess the evidence on whether a test is clinically valid and clinically useful.
Technical reliability is outside the scope of these reviews, and credible information on technical
reliability is available from other sources.

The use of various techniques of retinal nerve fiber layer (RNFL) analysis (confocal scanning
laser ophthalmoscopy [CSLO], scanning laser polarimetry [SLP], optical coherence tomography
[OCT]) for the diagnosis and management of glaucoma was addressed by 2 TEC Assessments

**Imaging of the Optic Nerve and RNFL**
**Clinical Context and Test Purpose**
The diagnosis and monitoring of optic nerve damage are essential for evaluating the
progression of glaucoma and determining appropriate treatment.

The question addressed in this evidence review is: Do imaging techniques for the optic nerve
and RNFL improve diagnosis and monitoring of glaucoma?

The following PICOTS were used to select literature to inform this review.

*Patients*
The relevant populations are patients with glaucoma or who are suspected to have glaucoma
and are being evaluated for diagnosis and monitoring of glaucoma progression.
**Interventions**
The tests being considered for assessment of the optic nerve and RNFL include CLSO, SLP, and OCT. These tests are considered add-on to the standard clinical evaluation.

**Comparators**
There is no single criterion standard for the diagnosis of glaucoma. This diagnosis is made from a combination of visual field testing, intraocular pressure (IOP) measurement, and optic nerve and RNFL assessment by an ophthalmologist.

**Outcomes**
Relevant outcomes include the clarity of the images and how reliable the test is at evaluating the optic nerve and nerve fiber layer changes. Demonstration that the information can be used to improve patient outcomes is essential for determining the utility of an imaging technology. Although direct evidence on the impact of the imaging technology from controlled trials would be preferred, in most cases, a chain of evidence needs to be constructed to determine whether there is a tight linkage between the technology and improved health outcomes. The outcomes relevant to this evidence review are IOP, loss of vision, and changes in IOP-lowering medications used to treat glaucoma.

**Timing**
For patients with manifest glaucoma, the relevant period of follow-up is the immediate diagnosis of glaucoma. For patients with suspected glaucoma, longer term follow-up would be needed to detect changes in visual field or RNFL. Clinical utility might be demonstrated by a change in the management and reduction in glaucoma progression across follow-up.

**Setting**
Patients may be self-referred, referred by optometrists, or referred by a general ophthalmologist to a glaucoma specialist. These procedures can be performed in an ophthalmologist’s office.

**Simplifying Test Terms**
There are 3 core characteristics for assessing a medical test. Whether imaging, laboratory, or other, all medical tests must be:

- Technically reliable
- Clinically valid
- Clinically useful

Because different specialties may use different terms for the same concept, we are highlighting the core characteristics. The core characteristics also apply to different uses of tests, such as diagnosis, prognosis, and monitoring treatment.

Diagnostic tests detect presence or absence of a condition. Surveillance and treatment monitoring are essentially diagnostic tests over a time frame. Surveillance to see whether a condition develops or progresses is a type of detection. Treatment monitoring is also a type of detection because the purpose is to see if treatment is associated with the disappearance, regression, or progression of the condition.
Prognostic tests predict the risk of developing a condition in the future. Tests to predict response to therapy are also prognostic. Response to therapy is a type of condition and can be either a beneficial response or adverse response. The term predictive test is often used to refer to response to therapy. To simplify terms, we use prognostic to refer both to predicting a future condition or to predicting a response to therapy.

**Technically Reliable**
Assessment of technical reliability focuses on specific tests and operators and requires review of unpublished and often proprietary information. Review of specific tests, operators, and unpublished data are outside the scope of this evidence review and alternative sources exist. This evidence review focuses on the clinical validity and clinical utility.

**Clinically Valid**
A test must detect the presence or absence of a condition, the risk of developing a condition in the future, or treatment response (beneficial or adverse).

In 2012, the Agency for Healthcare Research and Quality published a comparative effectiveness review of screening for glaucoma.\(^4\) Included were randomized controlled trials (RCTs), quasi-RCTs, observational cohort and case-control studies, and case series with more than 100 participants. The interventions evaluated included ophthalmoscopy, fundus photography or computerized imaging (OCT, retinal tomography, SLP), pachymetry (corneal thickness measurement), perimetry, and tonometry. No evidence was identified that addressed whether an open-angle glaucoma screening program led to a reduction in IOP, less visual impairment, reduction in visual field loss or optic nerve damage, or improvement in patient-reported outcomes. No evidence was identified on harms of a screening program. Over 100 studies were identified on the diagnostic accuracy of screening tests. However, due to the lack of a definitive diagnostic reference standard and heterogeneity in study designs, synthesis of results could not be completed.

A Cochrane review (2015) assessed the diagnostic accuracy of optic nerve head and RNFL imaging for glaucoma.\(^5\) Included were 103 case-control studies and 3 cohort studies (total N=16,260 eyes) that evaluated the accuracy of recent commercial versions of OCT (spectral domain), Heidelberg Retinal Tomograph (HRT) III, or SLP (GDx VCC or ECC) for diagnosing glaucoma. The population was patients referred for suspected glaucoma, typically due to an elevated IOP, abnormal optic disc appearance, and/or an abnormal visual field identified in primary eye care. Population-based screening studies were excluded. Most comparisons examined different parameters within the 3 tests, and the parameters with the highest diagnostic odds ratio were compared. The 3 tests (OCT, HRT, SLP) had similar diagnostic accuracy. Specificity was close to 95%, while sensitivity was 70%. Because a case-control design with healthy participants and glaucoma patients was used in nearly all studies, concerns were raised about the potential for bias, overestimation of accuracy, and applicability of the findings to clinical practice.

**Clinically Useful**
A test is clinically useful if the use of the results informs management decisions that improve the net health outcome of care. The net health outcome can be improved if patients receive correct therapy, or more effective therapy, or avoid unnecessary therapy, or avoid unnecessary testing.
**Direct Evidence**

Direct evidence of clinical utility is provided by studies that have compared health outcomes for patients managed with and without the test. Because these are intervention studies, the preferred evidence would be from randomized controlled trials.

A technology assessment, conducted by Lin et al (2007) for the American Academy of Ophthalmology, reviewed 159 studies, published between 2003 and 2006, evaluating optic nerve head and RNFL devices used to diagnose or detect glaucoma progression. The assessment concluded: “The information obtained from imaging devices is useful in clinical practice when analyzed in conjunction with other relevant parameters that define glaucoma diagnosis and progression.” Management changes for patients diagnosed with glaucoma may include the use of IOP-lowering medications, monitoring for glaucoma progression, and potentially surgery to slow the progression of glaucoma.

**Section Summary: Imaging of the Optic Nerve and RNFL**

Numerous studies and systematic reviews have described findings from patients with glaucoma using CSLO, SLP, and OCT. Although the specificity in these studies was high, it is likely that accuracy was overestimated due to the case-control designs used in the studies. The literature and specialty society guidelines have indicated that optic nerve analysis using CSLO, SLP, and OCT are established add-on tests that can be used with other established tests to improve the diagnosis and direct management of patients with glaucoma and those who are glaucoma suspects. Management changes for patients diagnosed with glaucoma may include the use of IOP-lowering medications, monitoring for glaucoma progression, and potentially surgery.

**Evaluation of Ocular Blood Flow**

**Clinical Context and Test Purpose**

The diagnosis and monitoring of optic nerve damage are essential for evaluating the progression of glaucoma and determining appropriate treatment. Measurement of ocular blood flow has been studied as a technique to evaluate patients with glaucoma or suspected glaucoma.

The question addressed in this evidence review is: Do various techniques (eg, color Doppler imaging [CDI], Doppler Fourier domain OCT, laser Doppler velocimetry, confocal scanning laser Doppler flowmetry, retinal functional imager) for assessing ocular blood flow improve diagnosis and monitoring of glaucoma? One potential application is the early detection of normal tension glaucoma (NTG).

The following PICOTS were used to select literature to inform this review.

**Patients**

The relevant patient populations are patients with glaucoma or suspected glaucoma and are being evaluated for diagnosis and monitoring of glaucoma progression. These tests may have particular utility for NTG.

**Interventions**

The tests being considered for assessment of the optic nerve and optic nerve layer include CDI, Doppler Fourier domain OCT, laser Doppler velocimetry, confocal scanning laser Doppler flowmetry, and retinal functional imager.
Comparators
There is no criterion standard for the diagnosis of glaucoma. The diagnosis of glaucoma is made using a combination of visual field testing, IOP measurements, and optic nerve and RNFL assessment.

Outcomes
Relevant outcomes include the reliability of the test for evaluating ocular blood flow and the association between ocular blood flow parameters and glaucoma progression. Demonstration that the information can be used to improve patient outcomes is essential to determining the utility of a diagnostic technology. Although direct evidence on the impact of the imaging technology from controlled trials would be preferred, in most cases, a chain of evidence is needed to determine whether there is a tight linkage between the technology and improved health outcomes. The outcomes relevant to this evidence review are IOP, loss of vision, and changes in IOP-lowering medications used to treat glaucoma.

Timing
For patients with manifest glaucoma, the relevant period of follow-up is the immediate diagnosis of glaucoma. For patients with suspected glaucoma, longer term follow-up would be needed to detect changes in IOP and loss of vision. Clinical utility might be demonstrated by a change in the management and reduction in glaucoma progression across follow-up.

Setting
Many of these procedures are performed with specialized equipment. While reports of use are longstanding (eg, Bafa et al [2001])9, investigators have commented on the complexity of these parameters9 and have noted that many of these technologies are not commonly used in clinical settings.10

Technically Reliable
Assessment of technical reliability focuses on specific tests and operators and requires review of unpublished and often proprietary information. Review of specific tests, operators, and unpublished data are outside the scope of this evidence review and alternative sources exist. This evidence review focuses on the clinical validity and clinical utility.

Clinically Valid
A test must detect the presence or absence of a condition, the risk of developing a condition in the future, or treatment response (beneficial or adverse).

Abegao Pinto et al (2016) reported on the results from the prospective, cross-sectional, case-control, Leuven Eye Study, which included 614 individuals who had primary open-angle glaucoma (n=214), NTG (n=192), ocular hypertension (n=27), suspected glaucoma (n=41), or healthy controls (n=140).11 The study objective was to identify the blood flow parameters most highly associated with glaucoma using technology commonly available in an ophthalmologist’s office or hospital radiology department. Assessment of ocular blood flow included CDI, retinal oximetry, dynamic contour tonometry, and OCT enhanced-depth imaging of the choroid. The glaucoma groups had higher perfusion pressure than controls (p<0.001), with lower velocities in both central retinal vessels (p<0.05), and choroidal thickness asymmetries. The NTG group, but not the primary open-angle glaucoma group, had higher retinal venous saturation than
healthy controls (p=0.005). There were no significant differences in macular scans. The
diagnostic accuracy and clinical utility were not addressed.

Kurysheva et al (2017) compared ocular blood flow with choroidal thickness to determine which
had a higher diagnostic value for detecting early glaucoma.12 Thirty-two patients with pre-
perimetric glaucoma were matched with 30 control patients. Using OCT, RNFL thickness
between groups was found to be comparable; the ganglion cell complex was thicker in the
control patients, and there was no significant difference between groups for choroid foveal loss
volume. Mean blood flow velocity in the vortex veins had the highest area under the receiver
operating characteristic curve ROC (1.0) and z-value (5.35). Diastolic blood flow velocity in the
central retinal artery had a diagnostic value of 2.74 and area under the receiver operating
characteristic curve of 0.73. The authors concluded that this study suggested a diagnostic
benefit in measuring blood flow velocities.

individuals.13 In this prospective study, the authors specifically looked at mean blur rate blood
flow in the optic nerve head and a peripapillary region. First, participants’ blood flow was
measured when they were in a sitting position; then, participants were asked to perform an
isometric “squatting” exercise for 6 minutes. Compared with baseline (sitting), exercise
significantly increased ocular perfusion blood pressure (78.5%), mean blur rate in the tissue of
the optic nerve head (18.1%), and mean blur rate in the peripapillary region (21.18.3%)
(p<0.001). Few studies have used laser speckle flowgraphy to study autoregulation of ocular
blood flow during a change in blood pressure, and this study is limited to Japanese populations.
Despite the lack of literature and limited population, the authors noted laser speckle flowgraphy
could be a valuable tool to study the regulation of blood flow in the optic nerve head,
particularly in patients suspected of having glaucoma or patients who have glaucoma.

Rusia et al (2011) reported on use of CDI in normal and glaucomatous eyes.14 Using data from
other studies, a weighted mean was derived for the peak systolic velocity, end-diastolic velocity,
and Pourcelot Resistive Index in the ophthalmic, central retinal, and posterior ciliary arteries.
Data from 3061 glaucoma patients and 1072 controls were included. Mean values for
glaucomatous eyes were within 1 standard deviation of the values for controls for most CDI
parameters. Methodologic differences created interstudy variance in CDI values, complicating
the construction of a normative database and limiting its utility. The authors noted that because
the mean values for glaucomatous and normal eyes had overlapping ranges, caution should be
used when classifying glaucoma status based on a single CDI measurement.

Clinically Useful
A test is clinically useful if the use of the results informs management decisions that improve
the net health outcome of care. The net health outcome can be improved if patients receive
correct therapy, or more effective therapy, or avoid unnecessary therapy, or avoid unnecessary
testing.

Direct Evidence
Direct evidence of clinical utility is provided by studies that have compared health outcomes for
patients managed with and without the test. Because these are intervention studies, the
preferred evidence would be from randomized controlled trials.
The clinical utility of techniques to evaluate ocular blood flow is similar to that for other imaging techniques. The objective is to improve the diagnosis and direct management of patients with glaucoma or suspected glaucoma. Measures of ocular blood flow may have particular utility for the diagnosis and monitoring of NTG.

The only longitudinal study identified is a study by Calvo et al (2012) on the predictive value of retrobulbar blood flow velocities in a prospective series of 262 who were glaucoma suspect. At baseline, all participants had normal visual field, increased IOP (mean, 23.56 mm Hg), and glaucomatous optic disc appearance. Blood flow velocities were measured by CDI during the baseline examination, and conversion to glaucoma was assessed at least yearly according to changes observed with CSLO. During the 48-month follow-up, 36 (13.7%) patients developed glaucoma and 226 did not. Twenty (55.5%) of those who developed glaucoma also showed visual field worsening (moderate agreement, $\kappa=0.38$). Mean end-diastolic and mean velocity in the ophthalmic artery were significantly reduced at baseline in subjects who developed glaucoma compared with subjects who did not.

**Chain of Evidence**
Indirect evidence on clinical utility rests on clinical validity. If the evidence is insufficient to demonstrate test performance, no inferences can be made about clinical utility.

The evidence does not permit any inferences about the utility of ocular blood flow evaluation in the evaluation of glaucoma.

**Section Summary: Evaluation of Ocular Blood Flow**
Techniques to measure ocular blood flow or ocular blood velocity are being evaluated for the diagnosis of glaucoma. Data for these techniques remain limited. Current literature focuses on which technologies are most reliably associated with glaucoma. Literature reviews have not identified studies that suggest whether these technologies improve the diagnosis of glaucoma or whether measuring ocular blood flow in patients with glaucoma or suspected glaucoma improves health outcomes.

**SUMMARY OF EVIDENCE**
For individuals who have glaucoma or suspected glaucoma who receive imaging of the optic nerve and retinal nerve fiber layer, the evidence includes studies on diagnostic accuracy. Relevant outcomes are test accuracy, symptoms, morbid events, functional outcomes, and medication use. Confocal scanning laser ophthalmoscopy (CSLO), scanning laser polarimetry (SLP), and optical coherence tomography (OCT) can be used to evaluate the optic nerve and retinal nerve fiber layer in patients with glaucoma and suspected glaucoma. Numerous articles have described findings from patients with known and suspected glaucoma using CSLO, SLP, and OCT. These studies have reported that abnormalities may be detected on these examinations before functional changes are noted. The literature and specialty society guidelines have indicated that optic nerve analysis using CSLO, SLP, and OCT are established add-on tests that may be used to diagnose and manage patients with glaucoma and suspected glaucoma. These results are often considered along with other findings to make diagnostic and therapeutic decisions about glaucoma care, including use of topical medication, monitoring, and surgery to lower intraocular pressure. Thus, accurate diagnosis of glaucoma would be expected to reduce the progression of glaucoma.
For individuals who have glaucoma or suspected glaucoma who receive evaluation of ocular blood flow, the evidence includes association studies. Relevant outcomes are test accuracy, symptoms, morbid events, functional outcomes, and medication use. Techniques to measure ocular blood flow or ocular blood velocity are used to determine appropriate glaucoma treatment options. The data for these techniques remain limited. Literature reviews have not identified studies on the technical performance of these tests (eg, test-retest reliability), whether these technologies improve diagnostic accuracy, or whether they improve health outcomes in patients with glaucoma. Some have suggested that these parameters may inform understanding of the variability in visual field changes in patients with glaucoma, ie, they may help explain why patients with similar levels of intraocular pressure develop markedly different visual impairments. However, data on use of ocular blood flow, pulsatile ocular blood flow, and/or blood flow velocity are currently lacking.

**CLINICAL INPUT FROM PHYSICIAN SPECIALTY SOCIETIES AND ACADEMIC MEDICAL CENTERS**

While the various physician specialty societies and academic medical centers may collaborate with and make recommendations during this process, through the provision of appropriate reviewers, input received does not represent an endorsement or position statement by the physician specialty societies or academic medical centers, unless otherwise noted.

In response to requests, input was received from 1 physician specialty society and 3 academic medical centers while this policy was under review in 2009. Most reviewers supported use of these techniques (confocal scanning laser ophthalmoscopy, scanning laser polarimetry, optical coherence tomography) in the care of patients with glaucoma and those with suspected glaucoma suspect. Reviewers provided data to demonstrate that this testing is equivalent to expert assessment of optic disc photography for both detecting glaucoma and showing disease progression. Reviewers also commented on favorable aspects of this testing. For example, unlike other glaucoma testing, these tests can be done more easily (eg, testing does not always need to be done with dilated pupils) and ambient light level may be (is) less critical. In addition, while serial stereophotographs of the optic nerves are considered by many as the criterion standard, they are not always practical, especially for general ophthalmologists. This testing also requires less cooperation from the patient, which can help when evaluating some older patients.

**PRACTICE GUIDELINES AND POSITION STATEMENTS**

*American Academy of Ophthalmology*

The American Academy of Ophthalmology’s (AAO) 2015 primary open-angle glaucoma (POAG) suspect and POAG preferred practice patterns recommend evaluating the optic nerve and retinal nerve fiber layer. The documents state that “Although they are distinctly different methodologies, stereoscopic disc photographs and computerized images of the nerve are complementary with regard to the information they provide the clinician who must manage the patient.” The guidelines describe 3 types of computer-based imaging devices (CSLO, OCT, SLP) that are currently available for glaucoma, which are similar in their ability to distinguish glaucoma from controls and state that “computer-based digital imaging of the ONH and RNFL is routinely used to provide quantitative information to supplement the clinical examination of the optic nerve.... One rationale for using computerized imaging is to distinguish glaucomatous damage from eyes without glaucoma when thinning of the RNFL is measured, thereby facilitating earlier diagnosis and detection of optic nerve damage”. In addition, AAO concluded
that, as device technology evolves the performance of diagnostic imaging devices is expected to improve.

**U.S. PREVENTIVE SERVICES TASK FORCE RECOMMENDATIONS**

Not applicable.

**ONGOING AND UNPUBLISHED CLINICAL TRIALS**

Some currently unpublished trials that might influence this review are listed in Table 1.

<table>
<thead>
<tr>
<th>NCT No.</th>
<th>Trial Name</th>
<th>Planned Enrollment</th>
<th>Completion Date</th>
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<tr>
<td>Ongoing</td>
<td>NCT02178085 Ocular Blood-flow Assessment by Magnetic Resonance Angiography in Glaucoma</td>
<td>62</td>
<td>Sep 2018</td>
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<td>NCT01957267 Longitudinal Observational Study Using Functional and Structural Optical Coherence Tomography to Diagnose and Guide Treatment of Glaucoma</td>
<td>150</td>
<td>Oct 2018</td>
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NCT: national clinical trial.

**CODING**

The following codes for treatment and procedures applicable to this policy are included below for informational purposes. Inclusion or exclusion of a procedure, diagnosis or device code(s) does not constitute or imply member coverage or provider reimbursement. Please refer to the member’s contract benefits in effect at the time of service to determine coverage or non-coverage of these services as it applies to an individual member.

**CPT/HCPCS**

- 92133 Scanning computerized ophthalmic diagnostic imaging, posterior segment, with interpretation and report, unilateral or bilateral; optic nerve
- 92134 Scanning computerized ophthalmic diagnostic imaging, posterior segment, with interpretation and report, unilateral or bilateral; retina
- 0198T Measurement of ocular blood flow by repetitive intraocular pressure sampling, with interpretation and report

**ICD-10 Diagnoses**

- A18.53 Tuberculous chorioretinitis
- B39.4 Histoplasmosis capsulati, unspecified
- B39.9 Histoplasmosis, unspecified
- C69.31 Malignant neoplasm of right choroid
- C69.32 Malignant neoplasm of left choroid
- D31.31 Benign neoplasm of right choroid
- D31.32 Benign neoplasm of left choroid
- E08.311 Diabetes mellitus due to underlying condition with unspecified diabetic retinopathy with macular edema
- E08.3211 Diabetes mellitus due to underlying condition with mild nonproliferative diabetic retinopathy with macular edema, right eye
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E13.3593  Other specified diabetes mellitus with proliferative diabetic retinopathy without macular edema, bilateral
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E13.37X2  Other specified diabetes mellitus with diabetic macular edema, resolved following treatment, left eye
E13.37X3  Other specified diabetes mellitus with diabetic macular edema, resolved following treatment, bilateral
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H21.552  Recession of chamber angle, left eye
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H30.002  Unspecified focal chorioretinal inflammation, left eye
H30.003  Unspecified focal chorioretinal inflammation, bilateral
H30.011  Focal chorioretinal inflammation, juxtapapillary, right eye
H30.012  Focal chorioretinal inflammation, juxtapapillary, left eye
H30.013  Focal chorioretinal inflammation, juxtapapillary, bilateral
H30.021  Focal chorioretinal inflammation of posterior pole, right eye
H30.022  Focal chorioretinal inflammation of posterior pole, left eye
H30.023  Focal chorioretinal inflammation of posterior pole, bilateral
H30.031  Focal chorioretinal inflammation, peripheral, right eye
H30.032  Focal chorioretinal inflammation, peripheral, left eye
H30.033  Focal chorioretinal inflammation, peripheral, bilateral
H30.041  Focal chorioretinal inflammation, macular or paramacular, right eye
H30.042  Focal chorioretinal inflammation, macular or paramacular, left eye
H30.043  Focal chorioretinal inflammation, macular or paramacular, bilateral
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H30.122  Disseminated chorioretinal inflammation, peripheral, left eye
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H30.132  Disseminated chorioretinal inflammation, generalized, left eye
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H34.8111 Central retinal vein occlusion, right eye, with retinal neovascularization
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H34.8320 Tributary (branch) retinal vein occlusion, left eye, with macular edema
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**REVISIONS**

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<td>04-19-2007</td>
<td>Added the indications for OCT use for diagnosing and monitoring glaucoma, nerve fiber, and optic nerve conditions.</td>
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<tr>
<td>05-09-2007</td>
<td>The policy section was updated to split the first bullet under B. to create two bullets, one for age-related macular degeneration and one for diabetic macular edema and to set a maximum number of OCT services per year for each.</td>
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<tr>
<td>04-30-2010</td>
<td>In Policy Section:</td>
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<td>• Revised repeat testing For Diabetic Macular Edema (DME), from &quot;Repeat every 2 or 3 months&quot; to &quot;Repeat every 3 or 4 months&quot;.</td>
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<td>• Revised repeat testing For Epiretinal Membrane (ERM) from &quot;pre-treatment and post-surgical at 3 months, 6 months&quot; to &quot;pre-treatment and post-surgical after 6 weeks, 6 months&quot;.</td>
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<td>• Added &quot;If Cystoid Macular Edema: Repeat every 2 months during acute treatment.&quot;</td>
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<td>• Added &quot;If Branch Retinal Vein Occlusion: Repeat every 3 or 4 months indefinitely.&quot;</td>
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<tr>
<td></td>
<td>• Added &quot;If Central Retinal Vein Occlusion: Repeat every 3 or 4 months for approximately 2 years&quot;</td>
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</table>
| 10-26-2010 | Policy Section:  | - Added "If Macular Drusen: Repeat annually, allowing one study by treating MD / DO per year."  
- Corrected wording of "treating MD / OD" to "treating MD / DO"  

In Coding Section:  
- Updated wording for CPT code 92135.  
- Confirmed no diagnosis codes listed for OCT for the rhegmatogenous retinal detachment (361.00-361.07)  
- Added diagnosis code 362.51. |
| 2011-02-16 | Coding section | - Added CPT codes: 92133, 92134, 92227, 92228.  
- Removed CPT code: 92135. |
| 2012-01-01 | Coding section | - Removed HCPCS code: S0625. |
| 2013-01-15 | Policy section | - In the Policy section:  
  - In Item B, revised the following statement, "Optical Coherence (OCT) test is allowed for the diagnoses and the monitoring for retinal conditions." to "Optical Coherence (OCT) test is allowed for the diagnoses, listed below, monitoring for retinal conditions, and ocular toxicity secondary to high-risk medications (i.e., chloroquine [Aralen], hydroxychloroquine [Plaquenil], Interferon alpha-2b, Amiodarone, tamoxifen citrate [Nolvadex], fingolimod [Gilenya], Seroquel)."  

In Coding section:  
- Added Diagnosis codes: 362.57, 379.21, V58.69. |
| 2013-01-22 | | Corrections were made to the Current Effective Date and the Revision Date section. |
| 2013-07-30 | Policy section | - In Item B, 9 moved to become new #2. |
- In new Item B, 2, inserted "only" to read "Repeat annually, only if subjective visual changes..."

In Coding section:
- Added ICD-10 Diagnosis codes *(Effective October 1, 2014)*

Updated Reference section.

**04-28-2015**  Updated Description section.
- Added Rationale section.

In Coding section:
- Added ICD-9 Diagnosis codes
- Added H47.231-H47.233 to ICD-10 Diagnosis codes.

Updated References section.

**08-19-2015**  In Policy section:
- In Item B 3, added "8" and removed "Repeat every 3 or 4 months" and "4", to read "Maximum of 8 per year linked to intravitreal injections or laser treatment."
- In Item B 5, removed "after 6 weeks, 6 months", and "3", to read "Repeat pre-treatment and post-surgical (maximum of 4 per year) if with macular edema."
- In Item B 6, removed "at 2 or 3 months" and added "maximum of 4 per year) in", to read "Repeat pre-treatment and post-treatment (maximum of 4 per yer) in cases of partially closed hole."
- In Item B 8, removed "Repeat every 3 or 4 months for approximately 2 years" and added "Maximum of 8 per year linked to intravitreal injections"
- In Item B 9, removed "Repeat every 3 or 4 months for approximately 2 years" and added "Maximum of 8 per year linked to intravitreal injections"

Updated Rationale section.


In Coding section:


In Coding section:
- Added ICD-10 diagnosis codes: H40.021, H40.022, H40.023, H40.31X1, H40.31X2, H40.31X3, H40.31X4, H40.32X1, H40.32X2, H40.32X3, H40.32X4, H40.33X1, H40.33X2, H40.33X3, H40.33X4, H40.41X1, H40.41X2, H40.41X3, H40.41X4, H40.42X1, H40.42X2, H40.42X3, H40.42X4, H40.43X1, H40.43X2, H40.43X3, H40.43X4.

**10-01-2016**  In Coding section:
- Added ICD-10 codes effective 10-01-2016: E08.3211, E08.3212, E08.3213, E08.3291, E08.3292, E08.3293, E08.3311, E08.3312, E08.3313, E08.3391, E08.3392, E08.3393, E08.3411, E08.3412, E08.3413, E08.3491, E08.3492, E08.3493, E08.3511, E08.3512, E08.3513, E08.3521, E08.3522, E08.3523, E08.3531, E08.3532, E08.3533, E08.3541, E08.3542, E08.3543, E08.3551, E08.3552, E08.3553, E08.3591, E08.3592, E08.3593, E08.37X1, E08.37X2, E08.37X3, E09.3211, E09.3212, E09.3213, E09.3291, E09.3292, E09.3293, E09.3311, E09.3312, E09.3313, E09.3391, E09.3392, E09.3393, E09.3411, E09.3412, E09.3413, E09.3491, E09.3492, E09.3493, E09.3511, E09.3512, E09.3513, E09.3521, E09.3522, E09.3523, E09.3531, E09.3532, E09.3533, E09.3541, E09.3542, E09.3543, E09.3551, E09.3552, E09.3553, E09.3591,

Updated References section.

10-12-2016
Updated Description section.
Updated Rationale section.
Updated References section.

05-12-2017
Updated Description section.

In Policy section:
- In Item B, removed "diagnosis" and "and the" and added "diagnoses, listed below" and ", and ocular toxicity secondary to high-risk medications (ie, chloroquine [Aralen], hydroxychloroquine [Plaquenil], Interferon alpha-2b, Amiodarone, tamoxifen citrate [Nolvadex], fingolimod [Gilenya], Seroquel)" to read, "Optical Coherence Tomography (OCT) test is allowed for the diagnoses, listed below, and the monitoring for retinal conditions, and ocular toxicity secondary to high-risk medications (ie, chloroquine [Aralen], hydroxychloroquine [Plaquenil], Interferon alpha-2b, Amiodarone, tamoxifen citrate [Nolvadex], fingolimod [Gilenya], Seroquel)." (These revisions to policy language were inadvertently removed in the revision of 07-30-2013.)

Updated Rationale section.

In Coding section:
- Added CPT code: 0198T.
• Removed CPT codes: 92227, 92228.
• Added ICD-10 codes: H33.001, H33.002, H33.003, H33.011, H33.012, H33.013, H33.021, H33.022, H33.023, H33.031, H33.032, H33.033, H33.041, H33.042, H33.043, H33.051, H33.052, H33.053, H35.50, H35.51, H35.53, H35.54, H43.811, H43.812, H43.813, H47.031, H47.032, H47.033, H47.20, H47.211, H47.212, H47.213, H47.22, H47.291, H47.292, H47.293, H47.321, H47.322, H47.323, H47.331, H47.332, H47.333, H47.391, H47.392, H47.393.

In Revision section, revision date was changed from "01-15-2012" to "01-15-2013."

Updated References section.

10-01-2017
In Coding section:
• Added ICD-10 codes: H44.2A1, H44.2A2, H44.2A3, H44.2B1, H44.2B2, H44.2B3, H44.2C1, H44.2C2, H44.2C3, H44.2D1, H44.2D2, H44.2D3, H44.2E1, H44.2E2, H44.2E3.

04-11-2018
Updated Description section.
Updated Rationale section.
In Coding section:
• Removed ICD-9 codes.
Updated References section.

08-01-2018
In Policy section:
• Added new Item B 10, "If Vitreomacular Traction / Adhesion: Maximum of 4 per year."

In Coding section:
• Added ICD-10 codes: H43.821, H43.822, H43.823.
Updated References section.

04-15-2019
In Coding section:
• Added ICD-10 code: H35.051.

09-27-2019
Policy published to the bcbsks.com website on 08-28-2019 with an effective date of 09-29-2019.
In Coding section:
• Added ICD-10 codes: H59.031, H59.032, H59.033.

REFERENCES


**Other References**


2. Blue Cross and Blue Shield of Kansas Ophthalmology Liaison Committee minutes, May 9, 2007.


6. Blue Cross and Blue Shield of Kansas Optometry Liaison Committee, June 2010; May 2013; August 2016.

7. Blue Cross and Blue Shield of Kansas Ophthalmology/Optometry Liaison Committee, February 2017; May 2018; August 2019.