MP 9.03.506
Ophthalmologic Techniques That Evaluate the Posterior Segment for Glaucoma

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Last Review: 03/19/2020
Effective Date: 03/19/2020
Section: Other

Related Policies
9.03.18 Optical Coherence Tomography of the Anterior Eye Segment

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POLICY

Analysis of the optic nerve (retinal nerve fiber layer) in the diagnosis and evaluation of patients with glaucoma or glaucoma suspects may be considered medically necessary when using scanning laser ophthalmoscopy, scanning laser polarimetry, and optical coherence tomography.

Performance of this test more than once per year is considered not medically necessary by Blue Cross of Idaho.

The measurement of ocular blood flow, pulsatile ocular blood flow, or blood flow velocity is considered investigational in the diagnosis and follow-up of patients with glaucoma.

POLICY GUIDELINES

This policy addresses techniques used to evaluate for glaucoma and does not address other ophthalmic conditions.

Coding

Please see the Codes table for details.

BENEFIT APPLICATION

BLUECARD/NATIONAL ACCOUNT ISSUES

State or federal mandates (e.g., Federal Employee Program) may dictate that certain U.S. Food and Drug Administration–approved devices, drugs, or biologics may not be considered investigational, and thus...
these devices may be assessed only by their medical necessity.

Optic nerve and retinal nerve fiber analysis may be performed by both ophthalmologists and optometrists.

**BACKGROUND**

*Diagnosis and Management*

A comprehensive ophthalmologic exam is required for the diagnosis of glaucoma, but no single test is adequate to establish diagnosis. A comprehensive ophthalmologic examination includes assessment of the optic nerve, 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 (IOP), is sufficient for a definitive diagnosis. However, some patients will show ophthalmologic evidence of glaucoma with normal intraocular pressures (IOPs). These cases of normal-tension glaucoma are considered to be a type of primary open-angle glaucoma. Angle-closure glaucoma is another type of glaucoma associated with an increase in intraocular pressure (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. Diagnosis of angle-closure glaucoma is detailed in evidence review 9.03.18.

Conventional management of patients 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 stereo photography 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 retinal nerve fiber layer before the development of permanent visual field deficits. Specifically, evaluating changes in retinal nerve fiber layer thickness 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 normal-tension glaucoma, there is never an increase in IOP. It has been proposed that vascular dysregulation is a significant cause of damage to the retinal nerve fiber layer, 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 normal-tension glaucoma. A variety of techniques have been developed, as described below. (Note: This evidence review only addresses techniques related to the evaluation of the optic nerve, retinal nerve fiber layer, or blood flow to the retina and choroid in patients with glaucoma.)

**Techniques to Evaluate the Optic Nerve and Retinal Nerve Fiber Layer**

*Confocal Scanning Laser Ophthalmoscopy*

Confocal scanning laser ophthalmoscopy is an image acquisition technique intended to improve the quality of the eye 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 retinal nerve fiber layer thickness. In addition, this technique does not require maximal mydriasis, which may be problematic in patients with glaucoma. The Heidelberg Retinal Tomograph is a commonly used technology.
**Scanning Laser Polarimetry**

The retinal nerve fiber layer is birefringent (or biorefractive), meaning that it causes 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 retinal nerve fiber layer thickness. Unlike confocal scanning laser ophthalmoscopy, scanning laser polarimetry can directly measure the thickness of the retinal nerve fiber layer. GDx is a common scanning laser polarimetry device. GDx contains a normative database and statistical software package that compare scan results 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 completed in 10 minutes. Current instruments have added enhanced and variable corneal compensation technology to account for corneal polarization.

**Optical Coherence Tomography**

Optical coherence tomography uses near-infrared light to provide direct cross-sectional measurement of the retinal nerve fiber layer. 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. Optical coherence tomography analysis software is being developed to include optic nerve head parameters with spectral domain optical coherence tomography, analysis of macular parameters, and hemodynamic parameters with Doppler optical coherence tomography and optical coherence tomography 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 relation 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 optical coherence tomography, 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 Imaging

Color Doppler imaging has also been investigated as a technique to measure the blood flow 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 Optical Coherence Tomography

Doppler Fourier domain optical coherence tomography 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 with 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 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 optical coherence tomography Avanti™ (Optovue) is an optical coherence tomography 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 clinical diagnosis and management of retinal diseases. The RTVue XR optical coherence tomography Avanti™ with Normative Database is a quantitative tool for comparing retina, retinal nerve fiber layer, and optic disk measurements in the human eye with a database of known normal subjects. It is intended as a diagnostic device to aid in the detection and management of ocular diseases. In 2016, the RTVue XR optical coherence tomography and Avanti™ with AngioVue™ Software was cleared by the 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) was cleared for marketing by the 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 PanOptic™ Ophthalmoscope (Welch Allyn) using an iPhone. FDA product code: HKI.
### Table 1. Ocular Imaging Devices Cleared by the U.S. Food and Drug Administration

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<tr>
<th>Device</th>
<th>Manufacturer</th>
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Ophthalmologic Techniques That Evaluate the Posterior Segment for Glaucoma

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<th>Technique</th>
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**RATIONALE**

This evidence review was created in April 1998 and has been updated regularly with searches of the MEDLINE database. The most recent literature update was performed through January 9, 2020.

Glaucoma is characterized by degeneration of the optic nerve (optic disc). Elevated intraocular pressure (IOP) has long been thought to be the primary etiology, but the relation between intraocular pressure (IOP) and optic nerve damage varies among patients, suggesting a multifactorial origin. For example, some patients with clearly elevated intraocular pressure (IOP) will show no optic nerve damage, while others with marginal or no pressure elevation will show optic nerve damage. The association between glaucoma and other vascular disorders (eg, diabetes, 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.

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 analysis (confocal scanning laser ophthalmoscopy, scanning laser polarimetry, optical coherence tomography) for the diagnosis and management of glaucoma was addressed by 2 TEC Assessments (2001, 2003).2-4.
Imaging of the Optic Nerve and Retinal Nerve Fiber Layer

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 retinal nerve fiber layer improve diagnosis and monitoring of glaucoma?

The following PICO was used to select literature to inform this review.

Patients

The relevant population is 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 retinal nerve fiber layer include confocal scanning laser ophthalmoscopy, scanning laser polarimetry, and optical coherence tomography. These tests are considered add-ons to the standard clinical evaluation.

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.

Comparators

There is no single criterion standard for the diagnosis of glaucoma. This diagnosis is made from a combination of visual field testing, IOP measurement, and optic nerve and retinal nerve fiber layer assessment by an ophthalmologist.

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.

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.

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 retinal nerve fiber layer. Clinical utility might be demonstrated by a change in the management and reduction in glaucoma progression across follow-up.

**Study Selection Criteria**

Below are selection criteria for studies to assess whether a test is clinically valid.

1. The study population represents the population of interest. Eligibility and selection are described.
2. The test is compared with a credible reference standard.
3. If the test is intended to replace or be an adjunct to an existing test; it should also be compared with that test.
4. Studies should report sensitivity, specificity, and predictive values. Studies that completely report true- and false-positive results are ideal. Studies reporting other measures (eg, receiver operating characteristic, area under receiver operating characteristic, c-statistic, likelihood ratios) may be included but are less informative.
5. Studies should also report reclassification of diagnostic or risk category.

**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. 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 (optical coherence tomography, retinal tomography, scanning laser polarimetry), 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 retinal nerve fiber layer imaging for glaucoma. Included were 103 case-control studies and 3 cohort studies (total N=16,260 eyes) that evaluated the accuracy of recent commercial versions of optical coherence tomography (spectral domain), Heidelberg Retinal Tomograph III, or scanning laser polarimetry (with the variable corneal compensator or enhanced corneal compensation) 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 (optical coherence tomography, Heidelberg Retinal Tomograph III, scanning laser polarimetry) 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 RCTs.
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 retinal nerve fiber layer 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 Retinal Nerve Fiber Layer**

Numerous studies and systematic reviews have described findings from patients with glaucoma using confocal scanning laser ophthalmoscopy, scanning laser polarimetry, and optical coherence tomography. 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 confocal scanning laser ophthalmoscopy, scanning laser polarimetry, and optical coherence tomography 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, Doppler Fourier domain optical coherence tomography, 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.

The following PICO was used to select literature to inform this review.

*Patients*

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

*Interventions*

The tests being considered for assessment of the optic nerve and optic nerve layer include color doppler imaging, Doppler Fourier domain optical coherence tomography, laser Doppler velocimetry, confocal scanning laser Doppler flowmetry, and retinal functional imager.
Many of these procedures are performed with specialized equipment. While reports of use are longstanding (eg, Bafa et al [2001]⁵), investigators have commented on the complexity of these parameters⁶ and have noted that many of these technologies are not commonly used in clinical settings.¹⁰

**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 retinal nerve fiber layer assessment.

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.

**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.

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.

**Study Selection Criteria**

Selection criteria for studies to assess whether a test is clinically valid are discussed in the first indication.

**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), normal tension glaucoma (n=192), ocular hypertension (n=27), suspected glaucoma (n=41), or healthy controls (n=140). 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 color doppler imaging, retinal oximetry, dynamic contour tonometry, and optical coherence tomography 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 normal tension glaucoma 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. Thirty-two patients with pre-perimetric glaucoma were matched with 30 control patients. Using optical coherence tomography, retinal nerve fiber layer 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 receiver operating characteristic curve (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 receiver operating characteristic curve of 0.73. The authors concluded that this study suggested a diagnostic benefit in measuring blood flow velocities.

Witkowska et al (2017) investigated blood flow regulation using laser speckle flowgraphy in 27 individuals. 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 color doppler imaging in normal and glaucomatous eyes. 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 1,072 controls were included. Mean values for glaucomatous eyes were within 1 standard deviation of the values for controls for most color doppler imaging parameters. Methodologic differences created interstudy variance in color doppler imaging 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 color doppler imaging measurement.
Table 2. Summary of Key Nonrandomized Study Characteristics

<table>
<thead>
<tr>
<th>Study</th>
<th>Study Type</th>
<th>Country</th>
<th>Dates</th>
<th>Participants</th>
<th>Treatment 1</th>
<th>Treatment 2</th>
<th>Follow-Up</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kurysheva et al (2017)</td>
<td>Prospective</td>
<td>Russia</td>
<td>NR</td>
<td>Patients with pre-perimetric glaucoma (n=32) and age-matched controls (n=30)</td>
<td>Optical coherence tomography</td>
<td></td>
<td>NR</td>
</tr>
<tr>
<td>Witkowska et al (2017)</td>
<td>Prospective</td>
<td>Austria</td>
<td>2015-2016</td>
<td>Healthy subjects (n=27)</td>
<td>Laser speckle flowgraphy</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

NR: not reported.

Table 3. Summary of Key Nonrandomized Study Results

<table>
<thead>
<tr>
<th>Study</th>
<th>AUC and Diagnostic Value AUC p-value</th>
<th>Increase in OPP from Baseline</th>
<th>Increase in MTONH from Baseline</th>
<th>Increase in MTPPR from Baseline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kurysheva et al (2017)</td>
<td>MBFV in VV 1.0; &lt;0.0001</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>MBFV in CRV 0.85; 0.0001</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>DBFV in CRA 0.73; 0.006</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>DBFV in LSPCAs 0.71; 0.011</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Witkowska et al (2017)</td>
<td>78.5+/-19.8%</td>
<td>18.1+/-7.7%</td>
<td>21.1+/-8.3%</td>
<td></td>
</tr>
</tbody>
</table>

AUC: area under the receiver operating characteristic curve; OPP: ocular perfusion pressure; MTONH: mean blur rate in the tissue of the optic nerve head; MTPPR: mean blur rate in the peripapillary region; MBFV: mean blood flow velocity; VV: vortex veins; CRV: central retinal vein; DBFV: diastolic blood flow velocity; CRA: central retinal artery; LSPCA: lateral short posterior ciliary artery.

**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 RCTs.

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 normal tension glaucoma.
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 color doppler imaging during the baseline examination, and conversion to glaucoma was assessed at least yearly according to changes observed with confocal scanning laser ophthalmoscopy. 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, κ=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, scanning laser polarimetry, and optical coherence tomography 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 confocal scanning laser ophthalmoscopy, scanning laser polarimetry, and optical coherence tomography. 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 confocal scanning laser ophthalmoscopy, scanning laser polarimetry, and optical coherence tomography 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. The evidence is sufficient to determine that the technology results in a meaningful improvement in the net health outcome.
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 addressing 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. The evidence is insufficient to determine the effects of the technology on health outcomes.

SUPPLEMENTAL INFORMATION

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 confocal scanning laser ophthalmoscopy, scanning laser polarimetry, and 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 stereo photographs 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

In 2015, the American Academy of Ophthalmology issued 2 preferred practice patterns on primary open-angle glaucoma suspect and primary open-angle glaucoma, both recommending evaluation of the optic nerve and retinal nerve fiber layer. The documents stated 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 described 3 types of computer-based imaging devices (confocal scanning laser ophthalmoscopy, scanning laser polarimetry, optical coherence tomography) currently available for glaucoma, which are similar in their ability to distinguish glaucoma from controls and noted that “computer-based digital imaging of the optic nerve head and retinal nerve fiber layer 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 retinal nerve fiber layer is measured, thereby facilitating earlier
diagnosis and detection of optic nerve damage”. In addition, the Academy 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.

**Medicare National Coverage**

There is no national coverage determination. In the absence of a national coverage determination,
coverage decisions are left to the discretion of local Medicare carriers.

**Ongoing and Unpublished Clinical Trials**

Some currently unpublished trials that might influence this review are listed in Table 4.

**Table 4. Summary of Key Trials**

<table>
<thead>
<tr>
<th>NCT No.</th>
<th>Trial Name</th>
<th>Planned Enrollment</th>
<th>Completion Date</th>
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<tbody>
<tr>
<td>Ongoing</td>
<td></td>
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<tr>
<td>NCT02178085</td>
<td>Ocular Blood-flow Assessment by Magnetic Resonance Angiography in Glaucoma</td>
<td>62</td>
<td>Sep 2019</td>
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<tr>
<td>NCT01957267</td>
<td>Longitudinal Observational Study Using Functional and Structural Optical Coherence Tomography to Diagnose and Guide Treatment of Glaucoma</td>
<td>160</td>
<td>Dec 2022</td>
</tr>
</tbody>
</table>

NCT: national clinical trial.

**ESSENTIAL HEALTH BENEFITS**

The Affordable Care Act (ACA) requires fully insured non-grandfathered individual and small group benefit plans to provide coverage for ten categories of Essential Health Benefits (“EHBs”), whether the benefit plans are offered through an Exchange or not. States can define EHBs for their respective state.

States vary on how they define the term small group. In Idaho, a small group employer is defined as an employer with at least two but no more than fifty eligible employees on the first day of the plan or contract year, the majority of whom are employed in Idaho. Large group employers, whether they are self-funded or fully insured, are not required to offer EHBs, but may voluntarily offer them.

The Affordable Care Act requires any benefit plan offering EHBs to remove all dollar limits for EHBs.

**REFERENCES**


**CODES**

<table>
<thead>
<tr>
<th>Codes</th>
<th>Number</th>
<th>Description</th>
</tr>
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<tbody>
<tr>
<td>CPT</td>
<td>92133</td>
<td>Scanning computerized ophthalmic diagnostic imaging, posterior segment; with interpretation and report, unilateral or bilateral; optic nerve</td>
</tr>
<tr>
<td>0198T</td>
<td></td>
<td>Measurement of ocular blood flow by repetitive pressure sampling, with interpretation and report</td>
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<td>HCPCS</td>
<td>No code</td>
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<tr>
<td>ICD-10-CM</td>
<td>H40.001-H42</td>
<td>Glaucoma, code range</td>
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<tr>
<td>Z01.00-Z01.01</td>
<td></td>
<td>Encounter for examination of eyes and vision</td>
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<tr>
<td>ICD-10-PCS</td>
<td></td>
<td>ICD-10-PCS codes are only used for inpatient services. There is no specific ICD-10-PCS code for this testing.</td>
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**Type of service** Vision
**MP 9.03.506**  
Ophthalmologic Techniques That Evaluate the Posterior Segment for Glaucoma

<table>
<thead>
<tr>
<th>Place of service</th>
<th>Physician’s office</th>
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</table>

**POLICY HISTORY**

<table>
<thead>
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<th>Action</th>
<th>Reason</th>
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<tr>
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<td>02/12/15</td>
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<td>07/25/16</td>
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<td>Blue Cross of Idaho annual review; no change to policy.</td>
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<tr>
<td>08/11/16</td>
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<td>Policy updated with literature review through July 11, 2016; reference 9 added; references 24-25 updated. Policy statements unchanged.</td>
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<tr>
<td>03/21/17</td>
<td>Replace policy</td>
<td>Policy updated with literature review through January 25, 2017; references 1 and 11 added; some references removed. Doppler ultrasonography removed from the second policy statement. The intent of the policy statement is unchanged. Title changed to “Ophthalmologic Techniques That Evaluate the Posterior Eye Segment for Glaucoma.”</td>
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<tr>
<td>03/29/18</td>
<td>Replace policy</td>
<td>Blue Cross of Idaho adopted changes as noted. Policy updated with literature review through January 8, 2018; references 12-13 added. Policy statements unchanged. Policy renumbered from 9.03.13 to 9.03.506.</td>
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<td>03/21/19</td>
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<td>03/19/20</td>
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<td>Policy updated with literature review through January 9, 2020; no references added. Policy statements unchanged.</td>
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