

## Medical Coverage Policy | Intraocular Lens (IOL) Implants



**EFFECTIVE DATE:** 10|01|2004  
**POLICY LAST UPDATED:** 07|11|2019

### OVERVIEW

This policy describes coverage of monofocal intraocular lenses (IOLs), presbyopia-correcting (P-C) IOLs and astigmatism-correcting (A-C) IOLs.

### MEDICAL CRITERIA

Not applicable

### PRIOR AUTHORIZATION

Prior authorization review is not required.

### POLICY STATEMENT

#### BlueCHiP for Medicare and Commercial Products

Monofocal intraocular lenses are covered.

Presbyopia-correcting and astigmatism-correcting IOLs following cataract surgery are not covered as there are no medical advantages of these lenses over standard monofocal IOLs.

However, members may request the insertion of presbyopia-correcting intraocular lenses or astigmatism-correcting intraocular lenses instead of monofocal IOLs following removal of a cataract and will be responsible for any additional cost of the P-C IOL or the A-C IOL, including physician services required to monitor a patient receiving a P-C or A-C IOL. For example, eye examinations performed to determine the refractive state of the eyes following insertion of a presbyopia-correcting IOL.

Members may choose to receive an astigmatism-correcting or presbyopia-correcting IOL. Members must agree to assume liability for the additional expense of the P-C IOL or the A-C IOL. Reimbursement will be provided for only the cost of a monofocal IOL. Members should be notified of this option by their eye surgeon prior to the cataract extraction surgery. When a member does choose a presbyopia-correcting or astigmatism-correcting IOL over a monofocal IOL, it is the member's responsibility to submit for possible reimbursement up to the allowance for the standard, monofocal, covered lens.

### COVERAGE

Benefits may vary between groups/contracts. Please refer to the appropriate Benefit Booklet, Evidence of Coverage, or Subscriber Agreement for surgery benefits.

### BACKGROUND

A cataract is a hardening and opacification of the normally transparent crystalline lens within the eye. Cataract formation usually occurs as part of the aging process, but may also be congenital in nature. Rarely, a cataract may form when related to trauma or inflammation of the eye or may also result from the use of some medications. Cataracts may result in progressive loss of vision with the degree of loss depending on the location, size and density of the cataract. The primary indication for cataract surgery is that visual function no longer meets the patient's needs and also that there is a reasonable likelihood of vision improvement with the procedure. The current cataract procedure of choice is an extracapsular technique (removes only the lens) with the implantation of an intraocular lens. Replacement of the lens restores optical focusing power lost by

removal of the natural crystalline lens. Cataract removal surgery is an established surgical procedure with excellent outcomes in improving vision and removing visual impediments. Cataract surgery is usually performed under local anesthesia.

An intraocular lens implant is a small, clear, plastic lens that is used to replace the natural (native) lens of the eye when it has been surgically removed (most often during cataract surgery). The IOL becomes a permanent part of the eye, not requiring any care and cannot be seen or felt. An IOL is used to improve vision after the native lens is removed by helping to focus light directly onto the retina. The choice of IOL is dependent on physician recommendation and the visual needs of each individual patient. Monofocal IOLs meet the basic functional needs of an individual who undergoes cataract removal.

Conventional monofocal IOLs are designed with a fixed optical power to provide primarily distance vision, and thus these lenses are not designed to simultaneously correct the presbyopia, which is part of the natural process of aging seen in most adults undergoing cataract surgery. Therefore, individuals after cataract surgery who have presbyopia may continue to wear glasses or contact lenses for near vision and individuals with pre-existing astigmatism may require glasses or contact lenses for optimal vision following cataract extraction as well. Intraocular lenses are now available for the visual correction of presbyopia, and more recently IOLs have been developed for the visual correction of astigmatism following cataract surgery. The use of presbyopia-correcting IOLs and astigmatism-correcting IOLs as alternatives to monofocal IOLs is considered to be predominately for comfort and convenience, that is, to eliminate the need for spectacles or contact lenses.

Monofocal, or standard, IOLs are the current standard of treatment. These are small polymer discs designed to the same optical properties as an individual's natural lens. This type of IOL usually has a fixed focusing power, which provides good distance vision, sometimes intermediate vision, but does not correct the patient's near vision as the full accommodating ability of the eye is lost. Thus, the placement of a monofocal IOL usually requires corrective lenses or eyeglasses after surgery for reading and near vision tasks. While a traditional fixed monofocal IOL is spherical (the front surface is uniformly curved), an *aspheric* monofocal IOL is slightly flatter in the periphery, allowing for a better contrast sensitivity and a reduction in visual aberrations. The advent of aspheric IOLs has enhanced the quality of visual outcome for monofocal lenses.

Presbyopia-correcting IOLs are sometimes referred to as multifocal and accommodating IOLs.

Multifocal IOLs are designed to provide distance and near vision and are referred to as pseudoaccommodative lenses or dynamic lenses. The multifocal IOL structure allows light rays to be focused from both distance and near. This type of lens does not restore good intermediate vision, but the need for eyeglasses for near vision correction appears to be much less with the use of multifocal IOLs compared to the monofocal IOL. Reports of increased glare, halos at night, variable loss of clarity and low contrast acuity have been reported by patients with the use of multifocal IOLs, creating patient dissatisfaction with the multifocal IOL variety.

Accommodating IOLs are designed to provide good distance, intermediate, and near vision. These IOLs are designed to work with the muscles of the eye to reproduce the focusing function of the lens, by changing the position of the lens rather than changing its shape. The accommodating IOL has hinges at both ends to facilitate forward and backward movement and interacts with the eye's ciliary muscles and zonules allowing variable focus capability. This type of lens allows patients to see a continuous range of vision and greatly reduces the need for postoperative corrective lenses.

Astigmatism-correcting IOLs, also known as toric IOLs, provide correction or reduction of pre-existing astigmatism (astigmatism that was present before cataract surgery) by incorporating a special curvature into the IOL. Prior to the advent of toric IOLs, pre-existing astigmatism could only be corrected by making limbal

relaxing incisions into the cornea during cataract surgery to change its curvature, or by wearing astigmatism correcting eyeglasses after surgery.

The use of presbyopia-correcting and astigmatism-correcting IOLs as alternatives to monofocal IOLs is considered to be predominately for comfort and convenience, that is, to eliminate the need for spectacles or contact lenses. A medical necessity rationale for presbyopia-correcting IOLs and astigmatism-correcting IOLs would require evidence that presbyopia-correcting IOLs and astigmatism-correcting IOLs result in a clinically significant visual improvement over that achieved with monofocal IOLs with eyeglasses or contact lenses. The available peer-reviewed literature has failed to establish the superiority of presbyopia-correcting IOLs and astigmatism-correcting IOLs, in terms of safety and long-term benefit over monofocal IOLs and conventional eyewear.

## **CODING**

### **BlueCHiP for Medicare and Commercial Products**

The following HCPCS code for a standard IOL is covered:

**V2630** Anterior chamber intraocular lens

**V2631** Iris supported intraocular lens

**V2632** Posterior chamber intraocular lens

The following codes are not covered as they are considered a convenience item. However, if a member requests one of these lenses following intraocular lenses, payment is allowed up to the cost of standard monofocal intraocular lenses. The member is responsible for the difference in cost for lenses and any special services related to those lenses:

**V2787** Astigmatism correcting function of intraocular lens

**V2788** Presbyopia correcting function of intraocular lens

## **RELATED POLICIES**

Therapeutic Eyeglasses and Contact Lenses

## **PUBLISHED**

Provider Update, September 2019

Provider Update, November/December 2018

Provider Update, November 2017

Provider Update, September 2016

Provider Update, January 2016

## **REFERENCES**

1. Centers for Medicare and Medicaid Services (CMS). National Coverage Determination (NCD) for Intraocular Lenses (IOLs) (80.12)
2. Calladine D, Evans JR, Shah S, Leyland M. Multifocal versus monofocal intraocular lenses after cataract extraction. *Cochrane Database Syst Rev.* 2012;9:CD003169.
3. Chen CL, Lin GA, Bardach NS, et al. Preoperative medical testing in Medicare patients undergoing cataract surgery. *N Engl J Med.* 2015;372(16):1530-1538.
4. Guay J, Sales K. Sub-Tenon's anaesthesia versus topical anaesthesia for cataract surgery. *Cochrane Database Syst Rev.* 2015;8:CD006291.
5. Zhang ML, Hirunyachote P, Jampel H. Combined surgery versus cataract surgery alone for eyes with cataract and glaucoma. *Cochrane Database Syst Rev.* 2015;7:CD008671.
6. U.S. Food and Drug Administration (FDA). FDA approves first intraocular lens with extended range of vision for cataract patients. Silver Spring, MD: FDA; July 15, 2016. Available at: <https://www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/ucm511446.html>. Accessed March 12, 2018.
7. Do DV, Gichuhi S, Vedula SS, Hawkins BS. Surgery for postvitrectomy cataract. *Cochrane Database Syst Rev.* 2018;1:CD006366.

8. de Silva SR, Evans JR, Kirthi V, et al. Multifocal versus monofocal intraocular lenses after cataract extraction. *Cochrane Database Syst Rev.* 2016 (9):CD003169.
9. Ong HS, Evans JR, Allan BD. Accommodative intraocular lens versus standard monofocal intraocular lens implantation in cataract surgery. *Cochrane Database Syst Rev.* 2014; 5:CD009667.
10. Mesci C, Erbil HH, Olgun A, Yaylali SA. Visual performances with monofocal, accommodating, and multifocal intraocular lenses in patients with unilateral cataract. *Am J Ophthalmol.* 2010; 150(5):609-618.
11. Agresta B, Knorz MC, Kohnen T, et al. Distance and near visual acuity improvement after implantation of multifocal intraocular lenses in cataract patients with presbyopia: a systematic review. *J Refract Surg.* 2012; 28(6):426-435.
12. Zamora-Alejo KV, Moore SP, Parker DG, Ullrich K, Esterman A, Goggin M. Objective accommodation measurement of the Crystalens HD compared to monofocal intraocular lenses. *Refract Surg.* 2013 Feb;29(2):133-9.
13. Shah S, Peris-Martinez C, Reinhard T, Vinciguerra P. Visual Outcomes After Cataract Surgery: Multifocal Versus Monofocal Intraocular Lenses. *J Refract Surg.* 2015 Oct;31(10):658-66.
14. Shimoda T, Shimoda G, Hida WT, Nakano CT, Motta AF, Guimarães AS, Tzelikis PF. Visual outcomes after implantation of a novel refractive toric multifocal intraocular lens. *Arq Bras Oftalmol.* 2014 Apr;77(2):71-75.
15. National Institute for Health and Clinical Excellence (NICE). Implantation of multifocal (nonaccommodative) intraocular lenses during cataract surgery (IPG264). June 2008. Accessed July 2017. Available at URL address: <https://www.nice.org.uk/guidance>
16. Nagpal R, Sharma N, Vasavada V, Maharana PK, Titiyal JS, et al. Toric intraocular lens versus monofocal intraocular lens implantation and photorefractive keratectomy: a randomized controlled trial. *Am J Ophthalmol.* 2015 Sep;160(3):479-486.e2.
17. Labiris G, Giarmoukakis A, Patsiamanidi M, Papadopoulos Z, Kozobolis VP. Mini-monovision versus multifocal intraocular lens implantation. *J Cataract Refract Surg.* 2014 Jun 21. pii: S0886-3350(14)00807-4.

**CLICK THE ENVELOPE ICON BELOW TO SUBMIT COMMENTS**

This medical policy is made available to you for informational purposes only. It is not a guarantee of payment or a substitute for your medical judgment in the treatment of your patients. Benefits and eligibility are determined by the member's subscriber agreement or member certificate and/or the employer agreement, and those documents will supersede the provisions of this medical policy. For information on member-specific benefits, call the provider call center. If you provide services to a member which are determined to not be medically necessary (or in some cases medically necessary services which are non-covered benefits), you may not charge the member for the services unless you have informed the member and they have agreed in writing in advance to continue with the treatment at their own expense. Please refer to your participation agreement(s) for the applicable provisions. This policy is current at the time of publication; however, medical practices, technology, and knowledge are constantly changing. BCBSRI reserves the right to review and revise this policy for any reason and at any time, with or without notice. Blue Cross & Blue Shield of Rhode Island is an independent licensee of the Blue Cross and Blue Shield Association.

