

Medical Coverage Policy | Intraocular Lens (IOL) Implants



EFFECTIVE DATE: 10|01|2004
POLICY LAST UPDATED: 11|03|2015

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 intraocular lenses following cataract surgery are not covered as there are no medical advantages of these over standard monofocal intraocular lenses.

However, members may request the insertion of Presbyopia-Correcting Intraocular Lenses or Astigmatism-Correcting Intraocular Lenses instead of a standard, or monofocal, IOL 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.

When a member does choose a presbyopia-correcting or astigmatism-correcting IOL over a standard IOL, it is the member's responsibility to submit for possible reimbursement up to the allowance for the standard 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

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.

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. 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.

Monofocal IOLs are the current standard of treatment. 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.

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. 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. Multifocal and accommodating IOLs are sometimes referred to as presbyopia-correcting IOLs.

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.

CODING

BlueCHiP for Medicare and Commercial Products

The following HCPCS code for a standard IOL is covered:

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 cataract extractions, 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, January 2016
Provider Update, January 2015
Provider Update, November 2013
Provider Update, June 2012
Provider Update, July 2011
Provider Update, June 2010
Provider Update, July 2009

REFERENCES

1. Centers for Medicare and Medicaid Services (CMS). National Coverage Determination (NCD) for Intraocular Lenses (IOLs) (80.12)
2. Alfonso JF, et al. Intermediate visual function with different multifocal intraocular lens models. J Cataract Refract Surg 2010 May;36(5):733-9.
3. Agresta B, 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 Jun;28(6):426-35.
4. Agresta B, et al. Visual acuity improvements after implantation of toric intraocular lenses in cataract patients with astigmatism: a systematic review. BMC Ophthalmol 2012 Aug 15;12:41.
5. Gooi P, et al. Review of presbyopia IOLs: multifocal and accommodating IOLs. Int Ophthalmol Clin 2012 Spring;52(2):41-50.
6. Tsaousis KT, et al. Binocularity enhances visual acuity of eyes implanted with multifocal intraocular lenses. J Refract Surg 2013 Apr;29(4):246-50.
7. Bellucci R. Multifocal intraocular lenses. Curr Opin Ophthalmol 2005 Feb;16(1):33-7.
8. Hutz WW, et al. Reading ability with 3 multifocal intraocular lens models. J Cataract Refract Surg 2006 Dec;32(12):2015-21.
9. Labiris G, et al. Mini-monovision versus multifocal intraocular lens implantation. J Cataract Refract Surg 2014 Jun 14
10. Ong HS, et al. Accommodative intraocular lens versus standard monofocal intraocular lens implantation in cataract surgery. Cochrane Database Syst Rev 2014 May 1;5:CD009667.

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