

Medical Coverage Policy | Intraocular Lens (IOL) Implants



EFFECTIVE DATE: 10|01|2004
POLICY LAST UPDATED: 09|05|2017

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 a standard, or 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, multifocal, or accommodating IOL. Members must agree to assume liability for the additional expense of the multifocal or accommodating lens. Reimbursement will be provided for only the cost of a standard or 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 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

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. 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 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.

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

CODING

BlueCHiP for Medicare and Commercial Products

The following HCPCS code for a standard IOL is covered:

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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 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, November 2017

Provider Update, September 2016

Provider Update, January 2016

Provider Update, January 2015

Provider Update, November 2013

Provider Update, June 2012

Provider Update, July 2011

Provider Update, June 2010

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