MEDICAL POLICY

MEDICAL POLICY DETAILS	
Medical Policy Title	**Intraocular Lens (IOL) Implants**
Policy Number	**9.01.14**
Category	**Contract Clarification**
Original Effective Date	**10/27/05**
Committee Approval Date	**08/31/06, 08/23/07, 08/28/08, 10/28/09, 10/28/10, 12/08/11, 10/25/12, 10/24/13, 10/23/14, 10/28/15, 10/27/16, 10/26/17, 10/25/18, 10/24/19, 10/22/20, 10/28/21, 10/20/22, 10/19/23, 10/17/24**
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Archived Date	**N/A**
Archive Review Date	**N/A**
Product Disclaimer	• *Services are contract dependent; if a product excludes coverage for a service, it is not covered, and medical policy criteria do not apply.* • *If a commercial product (including an Essential Plan or Child Health Plus product), medical policy criteria apply to the benefit.* • *If a Medicaid product covers a specific service, and there are no New York State Medicaid guidelines (eMedNY) criteria, medical policy criteria apply to the benefit.* • *If a Medicare product (including Medicare HMO-Dual Special Needs Program (DSNP) product) covers a specific service, and there is no national or local Medicare coverage decision for the service, medical policy criteria apply to the benefit.* • *If a Medicare HMO-Dual Special Needs Program (DSNP) product DOES NOT cover a specific service, please refer to the Medicaid Product coverage line.*

POLICY STATEMENT

I. Based upon our criteria and assessment of the peer-reviewed literature, the use of a monofocal (spherical or aspheric) intraocular lens (IOL) as replacement of the natural crystalline lens of the eye following cataract extraction is considered **medically appropriate**.

II. Based upon our criteria and assessment of the peer reviewed literature, the use of a multifocal IOL, an astigmatism-correcting lens, or an accommodating/trifocal IOL following cataract extraction is considered **not medically necessary**, as no superior medical benefit for these lenses has been demonstrated over the monofocal IOL, other than decreasing the need for corrective eye wear.

POLICY GUIDELINES

In a manner similar to the Centers for Medicare and Medicaid Services (CMS), patients/members may choose to receive an astigmatism-correcting, multifocal or accommodating IOL (*please refer to the CMS synopsis at the end of this policy*). Patients/members must sign a beneficiary notice waiver and 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. Patients/ members should be apprised of this option by their eye surgeon prior to the cataract extraction surgery.

DESCRIPTION

The eye functions much like a camera with two lenses. The first lens is the cornea, a clear membrane that covers the front of the eye. The second lens is the eye's natural crystalline lens, which is located behind the pupil. The cornea is responsible for about 70 percent of the eye's focusing power, while the natural lens "fine-tunes" the image before it is focused on the retina at the back of the eye. The natural lens accomplishes this fine-tuning function by changing shape to accommodate both near objects and those that are further away. Ciliary muscles and zonules are attached to the lens and are responsible for its ability to change shape. 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. Cataract surgery is indicated when the visual function no longer meets the patient's needs and 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.

IOLs are used to replace the natural lens and restore the optical focusing power of the eye. The more common replacement lenses include monofocal, multifocal or accommodating IOLs.

Monofocal IOLs are the current standard of treatment. This type of IOL usually has a fixed focusing power, which provides good distance vision and sometimes intermediate vision, but does not correct the patient's near vision, because 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 or trifocal 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 post-operative 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.

RATIONALE

A Cochrane review (2003, 2006) comparing multifocal to monofocal lenses post-cataract surgery, found no statistical difference between the use of these IOLs relative to best-corrected visual acuity, although unaided near vision was improved with the use of multifocal lenses. Review of the literature found no studies to support that the pseudo-accommodating or accommodating lens technology is superior to standard-use monofocal IOLs. The long-term stability of the accommodative effect of these lenses is unknown, and some patients may still require corrective lenses after the multifocal or accommodative lenses are placed. A 2012 update of the Cochrane review by D. Calladine and colleagues noted that there was moderate quality evidence that similar distance acuity is achieved with both types of lenses. There was also evidence that people with multifocal lenses had better near vision, but methodological and statistical heterogeneity meant that they did not calculate a pooled estimate for effect on near vision. Total freedom from use of glasses was achieved more frequently with multifocal than monofocal IOLs. Adverse subjective visual phenomena, particularly haloes, or rings around lights, were more prevalent and more troublesome in participants with the multifocal IOL, and there was evidence of reduced contrast sensitivity with the multifocal lenses. They concluded that multifocal IOLs are effective at improving near vision relative to monofocal IOLs. Whether that improvement outweighs the adverse effects of multifocal IOLs will vary between patients. Motivation to achieve spectacle independence is likely to be the deciding factor.

The American Academy of Ophthalmology 2022 preferred practice pattern (Miller et al.) regarding care for cataracts in the adult eye states the use of presbyopia correcting IOLs may improve a patient's quality of life by improving near and

intermediate vision and decreasing the need for corrective eyewear after cataract surgery, though patient selection is critical. Patients should be informed of the potential compromise in quality of vision associated with the various choices. These patients were found to have more glare, halos, and reduced contrast sensitivity than patient with monofocal IOLs (good, strong quality of evidence). Intraocular lens implantation is the method of choice for correcting aphakia, unless there are specific contraindications. Posterior chamber IOL implantation inside the capsular bag is the optimal method for most cases. Cataract surgeons can choose from a wide variety of posterior chamber IOL styles and materials to find an appropriate lens to match their patients' needs. Intraocular lens optic size, shape, haptic configuration, optic edge design, optic and haptic materials, and chromophore content are engineered with a variety of characteristics. Foldable IOLs are commonly used because of their ability to fit through small incisions, and they have largely replaced rigid polymethyl methacrylate (PMMA) posterior chamber IOLs. Foldable IOLs can be made from silicone, hydrophilic acrylic, and hydrophobic acrylic. All foldable IOL materials are associated with minimal giant-cell foreign-body reaction. Surgeons should be familiar with the unique positive and negative features of each IOL type with regard to material, design, and insertion system.

CODES

- *Eligibility for reimbursement is based upon the benefits set forth in the member's subscriber contract.*
- *CODES MAY NOT BE COVERED UNDER ALL CIRCUMSTANCES. PLEASE READ THE POLICY AND GUIDELINES STATEMENTS CAREFULLY.*
- *Codes may not be all inclusive as the AMA and CMS code updates may occur more frequently than policy updates.*
- *Code Key: Experimental/Investigational = (E/I), Not medically necessary/ appropriate = (NMN).*

CPT Codes

Code	Description
66982	Extracapsular cataract removal with insertion of intraocular lens prosthesis (one-stage procedure), manual or mechanical technique (e.g., irrigation and aspiration or phacoemulsification), complex, requiring devices or techniques not generally used in routine cataract surgery (e.g., iris expansion device, suture support for intraocular lens, or primary posterior capsulorrhexis) or performed on patients in the amblyogenic developmental stage; without endoscopic cyclophotocoagulation
66983	Intracapsular cataract extraction with insertion of intraocular lens prosthesis (one-stage procedure)
66984	Extracapsular cataract removal with insertion of intraocular lens prosthesis (one-stage procedure), manual or mechanical technique (e.g., irrigation and aspiration or phacoemulsification); without endoscopic cyclophotocoagulation
66985	Insertion of intraocular lens prosthesis (secondary implant), not associated with concurrent cataract removal
66986	Exchange of intraocular lens
66987	Extracapsular cataract removal with insertion of intraocular lens prosthesis (one-stage procedure), manual or mechanical technique (e.g., irrigation and aspiration or phacoemulsification), complex, requiring devices or techniques not generally used in routine cataract surgery (e.g., iris expansion device, suture support for intraocular lens, or primary posterior capsulorrhexis) or performed on patients in the amblyogenic developmental stage; with endoscopic cyclophotocoagulation
66988	Extracapsular cataract removal with insertion of intraocular lens prosthesis (one-stage procedure), manual or mechanical technique (e.g., irrigation and aspiration or phacoemulsification); with endoscopic cyclophotocoagulation

Code	Description
66989	Extracapsular cataract removal with insertion of intraocular lens prosthesis (one-stage procedure), manual or mechanical technique (e.g., irrigation and aspiration or phacoemulsification), complex, requiring devices or techniques not generally used in routine cataract surgery (e.g., iris expansion device, suture support for intraocular lens, or primary posterior capsulorrhexis) or performed on patients in the amblyogenic developmental stage; with insertion of intraocular (e.g., trabecular meshwork, supraciliary, suprachoroidal) anterior segment aqueous drainage device, without extraocular reservoir, internal approach, one or more
66991	Extracapsular cataract removal with insertion of intraocular lens prosthesis (one-stage procedure), manual or mechanical technique (e.g., irrigation and aspiration or phacoemulsification); with insertion of intraocular (ego, trabecular meshwork, supraciliary, suprachoroidal) anterior segment aqueous drainage device, without extraocular reservoir, internal approach, one or more

HCPCS Codes

Code	Description
C1780	Lens, intraocular (new technology)
V2630	Anterior chamber intraocular lens
V2631	Iris supported intraocular lens
V2632	Posterior chamber intraocular lens
V2787 **(NMN)**	Astigmatism correcting function of intraocular lens
V2788 **(NMN)**	Presbyopia correcting function of intraocular lens

ICD10 Codes

Code	Description
E08.36	Diabetes mellitus due to underlying condition with diabetic cataract
E09.36	Drug or chemical induced diabetes mellitus with diabetic cataract
E10.36	Type 1 diabetes mellitus with diabetic cataract
E11.36	Type 2 diabetes mellitus with diabetic cataract
E13.36	Other specified diabetes mellitus with diabetic cataract
H25.011-H25.9	Age-related cataract (code range)
H26.001-H26.09	Infantile and juvenile cataract (code range)
H26.101-H26.139	Traumatic cataract (code range)
H26.20	Unspecified complicated cataract
H26.211-H26.219	Cataract with neovascularization (code range)
H26.221-H26.229	Cataract secondary to ocular disorders (degenerative) (inflammatory), (code range)
H26.231-H26.239	Glaucomatous flecks (subcapsular), (code range)
H26.30-H26.33	Drug-induced cataract (code range)
H26.40	Unspecified secondary cataract
H26.411-H26.419	Soemmerring's ring (code range)
H26.491-H26.499	Other secondary cataract (code range)
H26.8	Other specified cataract
H26.9	Unspecified cataract
H28	Cataract in diseases classified elsewhere
Z96.1	Presence of intraocular lens

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*Key Article

KEY WORDS

Accommodating, Aspheric, Astigmatism-correcting, Crystalens, dynamic, Monofocal, Multifocal, pseudoaccommodating, toric.

CMS COVERAGE FOR MEDICARE PRODUCT MEMBERS

There is currently a National Coverage Determination (NCD) for Intraocular Lenses (IOLs) (80.12). Please refer to the following NCD website for Medicare Members:

[http://www.cms.gov/medicare-coverage-database/details/ncd-details.aspx?NCDId=239&ncdver=1&CoverageSelection=Both&ArticleType=All&PolicyType=Final&s=New+York+-+Upstate&CptHcpcsCode=36514&bc=gAAAABAAAAAA&] accessed 09/17/24.