MEDICAL POLICY

Medical Policy Title	**Intraocular Lens (IOL) Implants**
Policy Number	**9.01.14**
Current Effective Date	**October 22, 2026**
Next Review Date	**October 2027**

Our medical policies are guides to evaluate technologies or services for medical necessity. Criteria are established through the assessment of evidence based, peer-reviewed scientific literature, and national professional guidelines. Federal and state law(s), regulatory mandates and the member's subscriber contract language are considered first in the determination of a covered service.
(Link to Product Disclaimer)

POLICY STATEMENT(S)

I. The use of a monofocal (spherical or aspheric) intraocular lens (IOL) is considered **medically appropriate** to replace the natural crystalline lens of the eye following cataract extraction.

II. The following are 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:

   A. Multifocal IOL;

   B. Astigmatism-correcting lens (Toric monofocal IOL);

   C. Accommodating/trifocal IOL.

RELATED POLICIES

Not Applicable

POLICY GUIDELINE(S)

I. Individuals may choose to receive an astigmatism-correcting (toric), multifocal or accommodating IOL. Reimbursement will be provided for only the cost of a standard or monofocal IOL.

II. Individuals must sign a beneficiary notice waiver and agree to assume liability for the additional expense of the multifocal or accommodating lens. Individuals 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 individual'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 individuals 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 individuals 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 individuals 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.

SUPPORTIVE LITERATURE

A Cochrane review (Leyland 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 individuals may still require corrective lenses after the multifocal or accommodative lenses are placed.

A 2012 update of the Cochrane review by 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 individuals. Motivation to achieve spectacle independence is likely to be the deciding factor.

de Silva et al (2016) updated the Cochrane review of multifocal versus monofocal IOL after cataract extraction. Their analysis included 20 trials that included data on 2,061 individuals (3,194 eyes). These trials were conducted in Europe (13), China (three), USA (one), Middle East (one), India (one) and one multicenter study in Europe and the USA. Most of these trials compared multifocal with monofocal lenses; two trials compared multifocal lenses with monovision. There was considerable variety in the make and model of lenses implanted. There was moderate-certainty evidence that the distance acuity achieved with multifocal lenses was not different to that achieved with monofocal lenses (eyes = 682; studies = 8). Individuals receiving multifocal lenses may achieve better near vision (eyes = 782; studies = 8). The authors noted this to be low-certainty evidence because of risk of bias in the included studies and high heterogeneity. Individuals receiving multifocal lenses may be less spectacle dependent (eyes = 1000; studies = 10). The authors again noted this to be low-certainty evidence because of risk of bias and evidence of publication bias. Adverse subjective visual phenomena were more prevalent and more troublesome in participants with a multifocal IOL compared with monofocals (glare, eyes = 544; studies = 7, low-certainty evidence and haloes, eyes = 662; studies = 7; moderate-certainty evidence). In one study, the investigators noted that more people in the multifocal group underwent IOL exchange in the first year after surgery (6 participants with multifocal vs 0 participants with monovision). The authors concluded multifocal IOLs are effective at improving near vision relative to monofocal IOLs although there is uncertainty as to the size of the effect. Whether that improvement outweighs the adverse effects of multifocal IOLs, such as glare and haloes, will vary between people. Motivation to achieve spectacle independence is likely to be the deciding factor.

PROFESSIONAL GUIDELINE(S)

The American Academy of Ophthalmology (AAO) 2022 preferred practice pattern (Miller 2022) 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 patients 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.

An AAO technology assessment regarding toric monofocal IOL for the correction of astigmatism during cataract surgery (Al-Mohtaseb 2024) states "toric monofocal IOLs are effective in neutralizing pre-existing corneal astigmatism at the time of cataract surgery and result in better uncorrected distance visual acuity (UCDVA) and significant reductions in postoperative refractive astigmatism compared with nontoric monofocal IOLs. Toric IOLs result in better astigmatic correction than corneal relaxing incisions (CRIs), particularly at high magnitudes of astigmatism".

An AAO technology Assessment regarding multifocal and accommodating intraocular lenses for the treatment of presbyopia (Schallhorn 2021) states "presbyopia-correcting lenses improve uncorrected near and distance visual acuity and decrease spectacle dependence after cataract surgery. Mesopic contrast sensitivity is decreased compared with monofocal lenses, and patient-reported visual phenomena are more likely in patients receiving multifocal or EDOF lenses".

REGULATORY STATUS

The United States Food and Drug Administration (FDA) regulates intraocular lenses as medical devices. All intraocular lenses including related components require FDA approval before marketing and use in the United States to ensure they are safe and effective for human use. Refer to the FDA Medical Device website. Available from: https://www.fda.gov/medical-devices [accessed 2026 Sep 26]

CODE(S)

- Codes may not be covered under all circumstances.
- Code list may not be all inclusive (AMA and CMS code updates may occur more frequently than policy updates).
- (E/I)=Experimental/Investigational
- (NMN)=Not medically necessary/appropriate

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
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

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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

Code	Description
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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SEARCH TERMS

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

CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS)

Intraocular Lenses (IOLs) (NCD 80.12) [accessed 2026 Sep 25]

PRODUCT DISCLAIMER

- Services are contract dependent; if a product does not cover a service, medical policy criteria do not apply.
- If a commercial product (including an Essential Plan or Child Health Plus product) covers a specific service, 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 HISTORY/REVISION

Committee Approval Dates

10/27/05, 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, 10/16/25, 10/22/26

Date	Summary of Changes

10/22/26	• Annual review, policy intent unchanged.
10/16/25	• Annual review, policy intent unchanged.
01/01/25	• Summary of changes tracking implemented.
10/27/05	• Original effective date