PREMERA | BLUE CROSS

An Independent Licensee of the Blue Cross Blue Shield Association

MEDICAL POLICY – 9.03.511

Presbyopia Correcting Intraocular Lenses (PIOLs) and Astigmatism Correcting Intraocular Lenses (ACIOLs)

Ref. Policy: MP-009

Effective Date:	Apr. 1, 2025	RELATED MEDICAL POLICIES:
Last Revised:	Mar. 24, 2025	None
Replaces:	N/A	

Select a hyperlink below to be directed to that section.

POLICY CRITERIA | CODING | RELATED INFORMATION
EVIDENCE REVIEW | REFERENCES | HISTORY

Clicking this icon returns you to the hyperlinks menu above.

Introduction

Cataracts occur when the eye's natural lenses become clouded, causing blurry vision and blindness. When cataracts need to be treated with surgery, the natural lens of the eye is replaced with an artificial lens. Presbyopia-correcting intraocular lenses (PIOLs) are artificial lenses that provide near, middle, and distance vision without the need for glasses or contacts after cataract surgery. Astigmatism correcting intraocular lenses (ACIOLs) are artificial lenses that provide the same vision benefits as PIOLs and also correct the irregular curve of the eye's front surface (astigmatism). This policy describes when presbyopia correcting intraocular lenses (PIOLs) and astigmatism correcting intraocular lenses (ACIOLs) may be considered medically necessary.

Note: The Introduction section is for your general knowledge and is not to be taken as policy coverage criteria. The rest of the policy uses specific words and concepts familiar to medical professionals. It is intended for providers. A provider can be a person, such as a doctor, nurse, psychologist, or dentist. A provider also can be a place where medical care is given, like a hospital, clinic, or lab. This policy informs them about when a service may be covered.

Policy Coverage Criteria

Service	Medical Necessity

Presbyopia correcting intraocular lenses (PIOLs) and astigmatism correcting intraocular lenses (ACIOLs)	**Presbyopia correcting intraocular lenses (PIOLs) and astigmatism correcting intraocular lenses (ACIOLs) may be considered medically necessary for the following indications:**
	• Conventional intraocular lenses (IOLs) during cataract surgery:
	  ○ If the individual requests ACIOLs or PIOLs, the Plan will pay the portion of the lens cost equal to the cost of IOLs.
	  ○ The additional costs of the specialty lenses will be the responsibility of the individual. The Plan will pay for insertion of the lenses.
	• The physician charges (for office procedures) will also be paid as the same level as the conventional IOLs.
	
	Note: See Related Information below for **Limitations**

Coding

Code	Description
CPT	
66982	Extracapsular cataract removal with insertion of intraocular lens prosthesis (1-stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification), complex, requiring devices or techniques not generally used in routine cataract surgery (eg, 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 (1 stage procedure)
66984	Extracapsular cataract removal with insertion of intraocular lens prosthesis (1 stage procedure), manual or mechanical technique (eg, irrigation and aspiration or phacoemulsification); without endoscopic cyclophotocoagulation
HCPCS Codes Covered if Selection Criteria are Met (If Appropriate):	
V2630	Anterior chamber intraocular lens
V2631	Iris supported intraocular lens

Code	Description
V2632	Posterior chamber intraocular lens
Applicable Coding for PIOL and A-CIOL Additional Costs are Not Covered:	
HCPCS Codes Covered at Cost of Regular IOL:	
V2787	Astigmatism correcting function of intraocular lens
V2788	Presbyopia correcting function of intraocular lens

Note: CPT codes, descriptions and materials are copyrighted by the American Medical Association (AMA). HCPCS codes, descriptions and materials are copyrighted by Centers for Medicare Services (CMS).

Related Information

Limitations

The additional cost of PIOLs and ACIOLs, when in excess of the cost of IOLs, is not covered and the individual assumes responsibility for the additional expenses.

Evidence Review

Background

The Centers for Medicare and Medicaid Services (CMS) announced the intent to provide beneficiaries with the choice to receive PIOLs when they have cataract surgery. In addition, in January 2007, CMS ruled that individuals with astigmatism can receive ACIOLs during cataract surgery.

The following non-inclusive list of manufacturers are recognized by CMS as resources for PIOLs:

- Cyrstalens by Eyeonics, Inc.
- AcrySof RESTOR by Alcon, Inc.
- ReZoom by Advanced Medical Optics Inc.

ACIOLs:

- Acrysof Toric IOL (models SN60TS, SN60T4 and SN60T5) manufactured by Alcon Labs, Inc.
- Silicon 2P Toric IOL (models AA4203TF and AA4203TL) manufactured by STARR Surgical

References

1. Miller KM, Oetting TA, Tweeten JP, Carter K, Lee BS, Lin S, Nanji AA, Shorstein NH, Musch DC; American Academy of Ophthalmology Preferred Practice Pattern Cataract/Anterior Segment Panel. Cataract in the Adult Eye Preferred Practice Pattern. Ophthalmology. 2022 Jan;129(1):P1-P126. doi: 10.1016/j.ophtha.2021.10.006.

History

Date	Comments
09/16/19	New policy, approved August 13, 2019, effective January 1, 2020. Presbyopia correcting intraocular lenses (PIOLs) and astigmatism correcting intraocular lenses (ACIOLs) may be considered medically necessary post-cataract surgery when criteria are met. Any additional cost above that of standard intraocular lenses (IOLs) is the responsibility of the patient.
08/01/20	Annual Review, approved July 2, 2020. No changes to policy statement.
08/01/21	Annual Review, approved July 9, 2021. No changes to policy statement, references updated.
05/01/22	Annual Review, approved April 25, 2022. No changes to policy statement, references updated.
10/01/22	Interim Review, approved September 12, 2022. References updated; no other changes made to the policy.
04/01/23	Annual Review, approved March 20, 2023. No changes to policy statement, references updated.
04/01/24	Annual Review, approved March 25, 2024. No changes to policy statement, references updated.
04/01/25	Annual Review, approved March 24, 2025. No changes to policy statement, references updated.

Disclaimer: This medical policy is a guide in evaluating the medical necessity of a particular service or treatment. The Company adopts policies after careful review of published peer-reviewed scientific literature, national guidelines and local standards of practice. Since medical technology is constantly changing, the Company reserves the right to review and update policies as appropriate. Member contracts differ in their benefits. Always consult the member benefit booklet or contact a member service representative to determine coverage for a specific medical service or supply.

Scope: Medical policies are systematically developed guidelines that serve as a resource for Company staff when determining coverage for specific medical procedures, drugs or devices. Coverage for medical services is subject to the limits and conditions of the member benefit plan. Members and their providers should consult the member benefit booklet or contact a customer service representative to determine whether there are any benefit limitations applicable to this service or supply. This medical policy only applies to Individual Plans.