

# Clinical Policy: Intraocular Lens Implants

Reference Number: OC.UM.CP.0082

Last Review Date: 12/2021

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## Description

This policy describes the medical necessity requirements for intraocular lens (IOL) implants.

## Policy/Criteria

- I. It is the policy of health plans affiliated with Envolve Vision, Inc.<sup>®</sup> (Envolve) that IOL implants are **medically necessary** for the following indications:
  - A. Following removal of an intraocular lens that meets medical necessity criteria for cataract surgery. *See clinical policy OC.UM.CP.0008 Cataract Extraction, and OC.UM.CP.0012 Complex Cataract Extraction.*

## Background

IOL implants designed to correct presbyopia (PC-IOL), HCPCS code V2788, are considered elective services. These implants are elective and therefore not covered. Additionally, charges for V2788 are not included in the payment for the facility charges for medically indicated cataract extractions. The member may be held responsible for charges exceeding the amount of a conventional IOL when the member requests this service and the member is informed in advance that this service is not covered. It is recommended that the provider obtain a signed waiver from the member prior to performing the procedure.

For contracts which cover payment of facility charges and a medically indicated cataract extraction is performed in a facility, Envolve does not make separate payment to the hospital or ambulatory surgical center (ASC) for the conventional IOL implanted subsequent to the cataract extraction.

## Coding Implications

This clinical policy references Current Procedural Terminology (CPT<sup>®</sup>). CPT<sup>®</sup> is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2018, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

HCPCS Codes	Description
V2630 <sup>1</sup>	Anterior chamber intraocular lens

<sup>1</sup> Payment for the conventional IOL is included in the payment for the facility charges for the cataract extraction procedure and should not be separately billed.

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HCP Codes	Description
V2631 <sup>1</sup>	Iris supported intraocular lens
V2632 <sup>1</sup>	Posterior chamber intraocular lens

Reviews, Revisions, and Approvals	Date	Approval Date
Annual review	12/2019	12/2019
Converted to new template	09/2020	10/2020
Annual Review	12/2020	12/2020
Annual Review; Updated References	12/2021	12/2021

#### References

1. OC.UM.CP.0008 Cataract Extraction
2. OC.UM.CP.0012 Complex Cataract Extraction
3. Medicare Learning Network; American Medical Association (August 2021). Medicare Vision Services. Department of Health and Human Services, Centers for Medicare and Medicaid Services. Retrieved from [https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/visionservices\\_factsheet\\_icn907165.pdf](https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/visionservices_factsheet_icn907165.pdf)

#### **Important Reminder**

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Envolve Vision, Inc., or any of such health plan’s affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the

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effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

**Note: For Medicaid members,** when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

**Note: For Medicare members,** to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at <http://www.cms.gov> for additional information.

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