Reimbursement Policy

Intraocular Lenses (IOLs)

REIMBURSEMENT POLICY NUMBER: 17

Effective Date: 7/1/2025

Last Review Date: 4/2025

Next Annual Review: 4/2026

INSTRUCTIONS FOR USE: Company reimbursement policies serve as guidance for the administration of plan benefits. Reimbursement policies do not constitute medical advice nor a guarantee of coverage. Company reimbursement policies are reviewed annually. The Companies reserve the right to determine the application of reimbursement policies and make revisions to reimbursement policies at any time. The scope and availability of all plan benefits are determined in accordance with the applicable coverage agreement. Any conflict or variance between the terms of the coverage agreement and Company Reimbursement Policy will be resolved in favor of the coverage agreement.

SCOPE AND APPLICATION

Provider Type:

☒ Professional Claims

☒ Facilities (Excluding Ambulatory Surgical Centers)

Plan Product:

☒ Commercial

☒ Medicare

☐ Medicaid/Oregon Health Plan (OHP)

POLICY STATEMENT

NOTE: Member benefit language applies and may vary, and provider contract language/payment methodology may also vary. IOLs and ambulatory surgical centers (ASCs) are addressed in a separate reimbursement policy specific to ASC payment structure.

SCOPE: Providence Health Plan, Providence Health Assurance, and Providence Plan Partners as applicable (referred to individually as "Company" and collectively as "Companies").

General

I. Plan members may be eligible for **conventional (standard)** intraocular lens implants (HCPCS V2630-V2632) following cataract surgery, as well as intraocular lens implant revision or replacement using conventional IOLs (when necessary). Coverage and reimbursement are subject to member plan limits.

II. The Plan will not cover **presbyopia correcting IOLs** (PC IOLs; V2788) or **astigmatism correcting IOLs** (AC IOLs; V2787) or **any other IOL that alters the refractive character of the eye** for initial implantation or replacement because these are **not a covered benefit** under most benefit plans.

A. Plan members may voluntarily select these specialty lenses, but they would be responsible for the difference in costs above the standard allowable rate and the PC-IOL/AC-IOL cost. *(See "Benefit Exclusions" below for more information)*

***Note**: Neither the physician nor the facility is allowed to require the member receive a PC-IOL or AC-IOL as a condition of performing a cataract extraction procedure with IOL insertion. Members **must** be notified of all charges that would result from the use of a PC-IOL or AC-IOL, and consent to these additional charges **prior to** the procedure being performed.*

BILLING

The Plan follows Centers for Medicare and Medicaid Services (CMS) instruction for the billing of IOLs.

III. Facility claims:

A. While a HCPCS code for an IOL may be included on a claim, a conventional IOL (V2630-V2632) is **not separately reimbursable** for both a hospital facility and an ambulatory surgical center (ASC) because payment for the conventional IOL is included (packaged) into the payment for the surgical cataract extraction/lens replacement procedure. *(Premium IOLs [V2787/V2788] may also be submitted separately, and will deny as member liability for benefit plans with the applicable exclusion.)*

B. For more information regarding IOLs and ASCs, see the separate reimbursement policy for ASC Payment Structure in Cross References below.

IV. Physician claims:

A. **Facility setting (e.g., inpatient hospital, outpatient hospital, ASC, etc.):** Physicians may bill **only** for professional services for the cataract removal procedure. In accordance with Medicare guidelines, physicians may **not** bill for the IOL (V-code), regardless of the type of IOL provided (conventional or premium). Physicians are also not permitted to supply the IOL on behalf of the ASC and bill for it.

B. **Physician office setting:** Physicians may bill for the IOL.

POLICY GUIDELINES

BACKGROUND

This policy is primarily based on the Center for Medicare and Medicaid Services (CMS) resources, in conjunction with Plan member Evidence of Coverage (EOC) and Benefit Handbook language.

Cataract Surgery and Conventional Intraocular Lens (IOL)

"Cataract is defined as an opacity or loss of optical clarity of the crystalline lens. Cataract development follows a continuum extending from minimal changes in the crystalline lens to the extreme stage of total opacity. Cataracts may be due to a variety of causes. Age-related cataract (senile cataract) is the most common type found in adults. Other types are pediatric (both congenital and acquired), traumatic, toxic and secondary (meaning the result of another disease process) cataract."[1] In other words, a cataract is when the eye's lens – which is supposed to be clear – becomes cloudy.

Medicare specifically excludes certain items and services from coverage, including eyeglasses and contact lenses. However, a coverage exception has been provided for the insertion of an intraocular lens (IOL) following cataract surgery. IOLs are eligible for coverage, classified as a "prosthetic device,"[2] because they replace the natural lens after cataract surgery.

According to the *Medicare Benefit Policy Manual Chapter 16 - General Exclusions From Coverage, 90 - Routine Services and Appliances*:

> "…eyeglasses, contact lenses, and eye examinations for the purpose of prescribing, fitting, or changing eyeglasses; eye refractions by whatever practitioner and for whatever purpose performed… are not covered.
>
> "… **The exclusions do not apply to** physicians' services (and services incident to a physicians' service) performed in conjunction with an eye disease, as for example, glaucoma or cataracts, or to **post-surgical prosthetic lenses which are customarily used during convalescence from eye surgery in which the lens of the eye was removed**, or to permanent prosthetic lenses required by an individual lacking the organic lens of the eye, whether by surgical removal or congenital disease. **Such prosthetic lens is a replacement for an internal body organ - the lens of the eye.**"[3]

As a prosthetic device, Medicare regulations regarding the provision of upgraded or deluxe items applies, and premium IOLs are considered upgrades or deluxe items. If the patient wishes to obtain an item with deluxe features, any allowance or payment made would be based on the payment amount for the standard item.[4]

Premium IOLs

The term "premium IOLs" includes, but is not limited to, presbyopia-correcting IOLs (P-C IOL) and astigmatism-correcting IOLs (A-C IOL).

Presbyopia-Correcting IOLs (P-C IOL) and Astigmatism-Correcting IOLs (A-C IOL)

Presbyopia is a type of refractive error. It is typically an age-associated progressive loss of the focusing power of the lens of the eye resulting in difficulty seeing objects at near distance, or close-up. It occurs as the natural lens of the eye becomes thicker and less flexible with age. A presbyopia-correcting IOL is intended to provide near, intermediate, and distance vision without, in many patients, the need for eyeglasses or contact lenses. A single presbyopia-correcting IOL essentially provides what is otherwise achieved by two separate items: an implantable conventional IOL (one that is not presbyopia-correcting), and eyeglasses or contact lenses.[5]

Regular astigmatism is a condition where part of an image is blurred due to uneven corneal curvature. A normal cornea has the same curvature at all axes, whereas the curvature of a regular astigmatic cornea differs in two primary axes, resulting in vision that is distorted at all distances. An astigmatism-correcting IOL may improve vision, especially distance vision, so much that no other vision enhancing intervention or support is required to provide adequate vision at certain distances. In some cases, a single IOL that also corrects pre-existing astigmatism may provide what is otherwise achieved by two separate items: the implantable conventional IOL that is covered by Medicare and the surgical correction, eyeglasses, or contact lenses.[6]

CMS publishes a list of products classified as either a PC IOL, AC IOL, or both, on the CMS website for ***CMS Recognized Presbyopia-Correcting (PC) IOLs and Astigmatism-Correcting (AC) IOLs***.[7]

IOLs are listed alphabetically by manufacturer. This list may not be all-inclusive of all IOLs. Inclusion on this list does not mean Medicare allows these IOLs, but rather, it is a list of IOLs considered to be PC-IOLs or AC-IOLs, and thus, excluded from coverage.

Benefit Exclusions

Refractive errors are a condition affecting vision, making it hard to see clearly. Four (4) common types of refractive errors are[8]:

- Nearsightedness (myopia) makes far-away objects look blurry (occurs when eyeball is too long)[8]
- Farsightedness (hyperopia) makes nearby objects look blurry[8]
- Astigmatism can make objects look blurry or distorted from all distances (caused by an irregularly shaped cornea[8]
- Presbyopia makes it hard for middle-aged and older adults to see things up close (age related condition of the lens)[8]

Refractive errors can be caused by a variety of factors, such as problems with the shape of the cornea or the natural aging process the lens. These types of vision conditions can generally be resolved with glasses or contact lenses, but some individuals may opt for resolution of vision problems using refractive surgery (e.g., LASIK, radial keratotomy, refractive keratoplasty, etc.). **Most PHP Plan Benefits directly exclude coverage of "surgical procedures which alter the refractive character of the eye," such as** (not an all-inclusive list of procedures) **laser eye surgery (LASIK), radial keratotomy, and other surgical procedures to treat or reduce refractive errors.** This also includes the use of presbyopia-correcting or

astigmatism-correcting IOLs, which are surgically implanted. These premium IOLs provide surgical refractive error correction, and refractive surgery is generally a direct benefit exclusion. Table 1 details what services may be eligible for coverage under most plans, but benefits may vary.

Members must be made aware of and acknowledge out-of-pocket costs associated with non-covered items and services prior to the cataract extraction procedure with IOL insertion being rendered.

Table 1:
Note: This is a representation of most plan benefits, but may not represent all plan benefits. We recommend checking specific plan benefits to verify.

Plan Benefit Summary	
Eligible Services as a Covered Benefit	**Non-Covered Benefits/Benefit Exclusions**
A conventional intraocular lens (IOL)	The presbyopia-correcting or astigmatism-correcting functionality of an IOL
Facility or physician services and supplies required to insert a conventional IOL.	Facility or physician services and resources required to insert and adjust a presbyopia-correcting IOL following cataract surgery that exceed the services and resources furnished for insertion of a conventional IOL.
	Facility or physician charges for additional work and resources required for insertion, fitting, and vision acuity testing, and monitoring of a PC-IOL or AC-IOL that exceed the charges for resources furnished for a conventional IOL.

CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS)

As of 2/28/2025, the following Centers for Medicare & Medicaid (CMS) guidance was identified which addresses inpatient hospital readmissions:

- 2005 CMS Rulings, No. CMS-05-01
- 2007 CMS Rulings, No. CMS-1536-R
- Medicare Claims Processing Manual, Ch. 20, §90
- Noridian Local Coverage Determination (LCD) for *Cataract Surgery in Adults* (L37027)
- Medicare National Coverage Determination (NCD) for *Intraocular Lenses (IOLs)* (80.12)
- Medicare Benefit Policy Manual, Ch. 16, §90
- CMS Recognized Presbyopia-Correcting (PC) IOLs and Astigmatism-Correcting (AC) IOLs
- CMS Pub 100-04, Transmittal 1430, CR5853
- Medicare Vision Services. MLN907165
- CMS Pub 100-04, Transmittal 1228, CR 5527
- Medlearn Matters Number: MM3927
- Medicare Claims Processing Manual, Ch. 32, §120
- Medicare Claims Processing Manual, Ch. 4, §240.3

The above criteria and reimbursement methodologies are consistent with the CMS guidance, as well as with member benefit language and exclusions.

BILLING AND CODING GUIDELINES

CLINICAL PRACTICE GUIDELINES

The American Society of Cataract and Refractive Surgery (ASCRS) and American Society of Ophthalmic Administrators (ASOA) (Stodola, 2013) stated that "According to the ASCRS/ASOA policy, the allowable Medicare reimbursement for cataract surgery does not change according to the surgical methods used. …The only way a patient can be billed extra is if he or she is receiving an additional service, such as a premium refractive IOL, and in this case, a doctor must first discuss the extra out-of-pocket costs with the patient and gain consent in advance."

This same requirement applies to all lines of business, to ensure plan members are aware of <u>all</u> potential financial obligations and to eliminate unexpected financial impact.

IOL HCPCS CODES

For most Plan members, only conventional IOLs are eligible for coverage.

V2630 *Anterior chamber intraocular lens*
V2631 *Iris supported intraocular lens*
V2632 *Posterior chamber intraocular lens*

Other types of IOLs are not eligible for coverage. These IOLs are considered to be an "upgrade" item. They also fall under member benefit exclusions for eye refraction procedures.

V2787 *Astigmatism correcting function of intraocular lens*
V2788 *Presbyopia correcting function of intraocular lens*

HCPCS codes V2787 and V2788 represent the astigmatism- or presbyopia-correcting **<u>function</u>** of the IOL. Therefore, the billed charges for either HCPCS code V2787 or V2788 should represent **<u>only</u>** the costs of the PC-IOL or AC-IOL that exceed the cost of a conventional IOL. That is, they would represent only the ***<u>difference in cost</u>*** between the conventional IOL and the astigmatism- or presbyopia-correcting IOL provided.

The billed charges for these codes should **<u>not</u>** represent the entire cost of the IOL provided.

IOL BILLING

To ensure accurate member cost-sharing, providers will need to submit claims accurately. The plan follows CMS billing rules for claim submission of IOLs. If payment is made inadvertently, recovery efforts may be made to recoup the erroneous payment.

Professional Claims

Facility Place of Service (POS)

Implant items and supplies are an overhead expense for the facility in which an IOL is provided during a surgical procedure. Therefore, professional claims for a surgical procedure (e.g., cataract surgery) should **not** include charges for any IOL, regardless of the type of IOL provided (conventional or premium) if the procedure was performed in any facility setting (e.g., place of service [POS] codes 21, 22, 24, etc.).

According to Medicare, "Any person or ASC, who presents or causes to be presented a bill or request for payment for an IOL inserted during or subsequent to cataract surgery for which payment is made under the ASC fee schedule, is subject to a civil money penalty."[9] Therefore, in accordance with Medicare guidelines, when the cataract surgery and IOL insertion are rendered **in a facility POS**, the surgeon must **not** bill or receive reimbursement for the IOL (V-code).

Physician Office Place of Service (POS)

If the surgical procedure for the IOL insertion is rendered in an office setting (e.g., POS 11) may the physician include charges for the IOL provided on their professional claim. Payment for a conventional IOL furnished in a physician's office is not bundled with the procedure to insert the IOL following cataract surgery. The IOL device and insertion procedure are two separate charges, and may be reported separately.[5,6]

Facility Claims

In accordance with CMS guidelines, no additional reimbursement is provided to hospitals, surgery centers and facilities for an IOL.

> "The payment for insertion of a conventional IOL furnished in a hospital outpatient department or in a Medicare-approved ambulatory surgical center is packaged or bundled into the payment for the surgical procedure performed to remove a cataractous lens. A beneficiary may request insertion of a presbyopia-correcting IOL in place of a conventional IOL following cataract surgery. In this case, the facility charge for insertion of the presbyopia-correcting IOL is considered partially covered. The beneficiary is responsible for payment of that portion of the facility charge that exceeds the facility charge for insertion of a conventional IOL following cataract surgery. In addition, the beneficiary is responsible for the payment of facility charges for resources required for fitting and vision acuity testing of a presbyopia-correcting IOL that exceeds the facility charges for resources furnished for a conventional IOL following cataract surgery."[5,6]
>
> "Under 42 CFR 419.2(b)(11), implantable prosthetic devices… which replace all or part of an internal body organ…, including replacement of these devices,… are therefore packaged with the surgical implantation procedure unless the device has pass-through payment status."[10]

Reimbursement methodologies for ambulatory surgical centers is addressed in a separate reimbursement policy for ASC Payment Structure.

Table 2 below is a quick billing guide.

Table 2:

Note: Codes for IOLs are reported **in addition to** the code for the cataract removal procedure.

IOL Billing Guide			
IOL Type	**Place of Service (POS)**	**Surgeon Claim**	**Facility (ASC/Hospital) Claim**
Conventional IOL	Office	Code for conventional IOL (V2630, V2631, or V2632)	N/A
	Facility (hospital or ASC)	Physician claim should **not** contain ANY charges for an IOL at all.	Separate payment is **not** made to a hospital or ASC for an IOL inserted during cataract surgery because payment for the IOL is packaged into the payment for the surgical cataract extraction/lens replacement procedure. However, a code for the IOL may be included for informational purposes.
PC-IOL and AC-IOL	Office	Code for both: • **Conventional** IOL V-code; **and** • **Premium** IOL (V2787 or V2788), as appropriate. ○ *Billed charges for V2787 or V2788 should represent **only** the costs of the PC-IOL or AC-IOL that **exceed** the cost of a conventional IOL.* V2787 and V2788 represent a "function," not an entire IOL. Physician charges for services and supplies required to insert and adjust a P-C or A-C IOL following removal of a cataract that exceed the physician charges for services and supplies required for the insertion of a conventional IOL are not covered, but may be billed separately.	N/A

	Facility (hospital or ASC)	Physician claim should **not** contain ANY charges for an IOL when performed **in a facility setting** because payment for the lens is included in the payment made to the facility for the surgical procedure.	Conventional IOL same facility note as above. For the premium IOLs (V2787 and V2788), billed charges should represent **only** the additional non-covered costs for the PC/AC-IOL functionality of the IOL provided. In addition, facility charges for additional resources required for insertion, fitting, and vision acuity testing, and monitoring of a PC-IOL or AC-IOL that exceed the charges for resources furnished for a conventional IOL may also be billed separately, but are not covered.

Example #1

Cataract surgery is performed, represented by CPT 66984, for a **right eye**, with a **conventional** IOL, in a **facility** setting.

Appropriate Coding

- Physician:
  - Cataract surgery CPT, with laterality modifier (in this example, CPT 66984-RT)
  - Place of service (POS) code should accurately reflect the appropriate POS (e.g., POS 22, 24, etc.).
  - NO separate code for the IOL should be reported. *Professional providers should **not** replace the cataract surgery code with an IOL code.*
- Facility:
  - Cataract surgery CPT only (in this example, CPT 66984)
  - A HCPCS code for the IOL can be reported as well for informational purposes, but the IOL will be bundled as directed above.

Inappropriate Coding

The following may result in a decreased payment, audit, or recoupment of funds paid:

- Physician billing an IOL code (with or without a cataract surgery code)
- Physician billing a POS that does not align with a facility claim received for the same date of service (e.g., claim for cataract surgery is received from an ASC, but the physician submits their claim with a POS of 11 or any other POS that does not reflect an ASC).

Example #2

Cataract surgery is performed, represented by CPT 66984, for a **left eye**, with a **premium** IOL, in an **office** setting (POS 11).

Appropriate Coding

- Physician:
  - Cataract surgery CPT, with laterality modifier (in this example, CPT 66984-LT)
  - POS code should accurately reflect the appropriate POS (e.g., POS 11)
  - A HCPCS code for a conventional IOL.
  - Either V2787 or V2788, as applicable. Billed charges should only be the difference in charges between the conventional IOL and premium IOL.
  - Charges for additional work and resources required for insertion, fitting, and vision acuity testing, and monitoring of a PC-IOL or AC-IOL which exceed work/resources furnished for a conventional IOL.
- Facility: N/A

CROSS REFERENCES

Reimbursement Policies

- Ambulatory Surgery Center (ASC) Payment Structure, RP3
- Associated Services and Related Claims, RP9

The full Company portfolio of current Reimbursement Policies is available online and can be accessed here.

REFERENCES

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POLICY REVISION HISTORY

Date	Revision Summary
7/2025	New reimbursement policy