Medical Coverage Policy

Effective Date.....02/15/2026
Next Review Date.....09/15/2026
Coverage Policy Number..... 0125

Intraocular Lens Implant

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INSTRUCTIONS FOR USE

The following Coverage Policy applies to health benefit plans administered by Cigna Companies. Certain Cigna Companies and/or lines of business only provide utilization review services to clients and do not make coverage determinations. References to standard benefit plan language and coverage determinations do not apply to those clients. Coverage Policies are intended to provide guidance in interpreting certain standard benefit plans administered by Cigna Companies. Please note, the terms of a customer's particular benefit plan document [Group Service Agreement, Evidence of Coverage, Certificate of Coverage, Summary Plan Description (SPD) or similar plan document] may differ significantly from the standard benefit plans upon which these Coverage Policies are based. For example, a customer's benefit plan document may contain a specific exclusion related to a topic addressed in a Coverage Policy. In the event of a conflict, a customer's benefit plan document always supersedes the information in the Coverage Policies. In the absence of a controlling federal or state coverage mandate, benefits are ultimately determined by the terms of the applicable benefit plan document. Coverage determinations in each specific instance require consideration of 1) the terms of the applicable benefit plan document in effect on the date of service; 2) any applicable laws/regulations; 3) any relevant collateral source materials including Coverage Policies and; 4) the specific facts of the particular situation. Each coverage request should be reviewed on its own merits. Medical directors are expected to exercise clinical judgment where appropriate and have discretion in making individual coverage determinations. Where coverage for care or services does not depend on specific circumstances, reimbursement will only be provided if a requested service(s) is submitted in accordance with the relevant criteria outlined in the applicable Coverage Policy, including covered diagnosis and/or procedure code(s). Reimbursement is not allowed for services when billed for conditions or diagnoses that are not covered under this Coverage Policy (see "Coding Information" below). When billing, providers must use the most appropriate codes as of the effective date of the submission. Claims submitted for services that are not accompanied by covered code(s) under the applicable Coverage Policy

will be denied as not covered. Coverage Policies relate exclusively to the administration of health benefit plans. Coverage Policies are not recommendations for treatment and should never be used as treatment guidelines. In certain markets, delegated vendor guidelines may be used to support medical necessity and other coverage determinations.

Overview

This Coverage Policy addresses intraocular lens (IOL) implant.

Coverage Policy

Coverage for the surgical treatment of a refractive error varies across plans. Refer to the customer's benefit plan document for coverage details.

Standard monofocal intraocular lens (IOL) implant is considered medically necessary for ANY of the following conditions:

- following cataract extraction
- trauma to the eye which has damaged the lens
- congenital cataract
- congenital aphakia
- lens subluxation/displacement
- anisometropia of 2 diopters or greater, and uncorrectable vision with the use of glasses or contact lenses
- aniseikonia

Standard monofocal intraocular lens (IOL) implant for any indication not listed above is not covered or reimbursable.

A capsular bag prosthesis (also known as an artificial capsular bag or a prosthetic capsular bag) is considered experimental, investigational or unproven for all indications.

Premium intraocular lens implants are intended to reduce the need for glasses and thus considered a convenience item. The following lenses are excluded in many benefit plans and/or not covered or reimbursable for any indication:

- presbyopia correcting IOL
- astigmatism correcting IOL
- phakic IOL

REPLACEMENT
Replacement of a medically necessary intraocular lens implant when anatomical change, inflammatory response or mechanical failure renders a previously implanted intraocular lens ineffective or nonfunctional is considered medically necessary.

Coding Information

Notes:

1. This list of codes may not be all-inclusive since the American Medical Association (AMA) and Centers for Medicare and Medicaid Services (CMS) code updates may occur more frequently than policy updates.
2. Deleted codes and codes which are not effective at the time the service is rendered may not be eligible for reimbursement.

Considered Medically Necessary when criteria in the applicable policy statements listed above are met:

CPT®* Codes	**Description**
66985	Insertion of intraocular lens prosthesis (secondary implant), not associated with concurrent cataract removal
66986	Exchange of intraocular lens

HCPCS Codes	**Description**
C1780	Lens, intraocular (new technology)
V2630	Anterior chamber intraocular lens
V2631	Iris supported intraocular lens
V2632	Posterior chamber intraocular lens

ICD-10-CM Diagnosis Codes	**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-H25.013	Cortical age-related cataract
H25.031-H25.039	Anterior subcapsular polar age-related cataract
H25.041-H25.049	Posterior subcapsular polar age-related cataract
H25.091-H25.099	Other age-related incipient cataract
H25.11-H25.13	Age-related nuclear cataract
H25.21-H25.23	Age-related cataract, morgagnian type
H25.811-H25.813	Combined forms of age-related cataract
H25.89	Other age-related cataract
H25.9	Unspecified age-related cataract
H26.001-H26.09	Infantile and juvenile cataract
H26.101-H26.139	Traumatic cataract
H26.20	Unspecified complicated cataract

ICD-10-CM Diagnosis Codes	Description
H26.211-H26.219	Cataract with neovascularization
H26.221-H26.229	Cataract secondary to ocular disorders (degenerative) (inflammatory)
H26.231-H26.239	Glaucomatous flecks (subcapsular)
H26.30-H26.33	Drug-induced cataract
H26.40-H26.493	Secondary cataract
H26.8	Other specified cataract
H26.9	Unspecified cataract
H27.00-H27.03	Aphakia
H27.10	Unspecified dislocation of lens
H27.111-H27.119	Subluxation of lens
H27.121-H27.129	Anterior dislocation of lens
H27.131-H27.133	Posterior dislocation of lens
H28	Cataract in diseases classified elsewhere
H52.31	Anisometropia
H52.32	Aniseikonia
Q12.0-Q12.9	Congenital lens malformations
T85.21XA-T85.21XS	Breakdown (mechanical) of intraocular lens
T85.22XA-T85.22XS	Displacement of intraocular lens
T85.29XA-T85.29XS	Other mechanical complication of intraocular lens
T85.79XA-T85.79XS	Infection and inflammatory reaction due to other internal prosthetic devices, implants and grafts
Z96.1	Presence of intraocular lens
Z98.41-Z98.42	Cataract extraction status

Not Covered or Reimbursable:

ICD-10-CM Diagnosis Codes	Description
H52.00-H52.03	Hypermetropia
H52.10-H52.13	Myopia
H52.201-H52.209	Unspecified astigmatism

ICD-10-CM Diagnosis Codes	Description
H52.211-H52.219	Irregular astigmatism
H52.221-H52.229	Regular astigmatism
H52.4	Presbyopia
H52.511-H52.519	Internal ophthalmoplegia (complete) (total)
H52.521-H52.529	Paresis of accommodation
H52.531-H52.539	Spasm of accommodation
H52.6	Other disorders of refraction
H52.7	Unspecified disorder of refraction
	All other codes

Considered Experimental/Investigational/Unproven:

CPT®* Codes	Description
0996T	Insertion and scleral fixation of a capsular bag prosthesis containing an intraocular lens prosthesis, with vitrectomy, including removal of crystalline lens or dislocated intraocular lens prosthesis, when performed

Premium Intraocular Lens Implant

Excluded in many benefit plans and/or not covered or reimbursable:

HCPCS Codes	Description
S0596	Phakic intraocular lens for correction of refractive error
V2787	Astigmatism correcting function of intraocular lens
V2788	Presbyopia correcting function of intraocular lens

ICD-10-CM Diagnosis Codes	Description
	All codes

General Background

The most common indication for an intraocular lens implant is cataract surgery. Cataracts – hardening or opacification (clouding) of the normally transparent crystalline lens within the eye –

usually occur as part of the aging process but may be congenital, traumatic or related to other systemic diseases or medications. The current cataract procedure of choice is an extracapsular technique (removal of only the lens) with implantation of a posterior chamber (behind the iris) intraocular lens within the capsular bag. An intraocular lens (IOL) is a tiny, artificial lens for the eye. It replaces the eye's natural lens that is removed during cataract surgery. Most IOLs are made of silicone or acrylic. They may also be coated with a special material to help protect the eyes from harmful ultraviolet rays. Replacement of the lens restores optical focusing power lost by removal of the natural crystalline lens. The choice of IOL is dependent on physician recommendation and the visual needs of each individual.

Other related vision disorders include:

- refractive error – any of a number of size- and shape-related abnormalities of the eyeball or other components of the eye that affect the normal ability of the eye to focus light on the retina.
- astigmatism – a refractive error caused by an uneven curve in the cornea or lens, so light (an image) fails to come to a single focus on the retina to produce clear vision. Instead, multiple focus points occur, either in front of the retina or behind it or both.
- nearsightedness (i.e., myopia) – a refractive error that occurs when the eyeball is too long, relative to the focusing power of the cornea and lens of the eye. This causes light rays to focus at a point in front of the retina, rather than directly on its surface. A nearsighted person typically will have difficulty reading road signs and seeing distant objects clearly. Myopia is the most common refractive error of the eye. It has become much more prevalent in recent years, purportedly due to eye fatigue from computer use and other extended near vision tasks and possibly genetic predisposition for myopia. Nearsightedness also can be caused by the cornea and/or lens being too curved for the length of the eyeball. In some cases, myopia is due to a combination of these factors.
- farsightedness (i.e., hyperopia) – a refractive error that occurs when light rays entering the eye focus behind the retina, rather than directly on it. A person may see distant objects very well but has difficulty focusing on objects that are up close. The eyeball of a farsighted person is shorter than normal. Many children are born farsighted, and some of them outgrow it as the eyeball lengthens with normal growth.
- presbyopia – a refractive error that frequently begins at around age 40, when people start having trouble reading small print. It is believed to stem from a gradual thickening and loss of flexibility of the natural lens inside your eye. This differs from astigmatism, nearsightedness and farsightedness, which are related to the shape of the eyeball and are caused by genetic and environmental factors.
- aphakia – the absence of the natural lens which may result from extraction of the lens (e.g., cataract surgery), penetrating trauma, or from congenital conditions.
- anisometropia – refers to the condition in which one eye has a different refractive error than the other. Usually, the eye with the least amount of refractive error is the dominant or preferred eye while the other eye may be suppressed and develop amblyopia (lazy eye). Greater degrees of anisometropia or astigmatism result in increased risk and severity of amblyopia.
- aniseikonia - is the difference in image size perceived between the eyes from unequal magnification. The two most common causes are anisometropia and retinal pathology. Symptoms of aniseikonia include diplopia, headache, dizziness, disorientation, and excessive eye strain.

Types of Intraocular lens (IOLs)
IOLs other than monofocal, referred to as premium or deluxe lenses, are often recommended to individuals undergoing cataract surgery. Premium lenses are intended to reduce the need for

vision correction following cataract surgery; however, they are considered not medically necessary.

Monofocal: The most common type of lens used with cataract surgery is a monofocal IOL set to focus for up-close, medium range or distance vision. Monofocal IOLs meet the basic functional needs of an individual who undergoes cataract removal. Most people have them set for clear distance vision. Conventional monofocal lenses are spherical, meaning they are designed to provide clear vision at a single focal point (usually far away for good driving vision, for example). A monofocal IOL does not allow focusing ability at varying distances or correct existing astigmatism. With conventional IOLs, typically eyeglasses or contact lenses are also needed in order to use a computer, read or perform other close-up tasks within arm's length.

Normally, the monofocal IOLs for both eyes are set to the same range (like distance). But with monovision, the lens for each eye has a different focusing power. For example, the lens for the right eye might correct for distance, with the lens for the left eye correcting for close-up vision. With monovision, the eyes work together to help the individual see both distant and close-up objects. One drawback is that it takes some time to adapt to monovision. Some people can’t adapt to monovision at all.

Multifocal: IOLs that provide both distance and near focus at the same time are called multifocal IOLs. The lens has different zones set at different powers. It is designed so that the brain learns to select the right focus automatically. Multifocal IOLs contain added magnification in different parts of the lens to help treat presbyopia, decreasing the need for reading glasses or computer glasses after cataract surgery. Multifocal IOLs tend to provide better near vision than accommodating IOLs, but they also are more likely to cause glare or mildly blurred distance vision. Examples of FDA-approved multifocal IOLs include AcrySof IQ PanOptix Trifocal IOL (Alcon), Tecnis Multifocal IOL (Abbott Medical Optics), and AcrySof IQ ReSTOR (Alcon).

Accommodative: These lenses move or change shape inside your eye, allowing focusing at different distances. Accommodative IOLs expand the range of clear vision with both an aspheric design (as opposed to spherical design of monofocal IOLs) and also flexible "haptics" — the supporting legs that hold the IOL in place inside the eye. These flexible legs allow the accommodating IOL to move forward slightly when looking at near objects, which increases the focusing power of the eye enough to provide better near vision than a conventional monofocal lens. Accommodating IOLs may not provide the same level of magnification for near vision that a multifocal IOL does. FDA-approved accommodating IOLs include Crystalens AO and Trulign Toric IOL, both made by Bausch + Lomb. (The Trulign Toric lens corrects astigmatism as well as presbyopia.)

Toric: A toric lens is custom made to correct astigmatism as well as nearsightedness or farsightedness. Astigmatism is a refractive error caused by an uneven curve in the cornea or lens. The toric lens is designed with different powers in different meridians of the lens. They also have alignment markings on the peripheral part of the lens that enable the surgeon to adjust the orientation of the IOL inside the eye for optimal correction. Prior to cataract surgery, the surgeon places temporary markings on the patient's cornea that identify the location of the most curved meridian of the front of the eye. When the toric IOL is implanted during the cataract procedure, the surgeon rotates the IOL so the markings on the IOL are aligned with the markings on the cornea to insure proper astigmatism correction. FDA-approved toric intraocular lenses available in the U.S. include: Tecnis Toric (Abbott Medical Optics), AcrySof IQ Toric (Alcon), Staar Toric IOL (Staar Surgical), and Trulign Toric (Bausch + Lomb).

Aspheric: The shape of the natural lens inside the eye may vary in curvature from center to periphery. In other words, the eye's natural lens is aspheric or not spherical. Aspheric IOLs are

designed to more closely match the shape and optical quality of the eye's natural lens, and thereby can provide sharper vision, especially in low light conditions. FDA-approved IOLs include: Tecnis Aspheric (Abbott Medical Optics), AcrySof IQ (Alcon), SofPort AO (Bausch + Lomb), and Softec HD (Lenstec).

Extended Depth of Focus (EDOF): EDOF IOLs, also referred to as Extended Range of Vision (EROV) IOL, are proposed for the treatment of presbyopia. In contrast to multifocal IOLs used in treatment of presbyopia, EDOF lenses work by creating a single elongated focal point to enhance "range of vision" or "depth of focus". A FDA-approved examples are Vivity Toric (Alcon), TECNIS Symfony® IOL, TECNIS Synergy, and TECNIS Symfony® Toric IOL. Extended depth of focus lenses are unique in that they are neither multifocals nor are they accommodative IOLs. However, the TECNIS Symfony® is a presbyopia-correcting lens and the TECNIS Symfony® Toric IOL addresses both presbyopia and astigmatism. The IC-8™ IOL (AcuFocu, Inc., Irvine, CA) and WIOL-CF (Medicem, Czech Republic) are not FDA-approved or available for sale in the United States.

Light-adjustable: A light-adjustable lens (LAL) allows the physician to make small adjustments to the implanted lens during several in-office procedures after the initial surgery to improve visual acuity without glasses. It is intended for patients who have astigmatism before surgery and who do not have macular diseases. The device should not be used in patients taking systemic medication that may increase sensitivity to UV light. An FDA-approved example is Light Adjustable Lens™ from RxSight®.

Phakic: Unlike the above-described lenses, phakic lens are not associated with cataract surgery. They are permanently implanted into the eye to reduce a person's need for glasses or contact lenses, without removing the natural lens. They are placed just in front of or just behind the iris while preserving the natural crystalline lens. This contrasts with intraocular lenses that are implanted into eyes after the eye's cloudy natural lens has been removed during cataract surgery. Phakic IOLs function very similarly to contact lenses. Phakic lenses are approved by the FDA for the correction of nearsightedness (myopia) only and include Visian Implantable Collamer Lens (ICL) (Staar Surgical) and Verisyse/ARTISAN (Abbott Medical Optics).

Other IOL Indications
Intraocular lens implant may be needed for conditions other than with cataract surgery. Less common uses include: trauma to the eye which has damaged the lens; congenital cataract; congenital aphakia; lens subluxation/displacement; and significant anisometropia that is uncorrectable with the use of glasses or contact lenses.

- Congenital or infantile cataracts may be unilateral or bilateral. Most unilateral cataracts are not inherited or associated with a systemic disease and are of unknown etiology. The majority of bilateral congenital cataracts not associated with a syndrome have no identifiable cause. Genetic mutation is likely the most common cause.
- Congenital aphakia is a rare anomaly that can be subdivided into two forms: primary and secondary. Histologically, the lens is absent in primary congenital aphakia. In secondary congenital aphakia, the lens has developed but has been resorbed or extruded before or during birth.
- Aniseikonia is the difference in image size perceived between the eyes from unequal magnification. The two most common causes are anisometropia and retinal pathology. Symptoms of aniseikonia include diplopia, headache, dizziness, disorientation, and excessive eye strain.
- Anisometropia, the condition in which one eye has a different refractive error than the other, can cause amblyopia. The threshold for anisometropia that is enough to cause amblyopia varies depending upon the type of refractive error. The level of anisometropia severity can be categorized into mild (SE difference ≥ 1.0 D and < 2.0 D), moderate (SE difference ≥ 2.0 D and <3.0 D), and severe (SE difference ≥ 3.0 D). Anisometropia is

treated with refractive correction. Early detection of refractive anisometropia in children with timely intervention could prevent permanent impairment in binocular vision and stereopsis. Refractive surgery may be performed in children with significant anisometropia who cannot or will not wear refractive correction. In children with extremely high refractive error in one eye only, correction with glasses causes a condition called aniseikonia (difference in image size) such that the eyes cannot function visually together. Secondarily, the children can experience asthenopia (eye fatigue, headache) from this correction and most refuse to wear the glasses. Contact lenses are another option, but they are difficult to insert in uncooperative children, loss is frequent, and they are costly. The consequence of this intolerance/noncompliance is severe amblyopia.

Food and Drug Administration (FDA)
On April 03, 2025, Bausch + Lomb Corporation announced a voluntary recall of intraocular lenses (IOLs) on its enVista platform. This action was taken after the company received reports of complications, the cause of which could not immediately be explained.

Literature Review
Both subjective and objective outcomes resulting from the use of varying types of IOLs have been reported in the peer-reviewed, published scientific literature (e.g., contrast sensitivity, glare acuity, pain score, up-close, medium range and distance visual acuity). Evidence in the published, peer-reviewed scientific literature generally supports improved visual acuity resulting in a decreased need for eyeglasses, with the use of premium lenses.

Generally, IOLs intended primarily for reducing an individual's dependence on additional vision correction (e.g., eyeglasses) following cataract removal and for other conditions are not considered medically necessary. Additional vision correction may be required after insertion of premium lenses. Monofocal IOLs are the standard treatment for replacement of the crystalline lens during cataract surgery. Intraocular lens replacement for the treatment of presbyopia, myopia, and/or other refractive correction is considered not medically necessary.

For more information on surgical treatment of refractive errors please refer to the Cigna Medical Coverage Policy Corneal Remodeling.

Professional Societies/Organizations
American Academy of Ophthalmology (AAO): A 2024 AAO Ophthalmic Technology Assessment Report on Toric Monofocal Intraocular Lenses for the Correction of Astigmatism during Cataract Surgery concluded that "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" (Al-Mohtaseb, et al., 2024).

The AAO 2023 Refractive Surgery Preferred Practice Pattern® states under Intraocular surgery:

- Lenticular surgery using a variety of IOL implants has also been used to address presbyopia. After the crystalline lens is removed, the IOL can be used to provide functional distance vision as well as near vision through monofocal, aspheric, multifocal, accommodative, extended depth of focus, and light-adjustable IOLs. There are advantages and disadvantages to each of these modalities, and the selection of the specific IOL depends on the patient's visual needs, expectations, motivation to be less dependent on eyeglasses, and willingness to accept potential compromises (Jacobs, et al., 2023).

The 2022 AAO Preferred Practice Pattern® on Cataract in the Adult Eye notes:

- 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 (Miller, et al., 2022).

A 2021 AAO Ophthalmic Technology Assessment Report on Multifocal and Accommodating Intraocular Lenses for the Treatment of Presbyopia reported:

- Presbyopia-correcting lenses were effective at improving distance and near visual acuity after cataract surgery.
- Near acuity at different focal lengths was related directly to the effective add power of multifocal and extended depth-of-focus (EDOF) IOLs.
- Most multifocal and EDOF lenses that were compared with a control monofocal lens demonstrated that patient-reported spectacle independence was superior to the monofocal lens.
- All patients who had multifocal and EDOF lenses implanted showed decreased contrast sensitivity and reported more visual phenomena as compared with control participants who received monofocal lenses (Schallhorn, et al., 2021).

The 2025 AAO policy Statement on Laser Surgery addresses Cataract Surgery but not intraocular lens implant.

Capsular Bag Prosthesis

The natural capsular bag in the eye is a thin, elastic membrane that originally housed the natural lens. After cataract removal, it serves as a natural "pocket" for the IOL implant. When intact, it provides a stable and centered environment for the lens. Damage to the capsular bag after cataract surgery can result from several intraoperative and postoperative factors.

A capsular bag prosthesis (also known as an artificial capsular bag or a prosthetic capsular bag) is a synthetic structure designed to mimic the natural lens capsule of the eye, primarily used in complex cataract surgeries or in cases where the natural capsular bag is compromised. It does not necessarily contain an IOL prothesis. New (01/01/2026) CPT code 0996T represents insertion and scleral fixation of a capsular bag prosthesis containing an IOL, with vitrectomy, including removal of crystalline lens or dislocated intraocular lens prosthesis, when performed.

FDA: An artificial capsular bag has not yet received full FDA approval. In 2023, OnPoint Vision Inc announced the FDA approval of their Investigational Device Exemption (IDE) application to begin Phase I of their pivotal clinical trial of the AccuraSee™ Intraocular Pseudophakic Capsular Lens (IOPCL) Magnifier (MAG) for secondary implantation in the capsular bag with a pre-existing 6mm acrylic posterior chamber IOL. It is designed to magnify near images when unilaterally implanted in low vision pseudophakic subjects with stable Age-Related Macular Degeneration (AMD) at least 6 months after cataract surgery.

OnPoint Vision also announced the FDA approval of an early feasibility study (EFS) to evaluate the initial safety and effectiveness of the AccuraSee™ IOPCL (monofocal) for secondary implantation

in the capsular bag to improve near and/or intermediate vision by inducing myopia (monovision) when implanted in the non-dominant eye in up to ten (10) pseudophakic subjects following at least 6 months after previous cataract surgery. This will be the second EFS of the monofocal IOPCL, whereas the first-in-human (FIH) study of the monofocal IOPCL was conducted in low vision subjects. This first EFS was completed and closed under a separate IDE.

The Omega Gemini Refractive Capsule is an investigational device and is not approved for use in the United States. Omega Ophthalmics is a registered trademark of Omega Ophthalmics, LLC.

Professional Society: The **American Society of Cataract and Refractive Surgery (ASCRS)** showed a video at the recent annual ASCRS meeting titled "breakthrough with artificial capsular bag in cataract surgery". The purpose was to show an artificial capsular bag that prevents secondary cataract and adhesion between IOL and capsular bag after cataract surgery. It can be combined with all 6mm diameter IOL. The video stated that the presenters had "clinically no cases with anterior or posterior capsule opacities or adhesions between capsule and IOL after more than one year surgery, allowing for prevention of secondary cataract and IOL exchange".

Health Equity Considerations

Health equity is the highest level of health for all people; health inequity is the avoidable difference in health status or distribution of health resources due to the social conditions in which people are born, grow, live, work, and age.

Social determinants of health are the conditions in the environment that affect a wide range of health, functioning, and quality of life outcomes and risks. Examples include safe housing, transportation, and neighborhoods; racism, discrimination and violence; education, job opportunities and income; access to nutritious foods and physical activity opportunities; access to clean air and water; and language and literacy skills.

Medicare Coverage Determinations

	Contractor	Determination Name/Number	Revision Effective Date
NCD	National	Intraocular Lenses (IOLs) (80.12)	5/19/1997
LCD		No Determination found	

Note: Please review the current Medicare Policy for the most up-to-date information.
(NCD = National Coverage Determination; LCD = Local Coverage Determination)

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Revision Details

Type of Revision	Summary of Changes	Date
Focused Review	• Updated policy statement for standard monofocal intraocular lens. • Added policy statement for capsular bag prosthesis	02/15/2026
Annual Review	• No clinical policy statement changes.	10/15/2025
Annual Review	• No clinical policy statement changes.	9/15/2024
Focused Review	• Added policy statement for standard monofocal intraocular lens. • Revised policy statement for premium intraocular lens. • Removed policy statement for intraocular lens implant (e.g., monofocal IOL, multifocal IOL, accommodating IOL) following clear lens extraction.	11/12/2023