Aqueous Shunts and Stents for Glaucoma

Policy # 00421
Original Effective Date: 05/21/2014
Current Effective Date: 02/20/2019

Applies to all products administered or underwritten by Blue Cross and Blue Shield of Louisiana and its subsidiary, HMO Louisiana, Inc. (collectively referred to as the “Company”), unless otherwise provided in the applicable contract. Medical technology is constantly evolving, and we reserve the right to review and update Medical Policy periodically.

Note: Ophthalmologic Techniques That Evaluate the Posterior Segment for Glaucoma is addressed separately in medical policy 00089.

Note: Viscocanalostomy and Canaloplasty is addressed separately in medical policy 00280.

When Services Are Eligible for Coverage

Coverage for eligible medical treatments or procedures, drugs, devices or biological products may be provided only if:

- Benefits are available in the member’s contract/certificate, and
- Medical necessity criteria and guidelines are met.

Based on review of available data, the Company may consider insertion of ab externo aqueous shunts approved by the U.S. Food and Drug Administration (FDA) as a method to reduce intraocular pressure (IOP) in patients with glaucoma where medical therapy has failed to adequately control intraocular pressure (IOP) to be eligible for coverage.**

Based on review of available data, the Company may consider insertion of ab interno aqueous stents approved by the U.S. Food and Drug Administration (FDA) as a method to reduce intraocular pressure (IOP) in patients with glaucoma where medical therapy has failed to adequately control intraocular pressure (IOP), is considered to be eligible for coverage.**

Based on review of available data, the Company may consider implantation of 1 or 2 U.S. Food and Drug Administration (FDA)-approved ab interno stents in conjunction with cataract surgery in patients with mild-to-moderate open-angle glaucoma treated with ocular hypotensive medication to be eligible for coverage.**

When Services Are Considered Investigational

Coverage is not available for investigational medical treatments or procedures, drugs, devices or biological products.

Based on review of available data, the Company considers the use of an ab externo aqueous shunt for all other conditions, including in patients with glaucoma when intraocular pressure (IOP) is adequately controlled by medications, to be investigational.*

Based on review of available data, the Company considers the use of ab interno stents for all other conditions, to be investigational.*
Policy Guidelines
Shunts and stents are only able to reduce intraocular pressure (IOP) to the mid-teens and may be inadequate when very low intraocular pressure is needed to reduce glaucoma damage.

Background/Overview
Glaucoma
Glaucoma is characterized by elevated intraocular pressure (IOP), which results in visual field loss and irreversible blindness if left untreated. In the primary (conventional) outflow pathway from the eye, aqueous humor passes through the trabecular meshwork, enters a space lined with endothelial cells (Schlemm canal), drains into collector channels, and then into the aqueous veins. Increases in resistance in the trabecular meshwork and/or the inner wall of the Schlemm canal can disrupt the balance of aqueous humor inflow and outflow, resulting in an increase in IOP and glaucoma risk.

Treatment
Ocular Medication
First-line treatment typically involves pharmacologic therapy. Topical medications either increase aqueous outflow (prostaglandins, alpha-adrenergic agonists, cholinergic agonists, Rho kinase inhibitors) or decrease aqueous production (alpha-adrenergic agonists, beta blockers, carbonic anhydrase inhibitors). Pharmacologic therapy may involve multiple medications, have potential side effects, and may be inconvenient for older adults or incapacitated patients.

Surgery
Surgical intervention may be indicated in patients with glaucoma when the target IOP cannot be reached pharmacologically. Surgical procedures for glaucoma aim to reduce IOP from impaired aqueous humor drainage in the trabecular meshwork and/or Schlemm canal. Trabeculectomy (guarded filtration surgery) is the most established surgical procedure for glaucoma, which involves dissecting the conjunctiva, creating a scleral flap and scleral ostomy then suturing down the flap and closing the conjunctiva, allowing aqueous humor to directly enter the subconjunctival space. This procedure creates a subconjunctival reservoir, which can effectively reduce IOP, but commonly results in filtering “blebs” on the eye, and is associated with numerous complications (eg, hemorrhage, scarring, hypotony, infection, leaks, bleb-related endophthalmitis) and long-term failure. Other surgical procedures (not addressed herein) include trabecular laser ablation, deep sclerectomy (which removes the outer wall of the Schlemm canal and excises deep sclera and peripheral cornea), and viscocanalostomy (which unroofs and dilates the Schlemm canal without penetrating the trabecular meshwork or anterior chamber) (see medical policy 00280). Canaloplasty involves dilatation and tension of the Schlemm canal with a suture loop between the inner wall of the canal and the trabecular meshwork. This ab externo procedure uses the iTrack illuminated microcatheter (iScience Interventional) to access and dilate the entire length of the Schlemm canal and to pass the suture loop through the canal (see medical policy 00280).

Insertion of shunts from outside the eye (ab externo) is another surgical option to lower IOP. Examples of ab externo devices cleared by the U.S. Food and Drug Administration (FDA) include the Ahmed, Baerveldt,
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Molteno, and EX-PRESS mini-shunt, which shunt aqueous humor between the anterior chamber and the suprachoroidal space. These devices differ by explant surface areas, shape, plate thickness, presence or absence of a valve, and details of surgical installation. Generally, the risk of hypotony (low pressure) is reduced with aqueous shunts compared with trabeculectomy, but IOP outcomes are worse than after standard guarded filtration surgery. Complications of anterior chamber shunts include corneal endothelial failure and erosion of the overlying conjunctiva. The risk of postoperative infection is lower with shunts than with trabeculectomy, and failure rates are similar (10% of devices fail annually). The primary indication for aqueous shunts is for failed medical or surgical therapy, although some ophthalmologists have advocated their use as a primary surgical intervention, particularly for selected conditions such as congenital glaucoma, trauma, chemical burn, or pemphigoid.

Minimally Invasive Glaucoma Surgeries
MIGS are alternative, less invasive techniques that are being developed and evaluated. MIGS, which use microscopic-sized equipment and smaller incisions, involves less surgical manipulation of the sclera and the conjunctiva compared with other surgical techniques. There are several categories of MIGS: miniaturized trabeculectomy, trabecular bypass, milder laser photocoagulation, and totally internal or suprachoroidal stents (ab interno). This policy evaluates the placement of ab interno stents.

Examples of ab interno devices either approved or given marketing clearance by the FDA include the iStent, which is a 1-mm long stent inserted into the end of the Schlemm canal through the cornea and anterior chamber; the CyPass suprachoroidal stent; and XEN gelatin stent.

Because aqueous humor outflow is pressure-dependent, the pressure in the reservoir and venous system is critical for reaching the target IOP. Therefore, some devices may be unable to reduce IOP below the pressure of the distal outflow system used (eg, <15 mm Hg) and are not indicated for patients for whom very low IOP is desired (eg, those with advanced glaucoma). It has been proposed that stents such as the iStent, CyPass, and Hydrus Microstent may be useful in patients with early-stage glaucoma to reduce the burden of medications and problems with compliance. One area of investigation is patients with glaucoma who require cataract surgery. An advantage of ab interno stents is that they may be inserted into the same incision and at the same time as cataract surgery. Also, most devices do not preclude subsequent trabeculectomy if needed. It may also be possible to insert more than one stent to achieve desired IOP. Therefore, health outcomes of interest are the IOP achieved, reduction in medication use, ability to convert to trabeculectomy, complications, and device durability.

FDA or Other Governmental Regulatory Approval

U.S. Food and Drug Administration (FDA)
The regulatory status of the various ab externo and ab interno aqueous shunts and microstents is summarized in Table 1. The first-generation Ahmed™ (New World Medical), Baerveldt® (Advanced Medical Optics), Krupin (Eagle Vision), and Molteno® (Molteno Ophthalmic) ab externo aqueous shunts were cleared for marketing by the FDA through the 510(k) process between 1989 and 1993; modified Ahmed and Molteno devices were cleared in 2006. They are indicated for use “in patients with intractable glaucoma to reduce intraocular pressure where medical and conventional surgical treatments have failed.”

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The AquaFlow™‡ Collagen Glaucoma Drainage Device (STAAR Surgical) was approved by the FDA through the premarket approval process for the maintenance of the sub scleral space following nonpenetrating deep sclerectomy. In 2003, the ab externo EX-PRESS®‡ Mini Glaucoma Shunt was cleared for marketing by the FDA through the 510(k) process. In 2016, the XEN®‡ Glaucoma Treatment System (Allergan), which consists of the XEN45 Gel Stent preloaded into the XEN Injector, was cleared for marketing by the FDA through the 510(k) process as an ab interno aqueous stent for management of refractory glaucoma. The approval was for patients with refractory glaucoma who failed previous surgical treatment or for patients with primary open-angle glaucoma unresponsive to maximum tolerated medical therapy. The FDA determined that this device was substantially equivalent to existing devices, specifically the Ahmed™‡ Glaucoma Valve and the EX-PRESS®‡ Glaucoma Filtration Device.

In 2018, the iStent®‡ Trabecular Micro-Bypass Stent preloaded into the iStent inject device (Glaukos) was approved by the FDA through the 515(d) process for use in conjunction with cataract surgery for the reduction of IOP in adults with mild-to-moderate open-angle glaucoma currently treated with ocular hypotensive medication.

The labeling describes the following precautions:

1. “The safety and effectiveness of the iStent Trabecular Micro-Bypass Stent has not been established as an alternative to the primary treatment of glaucoma with medications. The effectiveness of this device has been demonstrated only in patients with mild-to-moderate open-angle glaucoma who are undergoing concurrent cataract surgery for visually significant cataract.

2. The safety and effectiveness of the iStent Trabecular Micro-Bypass Stent has not been established in patients with the following circumstances or conditions, which were not studied in the pivotal trial:
   - In children
   - In eyes with significant prior trauma
   - In eyes with abnormal anterior segment
   - In eyes with chronic inflammation
   - In glaucoma associated with vascular disorders
   - In pseudophakic patients with glaucoma
   - In uveitic glaucoma
   - In eyes with prior incisional glaucoma surgery or cilioablative procedures
   - In eyes with prior laser trabeculoplasty with selective LT within 90 days prior to screening or prior to argon laser trabeculectomy at any time
   - In patients with medicated IOP greater than 24 mmHg
   - In patients with unmedicated IOP less than 21 mmHg nor greater than 36 mmHg after ‘washout’ of medications
   - For implantation of more or less than two stents
   - After complications during cataract surgery, including but not limited to, severe corneal burn, vitreous removal/vitrectomy required, corneal injuries, or complications requiring the placement of an anterior chamber IOL [intraocular lens]
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- When implantation has been without concomitant cataract surgery with IOL implantation for visually significant cataract"
- In patients with pseudoexfoliative glaucoma or pigmentary glaucoma, or in patients with other secondary open-angle glaucoma."

In August 2018, Alcon announced an immediate voluntary recall of the CyPass microstent, which had been approved by the FDA in 2016 for use in conjunction with cataract surgery in adults with mild-to-moderate open-angle glaucoma. The recall was based on five-year postsurgery data from the COMPASS-XT long-term safety study. Results showed a statistically significant increase in endothelial cell loss among patients receiving the CyPass microstent compared with patients receiving cataract surgery alone.

Table 1. Regulatory Status of Aqueous Shunts and Stents

<table>
<thead>
<tr>
<th>Device</th>
<th>Manufacturer</th>
<th>Type</th>
<th>FDA Status</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 AquaFlow</td>
<td>STAAR Surgical</td>
<td>Drainage device</td>
<td>PMA</td>
<td>2001</td>
</tr>
<tr>
<td>2 Ahmed</td>
<td>New World Medical</td>
<td>Aqueous glaucoma shunt, ab externo</td>
<td>510(k)</td>
<td>&lt;1993</td>
</tr>
<tr>
<td>3 Baerveldt</td>
<td>Advanced Medical Optics</td>
<td>Aqueous glaucoma shunt, ab externo</td>
<td>510(k)</td>
<td>&lt;1993</td>
</tr>
<tr>
<td>4 Krupin</td>
<td>Eagle Vision</td>
<td>Aqueous glaucoma shunt, ab externo</td>
<td>510(k)</td>
<td>&lt;1993</td>
</tr>
<tr>
<td>5 Molteno</td>
<td>Molteno Ophthalmic</td>
<td>Aqueous glaucoma shunt, ab externo</td>
<td>510(k)</td>
<td>&lt;1993</td>
</tr>
<tr>
<td>6 EX-PRESS</td>
<td>Alcon Ophthalmic</td>
<td>Mini-glaucoma shunt, ab externo</td>
<td>510(k)</td>
<td>2003</td>
</tr>
<tr>
<td>7 XEN Gel Stent; XEN injector</td>
<td>AqueSys/Allergan</td>
<td>Aqueous glaucoma stent, ab intern</td>
<td>510(k)</td>
<td>2016</td>
</tr>
<tr>
<td>8 iStent; iStent injector®</td>
<td>Glaukos</td>
<td>Microstent, ab intern</td>
<td>515(d) in conjunction with cataract surgery</td>
<td>2018</td>
</tr>
<tr>
<td>9 iStent supra®</td>
<td>Glaukos</td>
<td>Suprachoroidal stent</td>
<td>Not approved; in clinical trial</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11 CyPass®</td>
<td>Alcon</td>
<td>Suprachoroidal stent, ab intern</td>
<td>Company voluntarily recalled</td>
<td>2018</td>
</tr>
<tr>
<td>12 Hydrus™</td>
<td>Ivantis</td>
<td>Microstent, ab intern</td>
<td>PMA approval in conjunction with cataract surgery</td>
<td>2018</td>
</tr>
<tr>
<td>13 SOLX® Gold</td>
<td>SOLX</td>
<td>Micro-Shunt, ab externo</td>
<td>Not approved; in clinical trial</td>
<td></td>
</tr>
<tr>
<td>14</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

FDA: Food and Drug Administration; PMA: premarket approval.

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Centers for Medicare and Medicaid Services (CMS)

There is no national coverage determination. In the absence of a national coverage determination, coverage decisions are left to the discretion of local Medicare carriers.

Rationale/Source

Evidence reviews assess the clinical evidence to determine whether the use of technology improves the net health outcome. Broadly defined, health outcomes are the length of life, quality of life, and ability to function including benefits and harms. Every clinical condition has specific outcomes that are important to patients and managing the course of that condition. Validated outcome measures are necessary to ascertain whether a condition improves or worsens; and whether the magnitude of that change is clinically significant. The net health outcome is a balance of benefits and harms.

To assess whether the evidence is sufficient to draw conclusions about the net health outcome of a technology, two domains are examined: the relevance, and quality and credibility. To be relevant, studies must represent one or more intended clinical use of the technology in the intended population and compare an effective and appropriate alternative at a comparable intensity. For some conditions, the alternative will be supportive care or surveillance. The quality and credibility of the evidence depend on study design and conduct, minimizing bias and confounding that can generate incorrect findings. The randomized controlled trial (RCT) is preferred to assess efficacy; however, in some circumstances, nonrandomized studies may be adequate. RCTs are rarely large enough or long enough to capture less common adverse events and long-term effects. Other types of studies can be used for these purposes and to assess generalizability to broader clinical populations and settings of clinical practice.

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Clinical Context and Therapy Purpose

The purpose of aqueous shunts and stents in patients who have glaucoma is to provide a treatment option that is an alternative to or an improvement on existing therapies.

The question addressed in this evidence review is: Does the use of aqueous shunts and stents improve the net health outcomes of patients with glaucoma compared to standard of care (including medical therapy or trabeculectomy)?

The following PICOTS were used to select literature to inform this review.

Patients

The relevant populations of interest are:

- Patients with refractory open-angle glaucoma
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- Patients with mild-to-moderate open-angle glaucoma who are undergoing cataract surgery
- Patients with indications for glaucoma treatment other than cataract surgery or refractory open-angle glaucoma

**Interventions**
The therapies being considered are:

- For patients with refractory open-angle glaucoma
- Ab externo aqueous shunts
- Ab interno aqueous stents
- For patients with mild-to-moderate open-angle glaucoma undergoing cataract surgery: ab interno aqueous stents
- For patients with indications for glaucoma treatment other than cataract surgery or refractory open-angle glaucoma: ab externo aqueous shunts or ab interno aqueous stents

**Comparators**
Comparators include medical therapies and trabeculectomy.

**Outcomes**
The general outcomes of interest are change in intraocular pressure (IOP) and change in medication use.

**Timing**
Changes in IOP and medication use are measured for at least 12 months. Safety measures involve longer follow-up, for several years.

**Setting**
Insertion of aqueous shunts and stents are performed in tertiary care centers.

**Study Selection Criteria**
Methodologically credible studies were selected using the following principles:

- To assess efficacy outcomes, comparative controlled prospective trials were sought, with a preference for RCTs;
- In the absence of such trials, comparative observational studies were sought, with a preference for prospective studies.
- To assess long-term outcomes and adverse effects, single-arm studies that capture longer periods of follow-up and/or larger populations were sought.
- Studies with duplicative or overlapping populations were excluded.
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Ab Extern Aqueous Shunts
This section reviews the evidence for ab externo aqueous shunts with the U.S. Food and Drug Administration (FDA) approval.

Systematic Reviews
A Cochrane review by Minckler et al (2006) included 15 randomized or pseudo-RCTs (total N=1153 participants) evaluating the Ahmed, Baerveldt, Molteno, and Schocket shunts.

Trabeculectomy was found to lower mean IOP by 3.8 mm Hg more than the Ahmed shunt at one year. This systematic review did not compare complications, because reviewers considered them to be too variably reported to permit comparative tabulation. There was no evidence of the superiority of one shunt over another.

A technology assessment on commercially available aqueous shunts, including the Ahmed, Baerveldt, Krupin, and Molteno devices, from the American Academy of Ophthalmology was published by Minckler et al (2008).

It indicated that IOP would generally settle at higher levels (18 mm Hg) with aqueous shunts than with standard trabeculectomy (14-16 mm Hg) or trabeculectomy with antifibrotic agents 5-fluorouracil or mitomycin C (8-10 mm Hg). In 1 study, mean IOPs with the Baerveldt shunt and adjunct medications were equivalent to trabeculectomy with mitomycin C (13 mm Hg). Five-year success rates for the 2 procedures were similar (50%). The assessment concluded that, based on level 1 evidence, aqueous shunts were comparable to trabeculectomy for IOP control and duration of benefit. The risk of postoperative infection was lower with aqueous shunts than with trabeculectomy. Complications of aqueous shunts included: immediate hypotony after surgery, excessive capsule fibrosis and clinical failure, erosion of the tube or plate edge, strabismus, and, very rarely, infection. The most problematic long-term consequence of anterior chamber tube placement was accelerated damage to the corneal endothelium.

A comparative effectiveness review on glaucoma treatments, prepared for the Agency for Healthcare Research and Quality by Boland et al (2012), found that available data on the role of aqueous drainage devices in open-angle glaucoma (primary studies, systematic review) were inadequate to permit conclusions on the comparative effectiveness of these treatments versus laser and other surgical treatments.

Baerveldt Glaucoma Shunt

Randomized Controlled Trials
Early results from the open-label, multicenter, randomized Tube Versus Trabeculectomy (TVT) study were reviewed in the 2008 American Academy of Ophthalmology technology assessment and by Gedde et al (2012) who reported on the 5-year follow-up to TVT.
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That study included 212 eyes of 212 patients (age range, 18-85 years) from 17 study centers, who had trabeculectomy and/or cataract extraction with intraocular lens implantation and uncontrolled glaucoma with IOP of 18 mm Hg or greater and 40 mm Hg or lower on maximally tolerated medical therapy, randomized to tube (Baerveldt shunt) or trabeculectomy. Excluding patients who had died, the study had an 82% follow-up rate at 5 years, with a similar proportion of patients in the tube and trabeculectomy groups. At 5 years, neither IOP (14.3 mm Hg in the shunt group vs 13.6 mm Hg in the trabeculectomy group) nor the number of glaucoma medications (1.4 in the shunt group vs 1.2 in the trabeculectomy group) differed significantly based on intention-to-treat analysis. The cumulative probability of failure over the 5 years was lower in the shunt group (29.8%) than in the trabeculectomy group (46.9%), and the rates of reoperation were lower (9% vs 29%, respectively). The rates of loss of 2 or more lines of visual acuity were similar (46% in the shunt group vs 43% in the trabeculectomy group).


Quality of life was measured using the National Eye Institute Visual Functioning Questionnaire25, administered at baseline and annual follow-ups over 5 years. A comparison of composite quality of life scores and change in scores over time among the two groups revealed no significant differences at any of the follow-up measurements.

EX-PRESS Mini Shunt

Systematic Reviews

Three RCTs were included which compared trabeculectomy alone with trabeculectomy plus EX-PRESS Mini Shunt. These trials were rated as having a high or unclear risk of bias using the Cochrane criteria. None of the RCTs reported a significant improvement for the EX-PRESS group. However, in the pooled analysis, IOP was lower in the combination group than in the trabeculectomy alone group (weighted mean difference, -1.58; 95% confidence interval [CI], -2.74 to -0.42). Pooled analysis also showed that subsequent cataract surgery was less frequent in the combination group than in trabeculectomy alone (relative risk, 0.34; 95% CI, 0.14 to 0.74). The combination group had a lower rate of some complications (eg, hyphema, needling).

Randomized Controlled Trials
De Jong et al (2009) reported on a randomized study that compared the EX-PRESS Mini Shunt with standard trabeculectomy in 78 patients (80 eyes) diagnosed with open-angle glaucoma uncontrolled using maximally tolerated medical therapy (see Table 2).

Five-year follow-up was reported by de Jong et al (2011).
The 2 groups were similar after randomization, except mean age (62 years for the EX-PRESS group vs 69 years for the trabeculectomy group). At 12-month follow-up, mean IOP and antiglaucoma medications use decreased in both groups (see Table 2). Twelve-month Kaplan-Meier success rates (defined as an IOP > 4 mm Hg with medication and <= 18 mm Hg without medication) were 82% for the EX-PRESS shunt and 48% for trabeculectomy. At five years, success rates did not differ significantly between groups. In the EX-PRESS group, IOP remained stable from year 1 (12.0 mm Hg) to year 5 (11.5 mm Hg), while, in the trabeculectomy group, IOP decreased from year 3 (13.5 mm Hg) to year 5 (11.3 mm Hg) (see Table 3). More complications occurred after trabeculectomy than after EX-PRESS implantation.

A U.S. multicenter randomized trial by Netland et al (2014), compared trabeculectomy with EX-PRESS implantation in 120 patients (120 eyes) (see Table 2).

Comparator groups were similar at baseline. Throughout a two-year postsurgical follow-up, average IOP and number of medications were similar between groups (see Table 3). Surgical success was 90% and 87% at 1 year and 83% and 79% at 3 years in the EX-PRESS and trabeculectomy groups, respectively. Visual acuity returned to near baseline levels at one month after EX-PRESS implantation (median, 0.7 months) and at three months after trabeculectomy (median, 2.2 months; p=0.041). Postoperative complications were higher after trabeculectomy (41%) than after EX-PRESS implantation (18.6%).

One additional small RCT was published by Wagschal et al (2015), presenting 1-year results, and by Gonzalez-Rodriguez et al (2016), presenting 3-year results (see Table 2).

The trial corroborated the results of the earlier RCTs, reporting no differences between trabeculectomy and EX-PRESS shunt groups on outcomes for mean IOP, success rates, number of medications used, or complication rates (see Table 3).

Table 2. Summary of Key RCT Characteristics for the EX-PRESS Trial

<table>
<thead>
<tr>
<th>Study</th>
<th>Countries</th>
<th>Sites</th>
<th>Dates</th>
<th>Participants</th>
<th>Interventions</th>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Netland et al (2014)</td>
<td>U.S., Canada</td>
<td>7</td>
<td>NR</td>
<td>Patients with OAG treated with IOP medications who were candidates for</td>
</tr>
</tbody>
</table>
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<table>
<thead>
<tr>
<th>Study</th>
<th>Mean IOP (SD), mm Hg</th>
<th>p</th>
<th>Mean Medication Use (SD)</th>
<th>Ex-PRESS(n=33)</th>
<th>Trabeculectomy(n=31)</th>
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<tr>
<td>1</td>
<td>Ex-PRESS</td>
<td>Trabeculectomy</td>
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<td>2</td>
<td>de Jong et al (2009); de Jong et al (2011)</td>
<td>23.6 (7.0)</td>
<td>20.7 (7.0)</td>
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<td>NR</td>
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<tr>
<td>3</td>
<td>Baseline</td>
<td>12.2 (3.8)</td>
<td>13.9 (3.8)</td>
<td>0.05</td>
<td>0.31</td>
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<tr>
<td>4</td>
<td>Year 1</td>
<td>12.0 (3.3)</td>
<td>13.8 (3.2)</td>
<td>0.01</td>
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<td>5</td>
<td>Year 2</td>
<td>12.1 (3.4)</td>
<td>13.5 (3.4)</td>
<td>0.08</td>
<td>0.62</td>
</tr>
<tr>
<td>6</td>
<td>Year 3</td>
<td>11.4 (2.5)</td>
<td>11.6 (2.5)</td>
<td>0.69</td>
<td>0.69</td>
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<td>7</td>
<td>Year 4</td>
<td>11.4 (2.2)</td>
<td>11.2 (2.2)</td>
<td>0.71</td>
<td>0.85</td>
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<tr>
<td>8</td>
<td>Year 5</td>
<td>25.1 (6.0)</td>
<td>26.4 (6.9)</td>
<td>0.27</td>
<td>3.1 (1.1)</td>
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<td>9</td>
<td>Netland et al (2014)</td>
<td>13.8 (4.7)</td>
<td>11.9 (4.6)</td>
<td>0.03</td>
<td>NR</td>
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<td>10</td>
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<td>14.7 (4.6)</td>
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<td>0.9 (1.3)</td>
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<td>11</td>
<td>Month 6</td>
<td>22.6 (10.2)</td>
<td>21.9 (6.8)</td>
<td>0.75</td>
<td>3.5 (0.9)</td>
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<tr>
<td>12</td>
<td>Year 1</td>
<td>11.2 (4.3)</td>
<td>10.7 (3.5)</td>
<td>0.85</td>
<td>0.4</td>
</tr>
</tbody>
</table>

IOP: intraocular pressure; NR: not reported; OAG: open-angle glaucoma; RCT: randomized controlled trial.

Table 3. Summary of Key RCT Results for Ex-PRESS
Aqueous Shunts and Stents for Glaucoma

Policy # 00421
Original Effective Date: 05/21/2014
Current Effective Date: 02/20/2019

<table>
<thead>
<tr>
<th>Year</th>
<th>IOP (mmHg)</th>
<th>Glaucoma Medication Use</th>
</tr>
</thead>
<tbody>
<tr>
<td>16</td>
<td>12.5 (5.1)</td>
<td>10.3 (3.7) 0.07 0.6 (1.3) 1.3 (1.5)</td>
</tr>
<tr>
<td>17</td>
<td>13.3 (4.5)</td>
<td>11.1 (4.4) 0.10 1.4 (1.7) 1.2 (1.3)</td>
</tr>
</tbody>
</table>

IOP: intraocular pressure; NR: not reported; SD: standard deviation.

Observational Studies

Dib Bustros et al (2017) published a retrospective chart review that offered 1-year results from 56 African American patients who underwent EX-PRESS (n=28) implantation or trabeculectomy (n=28).

Outcomes included IOP and glaucoma medication used presurgery, postsurgery, and at 12-months of follow-up. In both groups, IOP and glaucoma-related medication use dropped significantly. Postoperative and follow-up interventions included 5-fluorouracil injections and laser suture lysis. Patients who underwent trabeculectomy needed a significantly greater number of laser suture lysis and 5-fluorouracil interventions in the 3 months after surgery (trabeculectomy: 3.89; EX-PRESS: 2.36, p=0.007). The results showed that EX-PRESS was noninferior to trabeculectomy in reducing IOP and reducing the need for glaucoma-related medications.

Omatsu et al (2018) compared changes in corneal endothelial cells among patients undergoing trabeculectomy (n=60) and patients receiving EX-PRESS shunts (n=50).

Both groups experienced significant decreases in IOP compared with baseline. After two years of follow-up, patients undergoing trabeculectomy experienced significant decreases in corneal endothelial cells compared with baseline, while the EX-PRESS group did not.

Comparative Effectiveness Analyses

Five-year results of two RCTs comparing the Ahmed and Baerveldt shunts have been published.

The Ahmed Baerveldt Comparison (ABC) study was a multicenter international RCT evaluating the comparative safety and efficacy of the Ahmed Glaucoma Valve FP7 and Baerveldt Glaucoma Implant BG 101-350 (1:1 ratio) in 276 adults with previous incisional eye surgery or refractory glaucoma.

Late complications were defined as those developing after three months. Such complications occurred in 56 (47%) patients in the Ahmed group and 67 (56%) patients in the Baerveldt group during 5 years of follow-up (p=0.08). The cumulative incidences of serious complications at 5 years were 16% and 25% in the Ahmed and Baerveldt groups, respectively (p=0.03).

The Ahmed Versus Baerveldt (AVB) study, reported by Christakis et al (2016), was an international, multicenter RCT enrolling 238 patients with uncontrolled glaucoma despite maximally tolerated medical therapy.
AVB is funded by the Glaucoma Research Society of Canada. Patients were randomized in a 1:1 ratio to the Ahmed FP7 implant and the Baerveldt 350 implant. Failure of the shunt implant was the primary outcome, defined as any one of the following: IOP of less than 5 mm Hg or greater than 18 mm Hg or a reduction of less than 20% from baseline for 2 consecutive visits after 3 months; de novo glaucoma surgery required; removal of the implant; severe vision loss related to the surgery; or progression to no light perception for any reason. The cumulative failure rate was 53% in the Ahmed group and 40% in the Baerveldt group at 5 years (p=0.04). In the Ahmed and Baerveldt shunts, the mean percent reduction in IOP was 47% and 57% (p=0.001) and mean percent reduction in medication use was 44% and 61% (p=0.03), all respectively. Hypotony was reported in 5 (4%) patients in the Baerveldt group but not in the Ahmed group (p=0.02).

Christakis et al (2017) analyzed 5-year pooled data from the ABC and AVB trials comparing the relative efficacy of the 2 implants. Patients were randomized to an Ahmed implant (n=267) or a Baerveldt implant (n=247). IOP, glaucoma medication use and visual acuity were compared. At year 5, mean IOP was 15.8 mm Hg in the Ahmed group and 13.2 mm Hg in the Baerveldt group (p=.007). The cumulative failure rate in the Ahmed group was 49%; in the Baerveldt group, it was 37%. Mean glaucoma medication use was significantly lower in patients receiving the Baerveldt implant than in patients receiving the Ahmed implant (p=0.007). Visual acuity was similar between both groups. While efficacy measures were significantly better in the Baerveldt group, these patients experienced more hypotony (4.5%) than patients in the Ahmed group (0.4%; p=.002).

A small RCT by Bo et al (2018) randomizing 68 patients compared the EX-PRESS shunt (n=33) and the Ahmed shunt (n=35).

Follow-up at nine months showed no difference in best-corrected visual acuity or in postoperative complications. Control of IOP was superior in EX-PRESS compared with the Ahmed shunt.

**Section Summary: Ab Externo Aqueous Shunts**

Evidence for the use of ab externo aqueous shunts for the treatment of open-angle glaucoma uncontrolled by medications consists of RCTs comparing shunts with trabeculectomy. Outcomes of interest are IOP and antiglaucoma medication use. Follow-up among the trials ranged from one to five years. Results showed that ab externo aqueous shunts are noninferior to trabeculectomy. Adverse event rates were higher among patients undergoing trabeculectomy.

The comparative effectiveness of two ab externo devices (the Ahmed and Baerveldt shunts) has been evaluated in two trials, the AVB, and the ABC trials. These trials reported similar results, with both devices lowering IOP significantly. Compared with patients receiving the Ahmed shunt, patients receiving the Baerveldt shunt experienced lower IOP and needed fewer medications. However, patients receiving the Baerveldt shunt experienced higher rates of hypotony-related complications.
Ab Interno Aqueous Stents

This section reviews the evidence for ab interno stents with the FDA approval or marketing clearance. At this time, the XEN gel stent and injector is the only stent system FDA-approved as a stand-alone procedure for the treatment of refractory open-angle glaucoma.

Xen Glaucoma Treatment System

Observational Studies

Comparative Studies

Schlenker et al (2017) published a multicenter, retrospective interventional cohort study that compared the risk, safety, and efficacy for stand-alone ab interno microstent implantation with mitomycin C (MMC) and trabeculectomy plus MMC (Table 4).

Implantations of the ab interno XEN 45 gelatin microstent is a less invasive surgery than trabeculectomy. Outcomes included: IOP differences, medication reductions, interventions, complications, and the need for additional surgery. The primary outcome was the hazard ratio of failure. Failure was defined as two consecutive IOP readings of less than 6 mm Hg, including vision loss. Success was measured by the withdrawal of glaucoma-related medications at one month postsurgery. The adjusted hazard ratio of failure of the microstent relative to trabeculectomy was 1.2 for complete success (95% CI, 0.7 to 2.0). Both surgeries had a 75% survival of approximately 10 months for complete success. During the last reported follow-up (varying times), antiglaucoma medications were being used by 25% of patients who received the microstent implantation and 33% of trabeculectomy patients. Patients in both groups reported similar numbers of postoperative interventions, such as laser suture lysis and needling. The need for reoperation was higher among those who had undergone microstent implantation—but this difference was not statistically significant. The authors concluded that the ab interno gelatin microstent with MMC was noninferior to trabeculectomy plus MMC. Changes in IOP and medication use appear in Table 5.

Noncomparative Studies

Mansouri et al (2018) reported on results from a study of 149 eyes (113 patients); 109 eyes received the XEN implant plus cataract surgery and 40 eyes received the implant alone (see Table 4).

There was a range of glaucoma severity represented in the study sample, with most patients in the mild-to-moderate stages. Of the 149 eyes, data for 87 (58%) eyes was available at 12 months. The high loss to follow-up was mainly due to high travel times for patients referred to the study treatment center from various provinces and countries, and to lack of interest among physicians to treat referred patients. At 12 months, mean IOP and mean medication use, both decreased (see Table 5). The proportion achieving 20% or more reduction in IOP was higher among patients receiving XEN alone than those undergoing cataract surgery and XEN implantation. Adverse events included bleb revision (n=5), choroidal detachment (n=2), and second glaucoma surgery (n=9).
Grover et al (2017) published results from the single-arm, open-label clinical study evaluating the effectiveness and safety of the XEN Glaucoma Treatment System in 65 patients with refractory glaucoma (see Table 4).

Effectiveness data were collected for 12 months and safety data for 18 months. Forty-six (75%) patients of 61 with available data had a 12-month mean diurnal IOP reduction of 20% or more without increasing IOP-lowering medications. The mean IOP reduction at 12 months was -9.1 mm Hg (95% CI, -10.7 to -7.5 mm Hg) on a mean of 1.7 medications (see Table 5). Efficacy was consistent across age groups, baseline IOP, baseline medication use, sex, and ethnicity. The most common adverse events were glaucoma surgery, hypotony, IOP increase of 10 mm Hg or more, and needling procedures. The FDA cited results from this study to conclude that the XEN System was as safe and effective as predicate devices.

Hengerer et al (2017) retrospectively analyzed 146 patients (242 eyes) receiving the XEN implant for treatment-refractory to antiglaucoma medication or glaucoma surgery (see Table 4).

In the subset of eyes with 12-month data (n=148), IOP reduction of 20% or more was achieved by 73.0% of patients. Mean antiglaucoma medications decreased (see Table 5). The decreases in IOP and medication use were statistically significant, in patients receiving the XEN implant alone and in patients receiving the XEN implant while undergoing cataract surgery.

Additional smaller case series assessing the use of the XEN implant are described in Tables 4 and 5. These case series, by Galal et al (2017), Ozal et al (2017), and Tan et al (2018), reported significant reductions in IOP and medication use. Low rates of the following complications were reported: hypotony (which resolved), need for bleb intervention, iris tissue obstruction, implant extrusion, and choroidal detachment.

Table 4. Summary Characteristics for Observational Studies Using the XEN Implant as a Stand-Alone Procedure for Refractory Open-Angle Glaucoma

<table>
<thead>
<tr>
<th>Study</th>
<th>Country</th>
<th>Participants</th>
<th>Treatment Delivery</th>
<th>FU</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Schlenker</td>
<td>Austria, Belgium, Canada,</td>
<td>Patients with OAG, pseudoxfoliation, pigment dispersion, normal-tension,</td>
<td>XEN alone (n=185)</td>
<td>Up to 30 mo(last visit</td>
</tr>
<tr>
<td>et al (2017)</td>
<td>Germany</td>
<td>angle-recession, combined mechanism, history of angle closure, or juvenile</td>
<td>Trabeculectomy (n=169)</td>
<td>in chart)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>glaucoma and no prior incisional surgery</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 Mansouri</td>
<td>Switzerland</td>
<td>Patients with OAG and uncontrolled IOP, progressive glaucoma, and/or</td>
<td>XEN alone (n=40)</td>
<td>12 mo</td>
</tr>
<tr>
<td>et al (2018)</td>
<td></td>
<td>refractory to IOP</td>
<td>XEN plus cataract surgery (n=109)</td>
<td></td>
</tr>
</tbody>
</table>
### Aqueous Shunts and Stents for Glaucoma

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**Current Effective Date:** 02/20/2019

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**Table 5. Summary of Results for the XEN Implant as Stand-Alone Procedure for Refractory Open-Angle Glaucoma**

<table>
<thead>
<tr>
<th>Study</th>
<th>Population</th>
<th>Median IOP (SD), mm Hg</th>
<th>Medication, Median (SD)</th>
<th>Baseline</th>
<th>1 Yeara</th>
<th>3.0 (IQR: 3 to 15)</th>
<th>0.0 (IQR: 0 to 1)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Schlenker et al (2017)</td>
<td>XEN alone</td>
<td>24.0 (IQR: 19 to 32)</td>
<td>13.0 (IQR: 10 to 15)</td>
<td>3.0 (IQR: 3 to 4)</td>
<td>0.0 (IQR: 0 to 1)</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Trabeculectomy</td>
<td>24.0 (IQR: 19 to 30)</td>
<td>13.0 (IQR: 10 to 16)</td>
<td></td>
<td>3.0 (IQR: 3 to 4)</td>
<td>0.0 (IQR: 0 to 1)</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Mansouri et al (2018)</td>
<td>XEN alone</td>
<td>20 (IQR: 17 to 23)</td>
<td>40.0% reduction</td>
<td>2.5 (IQR: 1 to 4)</td>
<td>NR</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Grover et al</td>
<td>XEN alone</td>
<td>25.1 (3.7)</td>
<td>15.9 (5.2)</td>
<td>3.5</td>
<td>1.7</td>
<td></td>
</tr>
</tbody>
</table>

**FU:** follow-up; **IOP:** intraocular pressure; **OAG:** open-angle glaucoma.
Section Summary: Ab Interno Aqueous Stents

Currently, the XEN gel stent is the only stent approved by the FDA for the treatment of refractory open-angle glaucoma as a stand-alone procedure. Clearance for the stent was based on a review in which the FDA concluded that while there were technical differences between the stent and predicate devices (shunts), the differences did not affect safety and effectiveness in lowering IOP and medication use. Evidence for the use of the XEN implant consists of a nonrandomized comparative study which retrospectively reviewed charts of patients either receiving the XEN implant or undergoing a trabeculectomy. Additional evidence consists of several single-arm studies. The comparative study included patients with different types of glaucoma (57% with OAG) and reported that patients receiving the XEN implant experienced reductions in IOP and medication use similar to patients undergoing a trabeculectomy. However, there was no discussion on how patients were chosen to receive the different treatments and no subgroup analysis by glaucoma type was provided. The single-arm studies, with 12 months of follow-up, consistently showed that patients receiving the XEN implant experienced reductions in IOP and medication use, with reductions in IOP ranging from 4 mm Hg to over 15 mm Hg.

Aqueous Microstents with Cataract Surgery

Several stents have the FDA approval for use in conjunction with cataract surgery and are discussed below. The iStent inject device is preloaded with two stents. An additional stent, the CyPass, had the FDA approval but has been voluntarily recalled by the manufacturer in 2018, as follow-up data has shown significant endothelial cell loss among patients receiving the CyPass in conjunction with cataract surgery compared with patients receiving cataract surgery alone. Studies comparing implantation of stents during cataract surgery with cataract surgery alone are discussed in the following section.

iStent

Randomized Controlled Trials with one iStent

Results from the iStent U.S. investigational device exemption, open-label, 29-site, multicenter RCT were reported to the FDA in 2010, with 1-year results published by Samuelson et al (2011) and 2-year results published by Craven et al (2012) (see Table 6).
Trial objectives were to compare the incremental effect on IOP of iStent implantation with that of cataract surgery alone and to determine the potential benefit of combining two therapeutic treatments into a single surgical event. A total of 240 patients (mean age, 73 years) with cataracts and mild-to-moderate open-angle glaucoma (IOP ≤24 mm Hg controlled on 1-3 medications) underwent a medication washout period. Patients were randomized to cataract surgery plus iStent implantation or cataract surgery only if unmedicated IOP was between 22 mm and 36 mm Hg. Follow-up visits were performed at 1, 3, 6, and 12 months. Results were assessed by intention-to-treat analysis with the last observation carried forward and per protocol analysis. Of the 117 subjects randomized to iStent implantation, 111 underwent cataract surgery with stent implantation, and 106 (91%) completed the 12-month postoperative visit. Of the 123 subjects randomized to cataract surgery only, 117 underwent cataract surgery, and 3 exited the trial because of surgical complications. Of the remaining 114 subjects, 112 (91%) completed the 12-month visit. The proportion of eyes meeting both the primary (unmedicated IOP ≤21 mm Hg) and secondary outcomes (IOP reduction ≥20% without medication) was higher in the treatment group than in the control group through 1-year follow-up (72% of treatment eyes vs 50% of control eyes achieved the primary efficacy endpoint, p < 0.001). The proportion of patients achieving the secondary efficacy endpoint was 66% in the treatment group and 48% in the control group (p = 0.003). Ocular hypotensive medications were initiated later in the postoperative period and used in a lower proportion of patients in the treatment group throughout 1-year follow-up (eg, 15% vs 35% at 12 months). Mean reduction in IOP was similar in both groups, though the control group used slightly more medication (mean, 0.4 medications) than the treatment group (0.2 medications) at 1 year (see Table 7).

At 2-year follow-up, 199 (83%) patients remained in the study. The primary endpoint (unmedicated IOP ≤21 mm Hg) was reached by 61% of patients in the treatment group and 50% of controls (p = 0.036).

Secondary outcomes IOP reduction of 20% or more without medication (53% vs 44%) and mean number of medications used (0.3 vs 0.5) no longer differed significantly between groups at 2 years. As noted by the FDA, this study was conducted in a restricted population with an unmedicated IOP of 22 mm Hg or higher and a medicated IOP of 36 mm Hg or lower. Study results suggested that microstent treatment in this specific group likely improved outcomes at one year compared with cataract surgery alone; however, two-year results make it difficult to conclude with certainty that health outcomes improved (see Table 7).

Fea et al (2010) reported on a randomized, double-blind, trial of 36 cataract surgery patients who did or did not receive an iStent implantation (2:1 ratio) (see Table 6). Inclusion criteria were a previous diagnosis of primary open-angle glaucoma with an IOP above 18 mm Hg at 3 separate visits and taking 1 or more hypotensive medications. Investigators were masked to the treatment condition and conducted follow-up at 24 hours, 1 week, and 1, 2, 3, 6, 9, 12, and 15 months. Prescription of hypotensive medications was performed according to preset guidelines. Primary outcomes were IOP and reduction in medication use over 15 months and IOP after a 1-month washout of ocular hypotensive agents (16 months postoperatively). Mean IOP at 15 months decreased in both treatment groups (see Table 7). Eight (67%) of 12 patients in the stent group and 5 (24%) of 21 in the control group did not require ocular hypotensive medication. Because treatment compliance is an ongoing concern for
most ophthalmologists, trialists sought to keep patients as medication free as possible postoperatively. Patients in the stent group had significantly lower medication use than patients in the cataract alone group. After washout of medications, mean IOP was 16.6 mm Hg in the stent group and 19.2 mm Hg in the control group. No adverse events related to stent implantation were reported. Four-year follow-up from this study was published by Fea et al (2015).

Twenty-four of 36 patients were available at 4 years. Differences between treatment groups remained statistically nonsignificant (mean IOP, 15.9 mm Hg in the stent group vs 17 mm Hg in the control group).

Table 6. Summary of Key RCT Characteristics for the iStent

<table>
<thead>
<tr>
<th>Study</th>
<th>Countries</th>
<th>Sites</th>
<th>Dates</th>
<th>Participants</th>
<th>Interventions</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>U.S.</td>
<td>29</td>
<td>2005-2007</td>
<td>Patients with mild-to-moderate OAG, IOP &gt;=22 and &lt;=36 mm Hg</td>
<td>iStent plus cataract(n=116) Cataract alone(n=123)</td>
</tr>
<tr>
<td>2</td>
<td>Italy</td>
<td>1</td>
<td>NR</td>
<td>Patients with primary OAG</td>
<td>iStent plus cataract(n=24) Cataract alone(n=12)</td>
</tr>
</tbody>
</table>

IOP: intraocular pressure; NR: not reported; OAG: open angle glaucoma; RCT: randomized controlled trial.

Table 7. Summary of Key RCT Results for the iStent

<table>
<thead>
<tr>
<th>Study</th>
<th>Mean IOP (SD), mm Hg</th>
<th>p</th>
<th>Mean Medication Use (SD)</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>iStent</td>
<td>Cataract Alone</td>
<td>iStent</td>
<td>Cataract Alone</td>
</tr>
<tr>
<td>3</td>
<td>Baseline</td>
<td>18.6 (3.4)</td>
<td>17.9 (3.0)</td>
<td>NR</td>
</tr>
<tr>
<td>4</td>
<td>Year 1</td>
<td>17.0 (2.8)</td>
<td>17.0 (3.1)</td>
<td>NR</td>
</tr>
<tr>
<td>5</td>
<td>Year 2</td>
<td>17.1 (2.9)</td>
<td>17.8 (3.3)</td>
<td>NR</td>
</tr>
</tbody>
</table>
Aqueous Shunts and Stents for Glaucoma

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<table>
<thead>
<tr>
<th></th>
<th>Baseline</th>
<th>Month 15</th>
<th>Year 4</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>IOP</td>
<td>IOP</td>
<td>IOP</td>
</tr>
<tr>
<td></td>
<td>(mm Hg)</td>
<td>(mm Hg)</td>
<td>(mm Hg)</td>
</tr>
<tr>
<td>7</td>
<td>17.9 (2.6)</td>
<td>17.3 (3.0)</td>
<td>17.5 (2.3)</td>
</tr>
<tr>
<td>8</td>
<td>14.8 (1.2)</td>
<td>15.7 (1.1)</td>
<td>20.4 (3.2)</td>
</tr>
<tr>
<td>9</td>
<td>14.8 (1.2)</td>
<td>15.7 (1.1)</td>
<td>20.4 (3.2)</td>
</tr>
<tr>
<td></td>
<td>0.51</td>
<td>0.03</td>
<td>0.02</td>
</tr>
<tr>
<td></td>
<td>(0.9)</td>
<td>(0.7)</td>
<td>(0.8)</td>
</tr>
<tr>
<td></td>
<td>1.9</td>
<td>0.4</td>
<td>0.5</td>
</tr>
<tr>
<td></td>
<td>(0.7)</td>
<td>(0.7)</td>
<td>(0.8)</td>
</tr>
<tr>
<td></td>
<td>1.8</td>
<td>1.3</td>
<td>0.9</td>
</tr>
<tr>
<td></td>
<td>(0.7)</td>
<td>(1.0)</td>
<td>(1.0)</td>
</tr>
</tbody>
</table>

IOP: intraocular pressure; NR: not reported; SD: standard deviation.

**Observational Studies with one iStent**


Fifty-five patients (70 eyes) were analyzed in this retrospective comparative case series, 36 receiving phaco-trabectome and 34 receiving phaco-iStent. Outcomes included IOP reduction, glaucoma medication reduction, patients' safety profile, and best-corrected visual acuity. At baseline, the mean IOP of patients in the phaco-trabectome group (30 patients [36 eyes], 20.92 mm Hg)) was higher than those in the phaco-iStent group (25 patients [34 eyes], 17.47 mm Hg; p=0.026). At 12-month follow-up, both groups experienced significant reductions in IOP; however, there was no statistically significant difference between groups (phaco-trabectome, -5.09 mm Hg 24% relative reduction vs phaco-iStent, -3.84 mm Hg, 22% relative reduction; p=0.331). Glaucoma medication usage did not decrease significantly from baseline to 12 months in either group; moreover, there was no significant difference in reduction between the groups. Phaco-iStent patients had fewer individual complications.

Ferguson et al (2018) reported on a series of 59 patients with severe primary open-angle glaucoma who were implanted with 1 trabecular micro-bypass stent (iStent) during cataract surgery.

Patients were followed for two years. IOP at baseline was 19.3 mm Hg at baseline, decreasing significantly to 14.4 mm Hg at 12 months and 14.9 mm Hg at 24 months (p<0.01). Mean number of glaucoma medications also decreased, from 2.3 at baseline to 1.6 at 24 months.

**Randomized Controlled Trials with two iStents**

Fernández-Barrientos et al (2010) randomized 33 patients with open-angle glaucoma or ocular hypertension to 2 iStent devices plus cataract surgery or cataract surgery alone.

The study was performed at a single-center in Spain. Eligible eyes had a medicated IOP between 17 mm and 31 mm Hg (exclusive) and between 21 mm and 35 mm Hg after medication washout. Mean IOP reduction was greater in the iStent plus surgery group (6.6 mm Hg) than in the surgery alone group (3.9 mm Hg; p=0.002). The mean number of IOP-lowering medications was also significantly lower in the iStent group (0.0 vs 0.7, respectively; p=0.007).
Aqueous Shunts and Stents for Glaucoma

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Observational Studies with two iStents

Use of multiple iStent devices with cataract surgery was reported in an open-label, prospective series of 53 eyes (47 patients) by Belovay et al (2012).

Twenty-eight of 53 eyes were implanted with 2 stents and 25 with 3 stents, based on the need for greater IOP control, as determined by the operating surgeon. Best-corrected visual acuity improved or remained stable in 89% of eyes. IOP decreased from a mean of 18.0 to 14.3 mm Hg, and the number of hypotensive medications decreased from a mean of 2.7 to 0.7 at 1 year postoperatively. Target IOP was reached in 77% of eyes, while 59% of patients discontinued all medications for the study eye. At one year, the mean number of hypotensive medications decreased to 1.0 in the 2-stent group and 0.4 in the 3-stent group. Medication use ceased in 46% of eyes in the 2-stent group and 72% in the 3-stent group. Stent blockage occurred in the early postoperative period in 15% of eyes and was successfully treated with laser.

Donnenfeld et al (2015) published a prospective case series enrolling 39 patients with open-angle glaucoma and IOP between 18 and 30 mm Hg.

Each patient received two micro stents and medications as needed, and was followed for three years. At trial completion, the mean reduction in IOP was 9.1 mm Hg (95% CI, 8.0 to 10.1 mm Hg). There was one postoperative complication (hyphema), which resolved without further intervention.

Vlasov et al (2017) conducted a retrospective chart review of patients with open-angle glaucoma receiving either 1 iStent (n=39) or 2 iStents (n=30) during cataract surgery.

Both groups experienced statistically significant reductions in IOP, and there was no significant difference between them in IOP reduction. Only the group receiving two iStents experienced a statistically significant reduction in medication use.

Hydrus Microstent

Randomized Controlled Trials

Pfeiffer et al (2015) reported on a single-masked, randomized trial with 100 patients (100 eyes) that compared the effectiveness of the Hydrus Microstent plus cataract surgery with cataract surgery alone.

At the 24-month follow-up, the proportion of patients with a 20% reduction in IOP was significantly higher with the Hydrus Microstent (80% vs 46%, p<0.001) and the mean IOP after medication washout was lower (16.9 mm Hg vs 19.2 mm Hg, p=0.009) compared with cataract surgery alone, respectively. The microstent group used significantly fewer medications (0.5 vs 1.0, p=0.019) and had a higher proportion of patients taking no hypotensive medications at the time of cataract surgery (73% vs 38%, p=0.001).
Xen Glaucoma Treatment System

Observational Studies
Mansouri et al (2018), Hengerer et al (2017), Galal et al (2017) and Ozal et al (2017) are described above in the section on aqueous stents used as a stand-alone treatment for refractory open-angle glaucoma. These studies also included patients who received the XEN implant in conjunction with cataract surgery and study characteristics and results for this subgroup appear in Tables 8 and 9.

Additional single-arm studies (Perez-Torregrosa et al [2016] and De Gregorio et al [2017]) evaluating the use of the XEN implant in conjunction with cataract surgery are also described in Tables 8 and 9 below.

Table 8. Summary of Key Case Series Characteristics for the XEN Implant with Cataract Surgery

<table>
<thead>
<tr>
<th>Study</th>
<th>Country</th>
<th>Participants</th>
<th>Treatment Delivery</th>
<th>FU</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Mansouri et al (2018)</td>
<td>Switzerland</td>
<td>Patients with OAG and uncontrolled IOP, progressive glaucoma, and/or refractory to IOP medications</td>
<td>XEN alone (n=40) XEN plus cataract surgery (n=109)</td>
<td>12 mo</td>
</tr>
<tr>
<td>2 Hengerer et al (2017)</td>
<td>Germany</td>
<td>Patients with OAG and uncontrolled IOP, optic disc damage, and refractory to IOP medications or prior surgery</td>
<td>XEN alone (n=203) XEN plus cataract surgery (n=39)</td>
<td>12 mo</td>
</tr>
<tr>
<td>3 Perez-Torregrosa et al</td>
<td>Spain</td>
<td>Patients with OAG and cataract and taking at least 2 IOP-lowering medications</td>
<td>XEN plus cataract (n=30)</td>
<td>12 mo</td>
</tr>
<tr>
<td>4 De Gregorio et al (2017)</td>
<td>Italy</td>
<td>Patients with OAG under maximally tolerated medical therapy and with cataract</td>
<td>XEN plus cataract (n=41)</td>
<td>12 mo</td>
</tr>
<tr>
<td>5 Galal et al (2017)</td>
<td>Germany</td>
<td>Patients with OAG</td>
<td>XEN alone (n=3) XEN plus cataract surgery (n=10) Both groups also received subconjunctival mitomycin-C</td>
<td>12 mo</td>
</tr>
<tr>
<td>6 Ozal et al (2017)</td>
<td>Turkey</td>
<td>Patients with OAG and uncontrolled IOP, progressive glaucoma, and/or refractory to IOP medications or prior surgery</td>
<td>XEN alone (n=9) XEN plus cataract surgery (n=6)</td>
<td>12 mo</td>
</tr>
</tbody>
</table>

FU: follow-up; IOP: intraocular pressure; OAG: open-angle glaucoma.
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Table 9. Summary of Key Case Series Results for the XEN Implant with Cataract Surgery

<table>
<thead>
<tr>
<th>Study</th>
<th>Population</th>
<th>IOP (SD), mm Hg</th>
<th>Medication, Median (SD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Baseline</td>
<td>1 Year</td>
<td>Baseline</td>
</tr>
<tr>
<td>2 Mansouri et al (2018)</td>
<td>XEN + cataract</td>
<td>18 (IQR: 14 to 23)</td>
<td>22.9% reduction</td>
</tr>
<tr>
<td>3 Hengerer et al (2017)</td>
<td>XEN + cataract</td>
<td>35.7 (12)</td>
<td>13.9 (2.5)</td>
</tr>
<tr>
<td>4 Perez-Torregrosa et al (2016)</td>
<td>XEN + cataract</td>
<td>21.2 (3.4)</td>
<td>8.1 (3.0)</td>
</tr>
<tr>
<td>5 De Gregorio et al (2017)</td>
<td>XEN + cataract</td>
<td>22.5 (3.7)</td>
<td>13.1 (2.4)</td>
</tr>
<tr>
<td>6 Galal et al (2017)</td>
<td>All patients</td>
<td>16 (4)</td>
<td>12 (3)</td>
</tr>
<tr>
<td>7 Ozal et al (2017)</td>
<td>All patients</td>
<td>36.1</td>
<td>16.7</td>
</tr>
</tbody>
</table>

IOP: intraocular pressure; IQR: interquartile range; NR: not reported; SD: standard deviation.

CyPass

Randomized Controlled Trials


A total of 505 patients (1 eye per patient) were assigned in a 1:3 ratio to phacoemulsification only (control) or supraciliary micro stenting with phacoemulsification (microstent). Baseline mean IOPs and number of IOP-lowering medications were similar in both treatment groups (24.4 mm Hg and 1.4 medications, respectively). In the intention-to-treat analysis, 58% of controls vs 73% of microstent patients achieved 20% or greater unmedicated IOP-lowering at 24 months compared with baseline (p=0.002). The difference in mean IOP reduction at 24 months was 1.8 mm Hg (95% CI, 1.0 to 2.6 mm Hg; p<0.001), favoring the microstent group. In the control group, 59% were medication free at 24 months vs 85% in the microstent group. Mean medication use decreased to 0.6 drugs at 24 months in the control group and to 0.2 drugs in the microstent group (p<0.001). There were no vision-threatening microstent-related adverse events. Thirty-nine percent of microstent patients vs 36% of control patients experienced ocular adverse events in the 24-month period. The following ocular adverse events were reported: hypotony (3% microstent vs 0% control), maculopathy (1.3% microstent vs 0.8% control), corneal edema (4% microstent vs 2% control), cyclodialysis cleft greater than 2 mm in circumference (2% microstent vs 0% control), iritis (9% microstent vs 4% control), and subconjunctival hemorrhage (2% microstent vs 1% control). Best-corrected visual acuity...
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was 20/40 or better in more than 98% of all patients. Eleven patients in the microstent group and 1 patient in the control group died during the 24-month period; however, the deaths were classified as unrelated to the intervention.

Section Summary: Aqueous Microstents with Cataract Surgery
Currently, the FDA has approved several stents for the treatment of patients with mild-to-moderate open-angle glaucoma considering cataract surgery. Several RCTs and single-arm studies have compared cataract surgery alone with stent implantation in conjunction with cataract surgery. When compared to cataract surgery alone, a majority of the studies showed significant decreases in IOP and medication use when stents were implanted in addition to the cataract surgery.

Evidence from an RCT supported the use of the CyPass stent in conjunction with cataract surgery; however, in August 2018, the manufacturer of CyPass voluntarily withdrew CyPass from the market because a long-term study showed that patients receiving CyPass in conjunction with cataract surgery experienced statistically significant endothelial cell loss compared with patients who underwent cataract surgery alone.

Other Indications for Glaucoma Treatment
Glaucoma shunts and microstent have also been studied in patients for indications other than cataract surgery or refractory open-angle glaucoma. The following section describes implantation of more than two stents.

Greater than Two Stents

Randomized Controlled Trial
An RCT comparing the efficacy of 1 iStent with multiple iStent devices was published by Katz et al (2015). This trial, from a single institution in Armenia, randomized 119 patients with mild-to-moderate open-angle glaucoma and an IOP between 22 and 38 mm Hg (off medications) to 1 stent (n=38), 2 stents (n=41), or 3 stents (n=40). Randomization was performed using a pseudorandom number generator. The main outcome was IOP at 12 months. The primary endpoint was the percentage of patients with a reduction of 20% or more in IOP off medications. This endpoint was reached by 89.2% (95% CI, 74.6% to 97.0%) of the 1-stent group, by 90.2% (95% CI, 76.9% to 97.3%) of the 2-stent group, and by 92.1% (95% CI, 78.6% to 98.3%) of the 3-stent group. The secondary endpoint (percentage of patients achieving an IOP 15 mm Hg off medication) was reached by 64.9% (95% CI, 47.5% to 79.8%) of the 1-stent group, by 85.4% (95% CI, 70.8% to 94.4%) of the 2-stent group, and by 92.1% (95% CI, 78.6% to 98.3) of the 3-stent group. Forty-two-month follow-up results for 109 patients were published by Katz et al (2018).

Mean medicated IOPs for the 1-stent, 2-stent, and 3-stent groups were 15.0 2.8 mm Hg, 15.7 1.0 mm Hg, and 14.8 1.3 mm Hg, respectively. No between-group statistical comparisons were reported.
Observational Studies
Use of multiple iStent devices with cataract surgery was reported in an open-label, prospective series of 53 eyes (47 patients) by Belovay et al (2012).

Twenty-eight of 53 eyes were implanted with 2 stents and 25 with 3 stents, based on the need for greater IOP control, as determined by the operating surgeon. Best-corrected visual acuity improved or remained stable in 89% of eyes. IOP decreased from a mean of 18.0 to 14.3 mm Hg, and the number of hypotensive medications decreased from a mean of 2.7 to 0.7 at 1 year postoperatively. Target IOP was reached in 77% of eyes, while 59% of patients discontinued all medications for the study eye. At one year, the mean number of hypotensive medications decreased to 1.0 in the 2-stent group and 0.4 in the 3-stent group. Medication use ceased in 46% of eyes in the 2-stent group and 72% in the 3-stent group. Stent blockage occurred in the early postoperative period in 15% of eyes and was successfully treated with laser.

Section Summary: Other Indications for Glaucoma Treatment
Studies have evaluated the use of more than two stents, but comparators differed. One RCT compared implantation of a single iStent with 2 or 3 stents; it reported similar rates of patients with a 20% or more reduction in IOP. There were some group differences in secondary outcomes, but statistical testing was not reported. An observational study described implantation of two or three stents, at the discretion of the operating surgeon.

Summary of Evidence
For individuals who have refractory open-angle glaucoma who receive ab externo aqueous shunts, the evidence includes randomized controlled trials (RCTs), retrospective studies, and systematic reviews. The relevant outcomes are a change in disease status, functional outcomes, medication use, and treatment-related morbidity. RCTs assessing U.S. Food and Drug Administration (FDA) approved shunts have shown that the use of large externally placed shunts reduces IOP to slightly less than standard filtering surgery (trabeculectomy). Reported shunt success rates show that these devices are noninferior to trabeculectomy in the long-term. The FDA approved shunts have different adverse event profiles and avoid some of the most problematic complications of trabeculectomy. Two trials have compared the Ahmed and Baerveldt shunts. Both found that eyes treated with the Baerveldt shunt had slightly lower average IOP at five years than eyes treated with the Ahmed but the Baerveldt also had a higher rate of serious hypotony-related complications. The evidence is sufficient to determine that the technology results in a meaningful improvement in the net health outcome.

For individuals who have refractory open-angle glaucoma who receive ab interno aqueous stents, the evidence includes a nonrandomized retrospective comparative study and several single-arm studies. The relevant outcomes are a change in disease status, functional outcomes, medication use, and treatment-related morbidity. The comparative study reported that patients receiving the stent experienced similar reductions in IOP and medication use as patients undergoing trabeculectomy. The single-arm studies, with 12-month follow-up results, consistently showed that patients receiving the stents experienced reductions in IOP and medication use. Reductions in IOP ranged from 4 mm Hg to over 15 mm Hg. In addition, the FDA has given clearance to a gel stent based on equivalent IOP and medication use reductions as seen with ab
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externo shunts. Clearance for the stent was based on a review in which the FDA concluded that while there were technical differences between the stent and predicate devices (shunts), the differences did not affect safety and effectiveness in lowering IOP and medication use. The evidence is sufficient to determine that the technology results in a meaningful improvement in the net health outcome.

For individuals who have mild-to-moderate open-angle glaucoma who are undergoing cataract surgery who receive aqueous microstents, the evidence includes RCTs. The relevant outcomes are a change in disease status, functional outcomes, medication use, and treatment-related morbidity. Implantation of one or two microstents has received FDA approval for use in conjunction with cataract surgery for reduction of IOP in adults with mild-to-moderate open-angle glaucoma currently treated with ocular hypotensive medication. RCTs have been conducted in patients with cataracts and less advanced glaucoma, where IOP is at least partially controlled with medication. Trial results have shown that IOP may be lowered below baseline with a decreased need for medication through the first two years. The evidence is sufficient to determine that the technology results in a meaningful improvement in the net health outcome.

For individuals with indications for glaucoma treatment other than cataract surgery or refractory open-angle glaucoma who receive aqueous shunts or microstents, the evidence includes an RCT and an observational study. The relevant outcomes are a change in disease status, functional outcomes, medication use, and treatment-related morbidity. Several RCTs have evaluated the use of multiple microstents, but comparators differed. One RCT compared a single microstent with multiple microstents. This trial reported no difference in the primary outcome (percentage of patients with 20% reduction in IOP); secondary outcomes favored the multiple microstent groups. An observational study described implantation of two or three stents, at the discretion of the operating surgeon. The evidence is insufficient to determine the effects of the technology on health outcomes.

References

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40. Vlasov A, Kim WJ. The efficacy of two trabecular bypass stents compared to one in the management of open-angle glaucoma. Mil Med. Mar 2017;182(S1):222-225. PMID 28291477

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05/01/2014 Medical Policy Committee review
05/21/2014 Medical Policy Implementation Committee approval. New policy.
09/04/2014 Medical Policy Committee review
01/01/2015 Coding Update
08/03/2015 Coding update: ICD10 Diagnosis code section added; ICD9 Procedure code section removed.
10/29/2016 Medical Policy Committee review
11/16/2015 Medical Policy Implementation Committee approval. Coverage eligibility unchanged.
10/01/2016 Coding update
11/03/2016 Medical Policy Committee review
01/01/2017 Coding update: Removing ICD-9 Diagnosis Codes
06/01/2017 Medical Policy Committee review
06/21/2017 Medical Policy Implementation Committee approval. Coverage eligibility unchanged.
07/05/2018 Medical Policy Committee review
07/11/2018 Medical Policy Implementation Committee approval. Replaced the insertion of “aqueous shunts” with “ab externo shunts” as a method to reduce intraocular pressure (IOP) in patients with glaucoma where medical therapy has failed to adequately control IOP to be eligible for coverage. Added “the insertion of ab interno aqueous stents approved by the U.S. FDA as a method to reduce IOP in patients with glaucoma where medical therapy has failed to adequately control IOP, to be investigational.” Replaced the use of an “aqueous shunt” with “ab externo aqueous shunt or ab interno aqueous stent” for all other conditions, including in patients with glaucoma when IOP is adequately controlled by medications, to be investigational.*
02/07/2019 Medical Policy Committee review
02/20/2019 Medical Policy Implementation Committee approval. Insertion of ab interno aqueous stents approved by the Food and Drug Administration as a method to reduce intraocular pressure in patients with glaucoma where medical therapy has failed to adequately control intraocular pressure, was changed from investigational to eligible for coverage. Changed the eligible for coverage statement for implantation of “a single U.S. FDA approved microstent” to “1 or 2 U.S. FDA-approved ab interno stents” in conjunction with cataract surgery in patients with mild-to-moderate open-angle glaucoma treated with ocular hypotensive medication. Investigational statements for ab externo shunt and ab interno aqueous stent separated into two statements for clarity. Removed the investigational statement for the use of a microstent for all other indications.

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<th>Code Type</th>
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<tr>
<td>CPT</td>
<td>0191T, 0253T, 0376T, 0449T, 0450T, 0474T, 66183</td>
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<td>HCPCS</td>
<td>C1783, L8612</td>
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