

9.03.21	Aqueous Shunts and Stents for Glaucoma		
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Policy Statement

Ab Externo Aqueous Shunts

Insertion of ab externo aqueous shunts approved by the U.S. Food and Drug Administration (FDA) may be considered **medically necessary** as a method to reduce intraocular pressure in patients with glaucoma where medical therapy has failed to adequately control intraocular pressure.

Use of an ab externo aqueous shunt for all other conditions, including in patients with glaucoma when intraocular pressure is adequately controlled by medications, is considered **investigational**.

Ab Interno Aqueous Stents

Insertion of ab interno aqueous stents approved by the U.S. 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 may be considered **medically necessary**.

Implantation of 1 or 2 U.S. Food and Drug Administration-approved ab interno stents in conjunction with cataract surgery may be considered **medically necessary** in patients with mild-to-moderate open-angle glaucoma treated with ocular hypotensive medication.

Use of ab interno stents for all other conditions is considered **investigational**.

NOTE: Refer to [Appendix A](#) to see the policy statement changes (if any) from the previous version.

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.

Note: Ab-interno refers to procedures inside the eye, and ab-externo are outside the eye. An aqueous shunt refers to the tube that drains some of the aqueous humor fluid from inside the eye into a bleb under the conjunctiva beneath the upper eyelid (so it is not visible). This reduces the increased pressure inside the eye (glaucoma).

Coding

There is a category I CPT code for insertion of aqueous shunt using an external approach:

- **66183:** Insertion of anterior segment aqueous drainage device, without extraocular reservoir, external approach

There are CPT category III codes for these procedures using an internal approach:

- **0253T:** Insertion of anterior segment aqueous drainage device, without extraocular reservoir, internal approach, into the suprachoroidal space
- **0449T:** Insertion of aqueous drainage device, without extraocular reservoir, internal approach, into the subconjunctival space; initial device
- **0450T:** Insertion of aqueous drainage device, without extraocular reservoir, internal approach, into the subconjunctival space; each additional device (List separately in addition to code for primary procedure)

There is a CPT category III code for insertion of the CyPass device:

- **0474T:** Insertion of anterior segment aqueous drainage device, with creation of intraocular reservoir, internal approach, into the supraciliary space

The category III CPT codes specify insertion of an aqueous drainage device without drainage to an extraocular reservoir and are therefore differentiated from the existing codes for trabeculectomy or placement of shunts that drain to an extraocular reservoir (below). Procedures using the Trabectome device are considered similar to trabecular laser ablation and are not within the scope of this policy.

There are two CPT codes that describes ab interno trabeculostomy. Per the manufacturer, excimer laser trabeculostomy is a treatment for glaucoma and is currently being evaluated in a clinical trial so as to obtain FDA approval. Trabeculostomy makes a series of small holes in the trabecular meshwork using excimer laser photoablation whereby reducing eye pressure in glaucoma patients. These services may have been previously reported using CPT 66999 and should not be reported in conjunction with 92020.

- **0621T:** Trabeculostomy ab interno by laser
- **0622T:** Trabeculostomy ab interno by laser; with use of ophthalmic endoscope

Effective January 1, 2022, there is a new category III code which was created to represent when a drainage device is placed into the eye and there is no cataract removal. Other related changes are the creation of 2 new Category I codes 66989 and 66991 and the deletion of Cat III codes 0191T and 0376T.

- **0671T:** Insertion of anterior segment aqueous drainage device into the trabecular meshwork, without external reservoir, and without concomitant cataract removal, one or more

Effective January 1, 2022, the following CPT codes have been **deleted**:

- **0191T:** Insertion of anterior segment aqueous drainage device, without extraocular reservoir, internal approach, into the trabecular meshwork; initial insertion
- **0376T:** Insertion of anterior segment aqueous drainage device, without extraocular reservoir, internal approach, into the trabecular meshwork; each additional device insertion (List separately in addition to code for primary procedure)

Description

Glaucoma surgery is intended to reduce intraocular pressure (IOP) when the target IOP cannot be reached using medications. Due to complications with established surgical approaches (e.g., trabeculectomy), a variety of shunts are being evaluated as alternative surgical treatments for patients with inadequately controlled glaucoma. Microstents are also being evaluated in patients with mild-to-moderate open-angle glaucoma (OAG) currently treated with ocular hypotensive medication.

Related Policies

- Ophthalmologic Techniques That Evaluate the Posterior Segment for Glaucoma

Benefit Application

Benefit determinations should be based in all cases on the applicable contract language. To the extent there are any conflicts between these guidelines and the contract language, the contract language will control. Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage of these services as it applies to an individual member.

Some state or federal mandates (e.g., Federal Employee Program [FEP]) prohibits plans from denying Food and Drug Administration (FDA)-approved technologies as investigational. In these instances, plans may have to consider the coverage eligibility of FDA-approved technologies on the basis of medical necessity alone.

Regulatory Status

The regulatory status of the various ab externo and ab interno aqueous shunts and microstents are summarized in Table 1.

The first-generation Ahmed™ (New World Medical), Baerveldt® (Advanced Medical Optics), Krupin (Eagle Vision), and Moltano® (Moltano Ophthalmic) ab externo aqueous shunts were cleared for marketing by the FDA through the 510(k) process between 1989 and 1993; modified Ahmed and Moltano devices were cleared in 2006. They are indicated for use “in patients with intractable glaucoma to reduce IOP where medical and conventional surgical treatments have failed.” The AquaFlow™ Collagen Glaucoma Drainage Device (STAAR Surgical) was approved by the FDA through the premarket approval process for the maintenance of the subscleral 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 first microstent, 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 OAG currently treated with ocular hypotensive medication.

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 OAG. The recall was based on 5 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

Device	Manufacturer	Type	FDA Status	Date
AquaFlow™	STAAR Surgical	Drainage device	PMA	2001
Ahmed™	New World Medical	Aqueous glaucoma shunt, ab externo	510(k)	<1993
Baerveldt®	Advanced Medical Optics	Aqueous glaucoma shunt, ab externo	510(k)	<1993
Krupin	Eagle Vision	Aqueous glaucoma shunt, ab externo	510(k)	<1993
Moltano®	Moltano Ophthalmic	Aqueous glaucoma shunt, ab externo	510(k)	<1993
EX-PRESS®	Alcon	Mini-glaucoma shunt, ab externo	510(k)	2003
XEN® Gel Stent; XEN injector	AqueSys/Allergan	Aqueous glaucoma stent, ab interno	510(k)	2016
iStent®; iStent inject®	Glaukos	Microstent, ab interno	515(d) in conjunction with cataract surgery	2018
iStent supra®	Glaukos	Suprachoroidal stent	Not approved; in clinical trial	
CyPass®	Alcon	Suprachoroidal stent, ab interno	Company voluntarily recalled	2018
Hydrus™	Ivantis	Microstent, ab interno	PMA approval	2018

Device	Manufacturer	Type	FDA Status	Date
Beacon Aqueous Microshunt	MicroOptx	Micro-Shunt, ab externo	Not approved; in clinical trial	
PRESEFLO® MicroShunt (previously InFocus)	Santen	Micro-Shunt, ab externo	Not approved; in clinical trial	
iStent Infinite	Glaukos	Microstent, ab interno	Not approved; in clinical trial	

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

FDA product codes: OGO, KYF.

Rationale

Background 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 the 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 (e.g., 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). Canaloplasty involves dilation 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.

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, 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. 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

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. Shunts and stents can be administered through an external flap of the conjunctiva and sclera (*ab externo*) or in a small incision in the cornea with the devices inserted through the anterior chamber of the eye (*ab interno*). Some *ab interno* microstents may be inserted with injectors. Examples of *ab externo* devices are the Ahmed, Baerveldt, and EX-PRESS shunts. 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, iStent inject, 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 (e.g., <15 mm Hg) and are not indicated for patients for whom very low IOP is desired (e.g., those with advanced glaucoma). It has been proposed that stents such as the iStent, iStent inject, 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 1 stent to achieve desired IOP.

Literature Review

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 technology, 2 domains are examined: the relevance, and quality and credibility. To be relevant, studies must represent 1 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.

Aqueous Shunts and Stents for Glaucoma

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 PICO was used to select literature to inform this review.

Populations

The relevant populations of interest are:

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

Interventions

The therapies being considered are:

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

Comparators

Comparators include medical therapies and trabeculectomy.

Outcomes

The general outcomes of interest are a change in intraocular pressure (IOP) and medication use. Changes in IOP and medication use are measured for at least 12 months. Safety measures involve longer follow-up, for several years.

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.

Review of Evidence

Ab Externo Aqueous Shunts

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.¹ Trabeculectomy was found to lower mean IOP by 3.8 mm Hg more than the Ahmed shunt at 1 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 1 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).² 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.

Baerveldt Glaucoma Shunt Randomized Controlled Trials

Results from the open-label, multicenter, randomized Tube vs Trabeculectomy 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.^{2,3,4} 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).

Subsequent publications have reported no significant differences between the groups for vision-related quality of life or visual field outcomes from the Tube vs Trabeculectomy study.^{5,6}

EX-PRESS Mini Shunt Systematic Reviews

A Cochrane review by Wang et al (2015) evaluated the efficacy of adjunctive procedures for trabeculectomy.⁷ 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). The pooled analysis also showed that subsequent cataract surgery was less frequent in the combination group than in trabeculectomy alone (relative risk [RR] 0.34, 95% CI, 0.14 to 0.74). The combination group had a lower rate of some complications (e.g., hyphema, needling).

Randomized Controlled Trials

A U.S. multicenter randomized trial by Netland et al (2014), compared trabeculectomy with EX-PRESS implantation in 120 patients (120 eyes) (Table 2).⁸ Comparator groups were similar at baseline. Throughout a 2 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 1 month after EX-PRESS implantation (median, 0.7 months)

and at 3 months after trabeculectomy (median, 2.2 months; $p = .041$). Postoperative complications were higher after trabeculectomy (41%) than after EX-PRESS implantation (18.6%).

Additional single-center RCTs have corroborated the results of the multicenter trial.⁹⁻¹³

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

Study	Countries	Sites	Dates	Participants	Interventions	
					Active	Comparator
de Jong et al (2009) ⁹ ; de Jong et al (2011) ¹⁰	Netherlands	1	2003-2004	Patients with primary OAG not controlled by IOP medication	EX-PRESS (n=39)	Trabeculectomy (n=39)
Netland et al (2014) ⁸	U.S., Canada	7	NR	Patients with OAG treated with IOP medications who were candidates for glaucoma surgery	EX-PRESS (n=59)	Trabeculectomy (n=61)
Wagschal et al (2015) ¹¹ ; Gonzalez-Rodriguez et al (2016) ¹²	Canada	1	2011-2012	Patients with OAG not controlled by IOP medication	EX-PRESS (n=33)	Trabeculectomy (n=31)
Konopinska et al (2021) ¹³ (NCT04335825)	Poland	1	2016-2019	Patients with OAG not controlled by IOP medication who qualified for both cataract and OAG surgery	Phaco EX-PRESS (n=43)	Phaco - Trabeculectomy (n=38)

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

Table 3. Summary of Key RCT Results for EX-PRESS

Study	Mean IOP (SD), mm Hg		p	Mean Medication Use (SD)	
	EX-PRESS	Trabeculectomy		EX-PRESS	Trabeculectomy
Netland et al (2014) ⁸					
Baseline	25.1 (6.0)	26.4 (6.9)	0.27	3.1 (1.1)	3.1 (1.2)
Month 6	13.8 (4.7)	11.9 (4.6)	0.03	NR	NR
Year 2	14.7 (4.6)	14.6 (7.1)	0.93	0.9 (1.3)	0.7 (1.2)

IOP: intra-ocular pressure; NR: not reported; SD: standard deviation; RCT: randomized controlled trial.

Comparative Effectiveness Analyses

Five-year results of 2 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 and Baerveldt Glaucoma Implant in 276 adults with previous incisional eye surgery or refractory glaucoma.^{14,15} The ABC was funded by National Eye Institute, Research to Prevent Blindness, and New World Medical. 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 that was funded by the Glaucoma Research Society of Canada.¹⁶

Christakis et al (2017) analyzed 5-year pooled data from the ABC and AVB trials comparing the relative efficacy of the 2 implants.¹⁷ 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 ($p = .007$). 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%; $p = .002$).

Section Summary: Ab Externo Aqueous Shunts

Evidence for the use of ab externo aqueous shunts for the treatment of OAG 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 1 to 5 years. Results from ab externo aqueous shunts are similar to trabeculectomy, while adverse event rates were higher among patients undergoing trabeculectomy.

The comparative effectiveness of 2 ab externo devices (the Ahmed and Baerveldt shunts) has been evaluated in 2 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 Food and Drug Administration (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 OAG.

Xen Glaucoma Treatment System**Non-Randomized Comparative Studies**

Schlenker et al (2017) published a multicenter, retrospective comparative study that compared the risk, safety, and efficacy for stand-alone ab interno microstent implantation with mitomycin C (MMC) to trabeculectomy plus MMC (Table 4).¹⁸ Implantations of the ab interno XEN 45 gelatin microstent is a less invasive surgery than trabeculectomy. The primary outcome was the hazard ratio (HR) of failure, defined as 2 consecutive IOP readings of less than 6 mm Hg, including vision loss. Success was measured by the withdrawal of glaucoma-related medications at 1-month post-surgery. The adjusted HR 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.

Wagner et al (2020) also reported similar success rates for trabeculectomy (65.5%, 95% CI, 55.6 to 75.9%) and XEN Implant (58.5%, 95% CI, 47.6 to 69.4%, $p = .16$; adjusted odds ratio 0.66, 95% CI, 0.32 to 1.37) but a greater reduction in IOP with trabeculectomy (10.5 mm Hg) compared to the XEN implant (7.2 mm Hg; $p = .003$).¹⁹ Baseline measurements showed older age (73.0 vs 67.2) and a lower number of medication classes (2.0 vs 3.0) for the XEN group. A regression mixed model that adjusted for gender, age, preoperative IOP, and medications did not indicate a difference in the proportion of success for the 2 groups.

Stoner et al (2021) conducted a retrospective comparative study of 100 eyes that had undergone either XEN or EX-PRESS standalone shunt implantation at a single center.²⁰ Surgical success was defined as IOP between 6 and 18 mm Hg without reoperation, loss of light perception, device removal, or use of glaucoma medications. The incidence of adverse effects during the first 3 months was lower with the XEN implant, but the failure rate at 1 year was higher (HR 3.94, 95% CI, 1.73 to 9.00, $p = .001$) compared to EX-PRESS. Sensitivity analysis to adjust for differences in baseline characteristics between the groups in this retrospective study achieved similar results.

Non-Comparative Observational Studies

The largest study with a follow-up of longer than 1 year was by Gabbay et al (2021), who reported a retrospective analysis of 205 patients/eyes that had received an XEN implant.²¹ At 3 years, 25% of eyes met the criteria for success, with a failure rate of 25% and requirement for needling in 36.6%. For eyes that retained an XEN implant, IOP decreased from an average of 22.6 mmHg (standard deviation [SD], 7.0) before surgery to 14.0 (SD, 2.9) at 3 years; the number of medications decreased from an average of 2.6 (SD, 1.1) to 0.6 (SD, 1.0) at 3 years. The failure rate was higher in non-Caucasians (74% of 13) compared to Caucasians (21% of 188, $p < .001$), with Caucasians comprising 93.5% of the study population.

Table 4. Summary Characteristics for Non-Randomized Comparative Studies Using the XEN Implant for Refractory Open-Angle Glaucoma

Study	Country	Participants	Treatment Delivery	FU
Schlenker et al (2017) ¹⁸	Austria, Belgium, Canada, Germany	Patients with OAG, pseudoexfoliation, pigment dispersion, normal-tension, angle-recession, combined mechanism, history of angle-closure, or juvenile glaucoma and no prior incisional surgery	<ul style="list-style-type: none"> XEN alone (n=185) Trabeculectomy (n=169) 	Up to 30 mo (last visit in chart)
Wagner et al (2020) ¹⁹	Germany	Consecutive patients with refractory OAG, pseudoexfoliation, pigment dispersion, or normal-tension glaucoma who underwent surgery from January 2016 to February 2018	<ul style="list-style-type: none"> XEN alone (n=82 eyes) Trabeculectomy (n=89 eyes) 	1 year
Stoner et al (2021) ²⁰	U.S.	Patients with uncontrolled glaucoma with either IOP uncontrolled by medications or progression of glaucoma.	<ul style="list-style-type: none"> XEN (n=52) EX-PRESS (n=48) 	1 Year

FU: follow-up; IOP: intraocular pressure; OAG: open-angle glaucoma; U.S: United States.

Table 5. Summary of Results for the XEN Implant for Refractory Open-Angle Glaucoma

Study	Population	Median IOP (IQR), or Mean (SD) mm Hg		Medication, Median (SD)	
		Baseline	1 Year ^a	Baseline	1 Year ^a
Schlenker et al (2017) ¹⁸	XEN alone	24.0 (IQR: 19 to 32)	13.0 (IQR: 10 to 15)	3.0 (IQR: 3 to 4)	0.0 (IQR: 0 to 1)
	Trabeculectomy	24.0 (IQR: 19 to 30)	13.0 (IQR: 10 to 16)	3.0 (IQR: 3 to 4)	0.0 (IQR: 0 to 0)
Wagner et al (2020) ¹⁹	XEN	19.0 (IQR 16.8–25.0)	7.2 (8.2) reduction	2.0 (1.0–3.0)	0.3 (0.5)
	Trabeculectomy	21.0 (IQR 17.0–27.0)	10.5 (9.2) reduction	3.0 (2.0–4.0)	0.2 (0.5)
Stoner et al (2021) ²⁰	XEN	21.4 (1.2)	13.0 (0.6)	2.8 (0.2)	1.5 (0.2)
	EX-PRESS	18.9 (1.1)	11.5 (0.8)	3.2 (0.2)	0.5 (0.2)

^a Follow-up for Schlenker (2017) was not 1 year, but last visit in retrospective chart review

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

Section Summary: Ab Interno Aqueous Stents

Currently, the XEN gel stent is the only stent approved by the FDA for the treatment of refractory OAG 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 nonrandomized comparative studies which retrospectively reviewed charts of patients either receiving the XEN implant or undergoing a trabeculectomy or implantation of an EX-PRESS shunt. Additional evidence consists of single-arm studies. The comparative studies included patients with different types of glaucoma and found that patients receiving the XEN implant experienced reductions in IOP and medication use similar to patients undergoing trabeculectomy. A retrospective study compared the XEN implant with the EX-PRESS implant and found fewer adverse events in the first 3 months, but lower efficacy and higher failure rates at 1 year. Although there was little information on how patients were chosen to receive the different treatments in these

comparative trials, statistical methods were used to address baseline differences between the groups. The single-arm studies, with up to 3 years of follow-up, consistently show that patients receiving the XEN implant experience reductions in IOP and medication use. RCTs with longer follow-up are needed to compare the outcomes of the different surgical treatments.

Aqueous Microstents in Conjunction with Cataract Surgery

The iStent and iStent *inject*, which is preloaded with 2 stents, have FDA approval for use in conjunction with cataract surgery. An additional stent, the CyPass, had FDA approval but was 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 the implantation of stents during cataract surgery with cataract surgery alone are discussed below.

iStent

Systematic Reviews

A 2019 Cochrane review on the iStent in patients with OAG was published by Le et al (2019, see Table 6).²² The authors identified 7 RCTs, all of which were considered to be at high or unclear risk of bias. Four of the trials compared iStent in combination with cataract surgery to cataract surgery alone, 2 RCTs compared treatment with iStent or iStent *inject* to medical therapy, and 1 RCT compared 1, 2, or 3 iStents. Results of the meta-analyses on the use of the iStent in combination with cataract surgery are shown in Table 7. Implantation of 1 or 2 iStents resulted in a higher proportion of patients who were drop free (RR 1.38) and reduced the mean number of drops when compared to phacoemulsification alone (-0.42 drops). The review concluded that based on the 4 trials, there was very low-quality evidence that iStent may result in a higher proportion of patients who are drop free or achieve better IOP control.

An industry-sponsored meta-analysis of standalone iStents was reported by Healy et al (2021).²³ The investigators included 4 RCTs and 9 non-randomized or single-arm studies with at least 6 months of follow-up. The number of eyes in the studies ranged from 15 to 99 (total N=778). The pooled weighted reduction in IOP was reported as 31.1% at 6 to 12 months and 32.9% at 60 months with a reduction of approximately 1 medication in the pooled analysis. In the individual studies, the reduction in IOP ranged from -1.0 to -10.7; the largest reduction in IOP was in a prospective case series (n=44) with 25% loss to follow-up. The lowest reduction in IOP (-1.0) was in a larger RCT (n=77) with low loss to follow-up (2.5%). Notably, the systematic review did not report the number of device failures in these studies. Additional limitations are the inclusion of retrospective case series and the high heterogeneity between studies, which would typically preclude meta-analysis.

Table 6. Meta-analysis Characteristics

Study	Dates	Trials	Participants	N (Range)	Design	Duration
Le et al (2019) ²²	Through Aug 2018	7	Eyes with open-angle glaucoma	765 (33 to 239)	RCT	42 months

RCT: randomized controlled trial

Table 7. Meta-analysis Results

Study	Drop Free Compared to Phacoemulsification Alone	Change in Drops Compared to Phacoemulsification Alone	Change in IOP Compared to Phacoemulsification Alone
Le et al (2019) ²²			
N	239 (2 RCTs)	282 (2 RCTs)	284 (3 RCTs)
Pooled effect (95% CI)	RR: 1.38 (1.18 to 1.63)	-0.42 (-0.60 to -0.23)	-1.24 mmHg
I ² (p)	67% (p)	0%	

CI: confidence interval; IOP: intraocular pressure; RCT: randomized controlled trial; RR: relative risk

iStent and iStent inject Pivotal Trials

Included in the Cochrane review were results from the iStent U.S. investigational device exemption, open-label, 29-site, multicenter RCT. Results 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 8).^{24,25} Trial objectives were to evaluate the incremental effect on IOP of iStent implantation compared to cataract surgery alone and to determine the potential benefit of combining 2 therapeutic treatments into a single surgical event. A total of 240 patients (mean age, 73 years) with cataracts and mild-to-moderate OAG (IOP \leq 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. 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. The proportion of eyes meeting both the primary (unmedicated IOP \leq 21 mm Hg) and secondary outcomes (IOP reduction \geq 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, $p < .001$). The proportion of patients achieving the secondary efficacy endpoint was 66% in the treatment group and 48% in the control group ($p = .003$). 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 (e.g., 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 9). At a 2-year follow-up, 199 (83%) patients remained in the study. The primary endpoint (unmedicated IOP \leq 21 mm Hg) was reached by 61% of patients in the treatment group and 50% of controls ($p = .036$).²⁵ Secondary outcomes—IOP reduction of 20% or more without medication (53% vs 44%) and the 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.

The pivotal trial on the iStent *inject* was reported by Samuelson et al (2019).²⁶ A total of 505 patients undergoing cataract surgery were randomized after lens implantation to insertion of 2 smaller iStents or control. Results were assessed by intention-to-treat analysis and per-protocol analysis, with patients requiring additional surgical procedures considered to be failures. The addition of medications was based on a standardized protocol. At the 2-year follow-up, a greater percentage of patients had achieved at least a 20% reduction in IOP (75.8% vs 61.9%, $p = .005$), had a greater reduction in IOP (7.0 vs 5.4, $p < .001$), and required fewer topical medications (0.4 vs 0.8, $p < .001$).

Limitations of these studies are described in Tables 10 and 11. The 2 main limitations are that there was no masking to treatment and durability of these microstents after 2 years was not reported. Continued patency of the stents and need for additional treatments has been evaluated through 4 years in studies from the Microinvasive Glaucoma Surgery (MIGS) study group and are described below.

Table 8. Summary of Pivotal RCT Characteristics

Study	Countries	Sites	Dates	Participants	Interventions
Samuelson et al (2011) ²⁴ ; Craven et al (2012) ²⁵	U.S.	29	2005-2007	Patients with mild-to-moderate POAG, unmedicated IOP \geq 22 and \leq 36 mm Hg	Active: iStent plus cataract surgery (n=116) Comparator: Cataract surgery alone (n=123)
Samuelson et al (2019) ²⁶	U.S.		2011-	Patients with mild-to-moderate POAG, unmedicated IOP	iStent <i>inject</i> (2 stents) plus cataract surgery (n=387) Comparator: Cataract surgery alone (n=118)

Study	Countries	Sites	Dates	Participants	Interventions
				≥ 21 and ≤ 36 mm Hg	

IOP: intraocular pressure; POAG: primary open-angle glaucoma; RCT: randomized controlled trial.

Table 9. Summary of Pivotal RCT Results

Study	≥ 20% Reduction in Unmedicated IOP at 24 mo n (%)	Mean Reduction in IOP at 24 mo mm Hg (SD)	Mean IOP (SD), mm Hg		p	Mean Medication Use (SD)		p
			iStent	Cataract Alone		iStent	Cataract Alone	
Samuelson et al (2011)²⁴; Craven et al (2012)²⁵								
Baseline			18.6 (3.4)	17.9 (3.0)	NR	1.6 (0.8)	1.5 (0.6)	
Year 1			17.0 (2.8)	17.0 (3.1)	NR	0.2 (0.6)	0.4 (0.7)	0.016
Year 2			17.1 (2.9)	17.8 (3.3)	NR	0.3 (0.6)	0.5 (0.7)	
Samuelson et al (2019)²⁶iStent inject	288/380 (75.8%)	7.0 (4.0)	17.1 (3.6)			0.4 (0.8)		
Cataract Alone	73/118 (61.9%)	5.4 (3.7)	17.8 (3.5)			0.8 (1.0)		
p-Value	0.005	<0.001				<0.001		

IOP: intraocular pressure; NR: not reported; RCT: randomized controlled trial SD: standard deviation.

Table 10. Study Relevance Limitations

Study	Population ^a	Intervention ^b	Comparator ^c	Outcomes ^d	Follow-Up ^e
Samuelson et al (2011)²⁴					Patency after 2 years is unknown
Samuelson et al (2019)²⁶					Patency after 2 years is unknown

The study limitations stated in this table are those notable in the current review; this is not a comprehensive gaps assessment.

^a Population key: 1. Intended use population unclear; 2. Clinical context is unclear; 3. Study population is unclear; 4. Study population not representative of intended use.

^b Intervention key: 1. Not clearly defined; 2. Version used unclear; 3. Delivery not similar intensity as comparator; 4. Not the intervention of interest.

^c Comparator key: 1. Not clearly defined; 2. Not standard or optimal; 3. Delivery not similar intensity as intervention; 4. Not delivered effectively.

^d Outcomes key: 1. Key health outcomes not addressed; 2. Physiologic measures, not validated surrogates; 3. No CONSORT reporting of harms; 4. Not establish and validated measurements; 5. Clinical significant difference not prespecified; 6. Clinical significant difference not supported.

^e Follow-Up key: 1. Not sufficient duration for benefit; 2. Not sufficient duration for harms.

Table 11. Study Design and Conduct Limitations

Study	Allocation ^a	Blinding ^b	Selective Reporting ^c	Data Completeness ^d	Power ^e	Statistical ^f
Samuelson et al (2011)²⁴		2, 3. No blinding of assessors				
Samuelson et al (2019)²⁶		2, 3. No blinding of assessors				

The study limitations stated in this table are those notable in the current review; this is not a comprehensive gaps assessment.

^a Allocation key: 1. Participants not randomly allocated; 2. Allocation not concealed; 3. Allocation concealment unclear; 4. Inadequate control for selection bias.

^b Blinding key: 1. Not blinded to treatment assignment; 2. Not blinded outcome assessment; 3. Outcome assessed by treating physician.

^c Selective Reporting key: 1. Not registered; 2. Evidence of selective reporting; 3. Evidence of selective publication.

^d Data Completeness key: 1. High loss to follow-up or missing data; 2. Inadequate handling of missing data; 3. High number of crossovers; 4. Inadequate handling of crossovers; 5. Inappropriate exclusions; 6. Not intent to treat analysis (per protocol for noninferiority trials).

^e Power key: 1. Power calculations not reported; 2. Power not calculated for primary outcome; 3. Power not based on clinically important difference.

^f Statistical key: 1. Analysis is not appropriate for outcome type: (a) continuous; (b) binary; (c) time to event; 2. Analysis is not appropriate for multiple observations per patient; 3. Confidence intervals and/or p values not reported; 4. Comparative treatment effects not calculated.

Hooshmand et al (2019) reported a non-randomized comparative study on outcomes with the use of the iStent inject, which simultaneously injects 2 stents through a single ab interno opening, compared to the first generation single iStent.²⁷ The iStent inject was developed to provide easier ab interno insertion and comes preloaded with 2 stents that are smaller than the first-generation iStent. There was no significant difference between the earlier model and the second generation device on outcomes at 12 months, but Kaplan-Meier analysis found an earlier time to add topical medications in the iStent inject patients. Limitations of the study include the length of follow-up, which was limited by the time that the iStent inject had been available, and the non-randomized design. In addition, the study compared 2 cohorts from different time periods, those who had been treated with the first generation device and those who had been treated with the second-generation device.

Al Yousef et al (2020) conducted a matched comparison of the iStent inject and ab interno trabeculectomy in 78 eyes.²⁸ IOP was reduced in both groups at 1-month follow-up but began to rise at 12 months in the iStent inject group. By 24 months, the IOP in the iStent inject group had returned to near preoperative levels. The IOP in the Trabectome group was lower than the iStent inject group throughout follow-up.

Efficacy of the iStent inject at 3-year follow-up was reported by Salimi et al (2021) in a consecutive case series of 124 eyes with different glaucoma subtypes and severities.²⁹ Mean IOP in patients who retained an implant was reduced from 16.9 mm Hg preoperatively to 13.17 mm Hg ($p < .001$) with a reduction in medications from 2.38 to 1.16 ($p < .001$). The 3-year survival rate of the implant was only 74%.

Hydrus Microstent Systematic Reviews

A Cochrane review by Otarola et al (2020) included 3 studies with 808 participants.³⁰ Two studies (described below) were conducted in patients with cataracts and OAG ($n=653$), and compared the Hydrus microstent combined with cataract surgery to cataract surgery alone.^{31,32} They found moderate-certainty evidence that adding the Hydrus microstent to cataract surgery in patients with mild or moderate OAG increased the proportion of participants who were medication-free at 12 months (RR 1.59, 95% CI, 1.39 to 1.83) and 24-month follow-up (RR 1.63, 95% CI, 1.40 to 1.888), and reduced unmedicated IOP by 2 mm Hg, the number of medications by -0.41, and the need for secondary glaucoma surgery.

The third study compared the Hydrus microstent with the iStent in patients without cataract surgery.³³ This study is described in the next section on microstents as a stand-alone procedure.

Randomized Controlled Trials

Trials on the Hydrus Microstent are described in Tables 12 and 13.

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.³¹ 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%, $p < .001$) and the mean IOP after medication washout was lower (16.9 mm Hg vs 19.2 mm Hg, $p = .009$) compared with cataract surgery alone, respectively. The microstent group used significantly fewer medications (0.5 vs 1.0, $p = .019$) and had a higher proportion of patients taking no hypotensive medications at the time of cataract surgery (73% vs 38%, $p = .001$).

Samuelson et al (2019) reported on a multicenter RCT (HORIZON) comparing implantation of a single Hydrus Microstent following cataract surgery vs cataract surgery alone (Table 13).³² Patients were masked to treatment assignment for the course of the study. The primary endpoint was percent demonstrating a 20% reduction in unmedicated IOP. Significantly more patients receiving the microstent following cataract surgery experienced a 20% reduction in unmedicated IOP compared with patients undergoing cataract surgery alone (77% vs 58%; $p < .001$).

Comparisons of mean washed out IOP and the mean number of medications used are presented in Table 13.

Table 12. Summary of Key RCT Characteristics for the Hydrus Microstent

Study	Countries	Sites	Dates	Participants	Interventions	
					Active	Comparator
Pfeiffer (2015)³¹	Germany, Italy, Spain, the Netherlands	7	2011 to 2012	Patients with concurrent open-angle glaucoma and cataract	Cataract surgery plus Hydrus Microstent implantation (n=50)	Cataract surgery alone (n=50)
Samuelson (2019)³²	Germany, Italy, Mexico, Philippines, Poland, Spain, United Kingdom, United States	26	2012 to 2015	Patients with age-related cataract and mild to moderate primary open-angle glaucoma	Cataract surgery plus Hydrus Microstent implantation (n=369)	Cataract surgery alone (n=187)

RCT: randomized controlled trial.

Table 13. Summary of Key RCT Results for the Hydrus Microstent

Study	Mean washed out IOP			Mean medication use		
	Hydrus Microstent	Cataract alone	p	Hydrus Microstent	Cataract alone	p
Pfeiffer (2015)³¹						
Baseline	26.3 +/- 4.4	26.6 +/- 4.2	0.7	2.0 +/- 1.0	2.0 +/- 1.1	0.8
Year 2	16.9 +/- 3.3	19.2 +/- 4.7	0.009	0.5 +/- 1.0	1.0 +/- 1.0	0.02
Samuelson (2019)³²						
Baseline mean	25.5 +/- 3.0	25.4 +/- 2.9	NS	1.7 +/- 0.9	1.7 +/- 0.9	NS
Year 2	17.4 +/- 3.7	19.2 +/- 3.8	NR	0.3 +/- 0.8	0.7 +/- 0.9	<0.001

IOP: intraocular pressure; NR: not reported; NS: not significant; RCT: randomized controlled trial.

Observational Study

Fea et al (2017) conducted a retrospective review of 92 patients undergoing cataract surgery plus Hydrus Microstent implantation.³⁴ Two year follow-up showed improvements in IOP and medication use. Mean IOP at baseline was 19.4 mm Hg, decreasing significantly by 6 months to 15.6 mm Hg, which was maintained at 2 years of follow-up (15.7 mm Hg). The mean number of medications was 2.1 at baseline, decreasing significantly by 6 months to 0.5, which was maintained through 2 years of follow-up (0.7).

CyPass

The FDA evaluated the clinical performance of the CyPass Micro-Stent system based on the pivotal Clinical Study to Assess the Safety and Effectiveness of the Transcend CyPass Glaucoma

Implant in Patients With OAG undergoing Cataract Surgery (COMPASS) trial (NCT01085357). COMPASS was a multicenter RCT comparing the safety and efficacy of CyPass Micro-Stent plus cataract surgery with cataract surgery alone for treating mild-to-moderate POAG in patients undergoing cataract surgery. Evidence from the RCT supported the use of the CyPass stent in conjunction with cataract surgery; however, in August 2018, the manufacturer voluntarily withdrew the device 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.

Section Summary: Ab Interno Aqueous Microstents

Implantation of 1 or 2 microstents has received FDA approval for use in conjunction with cataract surgery for reduction of IOP in adults with mild-to-moderate OAG currently treated with ocular hypotensive medication. RCTs and meta-analyses of RCTs have compared cataract surgery alone to microstent implantation in conjunction with cataract surgery when IOP is at least partially controlled with medication. When compared to cataract surgery alone, the studies showed modest but statistically significant decreases in IOP and medication use through the first 2 years when stents were implanted in conjunction with cataract surgery. A decrease in topical medication application is considered to be an important outcome for patients and reduces the problem of non-compliance that can affect visual outcomes.

Microstent Implantation as a Stand-Alone Procedure

iStent

The iStent was approved by the FDA to be used in conjunction with cataract surgery to reduce IOP in patients with mild-to-moderate OAG. The studies described below evaluated the use of the iStent or iStent inject as a stand-alone procedure.

The Cochrane review by Le et al (2019) on the iStent in patients with OAG identified 2 RCTs that compared treatment with iStent or iStent inject to medical therapy and 1 RCT that compared 1, 2, or 3 iStents.²² Results of the systematic review are shown in Table 14. Meta-analysis was not performed due to heterogeneity. However, in both trials, iStent implantation resulted in a higher proportion of patients who were drop free and reduced the mean number of drops when compared to medical therapy. One RCT indicated that compared to implantation of 1 stent, implantation of 2 or 3 stents resulted in a similar proportion of patients who were drop free at 36 months or less, but a higher proportion of patients who were drop free after 36 months. The 2 studies included in the 2019 Cochrane review are described in Tables 15 and 16. Limitations of these studies are described in Tables 17 and 18.

Table 14. Meta-analysis Results

Study	Drop Free Compared to Medical Therapy	Drop Free with 2 Stents Compared to 1 Stent at 42 months	Drop Free with 3 Stents Compared to 1 Stent at 42 months
Le et al (2019)²²			
N	2 RCTs	1 RCT	1 RCT
Pooled effect (95% CI)	90% of patients in the iStent groups were drop free	RR:0.51 (0.34 to 0.75)	RR:0.49 (0.34 to 0.73)

CI: confidence interval; RCT: randomized controlled trial; RR: relative risk.

A 2014 industry-sponsored, multicenter, unblinded, randomized trial compared implantation of 2 iStent inject devices to 2 ocular hypotensive agents.³⁵ The 192 patients enrolled in this unmasked trial had an IOP not controlled by 1 hypotensive medication. At 12-month follow-up, the 2 groups were comparable for IOP reduction of at least 20%, IOP of 18 mm Hg or less, and mean decrease in IOP. A greater proportion of patients in the iStent inject group achieved an IOP reduction of at least 50% (53.2% vs 35.7%, respectively). One patient in the iStent inject group experienced elevated IOP (48 mm Hg) and 4 required ocular hypotensive medication. Longer-term studies are in progress.

Vold et al (2016) reported results of an RCT comparing 2 stand-alone iStent inject implants to topical travoprost (1:1 ratio) in 101 phakic eyes with an IOP between 21 and 40 mm Hg and newly diagnosed POAG, pseudoexfoliative glaucoma, or ocular hypertension that had not been treated previously.³⁶ The patients were not undergoing cataract surgery. The trial was unmasked, and methods for allocation concealment and calculation of power were not described. One hundred patients (54 iStent; 47 travoprost) completed 24 months of follow-up and 73 completed 36 months of follow-up. The trial was performed at a single-center in Armenia with visiting surgeons from the U.S. Statistical analyses were not provided. Baseline mean IOP was 25 mm Hg in both groups. Mean IOP at 3 years was 15 mm Hg in both groups. Medication (or second medication) was added to 6 eyes in the iStent group and 11 eyes in the travoprost group. Progression of cataract was reported in 11 eyes in the iStent group and 8 eyes in the travoprost group, with cataract surgery being performed in 5 eyes in the iStent group and 1 eye in the travoprost group. The results would suggest that 2 iStents might reduce the number of medications required to maintain target IOP compared with travoprost but also hasten time to cataract surgery. However, the study methods were poorly reported, and statistical analyses were not reported.

Four year follow-up of iStent inject is reported in 2 phase 4 publications from the MIGS study group.^{37,38} Berdahl et al (2020) reported on 53 patients who were on 2 preoperative medications who received 2 iStent inject implants and started on travoprost on postoperative Day 1. At 48 month follow-up, 85% of eyes had reduced IOP ($\geq 20\%$) with a single medication as compared to the baseline IOP on 2 medications. Mean IOP on 1 medication was 11.9 to 13.0 mm Hg, compared to 19.7 on 2 medications preoperatively. Lindstrom et al (2020) reported on 57 patients who were on 1 preoperative medication before implantation of 2 iStent inject devices. Month 48 IOP without medication was reduced ($\geq 20\%$) in 95% of eyes with iStent inject. There were no adverse events that were considered to be related to the devices.

Hydrus versus iStent

Hydrus microstent was compared with the iStent in a double-blind multicenter RCT by Ahmed et al (COMPARE, 2020).³³ Eyes (n=152) with mild-to-moderate glaucoma and an IOP of 23 to 39 after washout of medication were randomized to either 1 Hydrus stent or 2 iStents as a stand-alone treatment. Both stents have FDA approval in the U.S. when used in conjunction with cataract surgery but not as a stand-alone procedure. Follow-up was performed through 12 months post-operatively with medications added at the investigator's discretion. The Hydrus outperformed 2 iStents in nearly every measure (see Table 16). Eyes implanted with the Hydrus microstent were able to maintain IOP < 18 mm Hg on fewer medications and a greater percentage of patients were medication-free compared to the iStent group (46.6% vs 24.0%, p < .001). The decision to increase medications was up to the investigator and not pre-specified, but posthoc analysis indicated that the IOP at which medications were increased was similar in the 2 groups.

Table 15. Summary of RCT Characteristics

Study; Trial	Countries	Sites	Dates	Participants	Interventions	
					Active	Comparator
Fea et al (2014) ³⁵	EU, Armenia	8		Patients with OAG not controlled on 1 medication, Post-washout IOP >22 and <38 mmHg	iStent inject (n=94)	Two medications (n=98)
Vold et al (2016) ³⁶	Armenia with U.S. surgeons	1		Patients with OAG (n=101) or PEX (n=1) who were naive to therapy with	Two iStents (n=54)	One medication (n=47)

Study; Trial	Countries	Sites	Dates	Participants	Interventions	
				IOP > 21 and < 40 mmHg		
Ahmed et al (2019)³³	U.S., E.U., Canada, Asia	12	2013-2015	152 patients with mild-to-moderate glaucoma (OAG, PEX, or PG and IOP 23 to 39 mmHg after washout	Hydrus (n=75)	Two iStents (n=77)

IOP: intraocular pressure; PEX: pseudoexfoliative glaucoma; PG: pigmentary glaucoma; OAG: open-angle glaucoma; RCT: randomized controlled trial.

Table 16. Summary of RCT Results

Study	>20% reduction in IOP n (%)	IOP < 18 mmHg n (%)	Mean IOP mmHg (SD)	Mean reduction in IOP from baseline mmHg (SD)	Mean number of medications at 12 months	Percent Medication Free at 12 months n (%)
Fea et al (2014)³⁵	<i>at 12 months</i>	<i>at 12 months</i>	<i>at 12 months</i>			
iStent inject	89/94 (94.7)	87/94 (92.6)	13.0 (2.3)	8.1 (2.6)		
Medical therapy	88/98 (91.8)	88/98 (89.8)	13.2 (2.0)	7.3 (2.2)		
p-Value	0.02	NR	NR	0.43		
Vold et al (2016)³⁶	<i>IOP < 18 mmHg n (%) at 24 months</i>	<i>at 36 months</i>	<i>at 36 months</i>			
iStent	90%	91%	14.6 mmHg			
Medical therapy	87%	79%	15.3 mmHg			
p-Value						
Ahmed et al (2020)³³		<i>without medication</i>				
Hydrus	39.7%	30.1%	17.3 (3.7)	-8.2 (3.7)	1.0	34 (46.6)
2 iStents	13.3%	9.3%	19.2 (2.4)	-5.1 (2.9)	1.7	18 (24.0)
p-Value	<0.001	<0.001	0.037	0.003	<0.001	0.006

IOP: intraocular pressure; NR: not reported; RCT: randomized controlled trial; SD: standard deviation.

Table 17. Study Relevance Limitations

Study	Population ^a	Intervention ^b	Comparator ^c	Outcomes ^d	Follow-Up ^e
Fea et al (2014)³⁵					1. Follow-up was limited to 12 months. Monitoring for occlusion of the stents at longer follow-up is needed
Vold et al (2016)³⁶		4. Not the currently marketed device			
Ahmed et al (2019)³³			4. Not the currently marketed device		1. Follow-up was through 12 months, longer follow-up is continuing.

The study limitations stated in this table are those notable in the current review; this is not a comprehensive gaps assessment

^a Population key: 1. Intended use population unclear; 2. Clinical context is unclear; 3. Study population is

unclear; 4. Study population not representative of intended use.

^b Intervention key: 1. Not clearly defined; 2. Version used unclear; 3. Delivery not similar intensity as comparator; 4. Not the intervention of interest.

^c Comparator key: 1. Not clearly defined; 2. Not standard or optimal; 3. Delivery not similar intensity as intervention; 4. Not delivered effectively.

^d Outcomes key: 1. Key health outcomes not addressed; 2. Physiologic measures, not validated surrogates; 3. No CONSORT reporting of harms; 4. Not establish and validated measurements; 5. Clinical significant difference not prespecified; 6. Clinical significant difference not supported.

^e Follow-Up key: 1. Not sufficient duration for benefit; 2. Not sufficient duration for harms.

Table 18. Study Design and Conduct Limitations

Study	Allocation ^a	Blinding ^b	Selective Reporting ^c	Data Completeness ^d	Power ^e	Statistical ^f
Fea et al (2014) ³⁵	3. Randomization procedure was not described	1, 2, 3. Study could not be blinded		1. Unequal loss to follow-up in the 2 groups, and the subjects lost to follow-up were treated as failures	1. Power calculations not reported	
Vold et al (2016) ³⁶	3. Randomization procedure was not described	1, 2, 3. Study could not be blinded		1. There was 27% loss to follow-up at 36 months	1. Power calculations not reported	4. Statistical analysis not reported
Ahmed et al (2020) ³³		2, 3. Investigators were not blinded and there was no independent adjudication or preset criteria for increase in medication				2. Did not use repeated measures for multiple assessments

The study limitations stated in this table are those notable in the current review; this is not a comprehensive gaps assessment.

^a Allocation key: 1. Participants not randomly allocated; 2. Allocation not concealed; 3. Allocation concealment unclear; 4. Inadequate control for selection bias.

^b Blinding key: 1. Not blinded to treatment assignment; 2. Not blinded outcome assessment; 3. Outcome assessed by treating physician.

^c Selective Reporting key: 1. Not registered; 2. Evidence of selective reporting; 3. Evidence of selective publication.

^d Data Completeness key: 1. High loss to follow-up or missing data; 2. Inadequate handling of missing data; 3. High number of crossovers; 4. Inadequate handling of crossovers; 5. Inappropriate exclusions; 6. Not intent to treat analysis (per protocol for noninferiority trials).

^e Power key: 1. Power calculations not reported; 2. Power not calculated for primary outcome; 3. Power not based on clinically important difference.

^f Statistical key: 1. Analysis is not appropriate for outcome type: (a) continuous; (b) binary; (c) time to event; 2. Analysis is not appropriate for multiple observations per patient; 3. Confidence intervals and/or p values not reported; 4. Comparative treatment effects not calculated.

Greater Than Two Stents

An RCT comparing the efficacy of 1 iStent with multiple iStent devices was published by Katz et al (2015).³⁹ This trial, from a single-institution in Armenia, randomized 119 patients with mild-to-moderate OAG 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). The primary endpoint, the percentage of patients with a reduction of 20% or more in IOP off medications at 12 months, was reached by 89.2% of the 1-stent group, by 90.2% of the 2-stent group, and by 92.1% of the 3-stent group. The secondary endpoint (percentage of patients achieving an IOP \leq 15 mm Hg off medication) was reached by 64.9% of the 1-stent group, by 85.4% of the 2-stent group, and by 92.1% of the 3-stent group. Forty-two-month follow-up results for 109 patients were published by Katz et al (2018).⁴⁰ Post-washout IOP was 17.4 \pm 0.9, 15.8 \pm 1.1 and 14.2 \pm 1.5 mmHg, for 1, 2, or 3 stents, respectively. The

need for additional medication increased in single-stent eyes from 4 eyes at 12 months to 18 eyes at 42 months, suggesting a reduction in patency of the microstents over time. The need for additional medication did not increase between months 12 and 42 in multi-stent eyes. No between-group statistical comparisons were reported.

Section Summary: Microstent Implantation as a Stand-Alone Procedure

The evidence on microstents as a stand-alone procedure in patients with mild-to-moderate glaucoma that is controlled on medical therapy includes RCTs and a systematic review of 3 heterogeneous RCTs. Two RCTs indicate that implantation of a microstent can reduce IOP at a level similar to ocular medications at 12-month follow-up. Reduction in medications is an important outcome for patients with glaucoma, both for the patients themselves and because lack of compliance can lead to adverse health outcomes. Whether microstents remain patent after 12 months is uncertain, and whether additional stents can subsequently be safely implanted is unknown. Some evidence on longer-term outcomes is provided by an RCT that compared implantation of a single iStent with multiple iStents. At longer-term (42-month) follow-up, the need for additional medication increased in eyes implanted with a single iStent but not with multiple iStents. The durability of multiple iStents is unknown. A fourth RCT compared implantation of the Hydrus microstent to 2 iStents. Outcomes from the Hydrus microstent were significantly better than 2 iStents, both statistically and clinically, for all outcome measures. The primary limitation of this study is that the duration of follow-up in the present publication is limited to 12 months. Longer-term follow-up from this study is continuing and will answer important questions on the durability of the procedure. Corroboration in an independent study and comparison with a medical therapy control group would also increase confidence in the results.

Summary of Evidence

For individuals who have refractory OAG who receive ab externo aqueous shunts, the evidence includes RCTs, retrospective studies, and systematic reviews. Relevant outcomes are a change in disease status, functional outcomes, medication use, and treatment-related morbidity. RCTs assessing U.S. 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 5 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 an improvement in the net health outcome.

For individuals who have refractory OAG who receive ab interno aqueous stents, the evidence includes a nonrandomized retrospective comparative study and several single-arm studies. 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 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 an improvement in the net health outcome.

For individuals who have mild-to-moderate OAG who are undergoing cataract surgery who receive aqueous microstents, the evidence includes RCTs and meta-analyses of RCTs. Relevant outcomes are a change in disease status, functional outcomes, medication use, and treatment-related morbidity. Implantation of 1 or 2 microstents has received the FDA approval for use in

conjunction with cataract surgery for reduction of IOP in adults with mild-to-moderate OAG currently treated with ocular hypotensive medication. When compared to cataract surgery alone, the studies showed modest but statistically significant decreases in IOP and medication use through the first 2 years when stents were implanted in conjunction with cataract surgery. A decrease in topical medication application is considered to be an important outcome for patients and reduces the problem of non-compliance that can affect visual outcomes. The evidence is sufficient to determine that the technology results in an improvement in the net health outcome.

For individuals with mild-to-moderate OAG who are not undergoing cataract surgery who receive aqueous microstents as a stand-alone procedure, the evidence includes RCTs and a systematic review of 3 heterogeneous RCTs. 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. Two RCTs indicate that implantation of a microstent can reduce IOP at a level similar to ocular medications at 12-month follow-up. Reduction in medications is an important outcome for patients with glaucoma. Whether microstents remain patent after 12 months is uncertain, and whether additional stents can subsequently be safely implanted is unknown. Some evidence on longer-term outcomes is provided by an RCT that compared implantation of a single iStent to implantation of multiple iStents. At longer-term (42-month) follow-up, the need for additional medication increased in eyes implanted with a single microstent but not with multiple microstents. The durability of multiple iStents is unknown. A fourth RCT compared implantation of the Hydrus microstent to 2 iStents. Outcomes from the Hydrus microstent were significantly better than 2 iStents, both statistically and clinically, for all outcome measures. The primary limitation of this study is that the duration of follow-up in the present publication is limited to 12 months. Longer-term follow-up from this study is continuing and will answer important questions on the durability of the procedure. Corroboration in an independent study and comparison with a medical therapy control group would also increase confidence in the results. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

Supplemental Information

The purpose of the following information is to provide reference material. Inclusion does not imply endorsement or alignment with the evidence review conclusions.

Clinical Input From Physician Specialty Societies and Academic Medical Centers

While the various physician specialty societies and academic medical centers may collaborate with and make recommendations during this process, through the provision of appropriate reviewers, input received does not represent an endorsement or position statement by the physician specialty societies or academic medical centers, unless otherwise noted.

In response to requests from Blue Cross Blue Shield Association, input was received from 1 physician specialty society and 2 academic medical centers in 2013. Input supported the use of aqueous shunts in patients with glaucoma uncontrolled by medication. Input supported the use of a single microstent in patients with mild-to-moderate glaucoma undergoing cataract surgery to reduce the adverse events of medications and to avoid noncompliance.

Practice Guidelines and Position Statements

Guidelines or position statements will be considered for inclusion in 'Supplemental Information' if they were issued by, or jointly by, a US professional society, an international society with US representation, or National Institute for Health and Care Excellence (NICE). Priority will be given to guidelines that are informed by a systematic review, include strength of evidence ratings, and include a description of management of conflict of interest.

American Academy of Ophthalmology

The AAO (2008) published a technology assessment on commercially available aqueous shunts, including the Ahmed, Baerveldt, Krupin, and Molteno devices.² The assessment indicated that,

in general, IOP would settle at higher levels ($\gg 18$ mm Hg) with shunts than after standard trabeculectomy (14-16 mm Hg). Five-year success rates of 50% were found for the 2 procedures, indicating that aqueous shunts are comparable with trabeculectomy for IOP control and duration of benefit (based on level I evidence; well-designed randomized controlled trials). The assessment also indicated that although aqueous shunts have generally been reserved for intractable glaucoma when prior medical or surgical therapy has failed, indications for shunts have broadened (based on level III evidence; case series, case reports, and poor-quality case-control or cohort studies). The AAO concluded that, based on level I evidence, aqueous shunts offer a valuable alternative to standard filtering surgery and cyclodestructive therapy for many patients with refractory glaucoma.

The AAO's (2015) preferred practice patterns on primary open-angle glaucoma (POAG) indicated that the Academy considered laser trabeculoplasty as initial therapy in select patients or an alternative for patients who cannot or will not use medications reliably due to cost, memory problems, difficulty with installation, or intolerance to the medication.⁴¹ The AAO stated that aqueous shunts have traditionally been used to manage refractory glaucoma when trabeculectomy has failed to control IOP or is unlikely to succeed, but these devices are being increasingly used in other indications for the surgical management of glaucoma. The AAO also stated that micro-invasive glaucoma surgeries that are frequently combined with phacoemulsification have limited long-term data but seem to result in modest IOP reduction with postoperative pressures in the mid to upper teens. Although they are less effective in lowering IOP than trabeculectomy and aqueous shunt surgery, micro-invasive glaucoma surgeries may have a more favorable safety profile in the short term.

American Glaucoma Society

In 2020, the American Glaucoma Society published a position paper on microinvasive glaucoma surgery.⁴² The Society supports efforts that facilitate patient access to these procedures, including more flexible regulatory pathways for new devices, expansion of the indications for already approved devices, and greater availability of information obtained by regulatory authorities.

National Institute for Health and Care Excellence

The National Institute for Health and Care Excellence (2017) updated guidance on trabecular stent bypass microsurgery for open-angle glaucoma (OAG).⁴³ The guidance stated that "Current evidence on trabecular stent bypass microsurgery for OAG raises no major safety concerns. Evidence of efficacy is adequate in quality and quantity."

The National Institute for Health and Care Excellence (2018) published guidance entitled "Microinvasive subconjunctival insertion of a trans-scleral gelatin stent for POAG"⁴⁴. The guidance states that evidence is limited in quantity and quality and therefore, the procedure should only be used with special arrangements and that patients should be informed of the uncertainty of the procedure.

U.S. Preventive Services Task Force Recommendations

Not applicable.

Medicare National Coverage

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.

Ongoing and Unpublished Clinical Trials

Some currently ongoing and unpublished trials that might influence this review are listed in Table 19.

Table 19. Summary of Key Trials

NCT No.	Trial Name	Planned Enrollment	Completion Date
Ongoing			
NCT01461278^a	A Prospective, Randomized, Single-Masked, Controlled, Parallel Groups, Multicenter Clinical Investigation of the Glaukos® Suprachoroidal Stent Model G3 In Conjunction With Cataract Surgery	1200	May 2022
NCT01841450^a	A Prospective, Randomized, Controlled, Parallel Groups, Multicenter Post-Approval Study Of The Glaukos® iStent® Trabecular Micro-Bypass Stent System In Conjunction With Cataract Surgery	360	Jul 2021
NCT01461291^a	A Prospective, Randomized, Single-Masked, Controlled, Parallel Groups, Multicenter Clinical Investigation of the Glaukos® Trabecular Micro-Bypass Stent Model GTS400 Using the G2-M-IS Injector System in Conjunction With Cataract Surgery	1200	May 2022
NCT04658095^a	A Prospective, Randomized, Multicenter Study To Compare The Safety And Effectiveness Of The OMNI® Surgical System And The iStent Inject In Pseudophakic Eyes With Open Angle Glaucoma. The TRIDENT European Trial	459	July 2023
NCT04629521^a	An Observational Multicenter Clinical Study to Provide Additional Long-Term Follow-up Beyond 60 Months for Subjects Implanted With a CyPass Micro-Stent in the COMPASS Trial	374	Aug 2023
NCT02327312^a	Multicenter Investigation of Trabecular Micro-Bypass Stents vs. Laser Trabeculoplasty	1200	May 2024
NCT04440527	Intraocular Pressure After Preserflo/Innofocus Microshunt vs Trabeculectomy: a Prospective, Randomised Control-trial (PAINT-Study)	70	Jul 2024
Unpublished			
NCT01444040^a	A Prospective, Randomized Evaluation of Subjects With Open-angle Glaucoma, Pseudoexfoliative Glaucoma, or Ocular Hypertension Naïve to Medical and Surgical Therapy, Treated With Two Trabecular Micro-bypass Stents (iStent Inject) or Travoprost Ophthalmic Solution 0.004%	200	Jun 2018 (unknown)

NCT: national clinical trial.

^a Denotes industry-sponsored or cosponsored trial.

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Documentation for Clinical Review

Please provide the following documentation:

- History and physical and/or consultation notes including:
 - Documented glaucoma diagnosis/type
 - Previous treatment and response
 - Documented intraocular pressure
 - Documented failure of medical therapy

Post Service (in addition to the above, please include the following):

- Procedure report(s)

Coding

This Policy relates only to the services or supplies described herein. Benefits may vary according to product design; therefore, contract language should be reviewed before applying the terms of the Policy.

The following codes are included below for informational purposes. Inclusion or exclusion of a code(s) does not constitute or imply member coverage or provider reimbursement policy. Policy Statements are intended to provide member coverage information and may include the use of some codes for clarity. The Policy Guidelines section may also provide additional information for how to interpret the Policy Statements and to provide coding guidance in some cases.

Type	Code	Description
CPT®	0191T	Insertion of anterior segment aqueous drainage device, without extraocular reservoir, internal approach, into the trabecular meshwork; initial insertion (Deleted code effective 1/1/2022)
	0253T	Insertion of anterior segment aqueous drainage device, without extraocular reservoir, internal approach, into the suprachoroidal space
	0376T	Insertion of anterior segment aqueous drainage device, without extraocular reservoir, internal approach, into the trabecular meshwork; each additional device insertion (List separately in addition to code for primary procedure) (Deleted code effective 1/1/2022)
	0449T	Insertion of aqueous drainage device, without extraocular reservoir, internal approach, into the subconjunctival space; initial device
	0450T	Insertion of aqueous drainage device, without extraocular reservoir, internal approach, into the subconjunctival space; each additional device (List separately in addition to code for primary procedure)
	0474T	Insertion of anterior segment aqueous drainage device, with creation of intraocular reservoir, internal approach, into the supraciliary space
	0621T	Trabeculostomy ab interno by laser
	0622T	Trabeculostomy ab interno by laser; with use of ophthalmic endoscope

Type	Code	Description
	0671T	Insertion of anterior segment aqueous drainage device into the trabecular meshwork, without external reservoir, and without concomitant cataract removal, one or more (Code effective 1/1/2022)
	66179	Aqueous shunt to extraocular equatorial plate reservoir, external approach; without graft
	66180	Aqueous shunt to extraocular equatorial plate reservoir, external approach; with graft
	66183	Insertion of anterior segment aqueous drainage device, without extraocular reservoir, external approach
	66184	Revision of aqueous shunt to extraocular equatorial plate reservoir; without graft
	66185	Revision of aqueous shunt to extraocular equatorial plate reservoir; with graft
HCPCS	C1783	Ocular implant, aqueous drainage assist device
	L8612	Aqueous shunt

Policy History

This section provides a chronological history of the activities, updates and changes that have occurred with this Medical Policy.

Effective Date	Action
01/30/2015	BCBSA Medical Policy adoption
06/01/2016	Policy revision without position change
12/01/2016	Coding update
02/01/2017	Coding update
05/01/2017	Policy revision without position change
08/01/2018	Policy revision without position change
02/01/2019	Policy revision with position change
05/01/2019	Policy revision without position change
12/01/2019	Policy revision without position change
09/01/2020	Policy reactivated. Previously archived from 8/1/2020 to 8/31/2020.
12/01/2020	Annual review. No change to policy statement. Literature review updated.
01/01/2021	Coding update
11/01/2021	Annual review. No change to policy statement. Literature review updated.
02/01/2022	Coding update

Definitions of Decision Determinations

Medically Necessary: Services that are Medically Necessary include only those which have been established as safe and effective, are furnished under generally accepted professional standards to treat illness, injury or medical condition, and which, as determined by Blue Shield, are: (a) consistent with Blue Shield medical policy; (b) consistent with the symptoms or diagnosis; (c) not furnished primarily for the convenience of the patient, the attending Physician or other provider; (d) furnished at the most appropriate level which can be provided safely and effectively to the patient; and (e) not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the Member's illness, injury, or disease.

Investigational/Experimental: A treatment, procedure, or drug is investigational when it has not been recognized as safe and effective for use in treating the particular condition in accordance

with generally accepted professional medical standards. This includes services where approval by the federal or state governmental is required prior to use, but has not yet been granted.

Split Evaluation: Blue Shield of California/Blue Shield of California Life & Health Insurance Company (Blue Shield) policy review can result in a split evaluation, where a treatment, procedure, or drug will be considered to be investigational for certain indications or conditions, but will be deemed safe and effective for other indications or conditions, and therefore potentially medically necessary in those instances.

Prior Authorization Requirements (as applicable to your plan)

Within five days before the actual date of service, the provider must confirm with Blue Shield that the member's health plan coverage is still in effect. Blue Shield reserves the right to revoke an authorization prior to services being rendered based on cancellation of the member's eligibility. Final determination of benefits will be made after review of the claim for limitations or exclusions.

Questions regarding the applicability of this policy should be directed to the Prior Authorization Department at (800) 541-6652, or the Transplant Case Management Department at (800) 637-2066 ext. 3507708 or visit the provider portal at www.blueshieldca.com/provider.

Disclaimer: This medical policy is a guide in evaluating the medical necessity of a particular service or treatment. Blue Shield of California may consider published peer-reviewed scientific literature, national guidelines, and local standards of practice in developing its medical policy. Federal and state law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over medical policy and must be considered first in determining covered services. Member contracts may differ in their benefits. Blue Shield reserves the right to review and update policies as appropriate.

Appendix A

POLICY STATEMENT (No changes)	
BEFORE	AFTER
<p>Aqueous Shunts and Stents for Glaucoma 9.03.21</p> <p>Policy Statement: Ab Externo Aqueous Shunts Insertion of ab externo aqueous shunts approved by the U.S. Food and Drug Administration (FDA) may be considered medically necessary as a method to reduce intraocular pressure in patients with glaucoma where medical therapy has failed to adequately control intraocular pressure.</p> <p>Use of an ab externo aqueous shunt for all other conditions, including in patients with glaucoma when intraocular pressure is adequately controlled by medications, is considered investigational.</p> <p>Ab Interno Aqueous Stents Insertion of ab interno aqueous stents approved by the U.S. 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 may be considered medically necessary.</p> <p>Implantation of 1 or 2 U.S. Food and Drug Administration-approved ab interno aqueous stents in conjunction with cataract surgery may be considered medically necessary in patients with mild-to-moderate open-angle glaucoma treated with ocular hypotensive medication.</p> <p>Use of ab interno aqueous stents for all other conditions is considered investigational.</p>	<p>Aqueous Shunts and Stents for Glaucoma 9.03.21</p> <p>Policy Statement: Ab Externo Aqueous Shunts Insertion of ab externo aqueous shunts approved by the U.S. Food and Drug Administration (FDA) may be considered medically necessary as a method to reduce intraocular pressure in patients with glaucoma where medical therapy has failed to adequately control intraocular pressure.</p> <p>Use of an ab externo aqueous shunt for all other conditions, including in patients with glaucoma when intraocular pressure is adequately controlled by medications, is considered investigational.</p> <p>Ab Interno Aqueous Stents Insertion of ab interno aqueous stents approved by the U.S. 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 may be considered medically necessary.</p> <p>Implantation of 1 or 2 U.S. Food and Drug Administration-approved ab interno stents in conjunction with cataract surgery may be considered medically necessary in patients with mild-to-moderate open-angle glaucoma treated with ocular hypotensive medication.</p> <p>Use of ab interno stents for all other conditions is considered investigational.</p>