

Medicare Advantage Medical Policy



Nonprofit corporations and independent licensees
of the Blue Cross and Blue Shield Association

Aqueous Shunts and Stents for Glaucoma – Medicare Advantage

Medicare Advantage Plan

☒ Medicare Plus BlueSM

☒ BCN AdvantageSM

UM Committee Approval Date:1/28/2026

Effective Date:2/28/2026

Description

The primary indication for aqueous shunts is for failed medical or surgical therapy to treat glaucoma, although some ophthalmologists have advocated their use as a primary surgical intervention. Trabeculectomy is the most established surgical procedure for glaucoma. Canaloplasty is another surgical procedure for glaucoma. 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.

Related Medical Coverage Policies

- Corneal Hysteresis Determination by Air Impulse Stimulation
 - Optical Coherence Tomography Imaging, Anterior Eye
 - Suprachoroidal Delivery of Pharmacologic Agent
 - Viscocanalostomy and Canaloplasty
-

Policy Guidelines

Blue Cross Blue Shield of Michigan (BCBSM) and Blue Care Network of Michigan (BCN) adhere to guidance from the Centers for Medicare and Medicaid Services (CMS), including when performing organization determinations for Medicare Advantage plan members. CMS Medicare statutes, regulations, manuals, National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), Local Coverage Articles (LCAs) and other sub-regulatory guidance provide the clinical guidelines for coverage determinations, payment integrity functions, and all other uses by CMS regulations. When CMS Medicare guidance is silent, incomplete, or insufficient, CMS permits BCBSM/BCN to utilize “internal coverage criteria”, such as independent criteria, health plan policy research, LCD/LCAs outside the services area or research from independent medical research repositories (i.e., Hayes) for coverage policies 42 CFR § 422.101. BCBSM/BCN internal medical coverage policies are developed and based on current evidence in widely accepted treatment guidelines or clinical literature; in addition, they address how clinical benefits may or may not outweigh member harm.

Clinical review follows guidance provided in the BCBSM Medicare Advantage Coverage Determination Hierarchy policy, which may be found at <https://www.bcbsm.com/providers/mpadmin/> by entering the policy name.

Coverage Guidance

To ensure consistency with coverage guidance, the Medicare statutes, regulations, coverage manuals, NCD, LCD, and LCA should be reviewed and applied first. BCBSM/BCN internal coverage criteria should only be applied when CMS guidance is silent, incomplete, or insufficient for a code.

Apart from durable medical equipment (DME), Medicare Administrative Contractor (MAC) jurisdiction for the purpose of clinical determination is based upon place of service. The place of service for laboratory testing is defined as the geographic location of the reference laboratory. Non-jurisdictional LCD/LCAs may not be utilized for a determination unless they have been specifically identified as internal coverage criteria by the policy. Alternatively, jurisdiction for DME MAC is determined by the member place of residence. Please see CMS Medicare Administrative Contractors (MAC) table for state MAC assignments below.

CMS Guidance	Additional Guidance
National Coverage Determinations 80.12: Intraocular Lenses 310.1: Routine Costs in Clinical Trials For clinical trial information related to variety of shunts, stents and microstents as alternatives to surgical treatments; Please refer to https://clinicaltrials.gov Local Coverage Determinations and Articles WPS L39907/ A59807 Micro-Invasive Glaucoma Surgery (MIGS) L39905/ A59805 Cataract Surgery CGS L37578/ A56491 Micro-Invasive Glaucoma Surgery (MIGS) L33954/ A56453 Cataract Extraction A52432 Insertion of Anterior Segment Aqueous Drainage Device, Without Extraocular Reservoir, External Approach First Coast L38233/ A56647 Micro-Invasive Glaucoma Surgery (MIGS) L38926/ A58592 Cataract Extraction (including complex cataract surgery) NGS L37244/ A56588 Micro-Invasive Glaucoma Surgery (MIGS) L33558/ A56544 Cataract Extraction Noridian	BCBSM/BCN will follow CMS guidance as the primary source for coverage determinations. However, in instances where CMS guidance is silent, incomplete, or insufficient for a particular code, BCBSM/BCN internal coverage criteria will be applied to ensure consistent and informed decision-making. In such cases, please refer to the relevant BCBSM/BCN policy for guidance: <i>Aqueous Shunts and Stents for Glaucoma</i> To access this policy, please visit the BCBSM Medical Policy Router Search page at https://www.bcbsm.com/providers/mpadmin/ and enter the policy name in the search field

L38299/ A57863 Micro-Invasive Glaucoma Surgery (MIGS) L34203/ A57195 Cataract Surgery in Adults Novitas L38223, A56633 Micro-Invasive Glaucoma Surgery (MIGS) L35091, A56615 Cataract Extraction (including Complex Cataract Surgery) Palmetto L37531, A56866 Micro-Invasive Glaucoma Surgery (MIGS) L34413, A56613 Cataract Surgery L38792, A58392 Dexamethasone Intracanalicular Ophthalmic Insert (Dextenza®)	
--	--

Code	Description
66179	Aqueous shunt to extraocular equatorial plate reservoir, external approach; without graft
66180	Aqueous shunt to extraocular equatorial plate reservoir, external approach; with graft (e.g., Ahmed, Baerveldt, ClearPath)
66183	Insertion of anterior segment aqueous drainage device, without extraocular reservoir, external approach [ExPRESS glaucoma shunt, AquaFlow]
66184	Revision of aqueous shunt to extraocular equatorial plate reservoir; without graft
66185	Revision of aqueous shunt to extraocular equatorial plate reservoir; with graft
0671T	Insertion of anterior segment aqueous drainage device into the trabecular meshwork, without external reservoir, and without concomitant cataract removal, one or more. (iStent Infinite)
66982	Extracapsular cataract removal with insertion of intraocular lens prosthesis (1-stage procedure), manual or mechanical technique (e.g., irrigation and aspiration or phacoemulsification), complex, requiring devices or techniques not generally used in routine cataract surgery (e.g., iris expansion device, suture support for intraocular lens, or primary posterior capsulorrhexis) or performed on patients in the amblyogenic developmental stage; without endoscopic cyclophotocoagulation.
66983	Intracapsular cataract extraction with insertion of intraocular lens prosthesis (1 stage procedure)
66984	Extracapsular cataract removal with insertion of intraocular lens prosthesis (1 stage procedure), manual or mechanical technique (e.g., irrigation and aspiration or phacoemulsification); without endoscopic cyclophotocoagulation.
66987	Extracapsular cataract removal with insertion of intraocular lens prosthesis (1-stage procedure), manual or mechanical technique (e.g., irrigation and aspiration or phacoemulsification), complex, requiring devices or techniques not generally used in routine cataract surgery (e.g., iris expansion device, suture support for intraocular lens, or primary posterior capsulorrhexis) or performed on patients in the amblyogenic developmental stage; with endoscopic cyclophotocoagulation
66988	Extracapsular cataract removal with insertion of intraocular lens prosthesis (1 stage procedure), manual or mechanical technique (e.g., irrigation and aspiration or phacoemulsification); with endoscopic cyclophotocoagulation

Code	Description
66989	Extracapsular cataract removal with insertion of intraocular lens prosthesis (1-stage procedure), manual or mechanical technique (e.g., irrigation and aspiration or phacoemulsification), complex, requiring devices or techniques not generally used in routine cataract surgery (e.g., iris expansion device, suture support for intraocular lens, or primary posterior capsulorrhexis) or performed on patients in the amblyogenic developmental stage; with insertion of intraocular (e.g., trabecular meshwork, supraciliary, suprachoroidal) anterior segment aqueous drainage device, without extraocular reservoir, internal approach, one or more
66991	Extracapsular cataract removal with insertion of intraocular lens prosthesis (1 stage procedure), manual or mechanical technique (e.g., irrigation and aspiration or phacoemulsification); with insertion of intraocular (e.g., trabecular meshwork, supraciliary, suprachoroidal) anterior segment aqueous drainage device, without extraocular reservoir, internal approach, one or more
66999	Unlisted procedure, anterior segment of the eye [replaced 0123T]
0253T	Insertion of aqueous drainage device, without extraocular reservoir, internal approach, into the subconjunctival space; initial device [AqueSys XEN Gel Stent AqueSys, Inc]
0449T	Insertion of aqueous drainage device, without extraocular reservoir, internal approach, into the subconjunctival space; initial device [AqueSys XEN Gel Stent AqueSys, Inc]
0450T	Each additional device (list separately in addition to code for primary procedure) [AqueSys XEN Gel Stent AqueSys, Inc]
0474T	Insertion of anterior segment aqueous drainage device, with creation of intraocular reservoir, internal approach, into the supraciliary space [CyPass® Micro-Stent-Transcend Medical, Inc]

CPT® codes, descriptions and materials are copyrighted by the American Medical Association (AMA).

HCPCS® codes, descriptions and materials are copyrighted by Centers for Medicare and Medicaid Services (CMS).

The above information is current as of the review date for this policy. However, the coverage issues and policies maintained by CMS are updated and/or revised periodically. Therefore, the most current CMS information may not be contained in this document.

Please refer to the Medicare Coverage Database website at <https://www.cms.gov/medicare-coverage-database/search.aspx> for the most current applicable NCD, LCD, LCA, and CMS Online Manual System Transmittals.

CMS Medicare Administrative Contractors (MAC) Jurisdictions Guidance

Part A and Part B MAC Jurisdictions	
Wisconsin Physicians Service Insurance Corporation (WPS)	IA, IN, KS, MI, MO, NE
CGS Administrators, LLC	KY, OH
First Coast Service Options, Inc	FL, PR, US VI
National Government Services, Inc (NGS)	CT, IL, MA, ME, MN, NH, NY, RI, VT, WI,
Noridian Healthcare Solutions, LLC,	CA, HI, NV, American Samoa, Guam, Northern Mariana Islands AK, AZ, ID, MT, ND, OR, SD, UT, WA, WY
Novitas Solutions, Inc	AR, CO, DC, DE, LA, MD, MS, NJ, NM, OK, PA, TX,
Palmetto GBA	AL, GA, TN NC, SC, VA, WV
DME MAC Jurisdictions	
CGS Administrators, LLC, Jurisdictions JB and JC	AL, AR, CO, FL, GA, IL, IN, KY, LA, MI, MN, MS, NM, NC, OH, OK, Puerto Rico, SC, TN, TX, VA, Virgin Island, WI, WV

Important Reminder

BCBSM and BCN follow CMS Medicare coverage guidance to limit coverage to items and services that are reasonable and necessary for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body member. Medicare Advantage Medical Policies list the criteria BCBSM and BCN use to decide which medical services are considered “reasonable and necessary” when Medicare coverage rules are not fully developed, or as otherwise may permitted by CMS Medicare regulations. Individual member benefit plan documents, such as the Evidence of Coverage and Annual Notice of Change, as well as applicable laws govern benefit coverage, including any inclusion, exclusion, and/or other restrictions.

Medicare Advantage Medical policies are created when permitted by CMS Medicare regulations, reviewed regularly, and may be revised periodically. BCBSM/BCN Medical Policies are proprietary and should not be copied or disseminated without the express, prior written approval of BCBSM. All providers are required to review applicable BCBSM reimbursement policies prior to claim submission and bill for covered services in accordance with those policies. Additionally, providers contracted with BCBSM or BCN’s Medicare Advantage network(s) should review the provider manual for any additional claim submission requirements. Providers not contracted with BCBSM or BCN’s Medicare Advantage network may be required to submit documentation to BCBSM, BCN, or its delegated entity supporting billed claims, including but not limited to applicable medical records.

Note: U.S. Food and Drug Administration (FDA) approval for a specific indication or the issuance of a CPT code is not sufficient for a procedure to be considered medically reasonable and necessary. Similarly, the presence of a procedure/device code or payment amount for the service in the Medicare fee schedule does not necessarily indicate coverage. If a service is deemed not reasonable and necessary, to treat illness or injury for any reason (including lack of safety and efficacy because it is an experimental procedure, etc.), the procedure is considered not covered.

Disclaimer: This medical policy is not an authorization, certification, explanation of benefits, or a contract for the services, devices, or drugs that is referenced in the medical policy. Medical policies do not constitute medical advice and do not guarantee any results or outcomes or guarantee payment. The medical policy is not intended to replace independent medical judgment for the treatment of individuals. Treating physicians and health care providers are solely responsible for determining what care to provide to their patients. Identification of selected brand names of devices, tests and procedures in a medical coverage policy is for reference only and is not an endorsement of any one device, test, or procedure over another.

Pursuant to Section 1557 and Section 504, Blue Cross does not discriminate on the basis of race, color, national origin, age, disability, or sex (including sex characteristics, intersex traits; pregnancy or related conditions; sexual orientation; gender identity, and sex stereotypes). This includes our rules, benefit designs and medical policies.

BCBSM/BCN Medicare Advantage Policy History

Policy Effective Date	UM Committee Approval Date	Comments
8/17/2024	07/17/2024	Medicare Advantage policy established
08/16/2025	07/16/2025	MA policy foundational language updated. Adoption of JUMP policy updates.
02/28/2026	01/28/2026	Adoption of JUMP policy updates.