Glaucoma Surgery

Lines of Business	Document Type
Commercial, Medicaid, Medicare	Policy
Who This Applies To	**States**
Health Services	Idaho, Montana, Oregon, Washington

Enterprise Policy

PacificSource is committed to assessing and applying current regulatory standards, widely-used treatment guidelines, and evidenced-based clinical literature when developing clinical criteria for coverage determination. Each policy contains a list of sources (references) that serves as the summary of evidence used in the development and adoption of the criteria. The evidence was considered to ensure the criteria provide clinical benefits that promote patient safety and/or access to appropriate care. Each clinical policy is reviewed, updated as needed, and readopted, at least annually, to reflect changes in regulation, new evidence, and advancements in healthcare.

Clinical Guidelines are written when necessary to provide guidance to providers and members in order to outline and clarify coverage criteria in accordance with the terms of the Member's policy. This Clinical Guideline only applies to PacificSource Health Plans, PacificSource Community Health Plans, and PacificSource Community Solutions in Idaho, Montana, Oregon, and Washington. Because of the changing nature of medicine, this list is subject to revision and update without notice. This document is designed for informational purposes only and is not an authorization or contract. Coverage determinations are made on a case-by-case basis and subject to the terms, conditions, limitations, and exclusions of the Member's policy. Member policies differ in benefits and to the extent a conflict exists between the Clinical Guideline and the Member's policy, the Member's policy language shall control. Clinical Guidelines do not constitute medical advice nor guarantee coverage.

Background

Glaucoma is an irreversible group of conditions/diseases involving damage to the optic nerve and loss of peripheral vision. Glaucoma was previously defined by high Intraocular Pressure (IOP); however, the condition is also found in individuals with normal or low eye pressure. Primary open-angle glaucoma (POAG) is the most common form, and other types include, but may not be limited to, angle-closure and congenital glaucoma; Prescription medication, in the form of eye drops, pills or both, is the most common early treatment for glaucoma.

Current standard surgical treatments for all types of glaucoma include; trabeculectomy, trabeculoplasty (incisional or laser), Iridotomy, iridectomy or iridopathy. The most common surgical procedure for lowering IOP in glaucoma is a trabeculectomy (guarded filtration surgery), which creates a hole in the sclera to let the aqueous fluid drain into the outer cyst or bleb. The iStent Trabecular Micro-Bypass Stent System creates a permanent opening from the anterior chamber into Schlemm's canal to improve aqueous humor outflow past the trabecular meshwork, thereby reducing IOP.

Canaloplasty is a surgical technique for glaucoma which aims to restore the natural drainage of fluid from the eye.

Criteria

Commercial

Prior authorization is required.

I. Trabecular bypass surgery (treatment examples: iStent, iStent Infinite, Xen Gel Stent)

A. PacificSource may consider Trabecular bypass surgery medically necessary when **ALL** of the following criteria have been met:

1. Member is eighteen (18) years or older
2. Diagnosis of open-angle glaucoma
3. Pharmacologic management has failed to adequately control intraocular pressure
4. Procedure is in conjunction with cataract surgery for the reduction of intraocular pressure (excluding iStent infinite and Xen Gel, which may be used without cataract surgery)
5. Member is not a candidate for selective laser trabeculoplasty, or it has failed to adequately control intraocular pressure

II. Canaloplasty (Ab Externo or Ab Interno)

A. PacificSource considers Canaloplasty, whether surgical approach is performed Ab Externo or Ab Interno, medically necessary as a method to reduce intraocular pressure when **ALL** of the following conditions are met:

1. The member has a diagnosis of either primary open-angle glaucoma (POAG) or normal-tension glaucoma
2. Pharmacologic management has failed to adequately control intraocular pressure
3. Less invasive surgical interventions (e.g., selective laser trabeculoplasty, trabeculectomy, repeat trabeculectomy, traculopasty or glaucoma drainage implant) have failed to adequately control intraocular pressure

III. Intracameral Implant(s) Related Procedures

A. PacificSource covers the procedure codes 0660T and 0661T for implementation and re-implementation of iDose TR (travoprost), (J7355), intracameral implant(s) when approved by PacificSource Pharmacy.

Medicaid

PacificSource Community Solutions (PCS) follows the general coverage, limitations, and exclusions outlined in OARs 410-130-0160, 410-141-3820, 410-141-3825, and 410-120-1200 and any relevant Guideline Notes of the Health Evidence Review Commission (HERC) Prioritized List of Health Services for coverage of Glaucoma Surgery for non-EPSDT beneficiaries.

PacificSource Community Solutions (PCS) follows the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) coverage requirements in OAR 410-151-0002 through 410-151-0003 for EPSDT beneficiaries. A case-by-case review for EPSDT Medical Necessity and EPSDT Medical

Appropriateness as defined in OAR 410-151-0001 is required prior to denying. Refer to the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) policy for details.

Medicare

PacificSource Medicare follows Local Coverage Determination L38299 for Micro-Invasive Glaucoma Surgery.

PacificSource Medicare follows CMS guidelines and criteria. In the absence of CMS guidelines and criteria, PacificSource Medicare will follow the PacificSource Commercial clinical criteria above for determination of coverage and medical necessity of coverage and medical necessity of Glaucoma Surgery.

Experimental/Investigational/Unproven

PacificSource considers Trabecular Micro Bypass to be experimental, investigational, or unproven for any other indications.

PacificSource considers Canaloplasty (Ab Externo or Ab Interno) to be experimental, investigational, or unproven for any other indications.

Note: PacificSource Community Solutions (PCS) and PacificSource Medicare require items listed on this policy's E/I/U list, to be reviewed by medical necessity review guidelines. Please see related policy, "Clinical Criteria Used in UM Decisions" to review criteria hierarchy and "Medical Necessity Reviews" for determination of coverage and medical necessity guidelines.

Coding Information

The following list of codes are for informational purposes only and may not be all-inclusive. Deleted codes and codes which are not effective at the time the service is rendered may not be eligible for reimbursement.

66174 Transluminal dilation of aqueous outflow canal; without retention of device or stent –

66175 Transluminal dilation of aqueous outflow canal; with retention of device or stent-

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

66989 Extracapsular cataract removal w/insert intraocular lens prosthesis, man/mech tech, complex, requ dev or tech not generally used routine cataract surg/amblyogenic dev stage;

66991 Extracapsular cataract removal w/insert intraocular lens prosthesis, man/ mech tech; w/insert of intraocular anterior segment aqueous drainage dev, w/o extraocular reservoir\

66999 Unlisted procedure, anterior segment of eye

0253T Insertion of anterior segment aqueous drainage device, without extraocular reservoir; internal approach, into the suprachoroidal space

0449T	Insertion of anterior segment aqueous drainage device, with creation of intraocular reservoir, internal approach, into the supraciliary
0450T	Insertion of aqueous drainage device, without extraocular reservoir, internal approach, into the subconjunctival space; each additional device
0660T	Implantation of anterior segment intraocular nonbiodegradable drug-eluting system, internal approach
0661T	Removal and reimplantation of anterior segment intraocular nonbiodegradable drug-eluting implant
0621T	Trabeculostomy ab interno by laser
0622T	Trabeculostomy ab interno by laser; with use of ophthalmic endoscope
0671T	Insertion of anterior segment aqueous drainage device into the trabecular meshwork, without external reservoir, and without concomitant cataract removal, one or more
L8612	Aqueous Shunt Prosthesis

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

Definitions

Ab Interno - A surgical approach performed from inside the eye, typically through a small corneal incision into the anterior chamber.

Ab Externo - A surgical approach performed from outside the eye, involving dissection through the conjunctiva and sclera to reach Schlemm's canal or create a filtration pathway.

Canaloplasty - Surgical procedure for glaucoma which attempts to widen the eye's natural drainage canal and reestablish normal eye pressure.

Primary Open-Angle Glaucoma (POAG) - The most common glaucoma subtype characterized by an open anterior chamber angle with progressive optic neuropathy and visual field loss

Schlemm's canal - Circular endothelial channel in the anterior segment that receives aqueous humor from the trabecular meshwork and drains it into collector channels.

Trabeculectomy - Surgical procedure either done with laser or incision used to create a new channel, or "bleb" through which fluid can drain from the eye.

Viscocanalostomy - Surgical procedure similar to canaloplasty in which tissue flaps are cut in the conjunctiva and the sclera.

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Appendix A. Document Control – to update appendix fields, go to Properties Wizard

Version 2 **of Doc #** 318

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Effective Date: 08/20/2026

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Applicable regulation(s):

- OAR 410-120-1200 Excluded Services and Limitations
- OAR 410-130-0160 Codes
- OAR 410-141-3820 Covered Services
- OAR 410-141-3825 Excluded Services and Limitations
- OAR 410-151-0001 Definitions
- OAR 410-151-0002 Coverage Requirements
- OAR 410-151-0003 Utilization Management Requirements

Policy Function: Posted to PacificSource.com - Clinical Policy

External entities affected: N/A

LOBO Committee Review completed: 08/20/2026