Medicare Policy:
Canaloplasty and Viscocanalostomy (Commercial)

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<th>POLICY NUMBER</th>
<th>EFFECTIVE DATE</th>
<th>APPROVED BY</th>
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<tr>
<td>MG.MM.SU.62C3</td>
<td>04/12/2019</td>
<td>MPC (Medical Policy Committee)</td>
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**IMPORTANT NOTE ABOUT THIS MEDICAL POLICY:**

Property of ConnectiCare, Inc. All rights reserved. The treating physician or primary care provider must submit to ConnectiCare, Inc. the clinical evidence that the patient meets the criteria for the treatment or surgical procedure. Without this documentation and information, ConnectiCare will not be able to properly review the request for prior authorization. This clinical policy is not intended to pre-empt the judgment of the reviewing medical director or dictate to health care providers how to practice medicine. Health care providers are expected to exercise their medical judgment in rendering appropriate care. The clinical review criteria expressed below reflects how ConnectiCare determines whether certain services or supplies are medically necessary. ConnectiCare established the clinical review criteria based upon a review of currently available clinical information (including clinical outcome studies in the peer-reviewed published medical literature, regulatory status of the technology, evidence-based guidelines of public health and health research agencies, evidence-based guidelines and positions of leading national health professional organizations, views of physicians practicing in relevant clinical areas, and other relevant factors). ConnectiCare, Inc. expressly reserves the right to revise these conclusions as clinical information changes, and welcomes further relevant information. 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. Each benefit plan defines which services are covered. The conclusion that a particular service or supply is medically necessary does not constitute a representation or warranty that this service or supply is covered and/or paid for by ConnectiCare, as some plans exclude coverage for services or supplies that ConnectiCare considers medically necessary. If there is a discrepancy between this guideline and a member's benefits plan, the benefits plan will govern. In addition, coverage may be mandated by applicable legal requirements of the State of CT and/or the Federal Government. Coverage may also differ for our Medicare members based on any applicable Centers for Medicare & Medicaid Services (CMS) coverage statements including including National Coverage Determinations (NCD), Local Coverage Determinations (LCD) and/or Local Medical Review Policies (LMRP). All coding and web site links are accurate at time of publication.

**Definitions**

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<th>Viscocanalostomy and Canaloplasty</th>
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<td>Viscocanalostomy and canaloplasty are non-penetrating surgical procedures proposed for the treatment of primary open-angle glaucoma (POAG) in an attempt to preclude some of the complications associated with trabeculectomy, the gold standard surgery. Intraocular pressure (IOP) is the most crucial factor in controlling glaucoma and preventing irreversible nerve damage resulting in blindness.</td>
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<td>Canaloplasty uses the natural drainage channel of the eye to lower the pressure by stretching the meshwork filter. It is this tissue filter that limits the flow of fluid making the pressure too high and causing vision loss.</td>
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Viscocanalostomy is similar to canaloplasty in that it attempts to open up the Schlemm’s canal, but instead of using a cannula and thread, the viscocanaloplasty uses an injection of a viscous, biocompatible polymer to partly open the canal.

Related Medical Guidelines
Glaucoma Surgery

Guideline
Canaloplasty is considered medically necessary for the treatment of primary open-angle glaucoma to reduce IOP.

Exclusions and Limitations:
Canaloplasty is not considered medically necessary for all other indications (e.g., for use in glaucoma gene therapy) due to insufficient evidence of therapeutic value in the peer reviewed literature.

Viscocanalostomy (including phacoviscocanalostomy) is not considered medically necessary for glaucoma or any other indication due to insufficient evidence of therapeutic value in the peer reviewed literature. Viscocanalostomy is not as effective as trabeculectomy in reducing IOP.

Applicable Coding
To access the codes, please download the policy to your computer, and click on the paperclip icon within the policy.

References


Cillino S, Di Pace F, Casuccio A, Lodato G. Deep sclerectomy versus punch trabeculectomy: effect of
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Specialty matched clinical peer review.


Revision history

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<tr>
<th>DATE</th>
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<tr>
<td>03/05/2020</td>
<td>Reformatted and reorganized policy, transferred content to new template</td>
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<tr>
<td>04/01/2019</td>
<td>Annual review. No changes to policy</td>
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