Canaloplasty

State(s):
- Idaho
- Montana
- Oregon
- Washington
- Other:

LOB(s):
- Commercial
- Medicare
- Medicaid

Enterprise Policy

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 determination 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

Surgical procedures for glaucoma aim to reduce intraocular pressure (IOP) resulting from impaired aqueous humor drainage in the trabecular meshwork and/or Schlemm’s canal. These procedures may be indicated where medical therapy has failed to adequately control the IOP.

Canaloplasty is a minimally invasive surgical technique for glaucoma which attempts to widen the eye’s natural drainage canal, and reestablish normal eye pressure. Canaloplasty involves viscodilation and tension of the Schlemm's canal with an illuminated tipped microcatheter (iTrack™). The microcatheter is used to place an intracanalicular suture that cinches and stretches the trabecular meshwork inwards while permanently opening the entire length of Schlemm's canal. This procedure is done under local anesthesia on an outpatient basis.

Criteria

Commercial

Prior Authorization is Required.

Canaloplasty may be considered medically necessary as a method to reduce intraocular pressure when ALL of the following conditions are met:

- The member has a diagnosis of chronic primary open-angle glaucoma AND
- Pharmacologic or laser treatment has been tried and failed to adequately control intraocular pressure, AND
- The patient is not a candidate for any other intraocular pressure lowering procedure (e.g. trabeculectomy or glaucoma drainage implant) due to a high risk for complications (e.g., high risk of infection, bleeding or history of complications from trabeculectomy.

- Exclusion: PacificSource considers canaloplasty experimental, investigational or unproven for all other indications, including angle closure (acute) glaucoma, because its effectiveness for indications other than the one listed above has not been established.

**Medicaid**

This policy does not apply to Medicaid members. PacificSource Medicaid follows Oregon Health Plan (OHP) Oregon Administrative Rules (OARs) 410-141-3820 to 3825 & 410-120-1200 and considers Canaloplasty an unproven treatment.

**Medicare**

This policy does not apply to Medicare members. Medicare does not require preauthorization for Canaloplasty, CPT 66174 and 66175.

**Coding Information**

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

**References**


http://one.aao.org/preferred-practice-pattern/primary-openangle-glaucoma-ppp--october-2010


http://www.hindawi.com/journals/tswj/2014/469609/


http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4771907/

http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4606093/


https://www.ncbi.nlm.nih.gov/pubmed/?term=Canaloplasty%3A+three-year+results+of+circumferential+viscodilation+and+tensioning+of+Schlemm+canal+using+a+microcatheter+to+treat+open-angle+glaucoma


Appendix

Policy Number: [Policy Number]
Effective: 2/1/2020 Next review: 2/1/2021
Policy Type: Enterprise