Medical Policy

PARAMOUNT

HMO AND PPO
ELITE (MEDICARE ADVANTAGE)
MARKETPLACE

Viscocanalostomy and Canaloplasty

Policy Number: PG0195
Last Review: 02/01/2023

GUIDELINES:

- This policy does not certify benefits or authorization of benefits, which is designated by each individual policyholder terms, conditions, exclusions, and limitations contract. It does not constitute a contract or guarantee regarding coverage or reimbursement/payment. Self-Insured group specific policy will supersede this general policy when group supplementary plan document or individual plan decision directs otherwise.
- Paramount applies coding edits to all medical claims through coding logic software to evaluate the accuracy and adherence to accepted national standards.
- This medical policy is solely for guiding medical necessity and explaining correct procedure reporting used to assist in making coverage decisions and administering benefits.

SCOPE:

X Professional
_ Facility

DESCRIPTION:

Viscocanalostomy and canaloplasty are non-penetrating surgical procedures proposed for the treatment of glaucoma 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 and is therefore a consistent outcome measurement in clinical trials.

Canaloplasty uses the natural drainage channel of your 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.

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.

POLICY:

Paramount Commercial Insurance Plans and Elite (Medicare Advantage) Plans
Canaloplasty (66174, 66175) does not require prior authorization for Paramount Commercial Insurance Plans and Elite (Medicare Advantage) Plans

Viscocanalostomy (66174, 66175) is non-covered for all product lines.

COVERAGE CRITERIA:

Paramount Commercial Insurance Plans and Elite (Medicare Advantage) Plans

Paramount considers canaloplasty medically necessary when ALL the following conditions have been met:

- Absence of contraindications (diagnosis other than OAG or history of blunt ocular trauma or prior surgery resulting in scarring that limits the canal space).
- Individual diagnosed with OAG (e.g., juvenile-onset, pigmentary dispersion, primary OAG, pseudoexfoliation, steroid-induced and other non-specific open angle glaucomas); and
- Individual is 18 years of age or older, and
- Conventional medical therapy including pharmacologically (topical and/or oral) and laser therapy has failed to control intraocular pressure; and

- Other intraocular pressure lowering procedure (e.g., aqueous drainage device, trabeculectomy) are not indicated due to a high risk of complications (e.g., anticoagulant therapy, high myopia, history of or potential for excessive scarring, immunocompromised individual, ocular surface disease, prior failure of trabeculectomy in 1 eye).

Paramount considers canaloplasty experimental and investigational for all other indications because it is considered experimental, investigational, or unproven.

Paramount considers viscocanalostomy or combined phacoemulsification and viscocanalostomy experimental and investigational for the treatment of primary open-angle glaucoma or any other indications because there is insufficient evidence in the peer-reviewed published medical literature to establish the effectiveness of these treatments on health outcomes when compared to established treatments or technologies.

CODING/BILLING INFORMATION:

The appearance of a code in this section does not necessarily indicate coverage. Codes that are covered may have selection criteria that must be met. Payment for supplies may be included in payment for other services rendered.

CPT CODES	
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

REVISION HISTORY EXPLANATION: ORIGINAL EFFECTIVE DATE: 01/30/2009

Date	Explanation & Changes
04/01/2010	• Updated references
01/01/2011	• Revised codes
02/14/2014	• Deleted codes 0176T & 0177T • Canaloplasty (66174, 66175) is now a covered service with prior authorization per TAWG committee's decision • Policy reviewed and updated to reflect most current clinical evidence per Medical Policy Steering Committee
11/21/2014	• TAWG committee determined canaloplasty would no longer require prior authorization • Policy reviewed and updated to reflect most current clinical evidence per TAWG committee
09/17/2015	• Policy reviewed and updated to reflect most current clinical evidence per TAWG committee
09/23/2016	• Procedure 66175 is now non-covered for Advantage per ODM guidelines • Policy reviewed and updated to reflect most current clinical evidence per TAWG committee
12/16/2020	• Medical policy placed on the new Paramount Medical Policy Format
02/01/2023	• Policy reviewed and updated to reflect most current clinical evidence • No changes to policy statement
02/13/2023	• Medical Policy updated to reflect Medicaid coverage to Anthem as of 02/01/2023

Paramount reserves the right to review and revise our policies periodically when necessary. When there is an update, we will publish the most current policy to
https://www.paramounthealthcare.com/providers/medical-policies/policy-library

REFERENCES/RESOURCES

Centers for Medicare and Medicaid Services, CMS Manual System and other CMS publications and services https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs

American Medical Association, *Current Procedural Terminology (CPT®)* and associated publications and services https://www.ama-assn.org/amaone/cpt-current-procedural-terminology

Centers for Medicare and Medicaid Services, Healthcare Common Procedure Coding System, HCPCS Release and Code Sets https://www.cms.gov/Medicare/Coding/HCPCSReleaseCodeSets/HCPCS-Quarterly-Update

U.S. Preventive Services Task Force, https://www.uspreventiveservicestaskforce.org/uspstf/
Industry Standard Review

Hayes, Inc., https://www.hayesinc.com/

Industry Standard Review

Paramount Commercial Plans, Medicare Advantage Plans and Paramount Medicaid Advantage
Canaloplasty (66174, 66175) does not require prior authorization for Paramount Commercial Plans and Medicare Advantage Plans **Canaloplasty (66174) does not require prior authorization for Paramount Medicaid Advantage.** **Procedure 66175 is non-covered for the Paramount Medicaid Advantage professional services reimbursement per the Ohio Department of Medicaid (ODM) Appendix DD. Procedure 66175 is listed as an outpatient facility covered services per ODM for Enhanced Ambulatory Patient Groups.** **Viscocanalostomy (66174, 66175) is non-covered for all product lines.**

Procedure 66175 is non-covered for the Advantage professional services reimbursement per the Ohio Department of Medicaid (ODM) Appendix DD. Procedure 66175 is listed as an outpatient facility covered services per ODM for the Enhanced Ambulatory Patient Groups (EAPG) reimbursement.

History