Viscocanalostomy and Canaloplasty

Preauthorization is not required.

The following protocol contains medical necessity criteria that apply for this service. The criteria are also applicable to services provided in the local Medicare Advantage operating area for those members, unless separate Medicare Advantage criteria are indicated. If the criteria are not met, reimbursement will be denied and the patient cannot be billed. Please note that payment for covered services is subject to eligibility and the limitations noted in the patient’s contract at the time the services are rendered.

<table>
<thead>
<tr>
<th>Populations</th>
<th>Interventions</th>
<th>Comparators</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
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DESCRIPTION

Glaucoma surgery is intended to reduce intraocular pressure (IOP) when the target IOP cannot be reached with medications. Due to complications with established surgical approaches (e.g., trabeculectomy), alternative surgical treatments (e.g., transluminal dilation by viscocanalostomy or canaloplasty) are being evaluated for patients with glaucoma.

SUMMARY OF EVIDENCE

For individuals who have open-angle glaucoma who have failed medical therapy who receive viscocanalostomy, the evidence includes small randomized controlled trials (RCTs) comparing viscocanalostomy with trabeculectomy. Relevant outcomes are symptoms, morbid events, quality of life, and medication use. Meta-analysis of these trials has indicated that trabeculectomy has a greater IOP-lowering effect than viscocanalostomy. Reduction in IOP was greater with canaloplasty than viscocanalostomy in a small within-subject comparison. Viscocanalostomy has not been shown to be as good as or better than established alternatives. The evidence is sufficient to determine that the technology is unlikely to improve the net health outcome.

For individuals who have open-angle glaucoma who have failed medical therapy who receive canaloplasty, the evidence includes an RCT, a comparative effectiveness review, and several case series. Relevant outcomes are symptoms, morbid events, quality of life, and medication use. The RCT found not only significantly higher complete success rates with trabeculectomy than with canaloplasty, but also higher complication rates. The qualified
success rate (with medication) was similar between groups. A systematic review found that canaloplasty pro-
vided modest IOP reduction (to \(\approx 16 \text{ mm Hg}\)) with minor intraoperative or postoperative complications. The evi-
dence is insufficient to determine the effects of the technology on health outcomes.

Clinical input obtained in 2011 considered canaloplasty to be appropriate for a select group of patients, includ-
ing those at risk for infection or hypotony, who have surface disease precluding the creation of good trabeculec-
tomy bleb, or for whom a patch would not cover a glaucoma drainage device implant. In this clinical context, the
evidence is sufficient to determine that the technology results in a meaningful improvement in the net health
outcome.

POLICY

Viscocanalostomy is considered **not medically necessary**.

Canaloplasty may be considered **medically necessary** as a method to reduce intraocular pressure (IOP) in
patients with chronic primary open-angle glaucoma under the following conditions:

- Medical therapy has failed to adequately control IOP, AND
- The patient is not a candidate for any other IOP-lowering procedure (e.g., trabeculectomy or glaucoma
  drainage implant) due to a high risk for complications.

Canaloplasty is considered **investigational** under all other conditions, including angle-closure glaucoma.

POLICY GUIDELINES

Tensioning devices are only able to reduce IOP to the mid-teens, and may be inadequate when very low IOP is
needed to reduce glaucoma damage.

BACKGROUND

IMPAIRED AQUEOUS HUMOR DRAINAGE

In the primary (conventional) outflow pathway from the eye, aqueous humor passes through the trabecular
meshwork, enters a space lined with endothelial cells (Schlemm canal), drains into collector channels, and then
into the aqueous veins. Increases in resistance in the trabecular meshwork and/or the inner wall of Schlemm
canal can disrupt the balance of aqueous humor inflow and outflow, resulting in an increase in intraocular pres-
sure (IOP) and glaucoma risk.

Treatment

Surgical intervention may be indicated in patients with glaucoma when the target IOP cannot be reached phar-
macologically. Trabeculectomy (guarded filtration surgery) is the most established surgical procedure for glau-
coma, allowing aqueous humor to directly enter the subconjunctival space. This procedure creates a subcon-
junctival reservoir with a filtering “bleb” on the eye, which can effectively reduce IOP, but is associated with
numerous and sometimes sight-threatening complications (e.g., leaks, hypotony, choroidal effusions and hem-
orrhages, hyphemas or bleb-related endophthalmitis) and long-term failure. Other surgical procedures (not
addressed herein) include trabecular laser ablation and deep sclerectomy, which removes the outer wall of
Schlemm canal and excises deep sclera and peripheral cornea.

More recently, the Trabectome™, an electrocautery device with irrigation and aspiration, has been used to
selectively ablate the trabecular meshwork and inner wall of Schlemm canal without external access or creation
of a subconjunctival bleb. IOP with this ab interno procedure is typically higher than the pressure achieved with
standard filtering trabeculectomy. Aqueous shunts may also be placed to facilitate drainage of aqueous humor
(see the Aqueous Shunts and Stents for Glaucoma Protocol). Complications from anterior chamber shunts
include corneal endothelial failure and erosion of the overlying conjunctiva.

Alternative nonpenetrating methods being evaluated to treat glaucoma are viscocanalostomy and canaloplasty.
Viscocanalostomy is a variant of deep sclerectomy and unroofs and dilates the Schlemm canal without pene-
trating the trabecular meshwork or anterior chamber. A high-viscosity viscoelastic solution (e.g., sodium hyalu-
ronate) is used to open the canal and create a passage from the canal to a scleral reservoir. It has been proposed
that viscocanalostomy may lower IOP while avoiding bleb-related complications.

Canaloplasty, which evolved from viscocanalostomy, involves dilation and tension of the Schlemm canal with a
suture loop between the inner wall of the canal and the trabecular meshwork. This ab externo procedure uses
the iTrack illuminated microcatheter to access and dilate the length of the Schlemm canal and to pass the suture
loop through the canal. An important difference between viscocanalostomy and canaloplasty is that canalo-
plasty attempts to open the entire length of the Schlemm canal, rather than one section of it.

Because aqueous humor outflow is pressure-dependent, the pressure in the reservoir and venous system is
critical for reaching the target IOP. Therefore, some procedures may not reduce IOP below the pressure of the
distal outflow system used (e.g., <15 mm Hg), and are not indicated for patients for whom very low IOP is
desired (e.g., those with advanced glaucoma).

Outcome Measures
Health outcomes of interest are the IOP achieved, reduction in medications, ability to convert to trabeculectomy
if the procedure is unsuccessful, complications, and durability of the procedure.

REGULATORY STATUS
In 2004, iTrack™ (iScience Interventional) was cleared for marketing by the U.S. Food and Drug Administration
through the 510(k) process as a surgical ophthalmic microcannula that is indicated for the general purpose of
“fluid infusion and aspiration, as well as illumination, during surgery.” In 2008, iTrack™ was cleared by the Food
and Drug Administration for “catheterization and viscodilation of [the] Schlemm canal to reduce intraocular
pressure in adult patients with open angle glaucoma.” Food and Drug Administration product code: MPA.

Services that are the subject of a clinical trial do not meet our Technology Assessment and Medically Necessary
Services Protocol criteria and are considered investigational. For explanation of experimental and investiga-
tional, please refer to the Technology Assessment and Medically Necessary Services Protocol.

It is expected that only appropriate and medically necessary services will be rendered. We reserve the right to
conduct prepayment and postpayment reviews to assess the medical appropriateness of the above-referenced
procedures. Some of this protocol may not pertain to the patients you provide care to, as it may relate to
products that are not available in your geographic area.

REFERENCES
We are not responsible for the continuing viability of web site addresses that may be listed in any references
below.