Varicose Vein Treatment

Origination Date: June 1, 1993
Review Date: July 20, 2016
Next Review: July, 2018

DESCRIPTION OF PROCEDURE OR SERVICE
Varicose veins of the lower extremities occur in sixty percent of the adult population. Conservative measures often yield satisfactory results in treatment of varicose veins. Treatments for varicose veins include:

1. **Varicose vein excision and ligation** involves tying off the affected vein and removing the varicosity. Removal of symptomatic, malfunctioning, superficial veins restores the venous circulation to a more normal state and provides relief of symptoms of venous hypertension.

2. **Sclerosing injections, or sclerotherapy of varicose veins** is performed generally for signs and symptoms of diseased vessels, as an adjunct to surgical therapy or for cosmetics. Sclerotherapy treatment destroys the lining of the affected vein by injecting an irritant solution (either a detergent, osmotic solution, or a chemical irritant), ultimately resulting in the complete obliteration of the vessel. Too little destruction leads to thrombosis without fibrosis and ultimate recanalization. Too much destruction leads to vascular dehiscence. The success of the treatment depends on accurate injection of the vessel, an adequate injectate volume and concentration of sclerosing solution, and post procedure compression. Sclerotherapy may be performed in conjunction with vein stripping or ligation (either simultaneously or delayed).

3. **Endovenous Radiofrequency Ablation (ERFA)** has been developed as an alternative to vein ligation and stripping. The procedure is designed to damage the intimal wall of the vein, resulting in fibrosis and subsequent obliteration of the lumen of a segment of the vessel thus eliminating reflux. The procedure is performed by means of a specially designed catheter inserted through a small incision in the distal medial thigh to within 1-2 cm of the sapheno-femoral junction. High frequency radiowaves (200-300 kHz) are delivered through the catheter electrode and cause direct heating of the vessel wall, causing the vein to collapse. The catheter is slowly withdrawn, closing the vein.

**POLICY STATEMENT**
Coverage will be provided for varicose vein treatment when it is determined to be medically necessary, as outlined in the below guidelines and medical criteria.
**BENEFIT APPLICATION**

Please refer to the member’s individual Evidence of Coverage (EOC) for benefit determination. Coverage will be approved according to the EOC limitations, if the criteria are met. Coverage decisions for members will be made in accordance with:

- The Centers for Medicare & Medicaid Services (CMS) national coverage decisions;
- General coverage guidelines included in original Medicare manuals unless superseded by operational policy letters or regulations; and
- Written coverage decisions of local Medicare carriers and intermediaries with jurisdiction for claims in the geographic area in which services are covered.

Benefit payments are subject to contractual obligations of the Plan. If there is a conflict between the general policy guidelines contained in the Medical Coverage Policy Manual and the terms of the member’s particular Evidence of Coverage (EOC), the EOC always governs the determination of benefits.

**INDICATIONS FOR COVERAGE**

1) Preauthorization by the Plan is required;

2) The surgical treatment of varicose veins may be medically necessary when A and B are met;

   A. The member is symptomatic and the varicosities result in **any one** or more of the following in spite of conservative therapy:

   1) Persistent symptoms interfering with activities of daily living in spite of conservative/non-surgical management. Symptoms include aching, cramping, burning, itching and/or swelling during activity or after prolonged standing.
   2) Significant recurrent attacks of superficial phlebitis;
   3) Hemorrhage from a ruptured varix;
   4) Non-healing skin ulceration of the lower extremity.

   B. A minimum 3-month trial of conservative therapy (such as exercise OR avoidance of prolonged immobility OR periodic elevation of the legs OR analgesic therapy; **AND**

   A minimum 3 month trial with graduated elasticized Compression stockings.

3) Duplex studies of the venous system are performed that fully defines the anatomy, size, and tortuosity of the great and small saphenous vein, superficial venous segments and perforators. Studies must demonstrate the following criteria:

   a. Absence of deep venous thrombosis **and**
   b. Saphenous (small or great) valvular incompetence/reflux that correlates with the patient’s symptoms and is CEAP Class C2 or greater.

4) Indications for Endovenous Radiofrequency Ablation (ERFA) or laser ablation (CPT codes 36475, 36476, 36478, 36479). In addition to the above criteria (#2 - A &B), the
patient’s anatomy and clinical condition are amenable to the proposed treatment including ALL of the following:
   a. Absence of aneurysm in the target segment.
   b. Maximum vein diameter of 20 mm (2cm) for ERFA or 30 mm (3cm) for laser ablation.
   c. Absence of thrombosis or vein tortuosity, which would impair catheter advancement.

5) In addition, the following conditions apply to specific individual procedures:

A. Injection/Compression Sclerotherapy
   1. No saphenofemoral insufficiency, incompetence, or occlusion of the deep venous system, and
   2. Vessel diameter should be at least 3 millimeters in size.

B. Surgical Ligation or Stripping
   1. May be covered as part of a combination procedure with sclerotherapy.
   2. Number of veins and their locations should be documented.

C. Ambulatory or Stab Phlebectomy
   1. Use of 2mm stab incisions to remove vein via crochet type hook.
   2. May be covered only when the patient displays symptoms and functional problems attributable only to the secondary, smaller vessels.
   3. Not covered on the same date of service as another vein procedure, such as ERFA.

D. Subfascial Endoscopic Perforator Surgery (SEPS)
   1. Must have symptoms of perforator incompetence.
   2. Must have a venous stasis ulcer in which a history of conservative measures failed.

6) The treatment of spider veins/telangiectasis (36468) will be considered medically necessary only if there is persistent and significant bleeding.

7) Stab phlebectomy of the same vein performed on the same day as endovenous radiofrequency or laser ablation may be considered medically necessary if the above criteria (#2 - A & B) are met.

WHEN COVERAGE WILL NOT BE APPROVED
A. When the above coverage criteria have not been met.
B. Any type of treatment (sclerotherapy, ligation with or without stripping, ERFA, or laser system ablation) of varicose veins for cosmetic reasons is not medically necessary and not covered.
C. The treatment of asymptomatic veins with endovenous ablation or sclerotherapy is not considered medically reasonable and necessary.
D. The treatment of spider veins or superficial telangiectasis by any technique is considered cosmetic, and therefore not covered, except as described in item #6 under Indications For Coverage above.
E. Laser treatment of superficial varicosities or spider veins is considered cosmetic and is not covered.

**LIMITATIONS**
The Plan will cover these procedures only when performed with FDA approved devices and when these approved devices are used only for their specific FDA approved indications.

**BILLING/ CODING/PHYSICIAN DOCUMENTATION INFORMATION**
This policy may apply to the following codes. Inclusion of a code in the section does not guarantee reimbursement.

Applicable Codes: 36468, 36470, 36471, 36475, 36476, 36478, 36479, 37500, 37700, 37718, 37722, 37735, 37760, 37761, 37765, 37766, 37780, 37785, 93965, 93970, 93971

The Plan may request medical records for determination of medical necessity. When medical records are requested, letters of support and/or explanation are often useful, but are not sufficient documentation unless all specific information needed to make a medical necessity determination is included.

**SPECIAL NOTES**
Doppler ultrasound is often used to map the anatomy of the venous system prior to the procedure and also during the procedure to guide treatment and monitor effectiveness of therapy. Coverage will include one ultrasound prior to the procedure and intraoperative ultrasonic guidance when medically necessary to improve outcomes and minimize complications.

A duplex ultrasound is also covered when performed within 1 week of EFRA to check for any evidence of thrombus extension from the saphenofemoral junction into the deep system.

Photographs may be requested by the medical director if the clinical received is inconclusive.

CEAP is method used to layer patients according to the severity of their venous disease. CEAP stands for Clinical Etiologic Anatomic Pathophysiologic. Based on these categories there are now 6 classifications that will allow treatment to be rendered appropriately based on the progression of the venous disease.
References:
1. Medicare Local Coverage Determination LCD L33454; Varicose Veins of the Lower Extremeties. Effective Date
2. Medicare Local Coverage Determination: Treatment of Varicose Veins of the Lower Extremeties (L34536 Wisconsin Part
   A); Effective date: 10/1/2015. Accessed Via Internet site www.cms.gov; viewed on 7/7/2016.
   on 7/11/16.

Policy Implementation/Update Information:
Revision Date: June 26, 2000; August 20, 2003; June 9, 2004; June 28, 2006
Revision Date: August 2012-Criteria updated to reflect CMS LCDs.
Revision Date: October 16, 2013; Clarified criteria for staff (Criteria 2); Updated codes and references.
Revision Date: Annual Review; revised item #6 added item #7 to Indications For Coverage, added item A and revised item D to
When Coverage Will Not Be Approved per LCD, updated code section.
Revision Date: July 20, 2016: CMS Update notification of LCD L33454. Description of Procedure or Service Section: #3 Endoluminal
   Changed to Endovenous. Indications for Coverage Section: #3.b “Greater saphenous vein” changed to “Saphenous (small or great)”
   and added “and is CEAP Class C2 or greater.” #4 “Endoluminal” changed to “Endovenous”#7 Spelling correction of
   “phlebectomy”Special Notes: Added definition of CEAP Classification Method.

Approval Dates:
Medical Coverage Policy Committee: July 20, 2016

Policy Owner: Carolyn Wisecarver, RN, BSN
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