Treatment of Varicose Veins

Policy Number: MM.06.016
Original Effective Date: 04/15/2005
Line(s) of Business: PPO; HMO
Current Effective Date: 07/01/2012
Section: Surgery
Place(s) of Service: Outpatient

I. Description

Varicose veins are veins of the lower extremity that become irregularly swollen or enlarged and may cause itching, heaviness, fatigue and pain. Complications can be caused by peripheral edema due to venous insufficiency, hemorrhage, thrombophlebitis, venous ulceration and chronic skin changes.

Treatment of symptomatic varicose veins involves two phases; the first is to eliminate the refluxing saphenous vein and the second is to eliminate the visible, superficial varices. Preservation of the saphenous vein using conservative treatment is of great importance as this vessel may be needed for future vascular or cardiovascular surgery.

II. Criteria/Guidelines

A. Surgical treatment for symptomatic patients is covered (subject to Limitations/Exclusions and Administrative Guidelines) when pre-operative doppler ultrasound or duplex scan has verified reflux at the saphenofemoral or saphenopopliteal junction, reflux in incompetent perforator veins, or axial reflux in the great saphenous or collateral veins; and

B. When a trial of conservative therapy has failed.
   1. Conservative therapy must include a trial using compression stockings and one of the following:
      a. Exercise;
      b. Periodic leg elevation;
      c. Avoidance of prolonged sitting or standing.
      d. Use of analgesics.
C. The following types of surgery are covered for the conditions indicated, if symptoms are present:

1. Ligation and stripping, or endovenous radiofrequency, or laser ablation of the greater or lesser (small/short) saphenous veins in patients with symptomatic saphenofemoral reflux or axial reflux of the great or lesser (small/short) saphenous veins.
   a. Endoluminal ablation will be considered for patients who have saphenofemoral junction incompetence and greater saphenous vein reflux or small saphenous vein reflux as documented by doppler ultrasonography.

2. Stab avulsion, hook phlebectomy, sclerotherapy or transilluminated powered phlebectomy as adjuvant treatment of symptomatic varicose veins concomitant with or after the underlying cause (reflux) is addressed.

3. Sclerotherapy as the sole treatment of varicose tributaries without associated ligation of the saphenofemoral junction and stripping of the saphenous vein when at least one of the following criteria is met and the supporting clinical documentation is submitted:
   a. There is need for preservation of the saphenous vein for possible bypass surgery in the future;
   b. The patient is very young and surgical removal will be premature;
   c. The patient is very old or medically fragile and surgical removal would be excessive;
   d. The patient is inactive and removal of the saphenous vein would serve no useful purpose;
   e. The patient is not in need of long-term control of venous reflux; such patients will include:
      i. An older patient with recurrent bleeding from varicose blebs
      ii. An older patient with recurrent thrombophlebitis in varicose tributaries

4. Retrograde injections of the sclerosing solution after ligation of the saphenofemoral junction when upper thigh branches are thought to be a source of recurrent varicosities.

5. Sclerotherapy or ligation of incompetent perforators will be covered when duplex scanning verifies reflux of the vessels and symptomatic varicosities result.

6. Sclerotherapy of superficial telangiectasias also known as spider veins when they threaten or cause rupture with spontaneous bleeding.

D. Ablation of incompetent perforator veins by thermal, laser, or radiofrequency ablation may be approved on a case by case basis in patients with severe skin changes or ulceration caused by these perforators and who have been resistant to other forms of conservative treatment.

III. Limitations/Exclusions

A. Sclerotherapy of the greater saphenous vein, with or without associated ligation of the saphenofemoral junction, does not meet HMSA’s payment determination criteria and is
not covered. HMSA would, however, cover endovascular closure of the saphenous vein.

B. Indications or conditions not listed in this policy are considered cosmetic and are not covered.

C. Energy-based ablation of veins other than those listed in this policy does not meet payment determination and will not be covered.

D. Post procedure ultrasound is covered only when there is documentation of a medically significant condition. Routine post procedure ultrasound is not covered.

E. Procedures performed over the course of more than one day/session must have clear documentation in the medical record for the specific reasons that each additional day/session is medically necessary.

IV. Administrative Guidelines

A. Precertification is required for the asterisked (*) procedures below. To precertify, please complete HMSA's Precertification Request and mail or fax the form as indicated.

B. All of the following documentation must be submitted:
   1. Imaging studies;
   2. Clinical notes describing symptoms and physical findings; and

C. Repeat sclerotherapy requires precertification including documentation of persistent functional complaints.

D. Documentation for follow up ultrasound and additional procedures must be maintained in the medical record and made available to HMSA upon request. HMSA reserves the right to perform retrospective review using the above criteria to validate if services rendered met payment determination criteria.

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Description</th>
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<tbody>
<tr>
<td>36468*</td>
<td>Single or multiple injections of sclerosing solutions, spider veins (telangiectasia); limb or trunk</td>
</tr>
<tr>
<td>36469*</td>
<td>face</td>
</tr>
<tr>
<td>36470*</td>
<td>Injection of sclerosing solution; single vein</td>
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<tr>
<td>36471*</td>
<td>multiple veins, same leg</td>
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<tr>
<td>36475*</td>
<td>Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radio frequency; first vein treated</td>
</tr>
<tr>
<td>36476*</td>
<td>second and subsequent veins treated in a single extremity, each through separate access sites</td>
</tr>
<tr>
<td>36478*</td>
<td>Endovenous ablation therapy of incompetent vein, extremity,</td>
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<td>CPT Code</td>
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<tr>
<td>36479*</td>
<td>inclusive of all imaging guidance and monitoring, percutaneous, laser; first vein treated</td>
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<tr>
<td>37500</td>
<td>second and subsequent veins treated in single extremity, each through separate access sites</td>
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<tr>
<td>37700</td>
<td>Vascular endoscopy, surgical, with ligation of perforator veins, subfascial (SEPS)</td>
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<tr>
<td>37718</td>
<td>Ligation and division of long saphenous vein at saphenofemoral junction, or distal interruptions</td>
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<tr>
<td>37722</td>
<td>Ligation, division, and stripping, short saphenous vein</td>
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<tr>
<td>37722</td>
<td>Ligation, division, and stripping, long (greater) saphenous veins from saphenofemoral junction to knee or below</td>
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<tr>
<td>37735</td>
<td>Ligature and division and complete stripping of long or short saphenous veins with radical excision of ulcer and skin graft and/or interruption of communicating veins of lower leg, with excision of deep fascia</td>
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<tr>
<td>37760</td>
<td>Ligation of perforator veins, subfascial, radical (Linton type), with or without skin graft, open</td>
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<tr>
<td>37761*</td>
<td>Ligation of perforator veins, subfascial, open, including ultrasound guidance, when performed, 1 leg (Modifier 50 if done bilaterally)</td>
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<td>37765*</td>
<td>Stab phlebectomy of varicose veins, one extremity; 10-20 stab incisions</td>
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<tr>
<td>37766*</td>
<td>more than 20 incisions</td>
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<tr>
<td>37780</td>
<td>Ligation and division of short saphenous vein at saphenopopliteal junction</td>
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<tr>
<td>37785</td>
<td>Ligation, division, and/or excision of varicose vein cluster(s), one leg</td>
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<tr>
<td>37799*</td>
<td>Unlisted procedure, vascular surgery</td>
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<tr>
<td>76942</td>
<td>Ultrasonic guidance for needle placement (e.g. biopsy, aspiration, injection, localization device), imaging supervision and interpretation</td>
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V. Important Reminder

The purpose of this Medical Policy is to provide a guide to coverage. This Medical Policy is not intended to dictate to providers how to practice medicine. Nothing in this Medical Policy is intended to discourage or prohibit providing other medical advice or treatment deemed appropriate by the treating physician.

Benefit determinations are subject to applicable member contract language. To the extent there are any conflicts between these guidelines and the contract language, the contract language will control.

This Medical Policy has been developed through consideration of the medical necessity criteria under Hawaii’s Patients’ Bill of Rights and Responsibilities Act (Hawaii Revised Statutes §432E-1.4), generally accepted standards of medical practice and review of medical literature and government approval status. HMSA has determined that services not covered under this Medical Policy will not be medically necessary under Hawaii law in most cases. If a treating physician disagrees with HMSA’s determination as to medical necessity in a given case, the physician may request that HMSA reconsider the application of the medical necessity criteria to the case at issue in light of any supporting documentation.

VI. References
