Treatment of Varicose Veins

Policy Number: MM.06.016
Original Effective Date: 04/15/2005
Line(s) of Business: PPO; HMO; QUEST Integration
Current Effective Date: 08/01/2016
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 of varicose veins is covered (subject to Limitations and Administrative Guidelines) when the following criteria are met:
   1. The patient is symptomatic. A patient is considered symptomatic if any of the following signs and symptoms is present and documented in the patient’s medical record.
      a. Stasis ulcer of the lower leg
      b. Significant pain and/or significant edema that interferes with activities of daily living
      c. Bleeding associated with the diseased vessels of the lower extremities
      d. Recurrent episodes of superficial phlebitis
      e. Stasis dermatitis, or
      f. Refractory dependent edema

   2. An eight week trial of conservative therapy has been ineffective. Conservative therapy must include all of the following:
      a. Compression stockings;
      b. Exercise;
      c. Periodic leg elevation;
      d. Avoidance of prolonged sitting or standing;
e. Use of analgesics

3. 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 vein

B. The following types of surgery are covered for the conditions indicated:
   1. Ligation and stripping, endovenous radiofrequency, or laser ablation of the greater or lesser (small/short) saphenous veins in patients with saphenofemoral reflux or axial reflux of the great or lesser (small/short) saphenous veins.
   2. Endoluminal ablation in patients with greater saphenous vein reflux or small saphenous vein reflux as documented by Doppler ultrasonography.
   3. Stab avulsion, hook phlebectomy, sclerotherapy or transilluminated powered phlebectomy as adjuvant treatment of varicose veins concomitant with or after the underlying cause (reflux) is addressed.
   4. 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 are 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
   5. 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.
   6. Sclerotherapy or ligation of incompetent perforators when duplex scanning verifies reflux of the vessels and varicosities result.
   7. Sclerotherapy of superficial telangiectasias also known as spider veins when they threaten or cause rupture with spontaneous bleeding.
   8. Ablation of incompetent perforator veins by thermal, laser, or radiofrequency ablation may be covered 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
   A. Sclerotherapy of the greater saphenous vein, with or without associated ligation of the saphenofemoral junction, is not covered because it is not known to improve health outcomes. 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, mechanical, or chemical based ablation of veins (e.g., Clarivein) other than those listed in this policy are not covered because they are not known to be effective in improving health outcomes.
   D. Post procedure ultrasound is covered only when there is documentation of a medically significant condition. Routine post procedure ultrasound is not covered.

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. Results of imaging studies;
      2. Clinical notes describing symptoms and physical findings; and
   C. 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.
   D. Precertification is required for repeat sclerotherapy. Documentation of persistent functional complaints must be submitted.
   E. 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.

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<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>
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<tr>
<td>36470*</td>
<td>Injection of sclerosing solution; single vein</td>
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<tr>
<td>36471*</td>
<td>Injection of sclerosing solution; 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>
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<tr>
<td>Procedure Code</td>
<td>Description</td>
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<tr>
<td>36476*</td>
<td>Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radio frequency; second and subsequent veins treated in a single extremity, each through separate access sites</td>
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<tr>
<td>36478*</td>
<td>Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, laser; first vein treated</td>
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<tr>
<td>36479*</td>
<td>Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, laser; second and subsequent veins treated in single extremity, each through separate access sites</td>
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<td>37500</td>
<td>Vascular endoscopy, surgical, with ligation of perforator veins, subfascial (SEPS)</td>
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<td>37700</td>
<td>Ligation and division of long saphenous vein at saphenofemoral junction, or distal interruptions</td>
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<td>37718</td>
<td>Ligation, division, and stripping, short saphenous vein</td>
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<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>Ligation 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, 1 leg</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>Stab phlebectomy of varicose veins, 1 extremity; more than 20 incisions</td>
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<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


