



Varicose Veins Treatment

I. Policy

University Health Alliance (UHA) will reimburse for treatment of primary venous insufficiency manifested by varicose vein disease when determined to be medically necessary and within the medical criteria guidelines (subject to limitations and exclusions) indicated below.

II. Criteria/Guidelines

A. Surgical treatment for primary venous insufficiency manifested by varicose veins is covered (subject to Limitations/Exclusions and Administrative Guidelines) when members show documented evidence of symptomatic varicose vein disease, or recognized complications of varicose vein disease, within the following parameters:

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. Significant pain and/or significant edema that interferes with activities of daily living
 - b. Bleeding associated with the diseased vessels of the lower extremities
 - c. Recurrent episodes of superficial phlebitis
 - d. Symptoms which are supportive of the diagnosis of symptomatic varicose veins such as heaviness, fatigability, itching, tingling, throbbing, and burning in the affected extremity, and night cramps. These symptoms are associated with the erect position when the legs are dependent, they are often worse at the end of the day, and usually relieved by elevation of the legs.
 - e. Additional value is attached to physical findings associated with C3-6 levels on CEAP scale to include swelling of the lower leg, ankle, or foot when associated with venous reflux, brownish pigmentation of the lower leg and ankle (gaiter area) associated with venous reflux, thickening of the skin and subcutaneous tissues (sclerosis) of the gaiter area, and ulceration of the skin of the lower leg and ankle associated with reflux.
2. Disease must be classified C3 or greater within the CEAP (Clinical, Etiology, Anatomy, Pathophysiology) classification system, graded as:

C3- Edema: The edema associated with chronic venous disease is due to an increase in the volume of fluid in the skin and subcutaneous tissues and will indent when pressure is applied. Lower extremity swelling due to lymphedema is often confused with that due to venous origin. Venous edema usually occurs at the ankle and may extend to the leg but less commonly extends to the foot and toes, distinguishing it from lymphedema. In addition, edema due to venous disease alone generally resolves or greatly improves overnight when the patient sleeps (elevated legs), while lymphedema is more recalcitrant and generally persists and is still present in the morning. The evaluation and management of lymphedema is discussed separately.

C4a- Pigmentation or eczema: Pigmentation related to venous disease is a characteristic brownish darkening of the skin due to hemosiderin deposition as a consequence of extravasated red blood cells. It usually occurs in the ankle region but may extend to the more proximal leg or to the foot.

Eczema is an erythematous dermatitis, which may progress to blistering, weeping, or scaling eruption of skin of the leg. It is often located near varicose veins, but the presence of varicosities is not required for eczema of venous origin, and venous eczema may be located anywhere on the leg below the knee.

C4b- Lipodermatosclerosis: Lipodermatosclerosis is localized chronic inflammation and fibrosis of the skin and subcutaneous tissues of the lower leg, sometimes associated with scarring or contracture of the Achilles tendon. It is sometimes preceded by diffuse inflammatory edema of the skin, which may be painful and which is often referred to as hypodermatitis. The differential diagnosis includes lymphangitis, erysipelas, or cellulitis.

C4c- Corona phlebectatica: Corona phlebectatica is described as a circular or fan-shaped collection, a "crown," of nonpalpable, small intradermal veins in the regions of the medial or lateral ankles, sometimes extending distally onto the foot. It is considered by many to be an early sign of more advanced underlying venous disease and is associated with an increased risk of venous ulcer. Synonyms include ankle flare or malleolar flare

C5- Healed venous ulcer: Healed venous ulcerations may also exhibit atrophic skin with pigmentary changes. Healed venous ulcers are distinguishable by appearance and history of ulceration from atrophie blanche.

C6, C6r- Active or recurrent venous ulcer: Active venous ulcers (C6) are full-thickness defects of the skin, most frequently in the ankle region, but they can extend more proximally, and even circumferentially around the distal to mid-calf. They generally will not heal spontaneously, but they can usually be healed with proper therapy and wound care. Recurrent venous ulcer (C6r) is an ulcer that occurs after a period of complete ulcer healing.

3. A trial of conservative therapy of eight weeks duration has been done and found to be unsatisfactory as a long-term treatment by the patient. Conservative therapy has included a trial of compression therapy.

C. The following types of surgery are covered for the conditions indicated, if criteria are met:

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. Mechanicochemical ablation (e.g. Clarivein) 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.
3. Endoluminal ablation in patients with greater saphenous vein reflux or small saphenous vein reflux as documented by Doppler ultrasonography.
4. 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.
5. 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 an older patient with recurrent bleeding from varicose blebs, or an older patient with recurrent thrombophlebitis in varicose tributaries.
6. 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.
7. Sclerotherapy or ligation of incompetent perforators will be covered when duplex scanning verifies reflux of the vessels and symptomatic varicosities result.
8. Sclerotherapy of superficial telangiectasias also known as spider veins when they truly threaten to, or cause rupture with spontaneous bleeding.
9. 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/Exclusions

- 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.
- B. Energy-based ablation of veins other than those listed in this policy are not covered because they are not known to be effective in improving health outcomes.
- C. Repeat sclerotherapy requires prior authorization and must include documentation of persistent functional complaints.
- D. If both lower extremities require treatment and this is not accomplished at one setting, payment will be denied in the absence of case specific and explicit documentation made available for UHA to conduct a retrospective review to show justification of staging.
- E. Indications or conditions not listed in this policy are considered cosmetic and are not covered.
- F. Post procedure ultrasound is covered only when there is documentation of a medically significant condition. Routine post procedure ultrasound is not covered.
- G. All covered procedures referenced in this policy are covered only when performed by a practitioner with the training and experience to comprehensively manage complicated or difficult cases and the potential complications that can arise. Vascular surgeons are the best trained and most skilled to manage venous disease. In the absence of board certification in vascular surgery, UHA may request documentation supporting the mastery of such expertise.

NOTE:

This UHA payment policy is a guide to coverage, the need for prior authorization and other administrative directives. It is not meant to provide instruction in the practice of medicine, and it should not deter a provider from expressing his/her judgment.

Even though this payment policy may indicate that a particular service or supply is considered covered, specific provider contract terms and/or member's individual benefit plans may apply, and this policy is not a guarantee of payment UHA reserves the right to apply this payment policy to all UHA companies and subsidiaries.

UHA understands that opinions about and approaches to clinical problems may vary. Questions concerning medical necessity (see Hawaii Revised Statutes §432E-1.4) are welcome. A provider may request that UHA reconsider the application of the medical necessity criteria in light of any supporting documentation.

IV. Administrative Guidelines

- A. Prior authorization is required.
- B. All of the following documentation must be submitted:
 - 1. Imaging studies and photographs;
 - 2. Clinical notes describing symptoms and physical findings; and
 - 3. Documentation of failure of conservative treatment.
- C. Photographs of affected limbs must be dated and made available for review at UHA's request.
- D. Duplex ultrasound studies must be dated, memorialized, and made available for review at UHA's request.
 - 1. The Duplex ultrasound report must document the following:
 - a. Presence or absence of reflux in GSV, SSV, AASV, other longitudinal veins connecting upper thigh to lower leg. The extent of reflux in target vein should be specified as either segmental or axial.
 - b. Connection of the vein intended to be treated to the symptomatic varicose veins, ulcer, or area of concern in the leg.
 - c. Presence or absence of reflux in the perforator anatomically related to site of symptoms or ulceration.
 - d. Presence or absence of reflux in deep veins. If present, the reflux should be specified as segmental or axial.
 - e. The cut-off criterion for pathological reflux should be specified.
 - 2. Ultrasound images must meet these criteria:
 - a. All relevant anatomical structures on the ultrasound images should be clearly labeled. The anatomical segment of the vein should be labeled (proximal, mid, distal thigh, etc.).
 - b. The anatomical landmarks should be identifiable. For example, the SFJ image should include CFV; SPJ image should include the popliteal vein and (when possible) femur, tibia, or knee joint. Saphenous compartment ("saphenous eye") should be visible on the transverse image of the GSV in proximal thigh.
 - c. The ultrasound image should be oriented in a standard manner. Longitudinal images should be taken with proximal direction to the left, and distal to the right. The medial and lateral directions on the transverse images should be labeled.
 - d. Spectral Doppler should be used for reflux identification; color Doppler images are not sufficient. All reflux measurements should be done in longitudinal (to the vein axis) position of the transducer.
 - e. The sample volume should be seen and properly positioned on the b-mode part of the duplex image. The ultrasound beam should be at an acute angle to the axis of the vein, and the angle correction should be 60-degrees or less.
 - f. Both outflow and reflux should be depicted on the image that documents the presence of reflux.
- E. To request prior authorization, please go to UHA's website: <https://uhahealth.com/page/prior-authorization-forms> and submit via UHA's online portal.
- F. This policy may apply to the following codes. Inclusion of a code in the table below does not guarantee that it will be reimbursed. The following CPT codes require prior authorization.

CPT Code	Description
36468	Injection(s) of sclerosant for spider veins (telangiectasia), limb or trunk
36470	Injection of sclerosant; single incompetent vein (other than telangiectasia)
36471	Injection of sclerosant; multiple incompetent veins (other than telangiectasia), same leg
36475	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency; first vein treated
36476	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency; subsequent vein(s) treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure)
36478	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, laser; first vein treated
36479	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, laser; subsequent vein(s) treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure)
37500	Vascular endoscopy, surgical, with ligation of perforator veins, subfascial (SEPS)
37700	Ligation and division of long saphenous vein at saphenofemoral junction, or distal interruptions
37718	Ligation, division, and stripping, short saphenous vein
37722	Ligation, division, and stripping, long (greater) saphenous veins from saphenofemoral junction to knee or below
37735	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
37760	Ligation of perforator veins, subfascial, radical (Linton type), including skin graft, when performed, open, 1 leg
37761	Ligation of perforator vein(s), subfascial, open, including ultrasound guidance, when performed, 1 leg
37765	Stab phlebectomy of varicose veins, 1 extremity; 10-20 stab incisions
37780	Ligation and division of short saphenous vein at saphenopopliteal junction (separate procedure)
37785	Ligation, division, and/or excision of varicose vein cluster(s), 1 leg
37799	Unlisted procedure, vascular surgery

V. Policy History

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