Benefit Coverage

<table>
<thead>
<tr>
<th>Covered Benefit for lines of business including:</th>
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<tbody>
<tr>
<td>Health Benefits Exchange (HBE), Rite Care (MED), Children with Special Needs (CSN), Substitute Care (SUB), Rhody Health Partners (RHP), Rhody Health Expansion (RHE), Rhody Health Options (RHO) Unity, Rhody Health Options (MMP) Integrity</td>
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Excluded from Coverage:
Extended Family Planning (EFP)

Approval is based on review of the medical necessity documentation.

Description

Endovenous laser ablation (EVLA) is a minimally invasive percutaneous technique that uses laser energy to ablate incompetent superficial veins. A catheter is threaded through the vein and the laser fiber inserted. As the laser fiber is withdrawn, high intensity laser light is used to induce photocoagulation of blood and vein occlusion.

Endovenous Radiofrequency Ablation (RFA) uses thermal energy via catheter to heat the vessel and causes it to collapse.

Coverage Determination

Neighborhood Health Plan of Rhode Island covers Varicose Vein Treatment as a clinical option when determined medically necessary by the Medical Management Department. Prior authorization and review for medical necessity is required. In the absence of medical necessity, surgery being performed solely to enhance physical appearance is considered “cosmetic,” and therefore is not covered.

The following procedures are covered when determined medically necessary for the treatment of varicose veins:

1. Endovenous Laser Ablation (EVLA)
2. Endovenous Radiofrequency Ablation (RFA)
3. Ligation and Stripping
4. Ambulatory Phlebectomy
5. Subfascial Endoscopic Perforator Surgery (SEPS)
6. Sclerotherapy associated with other vein procedures

Please access Prior Authorization forms by visiting Neighborhood’s website at www.nhpri.org.

1. Go to the section for Providers
2. Click on “Resources & FAQ's”
3. Click on “Medical Management Request Forms” - forms are listed alphabetically by program.

Prior Authorization Forms

For assistance with prior authorizations please contact Clinical Administrative Support at 401-459-6060, Fax authorization forms to 401-459-6023.

For More information on Coding please reference the Authorization Quick Reference Guide.
Criteria:

- The provider is a contracted Neighborhood practitioner or provider group.
- The disease state is classified as C2 or greater within the CEAP classification system.
- One of the following criteria for symptomatic venous disease must be met in section (A) OR (B) AND one of the criteria in section (C) must be met.

A. If saphenous varicosities result in any of the following:
   - Intractable ulceration secondary to venous stasis, or
   - More than one episode of minor hemorrhage from a ruptured superficial varicosity, or
   - A single significant hemorrhage from a ruptured superficial varicosity, especially if transfusion of blood is required or
   - Significant lipodermatosclerosis related to venous insufficiency

B. Or, if conservative management with appropriate length prescription 20-30mm pressure gradient compression stockings has been unsuccessful after a trial period of at least three (3) months, and the saphenous varicosities result in:
   - Recurrent superficial thrombophlebitis, or
   - Severe and persistent pain and swelling interfering with activities of daily living and failing reasonable attempts at conservative control.

C. Results of Duplex ultrasound of the deep and superficial venous system show any of the following findings in vessels that anatomically correlate to the symptomatic system.
   - Main axial superficial veins with reflux >0.5 second and venous diameter ≥3mm.
   - Nonaxial varicose veins with diameter ≥3mm and documented competency or successful ablation/removal of axial varicosities.
   - Perforator vein directly associated with a venous ulcer, with venous diameter ≥3.0mm at the fascia and NO post thrombotic deep system incompetence and NO main superficial vein connecting to this area with reflux >0.5second and a diameter ≥3.0mm which has not been treated.

Vein/Procedure List
The following procedures or combination of procedures may be authorized for the specific vein when the criteria above have been met.

1. Greater Saphenous Vein (GSV), Small Saphenous Vein (SSV), Anterior Accessory Great Saphenous Vein (AAGSV) with reflux >0.5 second and venous diameter ≥3mm
   a. Endovenous Laser Ablation (EVLA) or
   b. Endovenous Radiofrequency Ablation (RFA) or
   c. Ligation and Stripping

2. AAGSV with reflux >0.5 second and venous diameter ≥3mm
   a. EVLA or RFA
   b. Ambulatory Phlebectomy
   Nonaxial varicose veins with diameter ≥3mm without Axial vein incompetency.
   c. Ambulatory Phlebectomy
3. Perforator vein directly associated with a venous ulcer
   a. Subfascial Interruption or Ligation
   b. Subfascial Endoscopic Perforator Vein Surgery (SEPS)
   c. RFA/EVLA
   d. Ultrasound guided sclerotherapy

4. Symptomatic varicosities in the same vein field in conjunction with, or after a successful main axial superficial vein ablation/removal.
   a. Ambulatory Phlebectomy
   b. Sclerotherapy for remaining veins $\geq 3\text{mm}$ and $\leq 6\text{mm}$ diameter (limited to 3 procedures per leg.)

Exclusions
Neighborhood does not provide coverage for varicose vein treatment with any of the procedures listed for conditions that do not meet the criteria noted above, including but not limited to:

- Treatment of varicose veins without significant symptoms
- Cosmetic services or surgery including treatment of spider veins, broken blood vessels, reticular veins or telangiectasias.
- Use of experimental and investigational procedures or devices, or the use of any procedures or devices not listed above including
  a. Photothermal sclerosis (Intensive pulsed light therapy e.g. Photoderm Vasculight) or microsclerosis used to treat small varicose veins is not considered medical necessary
  b. External transdermal photoocoagulation or laser coagulation
  c. Endomechanical ablation using a percutaneous infusion catheter (e.g. ClariVein system)
  d. Echoscleretherapy
  e. Endovenous cryoablation
- Liquid or foam sclerotherapy for any of the following:
  a. Treatment of main axial varicose veins (GSV, SSV, AAGSV)
  b. Sole treatment of venous tributaries in the absence of successful prior ablation of superficial axial veins
  c. Sole treatment of nonaxial varicose veins
  d. Treatment of incompetent perforator veins without ulceration
  e. Treatment of veins $<3\text{mm}$ and $>6\text{mm}$ in diameter
  f. Treatment of veins that do not meet criteria
- Treatment that is contraindicated e.g. acute deep or superficial vein thrombosis or thrombophlebitis, difficulty with ambulation secondary to significant joint disease, history of congenital venous abnormality such as Klippel-Trenaunay Syndrome, pregnancy, moderate to severe peripheral artery disease (ABI $<0.9$) or advanced general systemic disease that will limit quality of life improvements expected from the intervention.
Clinical Medical Policy

Varicose Veins Treatment- # 009

Last reviewed: 01/10/2017

Neighborhood Health Plan of RI
910 Douglas Pike, Smithfield, RI 02917.


Neighborhood reviews clinical medical policies on an annual base.

Disclaimer:

This medical policy is made available to you for informational purposes only. It is not a guarantee of payment or a substitute for your medical judgment in the treatment of your patients. Benefits and eligibility are determined by the member's coverage plan; a member's coverage plan will supersede the provisions of this medical policy. For information on member-specific benefits, call member services. This policy is current at the time of publication; however, medical practices, technology, and knowledge are constantly changing. Neighborhood reserves the right to review and revise this policy for any reason and at any time, with or without notice.
References:

MedlinePlus.gov On-line dictionary


