

MEDICA®

UTILIZATION MANAGEMENT POLICY

TITLE: ENDOVENOUS RADIOFREQUENCY OR LASER ABLATION FOR VARICOSE VEINS AND CHRONIC VENOUS INSUFFICIENCY

Origination Date: January, 2004

Subsequent Endorsement Date(s): 11/2004, 06/2005, 11/2005, 11/2006, 11/2007, 11/2008, 11/2009

This policy was developed with input from specialists in general surgery, vascular surgery and interventional radiology, and endorsed by the Medical Policy Committee.

PRODUCT APPLICATION

This policy provides general information concerning Medica's administrative processes. It applies to all fully insured Medica Health Plans, Medica Insurance Company, and Medica Health Plans of Wisconsin products, unless a specific limitation or exception exists. For self-insured plans, consult individual plan sponsor benefit documents. If there is a discrepancy between a Utilization Management Policy and a self-insured benefit plan, the provisions of the benefit plan will govern. With respect to Medicare and Medicaid members, this policy will apply unless Medicare or Medicaid policies require different coverage.

IMPORTANT INFORMATION – PLEASE READ BEFORE USING THIS POLICY

Medica updates its Utilization Management Policies regularly, and reserves the right to amend these policies without notice to Medica members. Medica also reserves the right to amend these policies without notice to contracted health care providers unless the amendment materially alters the policy. If the amendment materially alters the policy, Medica will disclose the change to contracted health care providers not less than 45 days prior to implementation of the policy. Medica's Utilization Management Policies contain general information only and do not guarantee coverage. Receipt of benefits is subject to all terms and conditions of the member's coverage document. Members should consult their Certificates of Coverage or Plan Documents/Summary Plan Descriptions to review the provisions relating to a specific coverage determination. If there is a conflict between a Utilization Management Policy and the applicable coverage document, the coverage document will govern. Members may contact Medica Customer Service at the phone number listed on their member identification card to discuss their benefits more specifically. Providers with questions about this Utilization Management Policy may call Medica's Provider Service Center toll free at 1-800-458-5512.

Medica's Utilization Management Policies are not medical advice. Members should consult with appropriate health care providers to obtain needed medical advice, care and treatment.

PURPOSE

To promote consistency between reviewers in utilization management decision-making by providing the criteria that generally determine the medical necessity of endovenous radiofrequency or laser ablation for varicose veins and chronic venous insufficiency. The Coverage Issues box below outlines the process for addressing the needs of individuals who do not meet these criteria.

BACKGROUND

Definitions

- I. **Endovenous radiofrequency (RF) ablation and endovenous laser ablation** are treatments intended as less invasive alternatives to traditional vein ligation and stripping for symptomatic varicosities of the great (greater) or small (lesser) saphenous vein. These procedures are performed using percutaneous tumescent anesthesia. General anesthesia, conscious sedation, or a spinal block may also be used. A catheter is inserted through a small incision (usually near the knee) into the affected vein and advanced up to the saphenofemoral junction. Proper placement is confirmed by Duplex ultrasound imaging. The RF electrodes or the laser are slowly withdrawn, occluding the vein as the energy is applied. These procedures are also referred to as endoluminal or

endovascular ablation.

- II. **Varicose veins** are tortuous, dilated veins often associated with incompetent valves. Symptoms of varicose veins that are due to venous hypertension may be relieved by elevation and surgical gradient pressure stockings. Symptoms unrelieved by elevation and compression hosiery, especially overnight in bed, must be investigated for other causes.
- III. **Vein ligation** is a surgical procedure consisting of the tying off of varicose veins. Related surgical procedures include "ambulatory phlebectomy," or "stab avulsion," also known as microextraction.
- IV. **Vein stripping** is a surgical procedure to remove a vein or portion of a vein.
- V. **Venous insufficiency** occurs when incompetent valves allow blood leakage or reflux, leading to elevated ambulatory venous pressure and capillary damage with extravasation of red blood cells and serum. This may lead to signs and symptoms such as edema, hyperpigmentation, stasis dermatitis, spider veins, varicosities, and ulceration.

MEDICAL NECESSITY CRITERIA

- I. Indications for endovenous radiofrequency or laser ablation of the great saphenous vein or small saphenous veins between the groin and calf
All of the following criteria must be met:
 - A. Venous duplex scan demonstrates the following:
 - 1. Great saphenous vein incompetence with reflux at the saphenofemoral junction, and/or
 - 2. Small saphenous vein incompetence with reflux at the saphenopopliteal junction, and
 - 3. A patent deep venous system.
 - AND**
 - B. Medically-significant varicose veins causing one of the following:
 - 1. Persistent leg pain interfering with activities of daily living that has failed conservative treatment (refer to I.C. below)
 - 2. Recurrent superficial thrombophlebitis
 - 3. Stasis dermatitis (including edema, erythema, scaling, and brown discoloration of the ankle)
 - 4. External hemorrhage
 - 5. Venous ulceration
 - AND**
 - C. No improvement in condition after conservative treatment of 3 months duration (e.g., surgical pressure gradient stockings, leg elevation, use of analgesics, and weight loss); or attending physician statement that conservative treatment is inappropriate.
- II. Contraindications
 - A. Thrombus in the vein segment to be treated
 - B. Hypercoaguable state
- III. Relative Contraindications (Request requires medical director review)
 - A. History of deep venous thrombosis
 - B. Aneurysm in the vein segment to be treated
 - C. History of clotting disorders
 - D. Peripheral arterial disease as determined by a ankle-brachial index of less than 0.9
 - E. Pacemaker, internal defibrillator, or other active implanted device
- IV. Written documentation from the medical record specifying the medical necessity according to the above criteria may be required.
Documentation should include:
 - A. Detailed clinical history, and
 - B. Detailed description of conservative treatment failure (e.g., documentation of use of surgical pressure gradient stockings, leg elevation, analgesics and weight loss), or attending physician statement that conservative treatment is inappropriate; and

- C. Venous duplex scan results confirming incompetence of the saphenous vein with reflux at the saphenofemoral and/or saphenopopliteal junction and a patent deep venous system.

COVERAGE ISSUES

1. Prior authorization **is required** for endovenous radiofrequency or laser ablation for varicose veins.
2. Coverage may vary according to the terms of the member's coverage document.
3. For Medicare members, refer to the following, as applicable:
 - For Minnesota: Wisconsin Physicians Service Insurance Corporation. *Local Coverage Determination (LCD) for Treatment of Varicose Veins of the Lower Extremities (L30143)*. Available at: http://www.wpsic.com/medicare/part_b/policy/active/local_files/l30143_gsurg041.pdf Accessed March 26, 2010.
 - For Wisconsin: Wisconsin Physicians Service Insurance Corporation. *Local Coverage Determination (LCD) for Treatment of Varicose Veins of the Lower Extremities (L30143)*. Available at: http://www.wpsic.com/medicare/part_b/policy/active/local_files/l30143_gsurg041.pdf Accessed March 26, 2010.
 - For North Dakota and South Dakota: Noridian Administrative Services, LLC. *Local Coverage Determination (LCD) for Treatment of Varicose Veins of the Lower Extremities (L24375)*. Refer to the Medicare Coverage Database Search Page, available at: http://www.cms.hhs.gov/mcd/viewlcd.asp?lcd_id=24375&lcd_version=8&basket=lcd%3A24375%3A8%3ATreatment+of+Varicose+Veins+of+the+Lower+Extremities%3AMAC+%2D+Part+B%3ANoridian+Administrative+Services+%2803302%29%3A Accessed March 26, 2010.
 - For other states, refer to the Medicare Coverage Database Search Page, available at: <http://www.cms.hhs.gov/mcd/search.asp?>
4. Cosmetic surgery/procedures are generally an exclusion in the member's coverage document. Treatment of asymptomatic varicosities and transdermal laser or photothermal treatment of varicosities are considered cosmetic. Treatment for spider veins is excluded from coverage.
5. If the Medical Necessity and Coverage Criteria are met, Medica will authorize benefits within the limits in the member's coverage document.
6. If it appears that the Medical Necessity and Coverage Criteria are not met, the individual's case will be reviewed by the medical director or an external reviewer. Practitioners are advised of the appeal process in their Medica administrative handbook.
7. See also Medica Policy No. III-SUR.19 Sclerotherapy for Varicose Veins of the Leg.
8. See also Medica Coverage Policy: Transilluminated Powered Phlebectomy (TIPP) for Varicose Veins of the Legs.

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