The primary purpose of this document is to assist providers enrolled in the Connecticut Medical Assistance Program (CMAP) with the information needed to support a medical necessity determination for treatment of varicose veins of the lower extremities. By clarifying the information needed for prior authorization of services, HUSKY Health hopes to facilitate timely review of requests so that individuals obtain the medically necessary care they need as quickly as possible.

Varicose veins are abnormally enlarged and tortuous vessels caused by incompetent valves in the venous system that allow blood leakage or reflux. They are an indication of an underlying syndrome of venous insufficiency. Venous insufficiency syndromes allow venous blood to escape from its normal flow path and flow into an already congested leg. The condition becomes clinically significant when symptoms such as cramping, throbbing, burning and swelling become pronounced. Severe varicosities may be associated with dermatitis, ulceration, and thrombophlebitis.

Conservative measures often yield satisfactory results in relieving symptoms that produce functional impairment. When these don’t, however, a variety of invasive treatments are available. A significant number of individuals additionally seek treatment for cosmetic reasons. Invasive treatments include stab phlebectomy and sclerotherapy.

**Ambulatory phlebectomy** involves the removal of varicose veins through small “stab” 1-2 mm incisions in the skin overlying the vein. The varicose vein is hooked and brought to the surface at each incision site to release it from the surrounding tissues and to sever any connections to other veins.

**Injection/compression sclerotherapy** is a minimally invasive percutaneous technique using chemical irritants to close unwanted veins. Sclerotherapy works by destroying the endothelium of the target vessel in order to produce an inflammatory reaction which eventually leads to fibrosis and occlusion of the vessel lumen. This process is facilitated by the use of compression to keep the vein walls together.

**Microfoam sclerotherapy** (e.g., Varithena® [polidocanol injectable foam]) is a proprietary microfoam sclerosant that is dispersed from a canister. Varithena is intended for intravenous injection using ultrasound guidance, administered via a single cannula into the lumen of the target incompetent trunk veins or by direct injection into varicosities.

**The VenaSeal™ closure system** works to close a diseased vein by injecting a medical adhesive, cyanoacrylate, through a catheter into specific areas along the vein. Compression is applied during the procedure.
Radiofrequency Ablation (RFA), Endovenous laser therapy (EVLT), or Subfascial Endoscopic Perforator Surgery (SEPS)
Because prior authorization is not currently required for radiofrequency ablation (RFA), endovenous laser therapy (EVLT), or subfascial endoscopic perforator surgery (SEPS), they will not be addressed in this policy.

Ligation, Division and Excision
Because ligation, division and excision procedures as treatment for varicose veins either do not require prior authorization or are reviewed InterQual® criteria, they will not be addressed in this policy.

CLINICAL GUIDELINE
Coverage guidelines are made in accordance with the Department of Social Services (DSS) definition of Medical Necessity. The following criteria are guidelines only. Coverage determinations are based on an assessment of the individual and his or her unique clinical needs. If the guidelines conflict with the definition of Medical Necessity, the definition of Medical Necessity shall prevail. The guidelines are as follows:

Chemical Ablation and Cyanoacrylate Adhesive
(CPT Codes 36465, 36466, 36482, 36483)
Chemical ablation (microfoam sclerotherapy, e.g., Varithena) may be considered medically necessary for treatment of symptomatic varicose veins (great saphenous veins) and cyanoacrylate adhesive (e.g., Venaseal) may be considered medically necessary for treatment of symptomatic varicose veins (great or small saphenous veins) when the following criteria are met:
A. There is moderate to severe (greater than 0.5 second saphenous reflux documented, within the past 6 months, on venous studies and CEAP [Clinical-Etiology-Anatomy-Pathophysiology] class C2 or greater;
   AND
B. There is documentation of ONE or more of the following indications:
   • Venous stasis ulcers
   • Recurrent superficial thrombophlebitis
   • Hemorrhage or recurrent bleeding episodes from a superficial varicosity
   • Persistent pain, swelling, itching, burning at the affected area and:
     o These symptoms significantly interfere with activities of daily living; and
     o There is documentation of conservative management (including compression therapy) for at least 3 months that has not improved these symptoms. If compression therapy is contraindicated, documentation describing the contraindication is required.
       Note: Failure of conservative therapy is defined as pain, swelling, itching, burning, or other symptoms associated with vein reflux, despite conservative therapy, severe enough to require daily pain medicines and causing inability to manage daily activities at home or at work.

Chemical ablation (microfoam sclerotherapy, e.g., Varithena) or cyanoacrylate adhesive (e.g., Venaseal) may be considered medically necessary for treatment of symptomatic accessory saphenous
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veins/venous insufficiency when the following criteria are met:

A. Incompetence of the accessory saphenous vein is isolated;
   AND
B. Documented accessory saphenous reflux greater than 0.5 seconds;
   AND
C. There is documentation of ONE or more of the following indications:
   • Venous stasis ulcers
   • Recurrent superficial thrombophlebitis
   • Hemorrhage or recurrent bleeding episodes from a superficial varicosity
   • Persistent pain, swelling, itching, burning at the affected area and:
     o These symptoms significantly interfere with activities of daily living; and
     o There is documentation of conservative management (including compression therapy) for at least 3 months that has not improved these symptoms. If compression therapy is contraindicated, documentation describing the contraindication is required.
   Note: Failure of conservative therapy is defined as pain, swelling, itching, burning, or other symptoms associated with vein reflux severe enough to require daily pain medicines and causing an inability to complete activities of daily living.

Concurrent treatment of the accessory saphenous veins along with the great or small saphenous veins may be considered medically necessary when criteria are met for each vein and there is documentation of anatomy showing that the accessory saphenous vein discharged directly into the common femoral vein.

Ambulatory Phlebectomy (Stab Avulsion, Hook Phlebectomy, or Transilluminated Powered Phlebectomy [TIPP]) and Sclerotherapy
CPT Codes: 37765, 37766, 37799, 36470, 36471

Ambulatory phlebectomy or initial sclerotherapy (limited to a maximum of 3 sclerotherapy treatment sessions per leg) as a component of the treatment of symptomatic* varicose tributaries when performed either at the same time or following prior treatment (surgical, radiofrequency, or laser) of the saphenous veins is considered medically necessary.

*Symptoms include persistent pain, swelling, itching, and burning

For sclerotherapy treatment requests after ablation of the saphenous veins, when performed for the treatment of residual symptoms, there must be failure of 3 months of conservative therapy (weight reduction, daily exercise, periodic leg elevation, compression therapy) after the most recent varicose vein procedure.

Note: Failure of conservative therapy is defined as pain, swelling, itching, burning, or other symptoms associated with vein reflux, severe enough to require daily pain medicines and causing an inability to complete activities of daily living.

Investigational and Not Medically Necessary

• Sclerotherapy of isolated tributary veins without prior or concurrent treatment of saphenous veins is considered investigational.
• Techniques other than ambulatory phlebectomy or sclerotherapy (liquid or foam) for the treatment of symptomatic varicose tributaries, when performed either at the same time or following prior treatment of saphenous veins, is considered investigational.

• Sclerotherapy techniques, other than microfoam sclerotherapy (e.g. Varithena), of great, or accessory saphenous veins is considered investigational.

• Sclerotherapy of perforator veins is considered investigational

• Ambulatory phlebectomy of perforator, great or small saphenous, or accessory veins is considered investigational

Treatment of Telangiectasia
CPT Code 36468
Treatment, by any method, of telangiectasia (spider veins) or superficial reticular veins (1-2 mm) is considered cosmetic and therefore not medically necessary.

Note: Prior authorization requests received for services not addressed above will be reviewed on a case by case basis. Determinations will be made based on the available peer-reviewed literature and evidenced based guidelines and the DSS definition of Medical Necessity.

NOTE: EPSDT Special Provision
Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) is a federal Medicaid requirement that requires the Connecticut Medical Assistance Program (CMAP) to cover services, products, or procedures for Medicaid enrollees under 21 years of age where the service or good is medically necessary health care to correct or ameliorate a defect, physical or mental illness, or a condition identified through a screening examination. The applicable definition of medical necessity is set forth in Conn. Gen. Stat. Section 17b-259b (2011) [ref. CMAP Provider Bulletin PB 2011-36].

PROCEDURE
Prior authorization of the above treatments is required. Requests will be reviewed in accordance with procedures in place for reviewing requests for surgical procedures. Coverage determinations will be based upon a review of requested and/or submitted case-specific information.

The following information is needed to review requests for these treatments:

• Fully completed Outpatient Prior Authorization Request Form or fully completed authorization request via on-line web portal

• Specific vein(s)/leg(s) to be treated and whether the proposed treatment

• Results of duplex ultrasonography

• CEAP class

• Documentation from the requesting physician which includes:
  o History and physical examination with description of varicose vein(s)
  o Operative notes from primary procedure (i.e., ligation and stripping, endovenous ablation etc.), if applicable
  o Modalities used to manage the condition conservatively or documentation supporting the individual’s inability to fully participate in conservative management
  o Current symptoms
  o Functional impairment

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EFFECTIVE DATE
This Policy is effective for prior authorization requests for varicose vein treatments for individuals covered under the HUSKY Health Program beginning November 1, 2019.

LIMITATIONS
N/A

CODES:
Ambulatory Phlebectomy

<table>
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<th>Description</th>
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<tbody>
<tr>
<td>37765</td>
<td>Stab phlebectomy of varicose veins, 1 extremity; 10-20 stab incisions</td>
</tr>
<tr>
<td>37766</td>
<td>Stab phlebectomy of varicose veins, 1 extremity; more than 20 incisions</td>
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<tr>
<td>37799*</td>
<td>Unlisted procedure, vascular surgery</td>
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*May be used for TIPP

Sclerotherapy

<table>
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<tr>
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<th>Description</th>
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<tr>
<td>36465</td>
<td>Injection of non-compounded foam sclerosant with ultrasound compression maneuvers to guide dispersion of the injectate, inclusive of all imaging guidance and monitoring; single incompetent extremity truncal vein (eg, great saphenous vein, accessory saphenous vein)</td>
</tr>
<tr>
<td>36466</td>
<td>Injection of non-compounded foam sclerosant with ultrasound compression maneuvers to guide dispersion of the injectate, inclusive of all imaging guidance and monitoring; multiple incompetent truncal veins (eg, great saphenous vein, accessory saphenous vein), same leg</td>
</tr>
<tr>
<td>36468</td>
<td>Single or multiple injections of sclerosing solutions, spider veins (telangiectasia); limb or trunk</td>
</tr>
<tr>
<td>36470</td>
<td>Injection of sclerosant; single incompetent vein (other than telangiectasia)</td>
</tr>
<tr>
<td>36471</td>
<td>Injection of sclerosant; multiple incompetent veins (other than telangiectasia), same leg</td>
</tr>
</tbody>
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DEFINITIONS

1. HUSKY A: Connecticut children and their parents or a relative caregiver; and pregnant women may qualify for HUSKY A (also known as Medicaid). Income limits apply.
2. HUSKY B: Uninsured children under the age of 19 in higher income households may be eligible for HUSKY B (also known as the Children’s Health Insurance Program) depending on their family income level. Family cost-sharing may apply.
3. HUSKY C: Connecticut residents who are age 65 or older or residents who are ages 18-64 and who are blind, or have another disability, may qualify for Medicaid coverage under HUSKY C (this includes Medicaid for Employees with Disabilities (MED-Connect), if working). Income and asset limits apply.
4. HUSKY D: Connecticut residents who are ages 19-64 without dependent children and who: (1) do
not qualify for HUSKY A; (2) do not receive Medicare; and (3) are not pregnant, may qualify for HUSKY D (also known as Medicaid for the Lowest-Income populations).

5. **HUSKY Health Program**: The HUSKY A, HUSKY B, HUSKY C, HUSKY D and HUSKY Limited Benefit programs, collectively.

6. **HUSKY Limited Benefit Program or HUSKY, LBP**: Connecticut's implementation of limited health insurance coverage under Medicaid for individuals with tuberculosis or for family planning purposes and such coverage is substantially less than the full Medicaid coverage.

7. **Medically Necessary or Medical Necessity**: (as defined in Connecticut General Statutes § 17b-259b) Those health services required to prevent, identify, diagnose, treat, rehabilitate or ameliorate an individual's medical condition, including mental illness, or its effects, in order to attain or maintain the individual's achievable health and independent functioning provided such services are: (1) Consistent with generally-accepted standards of medical practice that are defined as standards that are based on (A) credible scientific evidence published in peer-reviewed medical literature that is generally recognized by the relevant medical community, (B)recommendations of a physician-specialty society, (C) the views of physicians practicing in relevant clinical areas, and (D) any other relevant factors; (2) clinically appropriate in terms of type, frequency, timing, site, extent and duration and considered effective for the individual's illness, injury or disease; (3) not primarily for the convenience of the individual, the individual's health care provider or other health care providers; (4) not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the individual's illness, injury or disease; and (5) based on an assessment of the individual and his or her medical condition.

8. **Prior Authorization**: A process for approving covered services prior to the delivery of the service or initiation of the plan of care based on a determination by CHNCT as to whether the requested service is medically necessary.

**ADDITIONAL RESOURCES AND REFERENCES:**


V1

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- Todd KL, 3rd, Wright D, for the Vanish-Investigator Group. The VANISH-2 study: a randomized, blinded, multicenter study to evaluate the efficacy and safety of polidocanol endovenous microfoam 0.5% and 1.0% compared with placebo for the treatment of saphenofemoral junction incompetence. Phlebology. Oct 2014;29(9):608-618. PMID 23864535
- Eroglu, EE, Yasim, AA. A Randomised Clinical Trial Comparing N-Butyl Cyanoacrylate, Radiofrequency Ablation and Endovenous Laser Ablation for the Treatment of Superficial Venous
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- Lam YL, Toonder IM, Wittens CH. Clarivein(R) mechano-chemical ablation an interim analysis of a randomized controlled trial dose-finding study. Phlebology. Apr 2016;31(3):170-176. PMID 26249150


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- Morrison, NN, Kolluri, RR, Vasquez, MM, Madsen, MM, Jones, AA, Gibson, KK. Comparison of cyanoacrylate closure and radiofrequency ablation for the treatment of incompetent great saphenous veins: 36-Month outcomes of the VeClose randomized controlled trial. Phlebology, 2018 Nov 8;268355518810259:268355518810259. PMID 30403154


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• Sarac, AA. Two-year follow-up of a n-butyl-2-cyanoacrylate glue ablation for the treatment of saphenous vein insufficiency with a novel application catheter with guiding light. Vascular, 2019 Feb 12;1708538118823838:1708538118823838. PMID 30739600


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<th>Status</th>
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<td>September 2019</td>
<td>Approved at the August 28, 2019 Medical Reviewer meeting.</td>
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<td>Approved by the CHNCT Clinical Quality Subcommittee on September 16, 2019.</td>
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|                       |                    | Approved by DSS on September 19, 2019.                                       

PUBLICATION HISTORY

V1

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