PROVIDER POLICIES & PROCEDURES

TREATMENT OF VARICOSE VEINS OF THE LOWER EXTREMITY - CYANOACRYLATE ADHESIVE

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 with cyanoacrylate adhesive (e.g., VenaSeal Closure System). 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.

Cyanoacrylate adhesive is a clear liquid that polymerizes in the vessel into a solid material on contact with body fluids or tissue. The adhesive is gradually injected along the length of the vein using ultrasound in conjunction with manual compression. The acute coaptation halts blood flow through the vein until the implanted adhesive becomes encapsulated and establishes permanent occlusion of the treated vein.

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 their 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:

Treatment of Great Saphenous Vein, Small Saphenous Vein, and Anterior Accessory Great Saphenous Vein

Cyanoacrylate adhesive may be considered medically necessary for treatment of symptomatic varicose veins/venous insufficiency when the following criteria are met:

A. There is demonstrated reflux (> 500 msec) and CEAP [Clinical-Etiology-Anatomy-Pathophysiology] class C2 – C6 disease;
   AND
B. There is documentation of **ONE or more** of the following indications:
   1. Venous stasis ulcers;

Please note that authorization is based on medical necessity at the time the authorization is issued and is not a guarantee of payment. Payment is based on the individual having active coverage, benefits and policies in effect at the time of service.

To determine if a service or procedure requires prior authorization, CMAP Providers may refer to the *Benefit and Authorization Grids* summaries on www.ct.gov/husky by clicking on "For Providers" followed by "Benefit Grids". For a definitive list of benefits and service limitations, CMAP Providers may access the CMAP provider fee schedules and regulations at www.ctdssmap.com.

2. Significant pain or significant edema associated with saphenous reflux that interferes with activities of daily living;
3. Bleeding associated with ruptured superficial varicosity;
4. Recurrent episodes of superficial phlebitis;
5. Stasis dermatitis; or
6. Refractory dependent edema.

Not Medically Necessary
Treatment of telangiectasia such as spider veins, angiomata, and hemangiomata is considered cosmetic and not medically necessary.

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 for treatment of varicose veins of the lower extremities with cyanoacrylate adhesive 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 authorization request via medical authorization portal
- Specific vein(s)/leg(s) to be treated
- Results of duplex ultrasonography
- CEAP class
- Documentation supporting medical necessity as outlined in the Clinical Guideline section

EFFECTIVE DATE
This Policy is effective for prior authorization requests for varicose vein treatments for individuals covered under the HUSKY Health Program beginning May 1, 2021.

LIMITATIONS
N/A

CODES:

36482	Endovenous ablation therapy of incompetent vein, extremity, by transcatheter delivery of a chemical adhesive (e.g., cyanoacrylate) remote from the access site, inclusive of all imaging guidance and monitoring, percutaneous; first vein treated
36483	Endovenous ablation therapy of incompetent vein, extremity, by transcatheter delivery of a chemical adhesive (e.g., cyanoacrylate) remote from the access site, inclusive of all imaging

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	guidance and monitoring, percutaneous; subsequent vein(s) treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure)

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.

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ADDITIONAL RESOURCES AND REFERENCES:

- Centers for Medicare and Medicaid Services. LCD L39121. Treatment of Varicose Veins of the Lower Extremities. Available at: https://www.cms.gov/medicare-coverage-database/view/lcd.aspx?lcdid=39121&ver=7&. Accessed on January 4, 2022.
- UpToDate. Nonthermal, nontumescent ablation techniques for the treatment of lower extremity superficial venous insufficiency. Literature review current through September 2023. Accessed on October 2, 2023.

PUBLICATION HISTORY

Status	Date	Action Taken
Original Publication	March 2021	Approved at the March 10, 2021 CHNCT Medical Reviewer meeting. Approved by the CHNCT Clinical Quality Subcommittee on March 15, 2021. Approved by DSS on March 22, 2021.
Review	March 2022	Reviewed and approved without changes at the January 12, 2022 CHNCT Medical Reviewer meeting. Approved by the CHNCT Clinical Quality Subcommittee on March 21, 2022. Approved by DSS on March 24, 2022.
Update	March 2023	Updates to Clinical Guideline section to fully align with CMS coverage guidelines for treatment of varicose veins of the lower extremities. Changes approved at the January 11, 2023, CHNCT Medical Reviewer meeting. Changes approved by the CHNCT Clinical Quality Subcommittee on March 20, 2023. Approved by DSS on March 27, 2023.
Update	December 2023	Update to Additional Resources and References section. Changes approved at the October 11, 2023 CHNCT Medical Reviewer meeting. Changes approved by the CHNCT Clinical Quality Subcommittee on December 18, 2023. Approved by DSS on January 03, 2024 .

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