Varicose Vein Procedures
MPM 22.1

Disclaimer
Refer to the member’s specific benefit plan and Schedule of Benefits to determine coverage. This may not be a benefit on all plans or the plan may have broader or more limited benefits than those listed in this Medical Policy.

Description
Varicose Veins are dilated, tortuous veins with reverse flowing blood secondary to valvular failure, vein wall dilatation or a combination of both. For many patients, varicose veins present only a cosmetic concern, but they can become clinically important when symptoms such as cramping, throbbing, burning, or swelling become pronounced. Severe varicosities may be associated with dermatitis, ulceration and thrombophlebitis. Conservative measures include compression hosiery, leg elevation, walking, and weight management. Surgical options are discussed below.

Coverage Determination
Prior Authorization is required. Logon to Pres Online to submit a request: https://ds.phs.org/preslogin/index.jsp

The Presbyterian Medical Policy for this procedure has been retired. Presbyterian now uses CMS LCD L34924, Treatment of Varicose Veins and Venous Stasis Disease of the Lower Extremities which is available on the Novitas website http://www.novitas-solutions.com.

Background
Varicose Veins are dilated, tortuous veins with reverse flowing blood secondary to valvular failure, vein wall dilatation or a combination of both. Clinical diagnosis is established with bi-directional Doppler or with Duplex/Doppler mapping. The latter test can quantify reflux (reverse flow). Reflux of 1.0 seconds or greater is considered clinically significant. The degree of reflux is a more relevant, reproducible and accurate measure of venous disease than measurement of vein diameters. This test should be the determinant of pathology and not vein size. However, recent data does suggest that vein diameter has some predictive value for reflux. All patients being examined for superficial vein reflux must be examined in the standing position. Data obtained supine may be erroneous.

Approval Signatures:
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Date: January 25, 2017
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Publication History:

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01-28-09: Transitioned to Medical Policy, Annual Review and Revision
01-27-10: Annual Review and Revision
01-19-11: Annual Review and Revision
08-22-12: Annual Review and Revision
01-29-14: Presbyterian Policy Retired
01-29-14: Presbyterian now uses MCG Criteria A-0170, A-0171, A-0172, A-0174, and A-0425
01-28-15: Changed to LCD L32678
10-19-15: Changed to LCD L34924 due to ICD 10 conversion. No change in criteria. Effective 10/15/15.
01-25-17: Annual Review. Accessed LCD L34924. Only changes are annual CPT/HCPCS updates.

This Medical Policy is intended to represent clinical guidelines describing medical appropriateness and is developed to assist Presbyterian Health Plan and Presbyterian Insurance Company, Inc. (Presbyterian) Health Services staff and Presbyterian medical directors in determination of coverage. The Medical Policy is not a treatment guide and should not be used as such.

For those instances where a member does not meet the criteria described in these guidelines, additional information supporting medical necessity is welcome and may be utilized by the medical director in reviewing the case. Please note that all Presbyterian medical policies are available on the Internet at: http://www.phs.org/phs/healthplans/providers/healthservices/Medical/index.htm