Division of Medical Assistance
Varicose Veins, Treatment for

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1.0 Description of the Procedure, Product, or Service

The venous system of the lower extremities consists of the superficial system (including the greater and lesser saphenous veins and their tributaries) and deep system (popliteal and femoral veins). These two (2) parallel systems are interconnected via perforating veins, often called the perforating or communicating system. One-way valves are present at the junctions between the deep and superficial systems, e.g., at the saphenofemoral junction (SFJ) or at the saphenopopliteal junction (SPJ). Venous insufficiency syndromes are caused by venous valves that are incompetent (not capable of closing completely) in the deep venous system and/or the superficial venous system. In people with weak venous valves, gravity forces large quantities of blood back down into distal parts of the vein. This pressure overloads the vein and pushes its wall outward. After repeated overloading, the walls lose their elasticity and become stretched and flabby. Such dilated and tortuous (full of turns and twists) veins caused by incompetent valves are called varicose veins or varicosities.

As the venous pressure in the deep system is generally greater than that of the superficial system, valve incompetence leads to backup and pooling of blood in the superficial (saphenous) vein system and its tributaries. While most varicose veins are secondary to incompetent valves at the saphenofemoral or saphenopopliteal junctions, a minority may be secondary to incompetence of valves within other perforator veins. Common perforating veins consist of anterior and posterior thigh perforators, the mid-thigh perforator, medical knee perforator, and the posteromedial calf perforators. Some of these perforating veins have been named, such as those of Hunter, Boyd, Dodd, Sherman, and Cockett.

Predisposition to the formation of varicose veins may be due to heredity, mechanical factors (prolonged standing, pregnancy), or aging. This condition usually occurs in the legs, but may also be seen in other parts of the body. Because a varicosed vein wall is not able to exert a firm resistance against the blood, blood tends to accumulate in the pouched-out area of the vein, causing it to swell. This may force fluid into the surrounding tissue, causing edema. This fluid may include red blood cells, whose pigment may then be deposited in the skin, causing characteristic reddish-brown or "brauny" discoloration. The stagnation of blood in varicose vessels may also predispose them to clotting, which results in thrombophlebitis. The pressure of backed up blood flow and the thinning of vessel walls with loss of elastic tissue support may result in bleeding or hemorrhage from the varicosities. Finally, venous stasis ulcers may result from the chronic edema that may be associated with severe varicose vein disease.

Many varicose veins cause no symptoms. However, when present, symptoms may include itching, burning, throbbing, aching, heaviness, tension, pressure and pain. In addition to varicose veins, venous insufficiency disease may be complicated by peripheral edema, hemorrhage, thrombophlebitis, ulceration, and chronic skin changes as discussed above.

The diagnosis of venous insufficiency is made largely by history and physical exam, but must be confirmed by Doppler ultrasound, which visualizes and defines the problematic anatomy. In the majority of recipients, venous insufficiency may be treated conservatively. Conservative measures include physical measures such as limb elevation, exercise, compression stockings, and avoidance of prolonged standing. Medications such as non-steroidal anti-inflammatory medications or other analgesics may also relieve some symptoms. Note that venous insufficiency of the deep system can only be treated conservatively. For superficial system venous insufficiency, when conservative treatment is not effective, treatment options include:

a. surgical removal (e.g., Ligation & Stripping, or Ligation & Excision) for incompetent saphenous veins and other large varicose veins;

b. endoluminal radiofrequency ablation (ERFA) or endovenous laser ablation (EVLA; also called endovenous laser therapy, or EVLT), for incompetent saphenous veins, and

c. ambulatory phlebectomy or microphlebectomy (e.g., stab avulsion, needle (hook) phlebectomy, transilluminated powered phlebectomy) for smaller tributary veins;

d. injection sclerotherapy for the smaller tributary varicose veins.

Procedural treatment options for varicose veins focus first on identifying and interrupting the source of reflux from the deep system, and second, on removal or obliteration of the affected (insufficient or varicose) veins in the superficial system. Thus procedural treatment of varicosities is based on the following three (3) principles:

a. Identification of the most proximal point of reflux from the deep system, typically at the saphenofemoral or saphenopopliteal junctions or other perforators, by preoperative Doppler ultrasonography.

b. Isolation of the refluxing greater or lesser saphenous veins from the deep venous circulation. The most typical strategy for isolation is ligation (tying off) of the incompetent junction which back-fills the affected saphenous vein, followed by division (cutting) of the junction. This may be followed by stripping of the vein. An alternative strategy is ablation of the refluxing vein.

c. Removal (including excision, or injection sclerotherapy) of the varicose tributaries.

1.1 Procedures for Treatment of Varicose Veins

a. Ligation and Stripping or Ligation and Excision

This has historically been the standard approach to venous insufficiency disease characterized by symptomatic varicosities in the superficial saphenous vein system and its tributaries. Over the years, less invasive ("minimally invasive") procedures have been developed as alternatives to this method, largely because of the need for general anesthesia, the use of an operating room, and because of significant scar production. Regardless of the procedure utilized, it is important that the flow from the deep venous system to the varicosities in the superficial system be interrupted, thus reducing the chance that the varicose veins reopen (recanalize) under the pressure of flow from the deep system.

b. Endoluminal Radiofrequency Ablation (ERFA) or Endovenous Laser Ablation/Endovenous Laser Therapy (EVLA/EVLT):

ERFA or EVLA/EVLT techniques have been utilized as minimally invasive alternatives to standard vein ligation and stripping or surgical excision. Both are similarly designed to use heat energy to damage the inner walls of the blood vessels (veins), causing the vein wall to collapse, scar, and seal shut, thus eliminating reflux or backflow of blood into the treated portion of the vein. ERFA is performed by means of a specially designed catheter inserted through a small incision in the medial thigh to within 1-2 cm. of the saphenofemoral junction (but not into or through the junction). The catheter's electrodes are deployed by retracting their protective sheath. The electrodes expand to touch the vessel walls. When the radiofrequency energy is

activated the catheter is pulled back slowly in order to maintain the set temperature. The catheter is slowly withdrawn, closing the vein. EVLA/EVLT is performed in a similar fashion. A flexible bare-tipped laser fiber is introduced into the vein under ultrasound guidance. The laser is then activated and slowly removed along the course of the vein (again, not traversing the saphenofemoral or saphenopopliteal junction). Several radiofrequency and laser devices have received specific FDA marketing clearance. These include the VNUS Closure System (a radiofrequency device) and the Diomed 810 nm surgical laser with EVLT procedure kit for treatment of recipients with "superficial vein reflux."

c. Subfascial Endoscopic Perforator Surgery (SEPS)

Subfascial (under the fibrous tissue beneath the skin) Endoscopic Perforator Surgery (SEPS) is a minimally invasive procedure that is designed to interrupt incompetent perforator veins as a treatment of chronic venous insufficiency. The incompetent perforator veins have improperly functioning valves that can lead to venous insufficiency disease with any of its complications, as described above. Guided by Duplex ultrasound scanning, small incisions are made, and, using endoscopic equipment (a narrow camera and other small instruments), the perforating veins are clipped or ligated and then divided by endoscopic scissors. This is the equivalent of surgical interruption of the SFJ or SPJ in the more standard Ligation & Excision procedure (above), but is performed instead on the junctions of the superficial system with the various perforator veins. SEPS has been used as an alternative to the traditional, more invasive, open surgical treatment of chronic venous insufficiency due to incompetent perforator veins (i.e., the Linton procedure). The Linton procedure involves a long incision to expose all the perforators in the leg, has a relatively high complication rate for infection, delayed healing and scar formation. It usually is performed in the hospital setting. SEPS can be performed as an outpatient procedure.

d. Ambulatory Phlebectomy/Microphlebectomy

Ambulatory phlebectomy/microphlebectomy includes several techniques that permit removal of incompetent superficial veins beyond the saphenofemoral or saphenopopliteal junctions and proximal saphenous veins. Stab avulsion, needle (hook) phlebectomy, and transilluminated powered phlebectomy are considered differing versions of ambulatory phlebectomy, and are alternatives to traditional varicose vein excision. No one technique of ambulatory phlebectomy has been shown to be superior to another. Transilluminated powered phlebectomy involves the use of two (2) instruments; an illuminator and a resector. The illuminator is introduced via a groin incision underneath the varicosities, and the lights in the operating room are dimmed so that the varicose veins become visible. The resector is inserted beneath the illuminated veins. The tip of the resector follows the veins slowly to chop the veins and aspirate the fragments. The Trivex system is a device for transilluminated powered phlebectomy that received U.S. Food and Drug Administration (FDA) clearance through the 510(k) process in October 2003. According to the label, the intended use is for "ambulatory phlebectomy procedures for the resection and ablation of varicose veins."

Veins that can be removed by using the ambulatory phlebectomy method include the saphenous veins and all their tributaries, reticular veins, and some larger telangiectasias. Skin incisions or needle punctures as small as 1 mm. are used to

extract veins with a phlebectomy hook. Long-term results are excellent as long as the most proximal source of reflux is also eliminated.

Ambulatory phlebectomy also often avoids some of the complications of other procedures. In contrast to traditional venous stripping, the small size of the skin incision or puncture usually results in little or no scarring. Because the procedure can be performed with the recipient under local anesthesia, ambulatory phlebectomy reduces surgical risks compared with traditional surgery under general anesthesia.

Phlebectomy can also be used to excise small vein segments affected by superficial phlebitis. Ambulatory phlebectomy is the preferred treatment for large, tortuous (full of turns and twists) distal varicosities, as tortuosity is considered a contraindication to the use of endovenous radiofrequency (ERFA) or laser ablation (EVLA) techniques.

e. Sclerotherapy

The objective of sclerotherapy is to destroy the lining of the affected vein by injecting an irritant solution (either a detergent, osmotic solution, or a chemical irritant), ultimately resulting in the complete obliteration of the vessel. Too little destruction leads to thrombosis without fibrosis and ultimate recanalization (reopening). Too much destruction leads to vascular dehiscence (breakdown). The success of the treatment depends on accurate injection of the vessel, an adequate injection volume and concentration of sclerosing solution, and postprocedure compression. Compression theoretically positions the treated vein walls closer together to provide more effective fibrosis. It may decrease the extent of the thrombosis formation. Therefore, due to technical limitations, larger veins and very tortuous veins may not be good candidates for sclera therapy.

While sclerotherapy is an accepted and effective treatment of smaller (telangiectatic) vessels, it has also been used in the treatment of varicose veins (i.e., the dilated tributaries of the saphenous veins) without prior ligation of the sources of reflux (with or without vein stripping). This application of sclerotherapy is less effective due to the absence of the control of the point of reflux and isolation of the refluxing saphenous vein or its tributaries. Some practitioners have utilized sclerosant injections into the greater or lesser saphenous vein as a minimally invasive alternative to vein stripping, either with or without ligation of the refluxing venous junction. Since the saphenous vein is not visible with the naked eye, injection is typically guided by ultrasonography, and the combined procedure may be referred to as "echosclerotherapy," Since the greater saphenous vein is larger and deeper than telangiectatic dermal veins or varicose tributary veins, sclerotherapy of this vein raises issues regarding appropriate volume and concentration of the sclerosant, and the ability to provide adequate post-procedure compression. Moreover, the use of sclerotherapy, as opposed to the physical removal of the vein (e.g., stripping), raises the issue of recurrence due to recanalization.

One protocol for sclerotherapy as the sole treatment of saphenofemoral incompetence has been referred to as the COMPASS procedure, an acronym for comprehensive objective mapping, precise image guided injection, antireflux positioning and sequential sclerotherapy. Comprehensive objective mapping describes the preoperative use of Doppler ultrasonography to identify the point of origin of reflux and other contributing refluxing sources. Precise image guided injection refers to the use of intraoperative Doppler ultrasonography to guide the injection of the sclerosant into the greater saphenous vein. Antireflux positioning refers to the positioning of the

recipient with the legs elevated to eliminate reflux and venous hypertension (pressure elevation). Finally sequential sclerotherapy refers to the use of two or three sessions of sclerotherapy until the varicosities resolve, with ongoing monitoring and repeat treatment, if needed for up to 12 months. It should be noted that all components of the COMPASS protocol are not unique.

Long-term recurrence rates are higher after sclerotherapy than after surgical approaches (e.g., ligation and stripping, ERFA or EVLA) for the treatment of varicose veins. The use of injection sclerotherapy for trunk varices has fallen in recent years, partly because of concerns about complications such as skin staining and ulceration and also because up to 65% of recipients treated by sclerotherapy develop recurrent varicose veins within five (5) years. Sclerotherapy alone is rarely if ever used as definitive therapy for significant varicosities.

1.2 Medical Term Definitions

a. Ablation: the removal or destruction of tissue or an abnormal growth, usually by cutting, burning or freezing; may also refer to a very high dose of chemotherapy or radiation treatment that is calculated to kill a tumor.

b. Analgesic: a drug that alleviates pain without causing loss of consciousness.

c. Aspirate: to draw by suction; to remove (as blood) by aspiration.

d. Avulsion: the ripping or tearing away of a part either accidentally or surgically.

e. Doppler Ultrasonography: that in which the shifts in frequency between emitted ultrasonic waves and their echoes are used to measure the velocities of moving objects, based on the principle of the Doppler effect. The waves may be continuous or pulsed; the technique is frequently used to examine cardiovascular blood flow (Doppler echocardiography).

f. Duplex Ultrasonography; a type that combines real-time with Doppler ultrasonography (real-time-a series of ultrasound images produced in rapid succession so that the video display shows motion of an organ or part).

g. Edema; excessive accumulation of fluid in the body tissues.

h. Endovenous: within a vein or veins.

i. Fibrosis: information of fibrous tissue as a reparative or reactive process, as opposed to formation of fibrous tissue as a normal constituent of an organ or tissue.

j. Hemorrhage: escape of blood from a ruptured blood vessel, externally or internally.

k. Obliteration: complete removal, whether by disease, degeneration, surgical procedure, irradiation, or otherwise.

l. Occlusion: the state of being blocked or closed.

m. Phlebectomy: excision of a vein, or of a part of a vein.

n. Phlebitis: inflammation of a vein.

o. Proximal: nearest the point of attachment, center of the body, or point of reference.

p. Reflux: backward or return flow.

q. Stasis: stagnation of normal flow of fluids, as of the blood or urine, or of the intestinal mechanism.

r. Superficial: pertaining to or situated near the surface.

s. Telangiectasia: permanent dilation of preexisting small blood vessels (capillaries, arterioles, venules), creating focal red lesions, usually in the skin or mucous membranes. Also called telangiectasis.

t. Thrombophlebitis: inflammation of a vein associated with a thrombus (clot) formation.

u. Thrombosis: the formation of a thrombus or clot.

v. Varices: enlarged and twisted veins.

w. Venous Insufficiency: inadequacy of the venous valves and impairment of venous return from the lower limbs (venous stasis), often with edema and sometimes with stasis ulcers at the ankle. Called also primary valvular incompetence and valvular incompetence.

2.0 Eligible Recipients

2.1 General Provisions

To be eligible, NCHC recipients must be enrolled on the date of service.

3.0 When the Procedure, Product, or Service Is Covered

3.1 General Criteria

NCHC covers procedures, products, and services related to this policy when they are medically necessary and

a. the procedure, product, or service is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the recipient's needs;

b. the procedure, product, or service can be safely furnished, and no equally effective and more conservative or less costly treatment is available; **AND**

c. the procedure, product, or service is furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

3.2 Specific Criteria

Treatment for varicose veins may be covered when it is determined to be medically necessary because the criteria and guidelines shown below are met and when the required documentation under **Subsection 5.2** has been provided for review, **AND** criteria listed in **Subsection 3.2.c** are met, AND no medical contraindications are present, the following procedures for treatment of varicose veins and venous insufficiency may be considered medically necessary:

a. Surgical procedures for the Greater Saphenous Vein [GSV], Lesser Saphenous Vein [LSV], or accessory saphenous vein that are incompetent include any of the following:

1. Varicose vein ligation and excision (VVLE)/varicose vein ligation and stripping (VVLS) for treatment of GSV, LSV, or accessory vein reflux;
2. Endoluminal radiofrequency ablation (ERFA) for treatment of GSV, LSV, or accessory vein reflux (ERFA is not covered for treatment of perforator veins);
3. Endovenous laser ablation (EVLA)/endovenous laser therapy (EVLT) for treatment of GSV, LSV, or accessory vein reflux (EVLA/EVLT is not covered for treatment of perforator veins).

b. Sclerotherapy or Microphlebectomy (including, but not limited to, stab phlebectomy, hook phlebectomy, or transilluminated power phlebectomy) are covered for the treatment of varicose tributaries and non-truncal incompetent veins of the superficial venous system when all proximal sources of reflux (i.e., incompetence of the GSV/SFJ or LSV/SPJ, or accessory saphenous vein, or of significant perforator veins [defined in **Subsection 3.2.c** below]), as demonstrated by Duplex Ultrasonography, already have been or are being treated.

Note: Coverage of sclerotherapy is limited to three (3) sessions per leg and coverage of microphlebectomy is limited to one (1) session per leg, to be accomplished over a period of not more than six (6) months from the primary procedure. Primary procedures may include ligation/division/stripping/excision, ERFA, or EVLA/EVLT). Sclerotherapy coverage does not include treatment of reticular veins, spider veins or telangiectasias. Sclerotherapy is not covered for treatment of saphenofemoral or saphenopopliteal junction incompetence or saphenous vein (GSV, LSV, or accessory saphenous vein) reflux. Also, sclerotherapy, ERFA and EVLA/EVLT are not covered for treatment of incompetent deep perforator veins.

c. SEPS procedure for treatment of significant reflux of perforator veins when symptoms of venous insufficiency persist despite previous treatment of any existing incompetence of GSV/SFJ and/or LSV/SPJ.

d. Treatment for varicose veins/venous insufficiency may be covered under the NC Health Choice Program when the required documentation under **Subsection 5.1** establishes that: either all of the criteria under **Subsection 3.3.a** or at least one of the criteria under **Subsection 3.3.b** is met.

1. The recipient has severe and persistent pain and/or swelling due to varicose veins/venous insufficiency
   (a) There is significant pain and/or swelling of a severity that it interferes with two or more normal daily activities (e.g., shopping, showering, etc.) or with essential job functions of the recipient's specific occupation;
   (b) The pain and/or swelling has been determined on a thorough evaluation to most likely be due to the documented vein disease and not to an alternative etiology;
   (c) Pre-treatment standing photographs are consistent with the other clinical information supplied including physical exam findings documented in the medical record;
   (d) Adequate symptom control has not been obtained after three (3) months of recipient compliance with conservative therapy as serially documented in the medical record, including follow-up visits after interventions were prescribed. Letters of medical necessity or letters of attestation are not

sufficient to satisfy this criterion. Failure of conservative therapy is defined by presence of severe and persistent edema or pain interfering with two or more normal daily activities or essential job functions of the recipient's own occupation; **AND**

(e) Conservative therapy must include ALL of the following:

(i) Oral analgesics are used as needed for intermittent symptoms of aching and pain, **AND**

(ii) Surgical grade compression hose (minimum 20-30 mm Hg) with prescription and trial of use documented in the medical record, **AND**

(iii) Elevation, exercise and avoidance of aggravating circumstances where possible.

OR

2. The recipient has any of the following complications due to varicose veins/venous insufficiency:

(a) Ulcerative disease (CEAP grades V-VI) with medical record documentation from the physician(s) who evaluated and treated the recipient for the ulcer(s) and photographs that are consistent with the clinical information supplied;

(b) Recurrent superficial phlebitis in a varicosity [two (2) or more episodes] with medical record documentation from the physician(s) who evaluated and treated the recipient for the superficial phlebitis and photographs that are consistent with the clinical information supplied; **OR**

(c) Recurrent hemorrhage in a varicosity [two (2) or more episodes)]or a single severe episode requiring transfusion with medical record documentation from the physician(s) who evaluated and treated the recipient for the hemorrhage(s) and photographs that are consistent with the clinical information supplied.

4.0 When the Procedure, Product, or Service Is Not Covered

4.1 General Criteria

Procedures, products, and services related to this policy are not covered when

a. the recipient does not meet the eligibility requirements listed in **Section 2.0;**
b. the recipient does not meet the medical necessity criteria listed in **Section 3.0;**
c. the procedure, product, or service unnecessarily duplicates another provider's procedure, product, or service; or
d. the procedure, product, or service is experimental or investigational.

4.2 Specific Criteria

Procedures to treat varicose veins/venous insufficiency are not covered in any of the following situations:

a. When coverage criteria in **Subsection 3.2** are not met.

b. When there are medical contraindications to the procedure, including ANY of the following:

   1. Occlusion of deep vein system or recent/active deep venous thrombosis (DVT) (i.e. within the past 6 months).

   2. Untreated or uncontrolled hypercoagulable state. Mild hypercoagulable states may not be a contraindication to treatment. If questionable, hematology consultation prior to treatment is recommended.

   3. Concurrent pregnancy.

   4. Nonambulatory condition of recipient.

   5. Inability to tolerate postoperative compressive stockings or dressings.

   6. Severe peripheral obstructive arterial disease that is not corrected prior to treatment of venous disease.

   7. Allergy or hypersensitivity to sclerosing agent or other injectable agent.

c. Sclerotherapy of the greater saphenous, small saphenous, or accessory saphenous vein (with or without associated ligation of the SFJ or SPJ for the treatment of saphenous vein reflux or SFJ or SPJ incompetence) is considered investigational and is not covered. Sclerotherapy of incompetent perforator veins is also considered investigational and is not covered.

d. In recipients with documented reflux of the saphenofemoral junction, reflux of the greater saphenous vein, or reflux isolated to the perforator veins of the upper thigh, sclerotherapy of varicose tributaries is considered investigational when performed without associated treatment of the source of reflux (either with ligation/stripping, or, for the greater saphenous vein, with EVLT or ERFA). This is based on the fact that any treatment of the tributaries alone is less effective than treatment that includes control of the underlying refluxing veins. Sclerotherapy alone in this situation is therefore not covered. However, since recurrence typically arises after two (2) to four (4) years, isolated sclerotherapy may be reviewed on an individual consideration basis in recipients in whom long-term control of venous reflux is not a treatment goal. Such recipients may include an older recipient who experiences recurrent bleeding from a varicosity or recurrent thrombophlebitis in varicose tributaries.

e. Endoluminal radiofrequency ablation or endovenous laser ablation of any vein other than the greater, lesser (small), and accessory saphenous veins is considered investigational and is not covered.

f. Treatment of reticular veins, telangiectasias, "spider" veins and "thread" veins is considered to be cosmetic and not medically necessary and is not covered.

g. More than three (3) sessions of sclerotherapy per leg or more than one session of microphlebectomy per leg to treat symptomatic varicose veins is considered not medically necessary and is not covered.

h. Transdermal laser therapy and photothermal sclerosis are considered not medically necessary (cosmetic) as they primarily treat small reticular veins, telangiectasias, "spider" and "thread" veins.

i. Surgical removal, EVLT, and/or ERFA can be performed safely and effectively on multiple veins of the same leg as part of a single surgery. Therefore, staging of

surgical procedures on different dates of service to treat more than one incompetent saphenous vein (GSV, LSV, accessory saphenous vein) in the same leg is considered to be not medically necessary.

5.0 Requirements for and Limitations on Coverage

5.1 Prior Approval

Prior approval is required for treatment of varicose veins and venous insufficiency.

5.2 Required Documentation

The following items of documentation **MUST** be supplied for consideration of coverage for any procedure for treatment of varicose veins/venous insufficiency:

1. Medical records from the treating physician which include a thorough history that is patient-specific and a thorough physical examination (with descriptions and locations of symptomatic veins, presence or absence of edema with quantification, skin changes, and other pertinent findings).
2. CEAP classification of venous disease (Refer to **Attachment B**).
3. For non-ulcerative disease (CEAP classes 0 - IV), there must be medical records from a prior treating physician who evaluated the recipient's leg symptoms and determined that the symptoms were not attributable to another etiology such as restless leg syndrome, orthopedic problems, spinal stenosis, etc.
4. Serial medical record documentation from treating physician(s) of all prior conservative management for symptoms/complications due to varicose veins/venous insufficiency with follow-up assessment of clinical response (documentation must include prescription for and use of surgical grade compression hose of 20-30 mm pressure or more, if applicable)
5. Pre-treatment standing photographs of the affected leg(s), including views of ankle and foot.
6. A separately identifiable Duplex Ultrasound report that addresses the patency of the deep system and anatomy/function of the superficial venous system, including the competence of the SFJ and SPJ, and the presence and extent of any saphenous vein reflux and perforator reflux.
7. Procedure (CPT) codes for proposed interventions specifying the vein(s) to be treated with each procedure (e.g. GSV, LSV, accessory saphenous vein, perforator, varicose tributaries, reticular veins, spider veins, telangiectasia) and whether Left, Right, or Bilateral; and for sclerotherapy also stating the number of sessions for each leg.

6.0 Providers Eligible to Bill for the Procedure, Product, or Service

To be eligible to bill for procedures, products, and services related to this policy, providers shall

a. meet NCHC qualifications for participation;
b. be currently enrolled with NCHC; **AND**

c. bill only for procedures, products, and services that are within the scope of their clinical practice, as defined by the appropriate licensing entity.

7.0 Additional Requirements

7.1 Compliance

Providers must comply with all applicable federal, state, and local laws and regulations, including the Health Insurance Portability and Accountability Act (HIPAA) and record retention requirements.

8.0 Policy Implementation/Revision Information

Original Effective Date: July 1, 2010

Revision Information:

Date	Section Revised	Change
July 1, 2010		Policy Conversion: Implementation of Session Law 2009-451, **Section 10.32 "NC HEALTH CHOICE/PROCEDURES FOR CHANGING MEDICAL POLICY."**
September 30, 2011	**Throughout**	**Policy Date of Termination**

Attachment A: Claims-Related Information

Reimbursement requires compliance with all NCHC guidelines.

A. Claim Type

Professional (CMS-1500/837P transaction)

Institutional (UB-04/837I transaction)

B. Diagnosis Codes

Providers must bill the ICD-9-CM diagnosis codes(s) to the highest level of specificity that supports medical necessity.

C. Procedure Code(s)

CPT Code(s)					
36470	36470	36471	36475	36476	36478
36479	37500	37700	37718	37722	37735
37760	37761	37765	37766	37780	37785

D. Modifiers

Providers are required to follow applicable modifier guidelines.

E. Billing Units

The appropriate procedure code(s) used determines the billing unit(s).

F. Place of Service

Outpatient Hospital and Office

G. Co-payments

Co-payment(s) may apply to covered prescription drugs and services.

H. Reimbursement

Providers must bill their usual and customary charges.

Attachment B: Classification of Chronic Venous Insufficiency

Class	Definition
C	Clinical signs (grade 0-6), supplemented by "A" for asymptomatic and "S" for symptomatic presentation
	0 no visible or palpable signs of venous disease
	1 telangiectases or reticular veins
	2 varicose veins
	3 edema
	4 skin changes ascribed to venous disease [e.g., pigmentation, venous eczema, lipodermatosclerosis (LDS)]
	5 skin changes as defined above + healed ulceration
	6 skin changes as defined above + active ulceration
E	Etiologic classification (congenital, primary, secondary)
A	Anatomic distribution (superficial, deep, or perforator, alone or in combination)
P	Pathophysiologic dysfunction (reflux or obstruction, alone or in combination)
	CEAP Classification of Chronic Venous Insufficiency retrieved from a PowerPoint presentation by Andrew C. Stanley, M.D., Section of Vascular Surgery at the University of Vermont. Varicose Veins: Causes, Symptoms and Management. Retrieved on 8/10/05 from http:// www.med.uvm.edu/downloads/CMS_VaricoseVeins_PowerPoint.pdf#search='Classification%20of%20varicose%20veins'