Medical Necessity Guidelines: Procedures for the Treatment of Symptomatic Varicose Veins Not Available From InterQual®: Stab Phlebectomy

Effective: October 10, 2018

Prior Authorization Required
If REQUIRED, submit supporting clinical documentation pertinent to service request.

| Yes ☒ | No ☐ |

Applies to:
COMMERCIAL Products
☒Tufts Health Plan Commercial products; Fax: 617.972.9409
☒Tufts Health Freedom Plan products; Fax: 617.972.9409
• CareLinkSM – Refer to CareLink Procedures, Services and Items Requiring Prior Authorization

TUFTS HEALTH PUBLIC PLANS Products
☒Tufts Health Direct – A Massachusetts Qualified Health Plan (QHP) (a commercial product); Fax:888.415.9055
☒Tufts Health Together – MassHealth MCO Plan and Accountable Care Partnership Plans; Fax: 888.415.9055
☒Tufts Health RITogether – A Rhode Island Medicaid Plan; Fax: 857.304.6404
☒Tufts Health Unify* – OneCare Plan (a dual-eligible product); Fax: 781.393.2607
*The MNG applies to Tufts Health Unify members unless a less restrictive LCD or NCD exists.

SENIOR Products
• Tufts Health Plan Senior Care Options (SCO), (a dual-eligible product) – Refer to the Tufts Health Plan SCO Prior Authorization List
• Tufts Medicare Preferred HMO, (a Medicare Advantage product) – Refer to the Tufts Medicare Preferred HMO Prior Authorization and Inpatient Notification List

Note: While you may not be the provider responsible for obtaining prior authorization, as a condition of payment you will need to make sure that prior authorization has been obtained.

Note: For procedures other than Stab phlebectomy refer to: Procedures for the Treatment of Varicose Veins and their applicable InterQual® SmartSheet(s)™.

OVERVIEW
Stab phlebectomy is a surgical treatment for varicose veins. This procedure 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.

CLINICAL COVERAGE CRITERIA
1. Tufts Health Plan may authorize the coverage of Stab Phlebectomy for Symptomatic Varicose Veins with Medical Record documentation of any ONE of the following:
   a. Leg ulcer(s) due to saphenous vein incompetence and is refractory to conservative management for at least 6 consecutive weeks, immediately prior to the request for authorization, including leg elevation, customized graded compression stockings and local wound care
   b. Recurrent bleeding from a ruptured superficial varicosity
   c. History of a single episode of significant bleeding requiring urgent medical care;

   OR

2. Medical Record documentation of ALL of the following:
   a. Failure of conservative management including leg elevation and customized graded compression stockings with an ankle pressure > 30 mmHg for 6 consecutive weeks
   b. At least one of the following:
      • Severe and persistent pain and swelling in the affected limb, resulting in clearly documented impairment in mobility and inability to perform activities of daily living

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Procedures for the Treatment of Symptomatic Varicose Veins Not Available From InterQual®:

- Superficial thrombophlebitis: either two or more episodes or one persistent episode unresponsive to ≥ 4 weeks of conservative therapy, including nonsteroidal anti-inflammatory drugs (NSAIDS)
- Refractory dependent edema
c. When the symptomatic varicosities, to be treated, are greater than 3mm in size

LIMITATIONS
- Tufts Health Plan will not cover any treatment of varicose veins for cosmetic purposes.
- Varicose veins less than 3mm in diameter are considered cosmetic (e.g., telangiectasia, spider veins, reticular veins)

CODES
The following CPT codes require prior authorization:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>37765</td>
<td>Stab phlebectomy of varicose veins, one extremity; 10-20 stab incisions</td>
</tr>
<tr>
<td>37766</td>
<td>Stab phlebectomy of varicose veins, one extremity; more than 20 incisions</td>
</tr>
</tbody>
</table>

REFERENCES

APPROVAL HISTORY
May 7, 2007: Reviewed by the Clinical Coverage Criteria Committee

Subsequent endorsement date(s) and changes made:
- July 25, 2007: Coverage of sclerotherapy clarified
- March 11, 2008: Changes to formatting only
- July 7, 2008: Conservative management clarified
- June 1, 2009: Changes made to when more than one type of vein treatment will be authorized
- September 2010: Reviewed by Medical Affairs-Medical Policy, no changes
- April 11, 2012: Reviewed by IMPAC (Integrated Medical Policy Advisory Committee), changes made to criteria; conservative management clarified
- October 10, 2012: Reviewed by IMPAC. Varicose Vein procedures will require an InterQual® SmartSheet(s)™ except Stab Phlebectomy which has separate Medical Necessity Guidelines.
- December 11, 2013: Reviewed by IMPAC, renewed without changes.
- December 10, 2014: Reviewed by IMPAC. Criteria 2c: symptomatic varicosities to be treated changed from equal to or greater than 5mm to equal to or greater than 3mm in size.
- July 23, 2015: Reviewed by IMPAC. Criterion 2c: symptomatic varicose veins to be treated changed from 'equal to or greater than 3mm' to 'greater than 3mm in size'. Varicose veins less than 3mm in diameter added to Limitations. These changes are effective January 1, 2016.
- September 2015: Branding and template change to distinguish Tufts Health Plan products in "Applies to" section. Added Tufts Health Freedom Plan products, effective January 1, 2016.
- July 20, 2016: Reviewed by IMPAC, renewed without changes
- April 2017: Added RITogether Plan product to template. For MNGs applicable to RITogether, effective date is August 1, 2017
- July 20, 2017: Reviewed by IMPAC, renewed without changes
- October 10, 2018: Reviewed by IMPAC, renewed without changes
- October, 2018: Template and disclaimer updated

Background, Product and Disclaimer Information
Medical Necessity Guidelines are developed to determine coverage for benefits, and are published to provide a better understanding of the basis upon which coverage decisions are made. We make coverage decisions using these guidelines, along with the Member’s benefit document, and in coordination with the Member’s physician(s) on a case-by-case basis considering the individual Member’s health care needs.
Medical Necessity Guidelines are developed for selected therapeutic or diagnostic services found to be safe and proven effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in our service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. We revise and update Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

For self-insured plans, coverage may vary depending on the terms of the benefit document. If a discrepancy exists between a Medical Necessity Guideline and a self-insured Member’s benefit document, the provisions of the benefit document will govern.

Treating providers are solely responsible for the medical advice and treatment of Members. The use of this guideline is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to eligibility and benefits on the date of service, coordination of benefits, referral/authorization, utilization management guidelines when applicable, and adherence to plan policies, plan procedures, and claims editing logic.