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**Utilization \*ALERT\***

- Prior to use of this MCP for evaluation of medical necessity, benefit coverage **MUST** be verified in the member's EOC or benefit document.
  - Please refer to CMS guidelines: National Coverage Determination (NCD) or Local Coverage Determination (LCD) for Medicare members. This MCP applies if no CMS criteria are available.
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**I. Procedure**

Referral to Vascular Surgery for evaluation and treatment of varicose veins of the lower extremities.

**II. Clinical Indications for Referral**

- A.** Diagnosis of venous insufficiency with varicose veins.
- B.** Referral to vascular surgery for evaluation and treatment of varicose veins is indicated for **ANY ONE** of the following:
1. Leg ulcerations associated with saphenous vein insufficiency;
  2. Recurrent bleeding from the saphenous vein or other varicosities; or
  3. History of a single, significant (i.e., requiring emergency medical care) episode of bleeding, especially if a transfusion is required; or
  4. Varicose veins with **ALL** of the following (site/modalities):
    - a. Documented vessel size greater than or equal to 3 mm; and
    - b. Failure of conservative management (e.g., leg elevation OTC graded compression stockings (minimum 12-18 mm Hg that are worn daily for 3 months.) for three consecutive months **and AT LEAST ONE** of the following associated conditions:
      - i. Pain in the affected extremity, resulting in impaired mobility or inability to perform activities of daily living; or
      - ii. Recurrent phlebitis or thrombophlebitis; or
      - iii. Refractory dependent edema; or
      - iv. Persistent stasis edema

**III. Pre-surgical Test Procedures**

The surgical specialists will ensure the appropriate pre and post treatment vascular doppler or duplex ultrasound scanning are completed for Endovenous Laser Therapy (EVLT), Transillumination for Vein Treatment, Transilluminated Powered Phlebectomy (TIPP), and Radiofrequency Ablation (RFA).

**IV. Limitations/Exclusions**

- A.** The goal of varicose vein treatment is to improve a member's physical function.
- B.** Procedures and services that are intended to improve or maintain appearance, and that are not expected to significantly improve physical function, are considered to be cosmetic and are not covered.



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**Varicose Veins, Evaluation and Treatment  
Medical Coverage Policy**

**Approval History**

<b>Date approved by RUMC*</b>	<b>Date filed with the State of Maryland</b>	<b>Date of Implementation (Ten days after filing)</b>
06/21/2012	06/21/2012	07/02/2012
06/28/2013	06/28/2013	07/09/2013
07/02/2014	07/07/2014	07/18/2014
07/30/2015	07/31/2015	08/11/2015

**Approval History**

Effective June 01, 2016, state filing is no longer required per Maryland House Bill [HB 798](#) – Health Insurance – Reporting

<b>Date approved by RUMC</b>	<b>Date of Implementation</b>
07/26/2016	07/26/2016
07/28/2017	07/28/2017
07/27/2018	07/27/2018
07/30/2019	07/30/2019
07/24/2020	07/24/2020
07/22/2021	07/22/2021
06/20/2022	06/20/2022
06/26/2023	06/26/2023
06/25/2024	06/25/2024

\*The Regional Utilization Management Committee received delegated authority in 2011 to review and approve designated Utilization Management and Medical Coverage Policies by the Regional Quality Improvement Committee.

Note: Kaiser Permanente Mid-Atlantic States (KPMAS) include referral and authorization criteria to support primary care and specialty care practitioners, as appropriate, in caring for members with selected conditions. Medical Coverage Policies are not intended or designed as a substitute for the reasonable exercise of independent clinical judgment by a practitioner in any particular set of circumstances for an individual member.

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