Varicose Vein Treatment

State(s):
- Idaho
- Montana
- Oregon
- Washington
- Other:

LOB(s):
- Commercial
- Medicare
- Medicaid

Commercial Policy

Clinical Guidelines are written when necessary to provide guidance to providers and members in order to outline and clarify coverage criteria in accordance with the terms of the Member’s policy. This Clinical Guideline only applies to PacificSource Health Plans in Idaho, Montana, Oregon, and Washington. Because of the changing nature of medicine, this list is subject to revision and update without notice. This document is designed for informational purposes only and is not an authorization or contract. Coverage determination are made on a case-by-case basis and subject to the terms, conditions, limitations, and exclusions of the Member’s policy. Member policies differ in benefits and to the extent a conflict exists between the Clinical Guideline and the Member’s policy, the Member’s policy language shall control. Clinical Guidelines do not constitute medical advice nor guarantee coverage.

Background

Varicose veins are swollen veins that can be see through the skin. They often look blue, bulging, and twisted. Left untreated, varicose veins may worsen over time. Varicose veins can cause aching and feelings of fatigue as well as skin changes like rashes, redness, and sores.

There are three kinds of veins in the legs; the superficial veins, which lie closest to the skin, the deep veins, which lie in groups of muscles and perforating veins, which connect the superficial veins to the deep veins. The deep veins lead to the vena cava, the body’s largest vein, which runs directly to the heart. Varicose veins occur in the superficial veins in the legs.

All of these veins contain one-way valves to ensure that the blood flows towards the heart. Failure of these valves allows blood to flow backwards down the veins and results in an overload of pressure when standing. This excess pressure leads to widening of the veins so that they do not close properly. Blood then flows back into the leg along these veins and causes varicose veins to develop. Raised pressure in these veins also encourages the development of spider veins and discolored areas which look like bruises.

Criteria

Preauthorization is Required

Multiple/Staged Procedure requests require Medical Director review:

Multiple/Staged Procedure requests: Endovenous ablation therapy of the first vein and of the second and subsequent veins in each affected extremity is considered medically necessary when performed on the same date of service and criteria are met. [Note: Thus one primary code and one secondary code
are considered medically necessary for initial endovenous ablation treatment.] Additional treatment requires a clinical reassessment and documentation that the member’s symptoms have remained unimproved after the initial approved intervention.

**Saphenous Vein Ablation (Great or Lesser, Accessory and Tributaries), Laser (EVLA) or Radiofrequency (RFA):**

- Endovascular laser saphenous vein ablation may be indicated when **ALL** of the following are present:
  - Duplex ultrasound or Doppler study confirms significant reflux of the incompetent vein exceeding 0.5 seconds and vein size 4.5 mm or greater in diameter measured by ultrasound immediately below the saphenofemoral or saphenopopliteal junction (not valve diameter at junction)
  - Saphenous venous insufficiency symptoms causing functional impairment, including 1 or more of the following:
    - Leg edema
    - Leg fatigue
    - Leg pain requiring chronic daily analgesics medication
    - Persistent or recurrent superficial thrombophlebitis
    - Persistent or recurrent venous stasis ulcer
  - No clinically significant lower extremity arterial disease
  - No deep venous thrombosis on duplex ultrasound or other imaging test
  - No significant symptomatic improvement in response to 3-month or longer trial of compression stockings when patient is able to wear them.

- In addition to meeting the above criteria the **accessory saphenous vein** ablation may be indicated when the following are present:
  - Persistent junctional reflux is demonstrated after GSV or SSV have been removed or ablated by EVLA or RFA at the saphenofemoral junction or saphenopopliteal junction
  - At least 3 months have passed since prior treatment

**Perforator Veins:**

Perforator veins connect superficial veins to deep veins. They contain one-way valves to direct the blood from the superficial system to the deep system and are generally < 3mm in their normal state.

**Preauthorization is required**

Treatment of incompetent perforator veins may be considered medically necessary as a **treatment of leg ulcers only**, including surgical ligation (including subfascial endoscopic perforator surgery) or endovenous radiofrequency or laser ablation of veins associated with chronic venous insufficiency when the following conditions have been met:

- There is demonstrated perforator reflux; AND
- The superficial saphenous veins (greater, lesser, or accessory saphenous and symptomatic varicose tributaries) have been previously eliminated; AND
- Symptoms have not resolved following combined superficial vein treatment and compression therapy for at least 3 months; AND
- The venous insufficiency is not secondary to deep venous thromboembolism.

Ligation or ablation of incompetent perforator veins performed concurrently with superficial venous surgery is not medically necessary.
Treatment of incompetent perforator veins using any other techniques than noted above are considered investigational, including, but not limited to:

- Sclerotherapy
- Stab avulsion
- Stab/Hook/Micro-phlebectomy
- Transilluminated powered phlebectomy (TIPP)

**Ambulatory Phlebectomy:**

*Preauthorization is required*

A. Ambulatory phlebectomy performed at the same time as surgical, laser or radiofrequency treatment of saphenous vein varicosities: The utilization reviewer may consider ambulatory phlebectomy medically necessary when the medical necessity criteria for the primary procedure is met.

B. Ambulatory phlebectomy performed as a stand-alone treatment: The utilization reviewer may consider ambulatory phlebectomy to be medically necessary when **ALL** of the following conditions are met:

1. The member's has **1 or more** of the following symptoms:
   a. Moderate to severe pain interfering with activities of daily living and requiring chronic analgesic medication
   b. Severe dermatitis or ulceration
   c. Two or more episodes of superficial thrombophlebitis
   d. Two or more episodes of bleeding

2. There is documentation that the member's symptoms have remained unimproved after 12 weeks of conservative measures such as exercise, compression hose and elevation.

**Sclerotherapy:**

*Preauthorization is required* used the following MCG Guidelines:

Sclerotherapy, Leg Veins ACG: **A-0170** (AC)
Sclerotherapy Plus Ligation, Saphenofemoral Junction ACG: **A-0171** (AC)

- If sclerotherapy is performed in conjunction with the EVLA or RFA Saphenous Vein the Nurse Case Manager can approve.
- Sclerotherapy with Varithena microfoam using MCG criteria ACG: **A-0170** (AC)
- Sclerotherapy with incompetent perforators is considered experimental, investigational or unproven.

**Stab Phlebectomy for Vulvar/Labial Varicosities:**

Stab phlebectomy may be considered medically necessary as a treatment for vulvar/labial varicosities (aka pelvic vein incompetence) when **ALL** of the following conditions are present:

- Member has persistent symptoms/signs of discomfort, aching, throbbing, heaviness and/or dull pain which has been present for at least 6 months; and
- Medication management for at least 3 months has not improved symptoms (ie., medroxyprogesterone or gonadotropin-releasing hormone agonists)
**Telangiectasia:**

Treatment by any method of small telangiectasia such as spider veins (1mm or less), superficial reticular veins (1-2mm), angiomata, and hemangiomata is considered cosmetic.

**Exclusions:**

The following are considered Experimental/Investigational or Unproven by PacificSource:

Mechanochemical Ablation (MOCA) (eg, ClariVein Occlusion Catheter, Nonthermal Vein Ablation System) is investigational for all veins. (no specific code, 37799)

Follow MCG Guidelines for: Ovarian and Internal Iliac Vein Embolization ACG: A-0567 (AC)

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**Definitions**

**Accessory saphenous veins** – Travel in parallel with the greater and lesser saphenous veins and are generally 2 - 2.5 mm in their normal state.

**Greater/long saphenous veins** – Superficial vein running the entire length of the leg and is generally 3 mm in its normal state. A typical GSV contains an average of 7 valves throughout its entire length, and it is the most common superficial vein to develop venous reflux.
Lesser/short saphenous veins – Superficial vein of the calf and is generally 2.5 mm in its normal state. The small saphenous vein originates at the back of the ankle near the outer malleous bone, and usually runs up the back of the lower leg to the popliteal vein behind the knee.

Moderate to severe reflux – In current practice, most vascular laboratories consider the presence of venous flow reversal for greater than 0.5 second with proximal compression, Valsalva maneuver, or distal compression and release to represent pathologic reflux.

Perforator veins – Connect superficial veins to deep veins. They contain one-way valves to direct the blood from the superficial system to the deep system and are generally less than 3mm in their normal state.

Stab avulsion - This technique is also known as stab/hook phlebectomy. Stab avulsion results in removal of the varicose veins through incisions that are 2-3 mm in length. The veins are hooked with a tiny hook-like instrument and pulled out. The wounds are closed with tapes, not sutures, and the leg is wrapped in elastic compression support. Once healed, the incision sites are almost invisible.

Telangiectasia/Spider veins – Very small (≤1 mm in diameter) thread veins found commonly just under the surface of the skin, usually not distorting skin or surrounding tissues

Tibutary Veins—Veins that empty into a larger vein

Coding Information

36465  Inject non-compounded foam sclerosant w/US compress maneuvers to guide dispersion of injectate inclusive of all img guidance & monitoring; single incompetent extrem truncal veins
36466  Inject non-compounded foam sclerosant w/US compress maneuvers to guide dispersion of injectate inclusive of all img guidance & monitoring; multi incompetent truncal veins
36468  Single or multiple Injections Sclerosing Solutions, spider Veins; Limb/Trunk
36469  Single or multiple injections of sclerosing solutions, spider veins (telangiectasia); face
36470  Injection of sclerosing solution; single vein
36471  Injection of sclerosing solution; multiple veins, same leg
36473  Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, mechanochemical; first vein treated
36474  Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, mechanochemical; sub vein treated in a single extremity
36475  Endovenous ablation therapy of incompetent vein, extremity, Inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency; first vein treated
36476  Endovenous ablation therapy of incompetent vein, extremity, Inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency; second and subsequent veins treated in a single extremity, each through separate access sites (list separately in addition to code for primary procedure)
36478  Endovenous ablation therapy of incompetent vein, extremity, Inclusive of all imaging guidance and monitoring, percutaneous, laser; first vein treated
36479  Endovenous ablation therapy of incompetent vein, extremity, Inclusive of all imaging guidance and monitoring, percutaneous; second and subsequent veins treated in a single extremity, each through separate access sites (list separately in addition to code for primary procedure)
37241  Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete
the intervention; venous, other than hemorrhage (eg, congenital or acquired venous
malformations, venous and capillary hemangiomas, varices, varicoceles)
37500 Vascular endoscopy, surgical, with ligation of perforator veins, subfascial (SEPS)
37700 Ligation and division of long saphenous vein at saphenofemoral junction, or distal
interruptions
37718 Ligation, division and stripping, short saphenous vein
37722 Ligation, division and stripping, long (greater) saphenous vein from saphenofemoral
junction to knee or below
37735 Ligation and division and complete stripping of long or short saphenous veins with radial
excision of ulcer and skin graft and/or interruption of communicating veins of lower leg, with
excision of deep fascia
37760 Ligation of perforator veins, subfascial, radial (Linton type), including skin graft, when
performed, open, 1 leg
37761 Ligation of perforator vein(s), subfascial, open, including ultrasound guidance, when
performed, 1 leg
37765 Stab phlebectomy of varicose veins, one extremity; 10-20 stab incisions
37766 Stab phlebectomy of varicose veins, one extremity; more than 20 incisions
37780 Ligation and division of short saphenous vein at saphenopopliteal junction (separate
procedure)
37785 Ligation, division, and/or excision of varicose vein cluster(s), 1 leg
37799 Unlisted procedure, vascular surgery (is utilized for phlebectomy “less than 10 incisions”)

References

Kim JW et.al. Outcome of transilluminated powered phlebectomy for varicose vein: review of 299
11/25/2019,06/01/2020


MCG Ambulatory Care 23rd Edition, Sclerotherapy, Leg Veins ACG: A-0170 (AC)

MCG Ambulatory Care 23rd Edition Sclerotherapy Plus Ligation, Saphenofemoral Junction ACG: A-
0171 (AC)

MCG Ambulatory Care 23rd Edition Saphenous Vein Ablation, radiofrequency ACG: A-0174 (AC)

MCG Ambulatory Care 23rd Edition Saphenous Vein Ablation, laser ACG: A-0425 (AC)

MCG Ambulatory Care 23rd Edition Stab Phlebectomy, ACG: A-0795 (AC)

Randall WF, et.al. Treatment of Varicose Veins by Transilluminated Powered Phlebectomy Surgery: A
January 29, 2019, November 25, 2019,06/01/2020
http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3578615/

7/13/2017, March 5, 2018, January 29, 2019, November 25, 2019, June 1, 2020
http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3217733/


Appendix

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<tr>
<th>Effective:</th>
<th>Next review:</th>
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<tr>
<td>12/1/2019</td>
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Policy type: Commercial

Author(s):

Depts: Health Services

Applicable regulation(s): N/A

External entities affected: N/A