

Medical Coverage Policy | Varicose Vein Treatment



EFFECTIVE DATE: 05|01|2019

POLICY LAST UPDATED: 04|02|2019

OVERVIEW

A variety of treatment modalities are available to treat varicose veins/venous insufficiency, including surgical approaches, thermal ablation, and sclerotherapy. The application of each of these treatment options is influenced by the severity of the symptoms, type of vein, source of venous reflux, and the use of other (prior or concurrent) treatments. This policy addresses the criteria for treatment and method.

MEDICAL CRITERIA

BlueCHiP for Medicare Products

Note See coding section for applicable codes

The treatments for symptomatic varicose tributaries are either compressive sclerotherapy or microphlebectomy.

RFA and EVLA are classified as thermal tumescent (TT) techniques; PEM, CAE and MOCA are non-thermal non-tumescent (NTNT) techniques. Each endovenous ablation approach has advantages and disadvantages; which one is best depends on the unique clinical/anatomical scenario. While saphenous vein ligation and stripping remains an important option in selected cases, it has been largely supplanted by endovenous ablation therapy as primary treatment of saphenous (axial/truncal) vein incompetence. The treatments to eliminate the saphenous vein reflux will be considered medically necessary if the patient remains symptomatic after a six-week trial of conservative therapy and has reflux in a saphenous vein.

The treatments of the tributary veins will be considered medically necessary if all of the following criteria are met:

- saphenous reflux is not present or already successfully eliminated
- the veins are > than 4 mm in diameter
- if the patient remains symptomatic after a six-week trial of conservative therapy.

The components of the conservative therapy include, but are not limited to:

- weight reduction,
- daily exercise plan,
- periodic leg elevation,
- the use of graduated compression stockings.

The conservative therapy must be documented in the medical record. Inability to tolerate compressive bandages or stockings and the reason for such intolerance must be documented in the medical record.

The patient is considered symptomatic if any of the following signs and symptoms of significantly diseased vessels of the lower extremities are documented in the medical record:

- stasis ulcer of the lower leg,
- significant pain and significant edema that interferes with activities of daily living,
- bleeding associated with the diseased vessels of the lower extremities,
- recurrent episodes of superficial phlebitis,
- stasis dermatitis, or

- refractory dependent edema.

Coverage of endovenous ablation therapy is limited to patients with:

- a maximum vein diameter of 12 mm for CAE, PEM and MOCA; and
- absence of thrombosis or vein tortuosity, which would impair catheter advancement (except for PEM).

Commercial

Note See coding section for applicable codes

Medical treatment of varicose veins of the lower extremities is considered medically if the member has had a duplex ultrasound, remains symptomatic after 6 weeks of conservative* and meets one of the listed criteria below:

- stasis ulcer of the lower leg,
- significant pain and significant edema that interferes with activities of daily living,
- bleeding associated with the diseased vessels of the lower extremities,
- recurrent episodes of superficial phlebitis,
- stasis dermatitis, or
- refractory dependent edema

*The conservative therapy must be documented in the medical record. Inability to tolerate compressive bandages or stockings and the reason for such intolerance must be documented in the medical record

The components of the conservative therapy include, but are not limited to:

- weight reduction,
- a daily exercise plan,
- periodic leg elevation, and
- use of graduated stockings

In addition to meeting the above treatment criteria, the patient must meet the following medical criteria for the methods of treatment below:

Ligation and Stripping by either Radiofrequency/Thermal ablation(RFA/EVLA) or endovenous laser therapy (EVLT®)

- The greater saphenous and/or lesser saphenous and/or accessory saphenous vein is incompetent

Sclerotherapy

- The veins must be >2 mm and <6 mm; and
- The greater saphenous and/or lesser saphenous and/or accessory saphenous vein is competent; removed, ablated, or EVLT/RFA/EVLA is planned.

Note: Requests for greater than 3 sclerotherapy sessions in a 12 month period will be reviewed to determine the need for additional treatment

Echosclerotherapy (Using duplex Ultrasound)

- The perforator veins greater than 3.5 mm in size; and
- The greater saphenous and/or lesser saphenous and/or accessory saphenous vein is competent; or removed or ablated.

Note: Requests for greater than 3 sclerotherapy sessions in a 12 month period will be reviewed to determine the need for additional treatment

Transilluminated powered phlebectomy and ambulatory phlebectomy

- The greater saphenous and/or lesser saphenous and/or accessory saphenous vein is competent; or has been removed or ablated.

Surgical ligation of incompetent subfascial perforator veins by subfascial endoscopic perforator surgery (SEPS), endovenous radiofrequency, laser ablation or Linton Procedure when all of the criteria are met

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

PRIOR AUTHORIZATION

BlueCHiP for Medicare and Commercial Products

Prior authorization is required for BlueChip for Medicare and recommended for Commercial Products via the online tool for participating providers. See the Related Policies section.

POLICY STATEMENT

BlueCHiP for Medicare Products

Treatment of symptomatic varicose veins is considered medically necessary when the medical criteria is met

Coil embolization (CPT code 37241) is non-covered for any varicose vein procedure.

Cosmetic surgery is excluded from coverage by Medicare. The following interventional treatments are considered to be cosmetic

- Interventional treatment of asymptomatic varicosities.
- Treatment of telangiectases (CPT code 36468).
- Sclerotherapy for cosmetic purposes.

The following interventional treatments are not considered not covered.

- Surgery, endovenous ablation, or sclerotherapy are typically not performed for varicose veins that develop or worsen during pregnancy because most will spontaneously resolve or improve after delivery.
- Reinjection following recanalization or failure of vein closure without recurrent signs or symptoms.
- Sclerotherapy of the saphenous vein at its junction with the deep system.
- Noncompressive sclerotherapy.
- Compressive sclerotherapy for large, extensive or truncal varicosities.
- Sclerotherapy, ligation and/or stripping of varicose veins, or endovenous ablation therapy are generally not covered for patients with severe distal arterial occlusive disease; obliteration of deep venous system; an allergy to the sclerosant; or a hypercoagulable state.
- Any interventional treatment that uses equipment or sclerosants not approved for such by the FDA.

Commercial Products

Treatment of symptomatic varicose veins is considered medically necessary when the medical criteria is met for both treatment and the method.

Mechanochemical ablation of any vein is considered not medically necessary as there is insufficient peer reviewed scientific literature that demonstrates that the procedure/service is effective.

Sclerotherapy when used in the treatment of telangiectasias is contract exclusion as it is always considered to be a cosmetic procedure.

Ligation or ablation of incompetent perforator veins performed concurrently with superficial venous surgery is not medically necessary as there is insufficient peer-reviewed literature that demonstrates that the procedure/service is effective.

BACKGROUND

The venous system of the lower extremities consists of the superficial veins (this includes the great and small saphenous and accessory, or duplicate, veins that travel in parallel with the great and small saphenous veins), the deep system (popliteal and femoral veins), and perforator veins that cross through the fascia and connect the deep and superficial systems. One-way valves are present within all veins to direct the return of blood up the lower limb. Because venous pressure in the deep system is generally greater than that of the superficial system, valve incompetence at any level may lead to backflow (venous reflux) with pooling of blood in superficial veins. Varicose veins with visible varicosities may be the only sign of venous reflux, although itching, heaviness, tension, and pain may also occur. Chronic venous insufficiency secondary to venous reflux can lead to thrombophlebitis, leg ulcerations, and hemorrhage. The CEAP classification considers the clinical, etiologic, anatomic, and pathologic (CEAP) characteristics of venous insufficiency, ranging from class 0 (no visible sign of disease) to class 6 (active ulceration). Treatment of venous reflux/venous insufficiency is aimed at reducing abnormal pressure transmission from the deep to the superficial veins.

BlueCHiP for Medicare

The accepted treatments for eliminating saphenous (great saphenous vein (GSV), anterior accessory GSV (AAGSV), small saphenous vein (SSV)) reflux (saphenofemoral or saphenopopliteal) are radiofrequency ablation (RFA), laser ablation (EVLA), polidocanol microfoam (PEM), cyanoacrylate embolization (CAE) ablation, and mechanochemical ablation (MOCA). Coverage is only for devices with FDA approval or clearance consistent with saphenous ablation and used according to its approved instructions for use (IFU).

RFA and EVLA are classified as thermal tumescent (TT) techniques; PEM, CAE and MOCA are non-thermal non-tumescent (NTNT) techniques. Each endovenous ablation approach has advantages and disadvantages; which one is best depends on the unique clinical/anatomical scenario. While saphenous vein ligation and stripping remains an important option in selected cases, it has been largely supplanted by endovenous ablation therapy as primary treatment of saphenous (axial/truncal) vein incompetence. The treatments to eliminate the saphenous vein reflux will be considered medically necessary if the patient remains symptomatic after a six-week trial of conservative therapy and has reflux in a saphenous vein.

Summary of Evidence

Mechanochemical endovenous ablation

The impetus for alternatives to RFA and EVLA is the desire to eliminate the need for thermal energy which necessitates tumescent anesthesia and can cause pain and complications.

In a randomized control trial (RCT) involving MOCA, the “Venefit™ versus ClariVein for varicose veins In a randomized control trial (RCT) involving MOCA, the “Venefit™ versus ClariVein for varicose veins trial”, 170 patients with symptomatic saphenous vein insufficiency were randomized to either MOCA or RFA (Bootun 2016, Lane 2016). MOCA was associated with significantly lower procedure related pain, and “occlusion rates, clinical severity scores, disease specific and generic quality of life scores were similar between groups at one and six months.”

Two non-randomized controlled studies have also been published. Van Eekeren prospectively compared MOCA with RFA in 68 consecutive patients (van Eekeren 2013). The treated great saphenous vein (GSV) was significantly wider at the saphenofemoral junction (SFJ) in the RFA group than in the MOCA group (P=.03). The primary endpoint, postoperative pain, was significantly less for MOCA initially and similar at 6 weeks. A major limitation to the study was that occlusion rates were not reported. The second prospective, non-randomized controlled study compared MOCA (n=57) with RFA (n=50) and EVLA (n=40) (Vun 2014). The MOCA group demonstrated significantly lower procedural pain scores and shorter treatment times, but occlusion rates beyond six weeks were not measured.

Among the several prospective, non-controlled, cohort studies, the one by Witte has the longest follow-up (Witte 2016). The midterm (median 3 year follow-up) results on a group of 85 consecutive MOCA patients showed an anatomic success rate of 92.8%/89.5%/86.5% at 1/2/3 years, respectively, with a mean GSV diameter of only 5.2mm. Three year clinical success (accounting for return of varicosities between 12 and 36 months) was 83%. The authors note: “Between 12 and 36 months, however, a significant deterioration was observed in venous clinical severity score (VCSS), which was accompanied by worsening of disease-specific and general quality of life, and also associated with recurrent varicosities between 12 and 36 months.”

In the largest multicenter prospective cohort study, 507 limbs in 449 patients were treated for incompetence of GSV or small saphenous vein (SSV) with MOCA (Deijen 2015). Rates of venous closure at 6 weeks and 3 months for GSV were 94.5% and 89%; and for SSV at 6 weeks 85% and 80.5% at 3 months.

Another prospective, multicenter, observational study of 126 patients treated with MOCA reported 2 year follow-up on 65 patients with a 92% GSV closure rate (Kim 2016). Overall clinical success rate at 2 years was 89%. Average GSV diameter was only 7.6mm. There was significant improvement in Classification for Chronic Venous Disorders (CEAP) and clinical severity scores compared with baseline.

A single center cohort study of 63 patients (73 limbs) treated with MOCA for GSV insufficiency reported an occlusion rate of 95% at 2 years and an associated significant improvement in VCSS (Ozen 2014). Another cohort study assessed MOCA in 50 patients with insufficiency of the SSV (Boersma 2013). The anatomic success rate was 94% at 1 year, also associated with a significant improvement in VCSS.

Commercial

Conservative medical treatment consists of elevation of the extremities, graded compression, and wound care when indicated. Conventional surgical treatment consists of identifying and correcting the site of reflux by ligation of the incompetent junction followed by stripping of the vein to redirect venous flow through veins with intact valves. While most venous reflux is secondary to incompetent valves at the saphenofemoral or saphenopopliteal junctions, reflux may also occur at incompetent valves in the perforator veins or in the deep venous system. The competence of any single valve is not static and may be pressure-dependent. For example, accessory saphenous veins may have independent saphenofemoral or saphenopopliteal junctions that become incompetent when the great or small saphenous veins are eliminated and blood flow is diverted through the accessory veins.

Saphenous Veins and Tributaries

Saphenous veins include the great and small saphenous and accessory saphenous veins that travel in parallel with the great or small saphenous veins. Tributaries are veins that empty into a larger vein. Treatment of venous reflux typically includes the following:

1. Identification by preoperative Doppler ultrasonography of the valvular incompetence
2. Control of the most proximal point of reflux, traditionally by suture ligation of the incompetent saphenofemoral or saphenopopliteal junction
3. Removal of the superficial vein from circulation, for example by stripping of the great and/or small saphenous veins

4. Removal of varicose tributaries (at the time of the initial treatment or subsequently) by stab avulsion (phlebectomy) or injection sclerotherapy.

Types of Treatment

Sclerotherapy

The objective of sclerotherapy is to destroy the endothelium of the target vessel by injecting an irritant solution (either a detergent, osmotic solution, or chemical irritant), ultimately resulting in the occlusion of the vessel. The success of the treatment depends on accurate injection of the vessel, an adequate injectate volume and concentration of sclerosant, and compression. Historically, larger veins and very tortuous veins were not considered to be good candidates for sclerotherapy due to technical limitations. Technical improvements in sclerotherapy have included the routine use of Duplex ultrasound to target refluxing vessels, luminal compression of the vein with anesthetics, and a foam/sclerosant injectate in place of liquid sclerosant. Foam sclerosants are commonly produced by forcibly mixing a gas (eg, air or carbon dioxide) with a liquid sclerosant (eg, polidocanol or sodium tetradecyl sulfate). The foam is produced at the time of treatment. Varithena™ (previously known as Varisolve; BTG Plc, London) is a proprietary microfoam sclerosant that is dispersed from a canister with a controlled density and more consistent bubble size.

Thermal Ablation

RFA/ELVA/EVLT is performed by means of a specially designed catheter inserted through a small incision in the distal medial thigh to within 1 to 2 cm of the saphenofemoral junction. The catheter is slowly withdrawn, closing the vein. Laser ablation is performed similarly; a laser fiber is introduced into the great saphenous vein under ultrasound guidance; the laser is activated and slowly removed along the course of the saphenous vein. Cryoablation uses extreme cold to cause injury to the vessel. The objective of endovenous techniques is to cause injury to the vessel, causing retraction and subsequent fibrotic occlusion of the vein. Technical developments since thermal ablation procedures were initially introduced include the use of perivenous tumescent anesthesia, which allows successful treatment of veins larger than 12 mm in diameter and helps to protect adjacent tissue from thermal damage during treatment of the small saphenous vein.

Cyanoacrylate Adhesive

Cyanoacrylate adhesive is a clear, free-flowing liquid that polymerizes in the vessel via an anionic mechanism (ie, polymerizes into a solid material on contact with body fluids or tissue). The adhesive is gradually injected along the length of the vein in conjunction with ultrasound and manual compression.

The acute coaptation halts blood flow through the vein until the implanted adhesive becomes fibrotically encapsulated and establishes chronic occlusion of the treated vein. Cyanoacrylate glue has been used as a surgical adhesive and sealant for a variety of indications, including gastrointestinal bleeding, embolization of brain arteriovenous malformations, and to seal surgical incisions or other skin wounds.

Transilluminated Powered Phlebectomy

TIPP is an alternative to stab avulsion or hook phlebectomy. This procedure uses 2 instruments: an illuminator, which also provides irrigation, and a resector, which has an oscillating tip and can perform suction. Following removal of the saphenous vein, the illuminator is introduced via a small incision in the skin and tumescence solution (anesthetic and epinephrine) is infiltrated along the course of the varicosity. The resector is then inserted under the skin from the opposite direction, and the oscillating tip is placed directly beneath the illuminated veins to fragment and loosen the veins from the supporting tissue.

Irrigation from the illuminator is used to clear the vein fragments and blood through aspiration and additional drainage holes. The illuminator and resector tips may then be repositioned, thereby reducing the number of incisions needed when compared with stab avulsion or hook phlebectomy. It has been proposed that TIPP might result in decreased operative time, decreased complications such as bruising, and faster recovery compared with the established procedures.

Treatment of Perforator Veins

Perforator veins cross through the fascia and connect the deep and superficial venous systems. Incompetent perforating veins were originally addressed with an open surgical procedure, called the Linton procedure, which involved a long medial calf incision to expose all posterior, medial, and paramedial perforators. While this procedure was associated with healing of ulcers, it was largely abandoned due to a high incidence of wound complications. The Linton procedure was subsequently modified by using a series of perpendicular skin flaps instead of a longitudinal skin flap to provide access to incompetent perforator veins in the lower part of the leg. The modified Linton procedure may occasionally be used for the closure of incompetent perforator veins that cannot be reached by less invasive procedures. Subfascial endoscopic perforator surgery is a less invasive surgical procedure for treatment of incompetent perforators and has been reported since the mid-1980s. Guided by Duplex ultrasound scanning, small incisions are made in the skin, and the perforating veins are clipped or divided by endoscopic scissors. The operation can be performed as an outpatient procedure. Endovenous ablation of incompetent perforator veins with sclerotherapy and RFA has also been reported.

Endovenous Mechanochemical Ablation

Endovenous mechanochemical ablation (MOCAT[™]) uses both sclerotherapy and mechanical damage to the lumen. Following ultrasound imaging, a disposable catheter with a motor drive is inserted into the distal end of the target vein and advanced to the saphenofemoral junction. As the catheter is pulled back, a wire rotates at 3500 rpm within the lumen of the vein, abrading the lumen. At the same time, a liquid sclerosant (sodium tetradecyl sulfate) is infused near the rotating wire. It is proposed that mechanical ablation allows for better efficacy of the sclerosant, and results in less pain and risk of nerve injury without need for the tumescent anesthesia used with thermal endovenous ablation techniques (radiofrequency ablation [RFA] and endovenous laser treatment [EVLV]).

Other

Deep vein valve replacement is being investigated. Outcomes of interest for venous interventions include healing and recurrence, recannulation of the vein,

and neovascularization. Recannulation (recanalization) is the restoration of the lumen of a vein after it has been occluded; this occurs more frequently following treatment with endovenous techniques.

Neovascularization is the proliferation of new blood vessels in tissue and occurs more frequently following vein stripping. Direct comparisons of durability for endovenous and surgical procedures are complicated by these different mechanisms of recurrence. Relevant safety outcomes include the incidence of paresthesia, thermal skin injury, thrombus formation, thrombophlebitis, wound infection, and transient neurologic effects.

The evidence on mechanochemical ablation, cyanoacrylate adhesive, and cryoablation in patients with varicose veins/venous insufficiency includes randomized controlled trials (RCTs) and multicenter series. Relevant outcomes are symptoms, morbid events, functional outcomes, and change in disease status. Several series have been reported on mechanochemical ablation (MCA), and a large RCT comparing MCA with radiofrequency (RF) ablation is ongoing. Efficacy of cyanoacrylate adhesion at 3 months has been shown to be noninferior to RF in a multicenter RCT. Longer term follow-up is needed to determine durability of this treatment. Results from a recent RCT of cryoablation indicate that this therapy is inferior to conventional stripping. The evidence is insufficient to determine the effects of the technology on health outcomes.

In 2015, the VenaSeal[®] Closure System (Sapheon, a part of Medtronic) was approved by the U.S. Food and Drug Administration (FDA) through the premarket approval process for the permanent closure of clinically significant venous reflux through endovascular embolization with coaptation. The VenaSeal Closure System seals the vein using a cyanoacrylate adhesive agent. FDA product code: PJQ. In 2013, Varithena[™] (formerly known as Varisolve[®]; BTG Plc, London), a sclerosant microfoam made with a proprietary gas mix, was approved by FDA under a new drug application for the treatment of incompetent great saphenous veins, accessory saphenous veins and visible varicosities of the great

saphenous vein system above and below the knee.

The following devices were cleared for marketing by FDA through the 501(k) process for the endovenous treatment of superficial vein reflux:

- In 1999, the VNUS® Closure™ System (a radiofrequency device) received FDA clearance through the 510(k) process for "endovascular coagulation of blood vessels in patients with superficial vein reflux." The VNUS RFS™ and RFSFlex™ devices received FDA clearance in 2005 for "use in vessel and tissue coagulation including: treatment of incompetent (ie, refluxing) perforator and tributary veins." The modified VNUS® ClosureFast™ Intravascular Catheter received FDA clearance through the 510(k) process in 2008. FDA product code: GEI.
- In 2002, the Diomed 810 nm surgical laser and EVLT™ (endovenous laser therapy) procedure kit received FDA clearance through the 510(k) process, "...for use in the endovascular coagulation of the great saphenous vein of the thigh in patients with superficial vein reflux." FDA product code: GEX.
- A modified Erbe Erbokryo® cryosurgical unit (Erbe USA) received FDA clearance for marketing in 2005. A variety of clinical indications are listed, including cryostripping of varicose veins of the lower limbs. FDA product code: GEH.
- The Trivex® system (InaVein LLC) is a device for transilluminated powered phlebectomy that received 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." FDA product code: DNQ.
- The ClariVein® Infusion Catheter (Vascular Insights) received marketing clearance through the 510(k) process in 2008 (K071468). It is used for mechanochemical ablation. Predicate devices were listed as the Trellis® Infusion System (K013635) and the Slip-Cath® Infusion Catheter (K882796). The system includes an infusion catheter, motor drive, stopcock and syringe and is intended for the infusion of physician-specified agents in the peripheral vasculature. FDA product code: KRA.

COVERAGE

Benefits may vary between groups/contracts. Please refer to the appropriate Evidence of Coverage, Subscriber Agreement for the applicable surgery services benefits/coverage.

CODING

BlueCHiP for Medicare and Commercial Products

The following CPT Codes are medically necessary medical criteria are met.

Note: Commercial Medical criteria above is used for both products

37500	Vascular endoscopy, surgical, with ligation of perforator veins, subfascial (SEPS)
37785	Ligation, division, and/or excision of varicose vein cluster(s), one leg
S2202	Echosclerotherapy

BlueCHiP for Medicare Products

The following CPT Codes are medically necessary when medical criteria are met:

* Add on code no prior authorization needed

36465	Injection of non-compounded foam sclerosant with ultrasound compression maneuvers to guide dispersion of the injectate, inclusive of all imaging guidance and monitoring; single incompetent extremity truncal vein (eg, great saphenous vein, accessory saphenous vein)
36466	Injection of non-compounded foam sclerosant with ultrasound compression maneuvers to guide dispersion of the injectate, inclusive of all imaging guidance and monitoring; multiple incompetent truncal veins (eg, great saphenous vein, accessory saphenous vein), same leg
36470	Injection of sclerosing solution; single vein
36471	Injection of sclerosing solution; multiple veins, same leg

- 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
- 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, laser; second and subsequent veins treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure)
- 36482 Endovenous ablation therapy of incompetent vein, extremity, by transcatheter delivery of a chemical adhesive (eg, cyanoacrylate) remote from the access site, inclusive of all imaging guidance and monitoring, percutaneous; first vein treated
- 36483* Endovenous ablation therapy of incompetent vein, extremity, by transcatheter delivery of a chemical adhesive (eg, cyanoacrylate) remote from the access site, inclusive of all imaging guidance and monitoring, percutaneous; subsequent vein(s) treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure)
- 37700 Ligation and division of long saphenous vein at saphenofemoral junction, or distal interruptions
- 37718 Ligation, division, and stripping, short saphenous
- 37722 Ligation, division, and stripping, long (greater) saphenous veins from saphenofemoral junction to knee or below
- 37735 Ligation and division and complete stripping of long or short saphenous veins with radical excision of ulcer and skin graft and/or interruption of communicating veins of lower leg, with excisions of deep fascia
- 37760 Ligation of perforator veins, subfascial, radical (Linton type), with or without skin graft, open
- 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
- 37766 Stab phlebectomy of varicose veins, one extremity; more than 20 incisions
- 37780 Ligation and division of short saphenous vein at saphenopopliteal junction

The following CPT code is not covered:

- 36468 Single or multiple injections of sclerosing solutions, spider veins (telangiectasia)

Commercial Products

The following CPT Codes are medically necessary when medical criteria are met:

- 36465 Injection of non-compounded foam sclerosant with ultrasound compression maneuvers to guide dispersion of the injectate, inclusive of all imaging guidance and monitoring; single incompetent extremity truncal vein (eg, great saphenous vein, accessory saphenous vein)
- 36466 Injection of non-compounded foam sclerosant with ultrasound compression maneuvers to guide dispersion of the injectate, inclusive of all imaging guidance and monitoring; multiple incompetent truncal veins (eg, great saphenous vein, accessory saphenous vein), same leg
- 36470 Injection of sclerosing solution; single vein
- 36471 Injection of sclerosing solution; multiple veins, same leg
- 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
- 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, laser; second and subsequent veins treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure)
- 36482 Endovenous ablation therapy of incompetent vein, extremity, by transcatheter delivery of a chemical adhesive (eg, cyanoacrylate) remote from the access site, inclusive of all imaging guidance and monitoring, percutaneous; first vein treated
- 36483 Endovenous ablation therapy of incompetent vein, extremity, by transcatheter delivery of a chemical adhesive (eg, cyanoacrylate) remote from the access site, inclusive of all imaging guidance and monitoring, percutaneous; subsequent vein(s) treated in a single extremity, each through separate access sites (List separately in addition to code for primary procedure)
- 37700 Ligation and division of long saphenous vein at saphenofemoral junction, or distal interruptions
- 37718 Ligation, division, and stripping, short saphenous
- 37722 Ligation, division, and stripping, long (greater) saphenous veins from saphenofemoral junction to knee or below
- 37735 Ligation and division and complete stripping of long or short saphenous veins with radical excision of ulcer and skin graft and/or interruption of communicating veins of lower leg, with excisions of deep fascia
- 37760 Ligation of perforator veins, subfascial, radical (Linton type), with or without skin graft, open
- 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
- 37766 Stab phlebectomy of varicose veins, one extremity; more than 20 incisions
- 37780 Ligation and division of short saphenous vein at saphenopopliteal junction
*only the primary procedure needs preauthorization

The following CPT code is not covered:

- 36468 Single or multiple injections of sclerosing solutions, spider veins (telangiectasia)

The following CPT codes are not medically necessary

- 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; Subsequent vein(s) treated in a single extremity, each through separate access sites (list separately in addition to code for the primary procedure)

RELATED POLICIES

Preauthorization via Web-Based Tool for Procedures
BlueCHiP for Medicare National and Local Coverage

PUBLISHED

Provider Update, July 2019
 Provider Update, September 2017
 Provider Update, November/December 2016
 Provider Update, June 2013
 Provider Update, March 2013
 Provider Update, March 2012

REFERENCES

1. O'Meara S, Cullum NA, Nelson EA. Compression for venous leg ulcers. Cochrane Database Syst Rev 2009; (1):CD000265.

2. O'Meara S, Cullum N, Nelson EA et al. Compression for venous leg ulcers. *Cochrane Database Syst Rev* 2012; 11:CD000265.
3. Shingler S, Robertson L, Boghossian S et al. Compression stockings for the initial treatment of varicose veins in patients without venous ulceration. *Cochrane Database Syst Rev* 2011; 11:CD008819.
4. Howard DP, Howard A, Kothari A et al. The role of superficial venous surgery in the management of venous ulcers: a systematic review. *Eur J Vasc Endovasc Surg* 2008; 36(4):458-65.
5. O'Donnell TF, Jr. The present status of surgery of the superficial venous system in the management of venous ulcer and the evidence for the role of perforator interruption. *J Vasc Surg* 2008; 48(4):1044-52.
6. Jones L, Braithwaite BD, Selwyn D et al. Neovascularisation is the principal cause of varicose vein recurrence: results of a randomised trial of stripping the long saphenous vein. *Eur J Vasc Endovasc Surg* 1996; 12(4):442-5.
7. Rutgers PH, Kitslaar PJ. Randomized trial of stripping versus high ligation combined with sclerotherapy in the treatment of the incompetent greater saphenous vein. *Am J Surg* 1994; 168(4):311-5.
8. Nesbitt C, Eifell RK, Coyne P et al. Endovenous ablation (radiofrequency and laser) and foam sclerotherapy versus conventional surgery for great saphenous vein varices. *Cochrane Database Syst Rev* 2011; (10):CD005624.
9. Luebke T, Gawenda M, Heckenkamp J et al. Meta-analysis of endovenous radiofrequency obliteration of the great saphenous vein in primary varicosis. *J Endovasc Ther* 2008; 15(2):213-23.
10. Merchant RF, Pichot O. Long-term outcomes of endovenous radiofrequency obliteration of saphenous reflux as a treatment for superficial venous insufficiency. *J Vasc Surg* 2005; 42(3):502-9; discussion 09.
11. Hoggan BL, Cameron AL, Maddern GJ. Systematic review of endovenous laser therapy versus surgery for the treatment of saphenous varicose veins. *Ann Vasc Surg* 2009; 23(2):277-87.
12. Rass K, Frings N, Glowacki P et al. Comparable effectiveness of endovenous laser ablation and high ligation with stripping of the great saphenous vein: two-year results of a randomized clinical trial (RELACS study). *Arch Dermatol* 2012; 148(1):49-58.
13. Christenson JT, Gueddi S, Gemayel G et al. Prospective randomized trial comparing endovenous laser ablation and surgery for treatment of primary great saphenous varicose veins with a 2-year follow-up. *J Vasc Surg* 2010; 52(5):1234-41.
14. Theivacumar NS, Darwood R, Gough MJ. Neovascularisation and recurrence 2 years after varicose vein treatment for sapheno-femoral and great saphenous vein reflux: a comparison of surgery and endovenous laser ablation. *Eur J Vasc Endovasc Surg* 2009; 38(2):203-7.
15. Rasmussen LH, Bjoern L, Lawaetz M et al. Randomised clinical trial comparing endovenous laser ablation with stripping of the great saphenous vein: clinical outcome and recurrence after 2 years. *Eur J Vasc Endovasc Surg* 2010; 39(5):630-5.
16. Theivacumar NS, Darwood RJ, Gough MJ. Endovenous laser ablation (EVLA) of the anterior accessory great saphenous vein (AAGSV): abolition of sapheno-femoral reflux with preservation of the great saphenous vein. *Eur J Vasc Endovasc Surg* 2009; 37(4):477-81. Klem TM, Schnater JM, Schutte PR et al. A randomized trial of cryo stripping versus conventional stripping of the great saphenous vein. *J Vasc Surg* 2009; 49(2):403-9.
17. National Institute for Health and Clinical Excellence. IPG435 Endovenous mechanochemical ablation for varicose veins: guidance. 2013. Available online at: <http://www.nice.org.uk/nicemedia/live/13702/62452/62452.pdf>. Last accessed 2013, February
18. Maleux G, Stockx L, Wilms G et al. Ovarian vein embolization for the treatment of pelvic congestion syndrome: long-term technical and clinical results. *J Vasc Interv Radiol* 2000; 11(7):859-64.
19. Venbrux AC, Chang AH, Kim HS et al. Pelvic congestion syndrome (pelvic venous incompetence): impact of ovarian and internal iliac vein embolotherapy on menstrual cycle and chronic pelvic pain. *J Vasc Interv Radiol* 2002; 13(2 pt 1):171-8.
20. National Government Services, Inc. (RI): Local Coverage Determination (LCD): Varicose Veins of the Lower Extremity, Treatment of (L33575) <https://www.cms.gov/medicare-coverage-database/details/lcd-details.asp?LCDId=33575&ver=33&Date=&DocID=L33575&bc=iAAAABABAAAA&>

CLICK THE ENVELOPE ICON BELOW TO SUBMIT COMMENTS

This medical policy is made available to you for informational purposes only. It is not a guarantee of payment or a substitute for your medical judgment in the treatment of your patients. Benefits and eligibility are determined by the member's subscriber agreement or member certificate and/or the employer agreement, and those documents will supersede the provisions of this medical policy. For information on member-specific benefits, call the provider call center. If you provide services to a member which are determined to not be medically necessary (or in some cases medically necessary services which are non-covered benefits), you may not charge the member for the services unless you have informed the member and they have agreed in writing in advance to continue with the treatment at their own expense. Please refer to your participation agreement(s) for the applicable provisions. This policy is current at the time of publication; however, medical practices, technology, and knowledge are constantly changing. BCBSRI reserves the right to review and revise this policy for any reason and at any time, with or without notice. Blue Cross & Blue Shield of Rhode Island is an independent licensee of the Blue Cross and Blue Shield Association.

