



**BlueCross BlueShield
of Vermont**

An Independent Licensee of the Blue Cross and Blue Shield Association.

Treatment of Varicose Veins/Venous Insufficiency Corporate Medical Policy

File Name: Treatment of Varicose Veins/Venous Insufficiency

File Code: UM.SURG.03

Origination: 09/01/2010

Last Review: 07/2018

Next Review: 07/2019

Effective Date: 11/01/2018

Description/Summary

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.

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. Since 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. 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.

Policy

Coding Information

Click the links below for attachments, coding tables & instructions.

[Attachment I - CPT® Code List & Instructions](#)

[Attachment II - ICD-10-CM Coding Tables](#)

When a service may be considered medically necessary/not medically necessary or investigational.

Great or Small Saphenous Veins

Treatment of the great or small saphenous veins by surgery (ligation and stripping), endovenous radiofrequency or laser ablation, or microfoam sclerotherapy may be considered **medically necessary** for symptomatic varicose veins/venous insufficiency when the following criteria have been met:

There is demonstrated saphenous reflux and CEAP [Clinical, Etiology, Anatomy, Pathophysiology] class C2 or greater; **AND** documentation of one or more of the following indications:

- Ulceration secondary to venous stasis; **OR**
- Recurrent superficial thrombophlebitis **OR**
- Hemorrhage or recurrent bleeding episodes from a ruptured superficial varicosity; **OR**
- Persistent pain, swelling, itching, burning, or other symptoms are associated with saphenous reflux, **AND** the symptoms significantly interfere with activities of daily living, **AND** conservative management including compression therapy for at least 3 months has not improved the symptoms.

Treatment of great or small saphenous veins by surgery, endovenous radiofrequency or laser ablation, or microfoam sclerotherapy that do not meet the criteria described above is considered cosmetic and **not medically necessary**.

Accessory Saphenous Veins

Treatment of accessory saphenous veins by surgery (ligation and stripping) or endovenous radiofrequency or laser ablation may be considered **medically necessary** for symptomatic varicose veins/venous insufficiency when the following criteria have been met:

Incompetence of the accessory saphenous vein is isolated, **OR** the great or small saphenous veins had been previously eliminated (at least 3 months); **AND**

There is demonstrated accessory saphenous reflux; **AND**

There is documentation of one or more of the following indications:

- Ulceration secondary to venous stasis; **OR**
- Recurrent superficial thrombophlebitis; **OR**
- Hemorrhage or recurrent bleeding episodes from a ruptured superficial varicosity; **OR**

- Persistent pain, swelling, itching, burning, or other symptoms are associated with saphenous reflux, AND the symptoms significantly interfere with activities of daily living, AND conservative management including compression therapy for at least 3 months has not improved the symptoms.

Treatment of accessory saphenous veins by surgery, endovenous radiofrequency or laser ablation, microfoam sclerotherapy, that do not meet the criteria described above is considered cosmetic and **not medically necessary**.

Symptomatic Varicose Tributaries

The following treatments are considered **medically necessary** as a component of the treatment of symptomatic *varicose tributaries* when performed either at the same time or following prior treatment (surgical, radiofrequency or laser) of the saphenous veins (none of these techniques has been shown to be superior to another):

- Stab avulsion
- Hook phlebectomy
- Sclerotherapy
- Transilluminated powered phlebectomy

Treatment of symptomatic *varicose tributaries* when performed either at the same time or following prior treatment of saphenous veins using any other techniques than noted above is considered **investigational**.

Perforator Veins

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

- There is demonstrated perforator reflux; **AND**
- The superficial saphenous veins (great, small, or accessory saphenous and symptomatic varicose tributaries) have been previously eliminated; **AND**
- Ulcers 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**.

Telangiectasia

Treatment of telangiectasia such as spider veins, angiomas, and hemangiomas is considered cosmetic and **not medically necessary**.

Other Veins

Techniques for conditions not specifically listed above are **investigational**, including, but not limited to:

- Sclerotherapy techniques, other than microfoam sclerotherapy, of great, small, or

- accessory saphenous veins
- Sclerotherapy of perforator veins
- Sclerotherapy of isolated tributary veins without prior or concurrent treatment of saphenous veins
- Stab avulsion, hook phlebectomy, or transilluminated powered phlebectomy of perforator, great or small saphenous, or accessory saphenous veins
- Endovenous radiofrequency or laser ablation of tributary veins
- Endovenous cryoablation of any vein
- Mechanochemical ablation of any vein
- Cyanoacrylate adhesive of any vein

The use of cyanoacrylate adhesive for permanent closure of lower extremity superficial truncal veins, such as the great saphenous vein (GSV), through endovascular embolization with coaptation is considered **not medically necessary**.

Policy Guidelines

The standard classification of venous disease is the CEAP (Clinical, Etiologic, Anatomic, Pathophysiologic) classification system. The following is the Clinical portion of the CEAP.

Clinical Classification

- C0 No visible or palpable signs of venous disease
- C1 Telangiectasies or reticular veins
- C2 Varicose veins
- C3 Edema
- C4a Pigmentation and eczema
- C4b Lipodermatosclerosis and atrophie blanche
- C5 Healed venous ulcer
- C6 Active venous ulcer
- S Symptoms including ache, pain, tightness, skin irritation, heaviness, muscle cramps, as well as other complaints attributable to venous dysfunction
- A Asymptomatic

The Etiologic, Anatomic, And Pathophysiologic portions of the classifications are online (<http://www.veinforum.org/uploadDocs/1/Revised-CEAP-Classification---May-2004.pdf>).

It should be noted that the bulk of the literature discussing the role of ultrasound guidance refers to sclerotherapy of the saphenous vein, as opposed to the varicose tributaries. When ultrasound guidance is used to guide sclerotherapy of the varicose tributaries, it would be considered either not medically necessary or incidental to the injection procedure.

There is no specific CPT® code for transilluminated powered phlebectomy. Providers might elect to use CPT® codes describing stab phlebectomy (37765 or 37766) or unlisted vascular surgery procedure (37799).

Mechanochemical ablation should be reported with the unlisted vascular surgery procedure code 37799.

There is no specific CPT® for microfoam sclerotherapy. Providers might elect to use CPT®

codes describing sclerotherapy (36468-36471) or the unlisted vascular surgery procedure code 37799. Use of codes 36475-36476 would be inappropriate as the procedure is not ablation therapy.

Reference Resources

1. O'Meara S, Cullum NA, Nelson EA. Compression for venous leg ulcers. *Cochrane Database Syst Rev.* 2009(1):CD000265. PMID 19160178
2. O'Meara S, Cullum N, Nelson EA, et al. Compression for venous leg ulcers. *Cochrane Database Syst Rev.* 2012;11:CD000265. PMID 23152202
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. PMID 22071857
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.* Oct 2008;36(4):458-465. PMID 18675558
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.* Oct 2008;48(4):1044-1052. PMID 18992425
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.* Nov 1996;12(4):442-445. PMID 8980434
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.* Oct 1994;168(4):311-315. PMID 7943585
8. Nesbitt C, Bedenis R, Bhattacharya V, et al. Endovenous ablation (radiofrequency and laser) and foam sclerotherapy versus open surgery for great saphenous vein varices. *Cochrane Database Syst Rev.* 2014;7:CD005624. PMID 25075589
9. Paravastu SC, Horne M, Dodd PD. Endovenous ablation therapy (laser or radiofrequency) or foam sclerotherapy versus conventional surgical repair for short saphenous varicose veins. *Cochrane Database Syst Rev.* Nov 29 2016;11:CD010878. PMID 27898181
10. Brittenden J, Cotton SC, Elders A, et al. A randomized trial comparing treatments for varicose veins. *N Engl J Med.* Sep 25 2014;371(13):1218-1227. PMID 25251616
11. 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.* Jan 2012;148(1):49-58. PMID 21931012
12. Rass K, Frings N, Glowacki P, et al. Same site recurrence is more frequent after endovenous laser ablation compared with high ligation and stripping of the great saphenous vein: 5 year results of a randomized clinical trial (RELACS Study). *Eur J Vasc Endovasc Surg.* Nov 2015;50(5):648-656. PMID 26319476
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.* Nov 2010;52(5):1234-1241. PMID 20801608
14. Biemans AA, Kockaert M, Akkersdijk GP, et al. Comparing endovenous laser ablation, foam sclerotherapy, and conventional surgery for great saphenous varicose veins. *J Vasc Surg.* Sep 2013;58(3):727-734 e721. PMID 23769603
15. van der Velden SK, Biemans AA, De Maeseneer MG, et al. Five-year results of a randomized clinical trial of conventional surgery, endovenous laser ablation and

- ultrasound-guided foam sclerotherapy in patients with great saphenous varicose veins. *Br J Surg.* Sep 2015;102(10):1184-1194. PMID 26132315
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.* Apr 2009;37(4):477-481. PMID 19201621
 17. Shadid N, Ceulen R, Nelemans P, et al. Randomized clinical trial of ultrasound-guided foam sclerotherapy versus surgery for the incompetent great saphenous vein. *Br J Surg.* Aug 2012;99(8):1062-1070. PMID 22627969
 18. U.S. Food and Drug Administration, Center for Drug Evaluation and Research. 205098 Varithena Summary Review. 2013; http://www.accessdata.fda.gov/drugsatfda_docs/nda/2013/205098Orig1s000SumR.pdf. Accessed April 4, 2017.
 19. Todd KL, 3rd, Wright D, for the Vanish-Investigator Group. The VANISH-2 study: a randomized, blinded, multicenter study to evaluate the efficacy and safety of polidocanol endovenous microfoam 0.5% and 1.0% compared with placebo for the treatment of saphenofemoral junction incompetence. *Phlebology.* Oct 2014;29(9):608-618. PMID 23864535
 20. Lane T, Bootun R, Dharmarajah B, et al. A multi-centre randomised controlled trial comparing radiofrequency and mechanical occlusion chemically assisted ablation of varicose veins - Final results of the Venefit versus Clarivein for varicose veins trial. *Phlebology.* Mar 2017;32(2):89-98. PMID 27221810
 21. Bishawi M, Bernstein R, Boter M, et al. Mechanochemical ablation in patients with chronic venous disease: a prospective multicenter report. *Phlebology.* Jul 2014;29(6):397-400. PMID 23820117
 22. Elias S, Raines JK. Mechanochemical tumescentless endovenous ablation: final results of the initial clinical trial. *Phlebology.* Mar 2012;27(2):67-72. PMID 21803800
 23. Boersma D, van Eekeren RR, Werson DA, et al. Mechanochemical endovenous ablation of small saphenous vein insufficiency using the ClariVein((R)) device: one-year results of a prospective series. *Eur J Vasc Endovasc Surg.* Mar 2013;45(3):299-303. PMID 23312507
 24. U.S. Food and Drug Administration. VenaSeal Closure System - P140018. 2015; <http://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfTopic/pma/pma.cfm?num=P140018>. Accessed April 4, 2017.
 25. Morrison N, Gibson K, McEnroe S, et al. Randomized trial comparing cyanoacrylate embolization and radiofrequency ablation for incompetent great saphenous veins (VeClose). *J Vasc Surg.* Apr 2015;61(4):985-994. PMID 25650040
 26. Almeida JI, Javier JJ, Mackay EG, et al. Two-year follow-up of first human use of cyanoacrylate adhesive for treatment of saphenous vein incompetence. *Phlebology.* Jul 2015;30(6):397-404. PMID 24789750
 27. Zierau UT. Sealing veins with the VenaSeal Saphenon Closure System: results for 795 treated truncal veins after 1000 days. *Vasomed.* 2015;27:124-127.
 28. 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.* Feb 2009;49(2):403-409. PMID 19028042
 29. Disselhoff BC, der Kinderen DJ, Kelder JC, et al. Randomized clinical trial comparing endovenous laser with cryostripping for great saphenous varicose veins. *Br J Surg.* Oct 2008;95(10):1232-1238. PMID 18763255
 30. Disselhoff BC, der Kinderen DJ, Kelder JC, et al. Five-year results of a randomized clinical trial comparing endovenous laser ablation with cryostripping for great saphenous varicose veins. *Br J Surg.* Aug 2011;98(8):1107-1111. PMID 21633948

31. Tisi PV, Beverley C, Rees A. Injection sclerotherapy for varicose veins. *Cochrane Database Syst Rev.* 2006(4):CD001732. PMID 17054141
32. Leopardi D, Hoggan BL, Fitridge RA, et al. Systematic review of treatments for varicose veins. *Ann Vasc Surg.* Mar 2009;23(2):264-276. PMID 19059756
33. El-Sheikha J, Nandhra S, Carradice D, et al. Clinical outcomes and quality of life 5 years after a randomized trial of concomitant or sequential phlebectomy following endovenous laser ablation for varicose veins. *Br J Surg.* Aug 2014;101(9):1093-1097. PMID 24916467
34. Yamaki T, Hamahata A, Soejima K, et al. Prospective randomised comparative study of visual foam sclerotherapy alone or in combination with ultrasound-guided foam sclerotherapy for treatment of superficial venous insufficiency: preliminary report. *Eur J Vasc Endovasc Surg.* Mar 2012;43(3):343-347. PMID 22230599
35. Michaels JA, Campbell WB, Brazier JE, et al. Randomised clinical trial, observational study and assessment of cost-effectiveness of the treatment of varicose veins (REACTIV trial). *Health Technol Assess.* Apr 2006;10(13):1-196, iii-iv. PMID 16707070
36. Luebke T, Brunkwall J. Meta-analysis of transilluminated powered phlebectomy for superficial varicosities. *J Cardiovasc Surg (Torino).* Dec 2008;49(6):757-764. PMID 19043390
37. Chetter IC, Mylankal KJ, Hughes H, et al. Randomized clinical trial comparing multiple stab incision phlebectomy and transilluminated powered phlebectomy for varicose veins. *Br J Surg.* Feb 2006;93(2):169-174. PMID 16432820
38. Barwell JR, Davies CE, Deacon J, et al. Comparison of surgery and compression with compression alone in chronic venous ulceration (ESCHAR study): randomised controlled trial. *Lancet.* Jun 5 2004;363(9424):1854-1859. PMID 15183623
39. Gohel MS, Barwell JR, Taylor M, et al. Long term results of compression therapy alone versus compression plus surgery in chronic venous ulceration (ESCHAR): randomised controlled trial. *BMJ.* Jul 14 2007;335(7610):83. PMID 17545185
40. Nelzen O, Fransson I. Early results from a randomized trial of saphenous surgery with or without subfascial endoscopic perforator surgery in patients with a venous ulcer. *Br J Surg.* Apr 2011;98(4):495-500. PMID 21656715
41. Blomgren L, Johansson G, Dahlberg-Akerman A, et al. Changes in superficial and perforating vein reflux after varicose vein surgery. *J Vasc Surg.* Aug 2005;42(2):315-320. PMID 16102633
42. Tenbrook JA, Jr., Iafrati MD, O'Donnell T F, Jr., et al. Systematic review of outcomes after surgical management of venous disease incorporating subfascial endoscopic perforator surgery. *J Vasc Surg.* Mar 2004;39(3):583-589. PMID 14981453
43. van Gent WB, Catarinella FS, Lam YL, et al. Conservative versus surgical treatment of venous leg ulcers: 10-year follow up of a randomized, multicenter trial. *Phlebology.* Mar 2015;30(1 Suppl):35-41. PMID 25729066
44. Luebke T, Brunkwall J. Meta-analysis of subfascial endoscopic perforator vein surgery (SEPS) for chronic venous insufficiency. *Phlebology.* Feb 2009;24(1):8-16. PMID 19155335
45. Hirsch SA, Dillavou E. Options in the management of varicose veins, 2008. *J Cardiovasc Surg (Torino).* Feb 2008;49(1):19-26. PMID 18212684
46. Hissink RJ, Bruins RM, Erkens R, et al. Innovative treatments in chronic venous insufficiency: endovenous laser ablation of perforating veins: a prospective short-term analysis of 58 cases. *Eur J Vasc Endovasc Surg.* Sep 2010;40(3):403-406. PMID 20547462
47. Myers KA, Jolley D. Factors affecting the risk of deep venous occlusion after ultrasound-guided sclerotherapy for varicose veins. *Eur J Vasc Endovasc Surg.* Nov 2008;36(5):602-605. PMID 18718772
48. Gloviczki P, Comerota AJ, Dalsing MC, et al. The care of patients with varicose veins and associated chronic venous diseases: clinical practice guidelines of the Society for Vascular

Surgery and the American Venous Forum. J Vasc Surg. May 2011;53(5 Suppl):2S-48S. PMID 21536172

49. Society of Interventional Radiology. Position Statement on Endovenous Ablation. 2003; https://www.sirweb.org/globalassets/society-of-interventional-radiology-home-page/practiceresources/standards_pdfs/sir_venous_ablation_statement_final2015.pdf. Accessed April 4, 2017.
50. Kundu S, Lurie F, Millward SF, et al. Recommended reporting standards for endovenous ablation for the treatment of venous insufficiency: joint statement of the American Venous Forum and the Society of Interventional Radiology. J Vasc Interv Radiol. Sep 2007;18(9):1073-1080. PMID 17804767
51. National Institute for Health and Care Excellence (NICE). Ultrasound-guided foam sclerotherapy for varicose veins [IPG440] 2013; <https://www.nice.org.uk/guidance/ipg440>. Accessed April 4, 2017.
52. National Institute for Health and Care Excellence (NICE). Endovenous mechanochemical ablation for varicose veins [IPG557]. 2016; <https://www.nice.org.uk/guidance/ipg557>. Accessed April 4, 2017.
53. National Institute for Health and Care Excellence (NICE). Varicose veins in the legs [CG168]. 2013; <https://www.nice.org.uk/guidance/cg168>. Accessed April 4, 2017.
54. Brittenden J, Cotton SC, Elders A, et al. Clinical effectiveness and cost-effectiveness of foam sclerotherapy, endovenous laser ablation and surgery for varicose veins: results from the Comparison of LAser, Surgery and foam Sclerotherapy (CLASS) randomised controlled trial. Health Technol Assess. Apr 2015;19(27):1-342. PMID 25858333

Document Precedence

Blue Cross and Blue Shield of Vermont (BCBSVT) Medical Policies are developed to provide clinical guidance and are based on research of current medical literature and review of common medical practices in the treatment and diagnosis of disease. The applicable group/individual contract and member certificate language, or employer's benefit plan if an ASO group, determines benefits that are in effect at the time of service. Since medical practices and knowledge are constantly evolving, BCBSVT reserves the right to review and revise its medical policies periodically. To the extent that there may be any conflict between medical policy and contract/employer benefit plan language, the member's contract/employer benefit plan language takes precedence.

Audit Information

BCBSVT reserves the right to conduct audits on any provider and/or facility to ensure compliance with the guidelines stated in the medical policy. If an audit identifies instances of non-compliance with this medical policy, BCBSVT reserves the right to recoup all non-compliant payments.

Administrative and Contractual Guidance

Benefit Determination Guidance

Prior approval is required and benefits are subject to all terms, limitations and conditions of the subscriber contract.

Incomplete authorization requests may result in a delay of decision pending submission of missing information. To be considered complete, see policy guidelines above.

An approved referral authorization for members of the New England Health Plan (NEHP) is required. A prior approval for Access Blue New England (ABNE) members is required. NEHP/ABNE members may have different benefits for services listed in this policy. To confirm benefits, please contact the customer service department at the member's health plan.

Federal Employee Program (FEP): Members may have different benefits that apply. For further information please contact FEP customer service or refer to the FEP Service Benefit Plan Brochure. It is important to verify the member's benefits prior to providing the service to determine if benefits are available or if there is a specific exclusion in the member's benefit.

Coverage varies according to the member's group or individual contract. Not all groups are required to follow the Vermont legislative mandates. Member Contract language takes precedence over medical policy when there is a conflict.

If the member receives benefits through an Administrative Services Only (ASO) group, benefits may vary or not apply. To verify benefit information, please refer to the member's employer benefit plan documents or contact the customer service department. Language in the employer benefit plan documents takes precedence over medical policy when there is a conflict.

Policy Implementation/Update information

09/2010	New policy. CAC approved 07/2010.
03/2014	ICD 10 remediation. Revised /updated standard language (document precedence and audit information sections) added. Code tables reformatted. Hyperlinks created for attachments. ICD diagnosis list hyperlink also created for URL for website.
03/2015	Local expert input and changes to be c/w BCBSA policy- eliminates prior requirement for treating saphenous vein if no reflux is identified for accessory, tributary and perforators.
10/2016	Adopted BCBSA MPRM 7.01.124, Updated coding table ICD 10 Section.
10/2017	Policy updated with literature review; references added, CPT® Codes 37473, 37474 & 37243 added to coding table Policy statements remain unchanged.
11/2017	Added codes effective 01/01/2018 36465 & 36466 to require prior authorization.
07/2018	Policy reviewed, aligned with MPRM 7.01.124 added language The use of cyanoacrylate adhesive for permanent closure of lower extremity superficial truncal veins, such as the great saphenous vein (GSV), through endovascular embolization with coaptation is considered not medically necessary.

Eligible providers

Qualified healthcare professionals practicing within the scope of their license(s).

Approved by BCBSVT Medical Directors

Date Approved

Joshua Plavin, MD, MPH, MBA
Chief Medical Officer

Attachment I CPT® Code List & Instructions

Code	Number	Description	Policy Instructions
The following codes will be considered as medically necessary when applicable criteria have been met.			
CPT®	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)	Prior approval required
CPT®	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	Prior approval required

CPT®	36468	Single or multiple injections of sclerosing solutions, spider veins (telangiectasia); limb or trunk	Prior approval required
CPT®	36470	Injection of sclerosing solution; single vein	Prior approval required
CPT®	36471	Injection of sclerosing solution; multiple veins, same leg	Prior approval required
CPT®	36473	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, mechanochemical; first vein treated	Prior approval required
CPT®	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 primary procedure)	Prior approval required
CPT®	36475	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency; first vein treated	Prior approval required

CPT®	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)	Prior approval required
CPT®	36478	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, laser; first vein treated	Prior approval required
CPT®	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)	Prior approval required
CPT®	37243	Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; for tumors, organ ischemia, or infarction	Prior approval required

CPT®	37500	Vascular endoscopy, surgical, with ligation of perforator veins, subfascial (SEPS)	Prior approval required
CPT®	37700	Ligation and division of long saphenous vein at saphenofemoral junction, or distal interruptions	Prior approval required
CPT®	37718	Ligation, division, and stripping, short saphenous vein	Prior approval required
CPT®	37722	Ligation, division, and stripping, long (greater) saphenous veins from saphenofemoral junction to knee or below	Prior approval required
CPT®	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 excision of deep fascia	Prior approval required
CPT®	37760	Ligation of perforator veins, subfascial, radical (Linton type), including skin graft, when performed, open, 1 leg	Prior approval required
CPT®	37761	Ligation of perforator vein(s), subfascial, open, including ultrasound guidance, when performed, 1 leg	Prior approval required
CPT®	37765	Stab phlebectomy of varicose veins, 1 extremity; 10-20 stab incisions	Prior approval required
CPT®	37766	Stab phlebectomy of varicose veins, one extremity; more than 20 incisions	Prior approval required

CPT®	37780	Ligation and division of short saphenous vein at saphenopopliteal junction (separate procedure)	Prior approval required
CPT®	37785	Ligation, division, and/or excision of varicose vein cluster(s), 1 leg	Prior approval required
CPT®	37799	Unlisted procedure, vascular surgery	Prior approval required
HCPCS	S2202	Echosclerotherapy	Prior approval required

Attachment II
ICD-10-CM Coding Tables

ICD-10	Description	ICD-10	Description
I83.001	Varicose veins of unspecified lower extremity with ulcer of thigh	I83.209	Varicose veins of unspecified lower extremity with both ulcer of unspecified site and inflammation
I83.002	Varicose veins of unspecified lower extremity with ulcer of calf	I83.211	Varicose veins of right lower extremity with both ulcer of thigh and inflammation
I83.003	Varicose veins of unspecified lower extremity with ulcer of ankle	I83.212	Varicose veins of right lower extremity with both ulcer of calf and inflammation
I83.004	Varicose veins of unspecified lower extremity with ulcer of heel and midfoot	I83.213	Varicose veins of right lower extremity with both ulcer of ankle and inflammation
I83.005	Varicose veins of unspecified lower extremity with ulcer other part of foot	I83.214	Varicose veins of right lower extremity with both ulcer of heel and midfoot and inflammation
I83.008	Varicose veins of unspecified lower extremity with ulcer other part of lower leg	I83.215	Varicose veins of right lower extremity with both ulcer other part of foot and inflammation

183.009	Varicose veins of unspecified lower extremity with ulcer of unspecified site	183.218	Varicose veins of right lower extremity with both ulcer of other part of lower extremity and inflammation
183.011	Varicose veins of right lower extremity with ulcer of thigh	183.219	Varicose veins of right lower extremity with both ulcer of unspecified site and inflammation
183.012	Varicose veins of right lower extremity with ulcer of calf	183.221	Varicose veins of left lower extremity with both ulcer of thigh and inflammation
183.013	Varicose veins of right lower extremity with ulcer of ankle	183.222	Varicose veins of left lower extremity with both ulcer of calf and inflammation
183.014	Varicose veins of right lower extremity with ulcer of heel and midfoot	183.223	Varicose veins of left lower extremity with both ulcer of ankle and inflammation
183.015	Varicose veins of right lower extremity with ulcer other part of foot	183.224	Varicose veins of left lower extremity with both ulcer of heel and midfoot and inflammation
183.018	Varicose veins of right lower extremity with ulcer other part of lower leg	183.225	Varicose veins of left lower extremity with both ulcer other part of foot and inflammation
183.019	Varicose veins of right lower extremity with ulcer of unspecified site	183.228	Varicose veins of left lower extremity with both ulcer of other part of lower extremity and inflammation
183.021	Varicose veins of left lower extremity with ulcer of thigh	183.229	Varicose veins of left lower extremity with both ulcer of unspecified site and inflammation
183.022	Varicose veins of left lower extremity with ulcer of calf	183.811	Varicose veins of right lower extremities with pain

183.023	Varicose veins of left lower extremity with ulcer of ankle	183.812	Varicose veins of left lower extremities with pain
183.024	Varicose veins of left lower extremity with ulcer of heel and midfoot	183.813	Varicose veins of bilateral lower extremities with pain
183.025	Varicose veins of left lower extremity with ulcer other part of foot	183.819	Varicose veins of unspecified lower extremities with pain
183.028	Varicose veins of left lower extremity with ulcer other part of lower leg	183.891	Varicose veins of right lower extremities with other complications
183.029	Varicose veins of left lower extremity with ulcer of unspecified site	183.892	Varicose veins of left lower extremities with other complications
183.10	Varicose veins of unspecified lower extremity with inflammation	183.893	Varicose veins of bilateral lower extremities with other complications
183.11	Varicose veins of right lower extremity with inflammation	183.899	Varicose veins of unspecified lower extremities with other complications
183.12	Varicose veins of left lower extremity with inflammation	187.2	Venous insufficiency (chronic) (peripheral)
183.201	Varicose veins of unspecified lower extremity with both ulcer of thigh and inflammation		Blank
183.202	Varicose veins of unspecified lower extremity with both ulcer of calf and inflammation		Blank

183.203	Varicose veins of unspecified lower extremity with both ulcer of ankle and inflammation		Blank
183.204	Varicose veins of unspecified lower extremity with both ulcer of heel and midfoot and inflammation		Blank
183.205	Varicose veins of unspecified lower extremity with both ulcer other part of foot and inflammation		Blank
183.208	Varicose veins of unspecified lower extremity with both ulcer of other part of lower extremity and inflammation		Blank