

Corporate Medical Policy

Varicose Veins, Treatment for

File Name: varicose_veins_treatment_for
Origination: 12/2000
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Description of Procedure or Service

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, the type of vein, the source of venous reflux, and the use of other (prior or concurrent) treatments.

Background

The venous system of the lower extremities consists of the superficial veins (this includes the greater and lesser saphenous, and accessory or duplicate veins that travel in parallel with the greater and lesser 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 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 greater or lesser saphenous veins are eliminated and blood flow is diverted through the accessory veins.

Saphenous Veins and Tributaries

Saphenous veins include the greater and lesser saphenous and accessory saphenous veins that travel in parallel with the greater or lesser 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 greater and/or

Varicose Veins, Treatment for

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

Minimally invasive alternatives to ligation and stripping include: sclerotherapy, transilluminated powered phlebectomy, and thermal ablation using cryotherapy, high frequency radiowaves (200–300 kHz), or laser energy.

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 produced by forcibly mixing a gas (e.g., air or carbon dioxide) with a liquid sclerosant (e.g., polidocanol or sodium tetradecyl sulfate). The foam is produced at the time of treatment and is considered an off-label use. A proprietary microfoam sclerosant (Varisolve, BTG PLC, London) with a controlled density and more consistent bubble sizes is being developed in Europe.

Thermal Ablation

Radiofrequency ablation is performed by means of a specially designed catheter inserted through a small incision in the distal medial thigh to within 1–2 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 greater 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 lesser saphenous vein.

Transilluminated Powered Phlebectomy

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 to 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 be occasionally utilized for the closure of incompetent perforator veins that cannot be reached by less

Varicose Veins, Treatment for

invasive procedures. Subfascial endoscopic perforator surgery (SEPS) 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 radiofrequency has also been reported.

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.

Regulatory Status

The following devices have received specific U.S. Food and Drug Administration (FDA) marketing clearance 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 RFS*Flex* devices received FDA clearance in 2005 for "use in vessel and tissue coagulation including: treatment of incompetent (i.e., refluxing) perforator and tributary veins. The modified VNUS® ClosureFAST™ Intravascular Catheter received FDA clearance through the 510(k) process in 2008.
- 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 greater saphenous vein of the thigh in patients with superficial vein reflux."
- 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.
- The Trivex system 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."
- Varisolve® (BTG PLC, London) is a sclerosant microfoam made with a proprietary gas mix. A phase II safety study for the FDA has been completed. In late October 2009, the sponsor submitted a request to the FDA for a protocol assessment to agree on the design, endpoints and statistical analyses for the phase III trial.

*****Note: This Medical Policy is complex and technical. For questions concerning the technical language and/or specific clinical indications for its use, please consult your physician.**

Policy

BCBSNC will provide coverage for treatment for varicose veins when it is determined to be medically necessary because the medical criteria and guidelines shown below are met.

Benefits Application

This medical policy relates only to the services or supplies described herein. Please refer to the Member's Benefit Booklet for availability of benefits. Member's benefits may vary according to benefit design; therefore member benefit language should be reviewed before applying the terms of this medical policy.

Varicose Veins, Treatment for

When treatment for varicose veins is covered

Greater or Lesser Saphenous Veins

Treatment of the greater or lesser 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:

There is demonstrated saphenous reflux; AND

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

- Ulceration secondary to venous stasis that fails to respond to compressive therapy; OR
- Recurrent superficial thrombophlebitis that fails to respond to compressive therapy; 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.

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:

The greater or lesser 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 that fails to respond to compressive therapy; OR
- Recurrent superficial thrombophlebitis that fails to respond to compressive therapy; 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.

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
- Ligation, division, and/or excision

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:

Varicose Veins, Treatment for

- There is demonstrated perforator reflux; AND
- The superficial saphenous veins (greater, lesser, 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.

When treatment for varicose veins is not covered

Treatment of greater or lesser saphenous veins by surgery or endovenous radiofrequency or laser ablation that do not meet the criteria described above is considered cosmetic and not medically necessary.

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

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.

Ligation or ablation of incompetent perforator veins performed concurrently with superficial venous surgery is not medically necessary.

Treatment of telangiectasia such as spider veins, angiomata, and hemangiomata is considered cosmetic and not medically necessary.

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

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

Policy Guidelines

Coverage of sclerotherapy is limited to 3 sessions per leg and coverage of microphlebectomy is limited to one session per leg, to be accomplished over a period of not more than 6 months from the primary procedure. Primary procedures may include ligation/division/stripping/excision, ERFA, or EVLA/EVLT.

Sclerotherapy coverage does not include treatment of reticular veins, spider veins or telangiectasias. Sclerotherapy is not covered for treatment of saphenofemoral or saphenopopliteal junction incompetence or saphenous vein (GVS, LSV, or accessory saphenous vein) reflux.

Compressive therapy is the use of surgical grade compression hose (minimum 20-30 mm Hg) that has been prescribed by a physician with the trial use documented in the medical record.

Rationale

Although randomized, controlled trials with longer follow-up are needed to evaluate long-term durability, and repeat treatments may be required, evidence indicates that endovenous treatment of saphenous veins with radiofrequency or laser ablation improves short-term clinical outcomes (e.g., pain and return to work) in comparison with surgery. In contrast, results from a recent randomized, controlled trial of cryoablation indicate that this therapy is inferior to conventional stripping. Sclerotherapy as the sole treatment of saphenofemoral or saphenopopliteal reflux has not been demonstrated to be as effective as available alternatives.

The literature indicates that sclerotherapy of tributaries following occlusion of the saphenofemoral or saphenopopliteal junction and saphenous veins may be considered medically necessary. Evidence is

Varicose Veins, Treatment for

insufficient to evaluate the health benefit of sclerotherapy as a sole treatment of varicose tributaries without prior or concurrent treatment of the saphenous veins. No studies have been identified that compare radiofrequency or laser ablation of tributary veins with standard procedures (microphlebectomy and/or sclerotherapy). Transilluminated powered phlebectomy is effective at removing varicosities; outcomes are comparable to available alternatives such as stab avulsion and hook phlebectomy.

The literature indicates that the routine ligation/ablation of incompetent perforator veins is not medically necessary for the treatment of varicose veins/venous insufficiency at the time of superficial vein procedures. However, when combined superficial vein procedures and compression therapy have failed to improve symptoms (i.e., ulcers), treatment of perforator vein reflux may be as beneficial as any alternative (e.g., deep vein valve replacement). Therefore, treatment of incompetent perforator veins may be considered medically necessary in this specific situation.

Comparative studies are needed to determine the most effective method of ligating/ablating incompetent perforator veins. SEPS has been shown to be as effective as the Linton procedure with a reduction in adverse events. Although no studies were identified showing an improvement in health outcomes, endovenous ablation with specialized radiofrequency probes has also been shown to effectively ablate incompetent perforator veins with a potential decrease in morbidity in comparison with surgical interventions. For sclerotherapy, concerns have been raised about the risk of deep vein occlusion, and evidence is currently insufficient to evaluate the safety or efficacy of this treatment for incompetent perforator veins.

Billing/Coding/Physician Documentation Information

This policy may apply to the following codes. Inclusion of a code in this section does not guarantee that it will be reimbursed. For further information on reimbursement guidelines, please see Administrative Policies on the Blue Cross Blue Shield of North Carolina web site at www.bcbsnc.com. They are listed in the Category Search on the Medical Policy search page.

Applicable service codes: 36468, 36469, 36470, 36471, 36475, 36476, 36478, 36479, 37500, 37700, 37718, 37722, 37735, 37760, 37761, 37765, 37766, 37780, 37785, S2202

There is no specific CPT code for transilluminated powered phlebectomy. CPT codes 37765, 37766 or 37799 could be used.

If CPT 76942 is used for ultrasound guidance of sclerotherapy of the varicose tributaries, it would be considered either not medically necessary or incidental to the injection procedure.

BCBSNC may request medical records for determination of medical necessity. When medical records are requested, letters of support and/or explanation are often useful, but are not sufficient documentation unless all specific information needed to make a medical necessity determination is included.

Scientific Background and Reference Sources

Policy entitled: VNUS Closure System

Chandler J, Pichot O, Sessa C, et al. Treatment of primary venous insufficiency by endovenous saphenous vein obliteration. *Vascular Surgery*. 2000; 34(3): 201-214.

Goldman M. Closure of the greater saphenous vein with endoluminal radiofrequency thermal heating of the vein wall in combination with ambulatory phlebectomy: preliminary 6-month follow-up. *Dermatol Surg* 2000; 26(5): 452-456.

Consultant Review - 6/2000

Medical Policy Advisory Group - 9/14/2000

Specialty Matched Consultant Advisory Group - 10/2000

Varicose Veins, Treatment for

New policy entitled: Venous Insufficiencies

BCBSA Medical Policy Reference Manual, 5/30/97

Sabiston: Textbook of Surgery, 15th Ed., 1997, W. B. Saunders Company

Medline search, 1999 - 2000

New policy entitled: Venous Insufficiency

Medline search, 1999-2001

Medical Policy Advisory Group 3/2001

BCBSA Medical Policy Reference Manual, 7.01.76; 5/31/01

BCBSA Medical Policy Reference Manual, 7.01.76; 5/15/02

Specialty Matched Consultant Advisory Panel review 8/2002

BCBSA Medical Policy Reference Manual, 7.01.55; 5/15/02

BCBSA Medical Policy Reference Manual, 7.01.90; 7/17/03

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Specialty Matched Consultant presentation to Medical Policy Advisory Group, 12/04/2003

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Specialty Matched Consultant Advisory Panel - 8/2004

From policy entitled: Endoluminal Radiofrequency or Laser Ablation for Venous Insufficiency

Specialty Matched Consultant presentation to BCBSNC Internal Medical Directors, 8/9/05

CEAP Classification of Chronic Venous Insufficiency retrieved from a PowerPoint presentation by Andrew C. Stanley, M.D., Section of Vascular Surgery at the University of Vermont. Varicose Veins: Causes, Symptoms and Management. Retrieved on 8/10/05 from http://www.med.uvm.edu/downloads/CMS_VaricoseVeins_PowerPoint.pdf#search='Classification%20of%20varicose%20veins'

BCBSNC Internal Medical Directors' review 6/06

From policy entitled: Sclerotherapy as a Treatment of Varicose Veins

Specialty Matched Consultant presentation to Medical Directors, 8/9/05

BCBSNC Internal Medical Directors' review 6/06

From policy entitled: Varicose Vein Excision and Ligation

Specialty Matched Consultant presentation to BCBSNC Internal Medical Directors, 8/9/05

CEAP Classification of Chronic Venous Insufficiency retrieved from a PowerPoint presentation by Andrew C. Stanley, M.D., Section of Vascular Surgery at the University of Vermont. Varicose Veins: Causes, Symptoms and Management. Retrieved on 8/10/05 from http://www.med.uvm.edu/downloads/CMS_VaricoseVeins_PowerPoint.pdf#search='Classification%20of%20varicose%20veins'

BCBSNC Internal Medical Directors' review 6/06

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BCBSA Medical Policy Reference Manual [Electronic Version]. 7.01.55, 11/9/04

BCBSA Medical Policy Reference Manual [Electronic Version]. 7.01.55, 8/17/05

BCBSA Medical Policy Reference Manual [Electronic Version]. 7.01.55, 10/10/06

Varicose Veins, Treatment for

BCBSA Medical Policy Reference Manual [Electronic Version]. 7.01.55, 12/13/07

BCBSA Medical Policy Reference Manual [Electronic Version]. 7.01.55, 2/14/08

BCBSA Medical Policy Reference Manual [Electronic Version]. 7.01.76, 2/25/04

BCBSA Medical Policy Reference Manual [Electronic Version]. 7.01.76, 11/9/04

BCBSA Medical Policy Reference Manual [Electronic Version]. 7.01.76, 1/26/05

BCBSA Medical Policy Reference Manual [Electronic Version]. 7.01.76, 4/25/06

BCBSA Medical Policy Reference Manual [Electronic Version]. 7.01.76, 4/17/07

BCBSA Medical Policy Reference Manual [Electronic Version]. 7.01.90, 11/9/04

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Specialty Matched Consultant Advisory Panel - 9/4/08

National Institute for Health and Clinical Excellence (NICE). Radiofrequency Ablation of Varicose Veins; Interventional Procedure Guidance IPG8 2003. Retrieved 6/24/2010 from: <http://www.nice.org.uk/nicemedia/pdf/IPG008guidance.pdf>.

National Institute for Health and Clinical Excellence (NICE). Endovenous Laser Treatment of the Long Saphenous Vein. Interventional Procedure Guidance IPG52. 2004. Retrieved 6/24/2010 from: <http://www.nice.org.uk/nicemedia/pdf/IPG052guidance.pdf>

National Institute for Health and Clinic Excellence (NICE). Ultrasound-guided foam sclerotherapy for varicose veins; IPG 314 2009. Retrieved 6/24/2010 from: <http://www.nice.org.uk/nicemedia/pdf/IPG314Guidance.pdf>

BCBSA Medical Policy Reference Manual [Electronic Version]. 7.01.124, 3/11/2010

BCBSA Medical Policy Reference Manual [Electronic Version]. 7.01.124, 3/10/11

Policy Implementation/Update Information

Policy entitled: VNUS Closure System

7/00 Original policy issued.

9/00 Medical Policy Advisory Group review. Approved. No change in criteria.

New policy entitled: Venous Insufficiencies

12/00 New policy issued. Combined policy for VNUS Closure System with new policy on Echosclerotherapy. Name changed from VNUS Closure System to Venous Insufficiencies. System coding changes.

New policy entitled: Venous Insufficiency

4/01 Revised. Policy renamed. Added criteria for Varicose Vein Excision and Ligation and Sclerotherapy. Echosclerotherapy and VNUS Closure System were combined. Medical Policy Advisory Group approved. System changes.

10/01 Revised. Added section on Endoluminal Radiofrequency Ablation for Varicose Veins as investigational. Typos corrected. Coding format changes.

8/02 Specialty Matched Consultant Advisory Panel review. Revised "Description" section for

Varicose Veins, Treatment for

- clarity. VNUS Closure System section removed. Endoluminal Radiofrequency Ablation for Varicose Veins section includes VNUS Closure System. Endoluminal Radiofrequency Ablation section revised to indicate procedure is no longer investigational and criteria added. Added section on Endoluminal Laser Ablation for Varicose Veins as investigational. Criteria clarified in sections for Varicose Vein Excision and Ligation and Sclerotherapy.
- 11/02 Added statement to Endoluminal Radiofrequency Ablation section to indicate that the procedure is not covered unless the coverage criteria is met.
- 8/03 Policy reviewed. Description rewritten to provide additional information. Additional information added to Sclerotherapy section. Removed Echosclerotherapy section. Added statement "use of surgical pressure gradient stockings (use of nonprescription support hose are not sufficient);" to the coverage criteria. Codes adjusted for Endoluminal Radiofrequency Ablation for Varicose Veins section of policy. Code 37204 removed from policy and code S2130 added.
- 1/04 Combined Endoluminal Radiofrequency Ablation and Laser Ablation sections with revisions as appropriate. Endoluminal Laser Ablation now covered. Section IV is now titled "Subfascial Endoscopic Perforator Surgery (SEPS)" and is investigational in the treatment of chronic venous insufficiency. Benefits Application and Billing/Coding sections revised. Added CPT codes 37765, 37766 to Billing/Coding section for Varicose Vein Excision and Ligation. Typos corrected.
- 4/22/04 Added new first quarter HCPCS code S2131 to the Billing /Coding section III, "Endoluminal Radiofrequency or Laser Ablation.
- 11/11/04 Specialty Matched Consultant Advisory Panel review - 8/27/04. Under Section I - Varicose Vein Excision and Ligation, "When Covered" added #3. "Doppler ultrasonographic documentation of saphenofemoral junction incompetence and greater saphenous vein reflux or saphenopopliteal junction incompetence and lesser saphenous vein reflux." Added codes 37700 & 37780 to Billing/ Coding section. Under Section II - Sclerotherapy, Reference to the COMPASS procedure added; Under "When Covered" A. added #3. "Doppler ultrasonographic documentation of reflux of the saphenofemoral junction or reflux isolated to the perforator veins of the upper thigh." Under "When not Covered", #4 following thrombophlebitis, added "(except as indicated above)". Added code S2202 to Billing/Coding section for Sclerotherapy. Under "When Covered" section for Endoluminal Radiofrequency or Laser Ablation, # 3., added e. "Endoluminal laser ablation of the lesser saphenous vein may be considered medically necessary when doppler ultrasonography documents saphenopopliteal junction incompetence and lesser saphenous vein reflux. The other medical necessity criteria listed in numbers 1. (significant medical problems) and 2. (trial of conservative measures) must be met." Under "Billing/Coding" section, deleted code 37799 and statements "There is no specific code for endoluminal laser ablation for treatment of varicose veins. Code 37799 may be used." S2131 is the appropriate code for endoluminal laser ablation. References added. Notice given 11/11/04. Effective date 1/20/05
- 1/20/05 Added 2005 CPT codes 36475, 36476, 36478, 36479 to Billing/Coding section for Endoluminal Radiofrequency or Laser Ablation and to final Billing/Coding section that includes all codes in policy.
- 2/02/06 Removed deleted CPT codes 37720 & 37730 from Billing/Coding section for Varicose Vein Excision and Ligation and from final Billing/Coding section that includes all codes in policy. Added 2006 CPT codes 37718 & 37722 to same sections.
- 10/2/06 Policy separated into Varicose Vein Excision and Ligation, Sclerotherapy as a Treatment of Varicose Veins, and Endoluminal Radiofrequency or Laser Ablation for Venous Insufficiency. Venous Insufficiency policy archived.

From policy entitled: Endoluminal Radiofrequency or Laser Ablation for Venous Insufficiency

- 7/24/06 Notification of new policy. This policy is NOT effective until 10/2/06. Prior to 10/2/06 refer

Varicose Veins, Treatment for

to policy number SUR6817, Venous Insufficiency. The Venous Insufficiency policy will be archived on 10/2/06. Notification given 7/24/06. Effective date 10/2/06. (pmo)

From policy entitled: Sclerotherapy as a Treatment of Varicose Veins

7/24/06 Notification of new policy. This policy is NOT effective until 10/2/06. Prior to 10/2/06 refer to policy number SUR6817, Venous Insufficiency. The Venous Insufficiency policy will be archived on 10/2/06. Notification given 7/24/06. Effective date 10/2/06. (pmo)

From policy entitled: Varicose Vein Excision and Ligation

7/24/06 Notification of new policy. This policy is NOT effective until 10/2/06. Prior to 10/2/06 refer to policy number SUR6817, Venous Insufficiency. The Venous Insufficiency policy will be archived on 10/2/06. CPT codes 37720 and 37730 removed from Billing/Coding section (codes deleted in 2005) and added CPT codes 37718, 37722 and 37760. Notification given 7/24/06. Effective date 10/2/06. (pmo)

New policy entitled: Varicose Veins, Treatment for

5/19/08 New policy issued. Policy combines and clarifies the following separate policies: Endoluminal Radiofrequency or Laser Ablation for Venous Insufficiency, Sclerotherapy as a Treatment of Varicose Veins and Varicose Vein Excision and Ligation. (pmo)

10/6/08 Revisions under "When Covered" section:

A.1.a. Varicose vein ligation and excision (VVLE/varicose vein ligation and stripping (VVLS) for treatment of GSV, LSV, or accessory vein reflux.

A.2. added "accessory saphenous vein" to list of "all proximal sources of reflux".

A. Note-added "and coverage of microphlebectomy is limited to one session per leg"; added reticular veins to list "Sclerotherapy coverage does not include treatment of....."; added (GSV, LSV, or accessory saphenous vein) following "saphenous vein" in next to last sentence.

B.7. Now reads: "Procedure (CPT) codes for proposed interventions specifying the vein(s) to be treated with each procedure (e.g. GSV, LSV, accessory saphenous vein, perforator, varicose tributaries, reticular veins, spider veins, telangiectasia) and whether Left, Right, or Bilateral; and for sclerotherapy also stating the number of sessions for each leg."

Revisions under "When Not Covered" section:

3. Added "or accessory saphenous vein" to investigational list.

7. Added "or more than one session of microphlebectomy per leg".

Added 9. "Surgical removal, EVLT, and/or ERFA can be performed safely and effectively on multiple veins of the same leg as part of a single surgery. Therefore, staging of surgical procedures on different dates of service to treat more than one incompetent saphenous vein (GSV, LSV, accessory saphenous vein) in the same leg is considered to be not medically necessary."

Other:

Reference sources added. Specialty Matched Consultant Advisory Panel review - 9/4/08.

Notification given 10/6/08. Effective date 1/5/09. (pmo)

1/5/10 Policy reformatted. CPT code 37761 effective January 1, 2010 added to Billing/Coding section. System Application Guidelines not updated due to conversion to the QMP real time database. (pmo)

6/22/10 Policy Number(s) removed (amw)

7/20/2010 Description section extensively revised. The sections for when treatment for varicose veins is

Varicose Veins, Treatment for

and is not covered were reformatted. The following was added to the When Varicose Vein Treatment Is Covered section: “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 (greater, lesser, 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.” The following statements were added to the **When Varicose Vein Treatment Is Not Covered** section: “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. Ligation or ablation of incompetent perforator veins performed concurrently with superficial venous surgery is not medically necessary.” Also “Endovenous cryoablation of any vein” is investigational and not covered. Definition of “compressive therapy” moved to **Policy Guidelines** section. Rationale for coverage added to Policy Guidelines section. The following statements were added to the Billing/Coding section: “There is no specific CPT code for transilluminated powered phlebectomy. CPT codes 37765, 37766 or 37799 could be used. If CPT 76942 is used for ultrasound guidance of sclerotherapy of the varicose tributaries, it would be considered either not medically necessary or incidental to the injection procedure”. References updated. Notification given 7/20/10 for effective date of 10/26/10. (adn)

- 12/21/10 Specialty Matched Consultant Advisory Panel review 11/29/10. Policy accepted as written. (adn)
- 3/1/11 Correction-the following statement was removed from paragraph 2 of the Policy Guidelines section: “Also, sclerotherapy, ERFA and EVLA/EVLT are not covered for treatment of incompetent deep perforator veins.” (adn)
- 12/20/11 Routine annual review. Added additional covered indication to bulleted list under “Symptomatic Varicose Tributaries. “Ligation, division, and/or excision” is also covered. Specialty Matched Consultant Advisory Panel review 11/30/11. (adn)

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