

## Clinical Policy: Varicose Vein Treatment

Reference Number: WA.CP.MP.522

Date of Last Revision: 06/24

Effective Date: 08/01/24

[Coding Implications](#)

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### Description

This policy describes the medical necessity requirements for endovenous laser ablation (EVLA), radiofrequency ablation (RFA), sclerotherapy and phlebectomy.

### Policy/Criteria

- I. It is the policy of Coordinated Care of Washington, Inc., in accordance with the Health Care Authority's Health Technology Assessment, that endovenous laser ablation (EVLA), radiofrequency ablation (RFA), phlebectomy and sclerotherapy using liquid or foam irritants including, but not limited to, Varithena, are **medically necessary** for the following indications:
  - A. Varicose veins, *all* of the following:
    - a. Demonstrated reflux in the affected vein
    - b. For tributary varicose veins **ONLY**, diameter must be  $\geq 3$ mm
    - c. Symptoms or complications, at least *one* of the following:
      - i. Pain and/or swelling sufficient to interfere with instrumental activities of daily living and duration  $\geq 3$  months
      - ii. Presence of complications (e.g. ulceration, bleeding, or recurrent thrombophlebitis)
  - B. None of the following contraindications:
    1. Pregnancy;
    2. Active infection;
    3. Peripheral arterial disease;
    4. Deep venous thrombosis (DVT).
  - C. If cyanoacrylate adhesive (e.g. VenaSeal™) CPT codes 36482 or 36483 is requested, utilize Centene Clinical Policy CP.MP.146 criteria for review.

Note: Coordinated Care of Washington, Inc., utilizes InterQual® criteria for review of ligation and/or stripping procedures for the treatment of varicose veins, including the following CPT codes: 37700, 37718, 37722, 37780, and 37785.

### Background

This policy is based entirely on Washington State Health Care Authority (HCA) Health Technology Assessment (HTA) and Health Care Authority Billing Guidelines.

**Coding Implications**

This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2019, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

CPT® Codes	Description
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 sclerosant; single incompetent vein (other than telangiectasia)
36471	Injection of sclerosant; multiple incompetent veins (other than telangiectasia), same leg
36473	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, mechanochemical; first vein treated
36474	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, mechanochemical; subsequent vein(s) treated in a single extremity, each through separate access sites.
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; subsequent vein(s) 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; subsequent vein(s) treated in a single extremity, each through separate access sites.
37765	Stab phlebectomy of varicose veins, 1 extremity; 10-20 stab incisions
37766	Stab phlebectomy of varicose veins, 1 extremity; more than 20 incisions.

Reviews, Revisions, and Approvals	Revision Date	Approval Date
Policy developed.	10/19	11/19
Background updated with no impact on criteria. References reviewed and updated. Corrected typos and grammatic errors. Changed structure to be more consistent with corporate policy.	05/20	06/20
Revised policy statement adding Varithena as an example of a foam irritant. Added 36468 to code list not medically necessary. In I.A.2., added tributary and accessory vein treatment as indications when meeting the established criteria.	09/20	10/20
“Experimental/investigational” verbiage replaced in policy statement with descriptive language. References reviewed and updated. Removed duplicate reference. Replaced all instances of member with member/enrollee.	05/21	06/21
Clarified in III to cyanoacrylate is used in endovenous ablation and not sclerotherapy. Updated background accordingly. Changed “review date” in policy header to “date of last revision,” and “date” in the revision log header to “revision date.” Updated references.	10/21	10/21
Annual review. Added I.C, that if cyanoacrylate adhesive (VenaSeal) is requested, it is for the smaller saphenous vein only. Removed section III stating that cyanoacrylate adhesive is not medically necessary. References reviewed and updated. Background updated with no impact on criteria. Specialist reviewed. Moved codes 36482 and 36483.	4/22	5/22
Annual review. References reviewed and updated. Section I. medical necessity criteria revised to align with HTA/HCA billing guidelines. Removed ligation/stripping procedures from policy description and criteria. Added note below section II. regarding use of InterQual criteria for review of ligation/stripping procedures. Removed ligation procedure codes 37780 and 37785 from CPT code table. Updated section B. contraindications to correspond to HTA/billing guidelines and current corporate sclerotherapy/EVLA policy CP.MP.146. Updated section C. Venaseal requirements per CP.MP.146. Background updated with no impact on criteria. Removed table of codes that do not support medical necessity.	05/23	05/23
Annual review. References reviewed and updated. Background updated with no impact on criteria. Section I. A. a. reflux measurement removed to align with billing guidelines. Section I. C. removed criteria and added note for reviewer to utilize CP.MP.146 for procedures 36482, 36483. Section II. removed. Codes 36482, 36483 and 0524T removed from coding table. Code 37799 removed from note regarding ligation/stripping procedures.	06/24	06/24

**References**

1. Hayes, Inc. *Selected Treatments for Varicose Veins*. Washington State Health Technology Assessment. April 20, 2017. Accessed June 10, 2024.

2. Washington State Health Care Authority. *Physician-Related Services/Health Care Professional Services Billing Guide*. <https://www.hca.wa.gov/assets/billers-and-providers/Physician-related-services-bg-20240401.pdf>. Revised April 1, 2024.

### **Important Reminder**

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

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**Note: For Medicaid members/enrollees**, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

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