MEDICAL POLICY

POLICY TITLE	TREATMENT OF VARICOSE VEINS/VENOUS INSUFFICIENCY
POLICY NUMBER	MP 1.061

CLINICAL BENEFIT	☐ MINIMIZE SAFETY RISK OR CONCERN. ☒ MINIMIZE HARMFUL OR INEFFECTIVE INTERVENTIONS. ☐ ASSURE APPROPRIATE LEVEL OF CARE. ☐ ASSURE APPROPRIATE DURATION OF SERVICE FOR INTERVENTIONS. ☐ ASSURE THAT RECOMMENDED MEDICAL PREREQUISITES HAVE BEEN MET. ☐ ASSURE APPROPRIATE SITE OF TREATMENT OR SERVICE.
Effective date:	**6/1/2026**

POLICY

Great or Small Saphenous Veins

Treatment of the great or small saphenous veins by surgery (ligation and stripping), endovenous thermal ablation (radiofrequency or laser), microfoam sclerotherapy or cyanoacrylate adhesive 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**
- There is documentation of 1 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, microfoam sclerotherapy or cyanoacrylate adhesive that does not meet the criteria described above is considered cosmetic and is considered **investigational.** There is insufficient evidence to support a general conclusion concerning the health outcomes or benefits associated with the above procedures for these indications.

Accessory Saphenous Veins

Treatment of accessory saphenous veins by surgery (ligation and stripping), endovenous radiofrequency or laser ablation, microfoam sclerotherapy or cyanoacrylate adhesive 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, **AND**
- There is demonstrated accessory saphenous reflux; **AND**
- There is documentation of 1 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.

Concurrent treatment of the accessory saphenous veins along with the great or small saphenous veins may be considered **medically necessary** when criteria is met for each vein and there is documentation of anatomy showing that the accessory saphenous vein discharged directly into the common femoral vein.

Treatment of accessory saphenous veins by surgery, endovenous radiofrequency or laser ablation, or microfoam sclerotherapy or cyanoacrylate adhesive that does not meet the criteria described above is considered cosmetic and **investigational**. There is insufficient evidence to support a general conclusion concerning the health outcomes or benefits associated with the above procedures for these indications.

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 those noted above is considered **investigational**. There is insufficient evidence to support a general conclusion concerning the health outcomes or benefits associated with the above procedures for these indications.

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 **investigational**. There is insufficient evidence to support a general conclusion concerning the health outcomes or benefits associated with the above procedures for these indications.

Telangiectasia

Treatment of telangiectasia such as spider veins, angiomata, and hemangiomata is considered cosmetic and **investigational.** There is insufficient evidence to support a general conclusion concerning the health outcomes or benefits associated with the above procedures for these indications.

Other

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
- Mechanochemical ablation of any vein
- Endovenous cryoablation of any vein

There is insufficient evidence to support a general conclusion concerning the health outcomes or benefits associated with the above procedures for these indications.

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:

Class	Definition
C_0	No visible or palpable signs of venous disease
C_1	Telangiectasies or reticular veins
C_2	Varicose veins
C_{2r}	Recurrent varicose veins
C_3	Edema

C_4	Changes in skin and subcutaneous tissue secondary to CVD
C_{4a}	Pigmentation and eczema
C_{4b}	Lipodermatosclerosis or atrophie blanche
C_{4C}	Corona phlebectatica
C_5	Healed venous ulcer
C_6	Active venous ulcer
C_{6r}	Recurrent active venous ulcer
S	Symptomatic
A	Asymptomatic

Adapted from: https://www.jvsvenous.org/article/S2213-333X(20)30063-9/pdf
CVD, Chronic venous disease. Each clinical class subcharacterized by a subscript indicating the presence (symptomatic, s) or absence (asymptomatic, a) of symptoms attributable to venous disease.
CEAP: Clinical, Etiologic, Anatomic, Pathophysiologic classification system.

Demonstrated vein reflux is defined as greater than or equal to 500ms.

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 investigational or incidental to the injection procedure.

PRODUCT VARIATIONS

This policy is only applicable to certain programs and products administered by Capital Blue Cross and subject to benefit variations. Please see additional information below.

FEP PPO: Refer to FEP Medical Policy Manual. The FEP Medical Policy manual can be found at:
https://www.fepblue.org/benefit-plans/medical-policies-and-utilization-management-guidelines/medical-policies.

DESCRIPTION/BACKGROUND

A variety of treatment modalities are available to treat varicose veins/venous insufficiency, including surgery, thermal ablation, sclerotherapy, mechanochemical ablation (MOCA), cyanoacrylate adhesive (CAC), and cryotherapy. The application of each modality is

influenced by the severity of the symptoms, type of vein, source of venous reflux, and the use of other (prior or concurrent) treatment.

Venous Reflux/Venous Insufficiency
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 the 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 of venous disease 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 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 has traditionally included the following:

- Identification by preoperative Doppler ultrasonography of the valvular incompetence
- Control of the most proximal point of reflux, traditionally by suture ligation of the incompetent saphenofemoral or saphenopopliteal junction
- Removal of the superficial vein from circulation, e.g., by stripping of the great and/or small saphenous veins.
- 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 have been investigated. They include forms of sclerotherapy, cyanocrylate adhesive, and thermal ablation using cryotherapy, high-frequency radio waves (200-300 kHz), or laser energy.

Thermal Ablation
Radiofrequency ablation (RFA) is performed by using 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 then activated and slowly removed, along the course of the saphenous vein. Cryoablation uses extreme cold. The objective of endovenous techniques is to injure 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.

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 occluding the vessel. Treatment success 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 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). Physician-compounded foam is produced at the time of treatment. A commercially available microfoam sclerosant with a proprietary gas mix is available that is proposed to provide smaller and more consistent bubble size than what is produced with physician-compounded sclerosant foam.

Endovenous Mechanochemical Ablation
Endovenous mechanochemical ablation 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 endovenous thermal ablation techniques (radiofrequency ablation, endovenous laser ablation).

Cyanoacrylate Adhesive
Cyanoacrylate adhesive is a clear, free-flowing liquid that polymerizes in the vessel via an anionic mechanism (i.e., 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 surgical incisions or other skin wounds.

Transilluminated Powered Phlebectomy
Transilluminated powered phlebectomy (TIPP) is an alternative to stab avulsion and hook phlebectomy. This procedure uses two instruments: an illuminator, which also provides irrigation, and a resector, which has an oscillating tip and suction pump. 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 decrease surgical time, decrease complications such as bruising, and lead to faster recovery than established procedures.

REGULATORY STATUS

In 2015, the VenaSeal® Closure System (Sapheon, part of Medtronic) was approved by the U.S. Food and Drug Administration (FDA) through the premarket approval (PMA P140018) 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 Varisolve), a sclerosant microfoam made with a proprietary gas mix, was approved by the FDA under a new drug application (205-098) 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 endovenous treatment of superficial vein reflux:

- In 1999, the VNUS Closure® System, a radiofrequency device, was cleared by the FDA through the 510(k) process for "endovascular coagulation of blood vessels in patients with superficial vein reflux." In 2005, the NUS RFS® and RFS*Flex*® devices were cleared by FDA for “use in vessel and tissue coagulation including treatment of incompetent (i.e., refluxing) perforator and tributary veins.” In 2008, the modified VNUS ClosureFast® Intravascular Catheter was cleared by the FDA through the 510(k) process. FDA product code: GEI.
- In 2002, the Diomed 810 nm surgical laser and EVLT® (endovenous laser therapy) procedure kit was cleared by the FDA 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.
- In 2005, a modified Erbe Erbokryo cryosurgical unit (Erbe USA) was approved by the FDA for marketing through the 510(k) process. A variety of clinical indications are listed, including cryostripping of varicose veins of the lower limbs. FDA product code: GEH.
- In 2003, the Trivex system (InaVein), a device for transilluminated powered phlebectomy, was cleared by the FDA through the 510(k) process for “ambulatory phlebectomy procedures for the resection and ablation of varicose veins.” FDA product code: DNQ.
- In 2008, the ClariVein® Infusion Catheter (Merit Medical) was cleared by the FDA through the 510(k) process (K071468) for mechanochemical ablation. The FDA determined that this device was substantially equivalent to 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.

RATIONALE

Summary of Evidence

Saphenous Veins

For individuals who have varicose veins/venous insufficiency and saphenous vein reflux who receive endovenous thermal ablation (radiofrequency or laser), the evidence includes randomized controlled trials (RCTs) and systematic reviews of controlled trials. The relevant outcomes are symptoms, change in disease status, morbid events, quality of life, and treatment-related morbidity. There are a number of large RCTs and systematic reviews of RCTs assessing endovenous thermal ablation of the saphenous veins. Comparison with the standard of ligation and stripping at 2- to 5-year follow-up has supported the use of both endovenous laser ablation and radiofrequency ablation (RFA). Evidence has suggested that ligation and stripping lead to more neovascularization, while thermal ablation leads to more recanalization, resulting in similar clinical outcomes for endovenous thermal ablation and surgery. The evidence is sufficient to determine that the technology results in an improvement in the net health outcome.

For individuals who have varicose veins/venous insufficiency and saphenous vein reflux who receive microfoam sclerotherapy, the evidence includes RCTs and systematic reviews. The relevant outcomes are symptoms, change in disease status, morbid events, quality of life, and treatment-related morbidity. In a Cochrane review, ultrasound-guided foam sclerotherapy was inferior to both ligation and stripping and endovenous laser ablation for technical success up to 5 years and beyond 5 years, but there was no significant difference between treatments for recurrence up to 3 years and at 5 years. For physician-compounded sclerotherapy, there is high variability in success rates and some reports of serious adverse events. By comparison, rates of occlusion with the microfoam sclerotherapy (polidocanol 1%) approved by the U.S. Food and Drug Administration (FDA) are similar to those reported for endovenous laser ablation or stripping. Results of a noninferiority trial of physician-compounded sclerotherapy have indicated that once occluded, recurrence rates at two years are similar to those of ligation and stripping. Together, this evidence indicates that the more consistent occlusion with the microfoam sclerotherapy preparation will lead to recurrence rates similar to ligation and stripping in the longer term. The evidence is sufficient to determine that the technology results in an improvement in the net health outcome.

For individuals who have varicose veins/venous insufficiency and saphenous vein reflux who receive mechanochemical ablation (MOCA), the evidence includes 4 RCTs with 6 months to 2-year results that compared MOCA to thermal ablation and 2 prospective cohorts with follow-up out to 8 years. Relevant outcomes are symptoms, change in disease status, morbid events, quality of life, and treatment-related morbidity. MOCA is a combination of liquid sclerotherapy with mechanical abrasion. A potential advantage of this procedure compared with thermal ablation is that MOCA does not require tumescent anesthesia and may result in less pain during the procedure. Results to date have been mixed regarding a reduction in intraprocedural pain compared to thermal ablation procedures. Occlusion rates at 6 months to 2 years from RCTs indicate lower anatomic success rates compared to thermal ablation, but a difference in clinical outcomes at these early time points has not been observed. Experience with other endoluminal

ablation procedures suggests that lower anatomic success in the short term is associated with recanalization and clinical recurrence between 2 to 5 years. The possibility of later clinical recurrence is supported by prospective cohort studies with up to 8-year follow-up following treatment with MOCA. However, there have been improvements in technique since the cohort studies began, and clinical progression is frequently observed with venous disease. Because of these limitations, longer follow-up of the more recently conducted RCTs is needed to establish the efficacy and durability of this procedure compared with the criterion standard of thermal ablation. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

For individuals who have varicose veins/venous insufficiency and saphenous vein reflux who receive cyanoacrylate adhesive (CAC), the evidence includes 3 RCTs and aprospective cohort studies. The relevant outcomes are symptoms, change in disease status, morbid events, quality of life, and treatment-related morbidity. Evidence includes a multicenter noninferiority trial with follow-up through 36 months, 2 RCTs with follow-up through 24 months, and a prospective cohort with 30-month follow-up. The short-term efficacy of VenaSeal CAC has been shown to be noninferior to RFA at up to 36 months. At 24 and 36 months, the study had greater than 20% loss to follow-up, but loss to follow-up was similar in the 2 groups at the long-term follow-up and is not expected to influence the comparative results. Another RCT (N=248) comparing VenaSeal CAC with RFA found similar proportions of vein closures at 24 months with both treatments, with potentially shorter procedure duration with CAC versus RFA. A third RCT (N=525) with an active CAC ingredient (N-butyl cyanoacrylate) that is currently available outside of the U.S. found no significant differences in vein closure between CAC and thermal ablation controls at 24-month follow-up. The CAC procedure and return to work were shorter and pain scores were lower compared to thermal ablation, although the subjective pain scores may have been influenced by differing expectations in this study. Prospective cohort studies report `high closure rates at 30 months. Overall, results indicate that outcomes from CAC are at least as good as thermal ablation techniques, the current standard of care. The evidence is sufficient to determine that the technology results in an improvement in the net health outcome.

For individuals who have varicose veins/venous insufficiency and saphenous vein reflux who receive cryoablation, the evidence includes RCTs. The relevant outcomes are symptoms, change in disease status, morbid events, quality of life, and treatment-related morbidity. Results from a recent RCT of cryoablation have indicated that this therapy is inferior to conventional stripping. Studies showing a benefit on health outcomes are needed. The evidence is insufficient to determine that the technology results in an improvement in the health outcomes.

Varicose Tributary Veins

For individuals who have varicose tributary veins who receive ablation (stab avulsion, sclerotherapy, or phlebectomy) of tributary veins, the evidence includes RCTs and systematic reviews of RCTs. The relevant outcomes are symptoms, change in disease status, morbid events, quality of life, and treatment-related morbidity. The literature has shown that sclerotherapy is effective for treating tributary veins following occlusion of the saphenofemoral or saphenopopliteal junction and saphenous veins. No studies have been identified comparing RFA or laser ablation of tributary veins with standard procedures (microphlebectomy and/or

sclerotherapy). Transilluminated powered phlebectomy (TIPP) is effective at removing varicosities; outcomes are comparable to available alternatives such as stab avulsion and hook phlebectomy. The evidence is sufficient to determine that the technology results in an improvement in the net health outcome.

Perforator Veins
For individuals who have perforator vein reflux who receive ablation (e.g., subfascial endoscopic perforator surgery) of perforator veins, the evidence includes RCTs, systematic reviews of RCTs and a retrospective study. The relevant outcomes are symptoms, change in disease status, morbid events, quality of life, and treatment-related morbidity. The literature has indicated that the routine ligation or ablation of incompetent perforator veins is not 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 an alternative (e.g., deep vein valve replacement). Comparative studies are needed to determine the most effective method of ligating or ablating incompetent perforator veins. Subfascial endoscopic perforator surgery is possibly as effective as the Linton procedure with a reduction in adverse events. Endovenous ablation with specialized laser or radiofrequency probes has been shown to effectively ablate incompetent perforator veins with a potential decrease in morbidity compared with surgical interventions. The evidence is sufficient to determine that the technology results in an improvement in the net health outcome.

DEFINITIONS

ABLATION is the removal of a part, pathway, or function by surgery, chemical destruction, electrocautery, or radiofrequency.

CHRONIC VENOUS INSUFFICIENCY refers to a collection of venous disorders that includes reflux disease and obstructive physiology. Symptoms include pain, edema, and skin irritation. Physical exam reveals ankle edema, subcutaneous fibrosis, hyperpigmentation, lipodermatosclerosia, eczema and dilation of subcutaneous veins and ulcers.

COSMETIC SURGERY is an elective procedure performed primarily to restore a person's appearance by surgically altering a physical characteristic that does not prohibit normal function but is considered unpleasant or unsightly.

ENDOLUMINAL means within the lumen of a tubular structure, such as a blood vessel.

ENDOSCOPIC refers to a medical procedure that uses a device with a light attached to look at the inside of a body cavity or organ.

FASCIA is the fibrous connective tissue of the body that can be separated from other specifically organized structures, such as tendons and ligaments.

MICROVASCULAR pertains to the portion of the circulatory system that is composed of the capillary network.

NECROTIZING refers to causing the death of tissues or organisms**.**

SUBFASCIAL means beneath a fascia.

TELANGIECTASIA is a vascular lesion formed by dilation of a group of small blood vessels.

DISCLAIMER

Capital Blue Cross' medical policies are used to determine coverage for specific medical technologies, procedures, equipment, and services. These medical policies do not constitute medical advice and are subject to change as permitted by law or applicable clinical evidence from independent treatment guidelines. Treating providers are solely responsible for medical advice and treatment of members. These policies are not a guarantee of coverage or payment. Payment of claims is subject to a determination regarding the member's benefit program and eligibility on the date of service, and a determination that the services are medically necessary and appropriate. Final processing of a claim is based upon the terms of contract that applies to the members' benefit program, including benefit limitations and exclusions. If a provider or a member has a question concerning this medical policy, please contact Capital Blue Cross' Provider Services or Member Services.

CODING INFORMATION

Note: This list of codes may not be all-inclusive, and codes are subject to change at any time. The identification of a code in this section does not denote coverage as coverage is determined by the terms of member benefit information. In addition, not all covered services are eligible for separate reimbursement.

Treatment of telangiectasia such as spider veins, angiomata, and hemangiomata is considered investigational and therefore not covered:

Procedure Codes								
36468								

Techniques for conditions not specifically listed above are investigational (e.g., ClariVein) therefore not covered:

Procedure Codes								
36473	36474							

Covered when medically necessary:

Procedure Codes								
0524T	36465	36466	36470	36471	36475	36476	36478	36479
36482	36483	37700	37718	37722	37735	37760	37761	37765
37766	37780	37785	S2202					

ICD-10-CM Diagnosis Codes	Description
I83.011	Varicose veins of right lower extremity with ulcer of thigh

POLICY TITLE	TREATMENT OF VARICOSE VEINS/VENOUS INSUFFICIENCY
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ICD-10-CM Diagnosis Codes	Description
I83.012	Varicose veins of right lower extremity with ulcer of calf
I83.013	Varicose veins of right lower extremity with ulcer of ankle
I83.014	Varicose veins of right lower extremity with ulcer of heel and midfoot
I83.015	Varicose veins of right lower extremity with ulcer other part of foot
I83.018	Varicose veins of right lower extremity with ulcer other part of lower leg
I83.019	Varicose veins of right lower extremity with ulcer of unspecified site
I83.021	Varicose veins of left lower extremity with ulcer of thigh
I83.022	Varicose veins of left lower extremity with ulcer of calf
I83.023	Varicose veins of left lower extremity with ulcer of ankle
I83.024	Varicose veins of left lower extremity with ulcer of heel and midfoot
I83.025	Varicose veins of left lower extremity with ulcer other part of foot
I83.028	Varicose veins of left lower extremity with ulcer other part of lower leg
I83.029	Varicose veins of left lower extremity with ulcer of unspecified site
I83.11	Varicose veins of right lower extremity with inflammation
I83.12	Varicose veins of left lower extremity with inflammation
I83.211	Varicose veins of right lower extremity with both ulcer of thigh and inflammation
I83.212	Varicose veins of right lower extremity with both ulcer of calf and inflammation
I83.213	Varicose veins of right lower extremity with both ulcer of ankle and inflammation
I83.214	Varicose veins of right lower extremity with both ulcer of heel and midfoot and inflammation
I83.215	Varicose veins of right lower extremity with both ulcer other part of foot and inflammation
I83.218	Varicose veins of right lower extremity with both ulcer of other part of lower extremity and inflammation
I83.219	Varicose veins of right lower extremity with both ulcer of unspecified site and inflammation
I83.221	Varicose veins of left lower extremity with both ulcer of thigh and inflammation
I83.222	Varicose veins of left lower extremity with both ulcer of calf and inflammation
I83.223	Varicose veins of left lower extremity with both ulcer of ankle and inflammation
I83.224	Varicose veins of left lower extremity with both ulcer of heel and midfoot and inflammation
I83.225	Varicose veins of left lower extremity with both ulcer other part of foot and inflammation
I83.228	Varicose veins of left lower extremity with both ulcer of other part of lower extremity and inflammation
I83.229	Varicose veins of left lower extremity with both ulcer of unspecified site and inflammation
I83.811	Varicose veins of right lower extremities with pain

ICD-10-CM Diagnosis Codes	Description
I83.812	Varicose veins of left lower extremities with pain
I83.813	Varicose veins of bilateral lower extremities with pain
I83.891	Varicose veins of right lower extremity with other complications
I83.892	Varicose veins of left lower extremity with other complications
I83.893	Varicose veins of bilateral lower extremities with other complications
I87.2	Venous insufficiency (chronic) (peripheral)

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POLICY HISTORY

MP 1.061	**05/29/2020 Minor Review.** Policy Statement updated to include clarification to conservative management, imaging requirements, added treatment requirements for initial superficial thrombophlebitis and CEAP criteria. Also clarified symptomatic varicose tributaries section. References added. Description/Background and Rationale updated. Coding reviewed.
	08/13/2021 Minor Review. Added vein size requirement to Great or Small Saphenous Veins. Clarified hemorrhage criteria by adding medical or surgical intervention to Great or Small Saphenous Veins and Accessory Saphenous Veins sections. Included reflux requirements for Perforator Veins. Background, Rationale and References updated.
	10/24/2022 Consensus Review. No change to policy statement. FEP language revised. Background, Rationale and References updated.
	07/27/2023 Minor Review. Added CEAP class C2 classification and specific saphenous reflux measurements to Accessory Saphenous Vein criteria. Added CEAP class C2 classification and perforator vein size to Perforator Vein criteria. Policy guidelines section expanded to include reflux evaluation with duplex ultrasound information. Policy Variation language updated. Rationale, Abbreviations and References updated.
	06/24/2024 Consensus Review. No change to policy statement. Rationale updated. References updated. New reference added.
	03/26/2025 Minor Review. Great or small saphenous veins: Criteria for reflux and vein size have been removed. Conservative management was redefined. Initial superficial thrombophlebitis criteria was removed. Accessory saphenous veins: CEAP classification, prior elimination of great or small saphenous veins, reflux, and vein size requirements have been removed. Symptomatic varicose tributaries: Symptoms and requirements for conservative treatment have been removed. Perforator veins: Criteria for CEAP classification, reflux, and vein size have been removed. Sclerotherapy for perforator veins changed from medically necessary to investigational. Policy Guidelines, Benefit Variation and Disclaimer revised. References added.

POLICY TITLE	TREATMENT OF VARICOSE VEINS/VENOUS INSUFFICIENCY
POLICY NUMBER	MP 1.061

	07/15/2025 Administrative Update. Removed Benefit Variations Section and updated Disclaimer.
	12/04/2025 Administrative Update. Removed code 37500 as its been deleted eff 01/01/2026.
	02/04/2026 Consensus Review. No change to policy statement. Rationale updated. References added.