Clinical Policy: Varicose Vein Treatment

Reference Number: WA.CP.MP.522
Date of Last Revision: 05/25
Effective Date: 07/01/25

Coding Implications
Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

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., and Coordinated Care Corporation, in accordance with the Health Care Authority's Health Technology Assessment, that endovenous laser ablation (EVLA), radiofrequency ablation (RFA), phlebectomy and sclerotherapy are **medically necessary** for the following indications:

A. Varicose veins, *all* of the following:
   a. Demonstrated reflux in the affected vein
   b. 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 ≥ 3 months
      ii. Presence of complications (e.g. ulceration, bleeding, or recurrent thrombophlebitis)
   c. For tributary varicose veins ONLY, diameter must be ≥ 3mm

B. None of the following contraindications:
   1. Pregnancy;
   2. Active infection;
   3. Peripheral arterial disease;
   4. Deep venous thrombosis (DVT).

II. It is the policy of Coordinated Care of Washington, Inc., and Coordinated Care Corporation, that there is insufficient evidence in the published peer-reviewed literature to support the use of sclerotherapy for any of the following indications:

A. Asymptomatic varicose veins such as superficial reticular veins and/or telangiectasias;
B. For the treatment of all other conditions than those specified above.

Note: Coordinated Care 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, 37735, 37760, 37761, 37780, and 37785.

Background
This policy is based 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.
36468	Injection of sclerosant for spider veins (telangiesctasia), limb or trunk
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.
36482	Endovenous ablation therapy of incompetent vein, extremity, by transcatheter delivery of a chemical adhesive (e.g., cyanoacrylate); first vein treated
36483	Endovenous ablation therapy of incompetent vein, extremity, by transcatheter delivery of a chemical adhesive (e.g., cyanoacrylate); subsequent veins, single extremity, separate access site
37765	Stab phlebectomy of varicose veins, 1 extremity; 10-20 stab incisions

CPT® Codes	Description
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

Reviews, Revisions, and Approvals	Revision Date	Approval Date
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
Annual review. Updated logo and added "Coordinated Care Corporation". Resequenced criteria in 1.A. to mirror Billing Guideline. Removed section I.C. Added Section II. Updated references.	04/25	05/25

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*. Physician-Related Services/Health Care Professional Services billing guide. Revised April 1, 2025.

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.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan

retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members/enrollees. This clinical policy is not intended to recommend treatment for members/enrollees. Members/enrollees should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members/enrollees and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members/enrollees and their representatives agree to be bound by such terms and conditions by providing services to members/enrollees and/or submitting claims for payment for such services.

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.