



MEDICAL COVERAGE GUIDELINES
SECTION: SURGERY

ORIGINAL EFFECTIVE DATE: 01/11/18
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VARICOSE VEIN TREATMENTS

Non-Discrimination Statement and Multi-Language Interpreter Services information are located at the end of this document.

Coverage for services, procedures, medical devices and drugs are dependent upon benefit eligibility as outlined in the member's specific benefit plan. This Medical Coverage Guideline must be read in its entirety to determine coverage eligibility, if any.

This Medical Coverage Guideline provides information related to coverage determinations only and does not imply that a service or treatment is clinically appropriate or inappropriate. The provider and the member are responsible for all decisions regarding the appropriateness of care. Providers should provide BCBSAZ complete medical rationale when requesting any exceptions to these guidelines.

The section identified as "Description" defines or describes a service, procedure, medical device or drug and is in no way intended as a statement of medical necessity and/or coverage.

The section identified as "Criteria" defines criteria to determine whether a service, procedure, medical device or drug is considered medically necessary or experimental or investigational.

State or federal mandates, e.g., FEP program, may dictate that any drug, device or biological product approved by the U.S. Food and Drug Administration (FDA) may not be considered experimental or investigational and thus the drug, device or biological product may be assessed only on the basis of medical necessity.

Medical Coverage Guidelines are subject to change as new information becomes available.

For purposes of this Medical Coverage Guideline, the terms "experimental" and "investigational" are considered to be interchangeable.

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VARICOSE VEIN TREATMENTS (cont.)

Description:

Varicose veins are dilated, tortuous veins that may cause pain or skin ulcers. Invasive treatment may include surgical removal and/or destruction using lasers, heat, or injection of sclerosing solution.

The venous system of the lower extremities consist of the superficial system (e.g., great and small saphenous veins and accessory or tributary veins that travel in parallel with the great and small saphenous veins) and the deep system (e.g., popliteal and femoral veins). These two parallel systems are interconnected via perforator veins and at the saphenofemoral and the saphenopopliteal junctions.

The long and short saphenous veins are also known as the great or greater and the small or lesser saphenous veins, respectively.

One-way valves are present within all veins to direct the return of blood up the lower limb. Larger varicose veins, many protruding above the surface of the skin, typically are related to valve incompetence. In the resting state the pressure in the deep venous system is less than in the superficial venous system, since in the hydrostatic system blood will flow with the pressure gradient towards the lower pressure system. However, during activity, the pressure created by muscular contraction will be greater in the deep system than in the superficial system. If valves in the perforator venous system or superficial system are incompetent, the increased pressure will force blood from high pressure deep venous system during systole into the lower pressure superficial venous system. In addition, clusters of varicosities may appear related to incompetent perforating veins in the calf and thigh, and/or associated with incompetence at the saphenofemoral or saphenopopliteal junction of the groin and popliteal area respectively. Also, valvular incompetence may be isolated to a perforator vein in the calf leading to varicosities in the proximal/mid anteromedial calf that are not related to proximal great saphenous vein incompetence.

Although many varicose veins are asymptomatic, when present, symptoms include itching, burning, heaviness, fatigue, pain, muscular cramping, restless leg and aching. In addition, chronic venous insufficiency secondary to venous reflux can lead to peripheral edema, hemorrhage, thrombophlebitis, venous ulceration, and chronic skin changes. In an effort to improve the consistency in diagnosing chronic venous disorders, particularly for selection of individuals for clinical trials, an international consensus committee developed CEAP classification. In this system, classification is based on clinical manifestations (C), etiology (E) anatomical distribution (A), and underlying pathophysiology. (P).

The term "varicose veins" does not apply to the telangiectatic dermal veins, which may be described as "spider veins" or broken blood vessels." While abnormal in appearance, these veins typically are not associated with any symptoms, such as pain or heaviness, and their treatment is considered cosmetic.

VARICOSE VEIN TREATMENTS (cont.)

Description: (cont.)

Treatment of Superficial Varicose Veins:

Conservative Therapy:

Treatment of venous reflux/ venous insufficiency is aimed at reducing abnormal pressure transmission from the deep to the superficial veins. Varicose veins can usually be treated with non-surgical measures. Symptoms often decrease when legs are elevated periodically, when prolonged standing is avoided, and when elastic compression stockings are worn.

Operative Therapy:

If conservative treatment measures fail, additional treatment options typically focus first on identifying and correcting the site of reflux, and second on redirecting venous flow through veins with intact valves. Thus conventional surgical treatment of varicosities is based on the following principals:

- Control of the most proximal point of reflux, typically at the saphenofemoral junction or the saphenopopliteal junction, as identified by preoperative Doppler ultrasonography. Surgical ligation and division of the saphenofemoral or saphenopopliteal junction is performed to treat the valvular incompetence.
- Removal or occlusion by ablation of the refluxing great and/or small saphenous vein from the circulation. The classic strategy for isolation is vein stripping in conjunction with vein ligation and division, however, because of high recurrence rates and complications with vein stripping and ligation, endovenous laser or radiofrequency ablation have become the more popular technologies.
- Removal or occlusion of the refluxing varicose tributaries. Strategies for removal include phlebectomy (i.e., ligation/division/stripping, powered phlebectomy, or stab avulsion) or occlusion by injection sclerotherapy: either at the time of the initial treatment, or subsequently. Over the years various different minimally invasive alternatives to ligation and stripping have been investigated, including sclerotherapy and thermal ablation using radiofrequency energy (high frequency radiowaves), laser energy or cryoablation (also called cryotherapy).

Cyanoacrylate Adhesive:

Cyanoacrylate adhesive is a clear, viscous liquefied polymer that polymerizes in the vessel via an anionic mechanism (i.e. polymerizes into a solid material upon contact with body fluids or tissues). 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 to seal surgical incisions or other skin wounds.

VARICOSE VEIN TREATMENTS (cont.)

Description: (cont.)

Treatment of Superficial Varicose Veins: (cont.)

Endovenous Ablation:

The objective of endovenous ablation techniques is to cause injury to the vessel, causing retraction and subsequent fibrotic occlusion of the vein.

Mechanochemical Ablation:

Endovenous mechanochemical ablation (MOCA) utilizes 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 3500rpm within the lumen of the vein, abrading the endothelium. At the same time, a liquid sclerosant (sodium tetradecyl sulphate) is infused near the rotating wire. It is proposed that mechanical ablation allows for better efficacy of the sclerosant, without the need for the tumescent anesthesia used in thermal ablation.

Thermal Ablation:

Three endovenous thermal ablation techniques have been investigated as minimally invasive alternatives to vein ligation and stripping:

- Cryoablation uses extreme cold to cause injury to the vessel.
- Laser ablation is performed by means of a laser fiber introduced into the saphenous vein under ultrasound guidance, the laser is activated and slowly removed along the course of the saphenous vein. Laser ablation may be referred to as endovenous laser ablation (EVLA) or endovenous laser treatment (EVLT).
- Radiofrequency (RF) ablation is performed by means of a specially designed catheter inserted through a small incision in the distal medial thigh or proximal calf to within 1-2 cm of the saphenofemoral junction. High frequency radio waves (200-300 kHz) are delivered through the catheter electrode and cause direct heating of the vessel wall, causing the vein wall to be damaged by thermal energy to become thrombosed as the catheter is slowly withdrawn, closing the vein.



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VARICOSE VEIN TREATMENTS (cont.)

Description: (cont.)

Treatment of Superficial Varicose Veins: (cont.)

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 a chemical irritant), ultimately resulting in the complete obliteration of the vessel. The success of the treatment depends on accurate injection of the vessel, as well as adequate inject volume and concentration of sclerosant, and post-procedure compression. Compression theoretically results in direct apposition of the treated vein walls to provide more effective fibrosis and may decrease the extent of the thrombosis formation.

Sclerotherapy is an accepted and effective treatment of telangiectatic vessels. Historically, larger veins and very tortuous veins were not considered to be good candidates for sclerotherapy. Technical improvements in sclerotherapy, including the routine use of Duplex ultrasound to target refluxing vessels, luminal compression of the vein with anesthetics, and foam sclerosant in place of liquid sclerosant, have improved its effectiveness in these veins. Other concerns have arisen with these expanded uses of sclerotherapy. For example, use of sclerotherapy in the treatment of varicose tributaries without prior ligation, with or without vein stripping creates issues regarding its effectiveness in the absence of the control of the point of reflux and isolation of the refluxing saphenous vein. Sclerotherapy of the great saphenous vein raises issues regarding appropriate volume and concentration of the sclerosant and the ability to provide adequate post-procedure compression. Moreover, the use of sclerotherapy, as opposed to the physical removal of the vein with stripping, raises the issue of recurrence due to recanalization.

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 paratibial perforators. Subfascial endoscopic perforator surgery (SEPS), reported since the mid 1980's, is a less-invasive surgical procedure with small incisions made proximal to the damaged skin and after subfascial dissection inferiorly incompetent perforators are ligated endoscopically. The operation can be performed as an outpatient procedure. Endovenous ablation of incompetent perforator veins with sclerotherapy, laser and radiofrequency has also been reported.

VARICOSE VEIN TREATMENTS (cont.)

Description: (cont.)

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

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

The following is the clinical portion of CEAP:

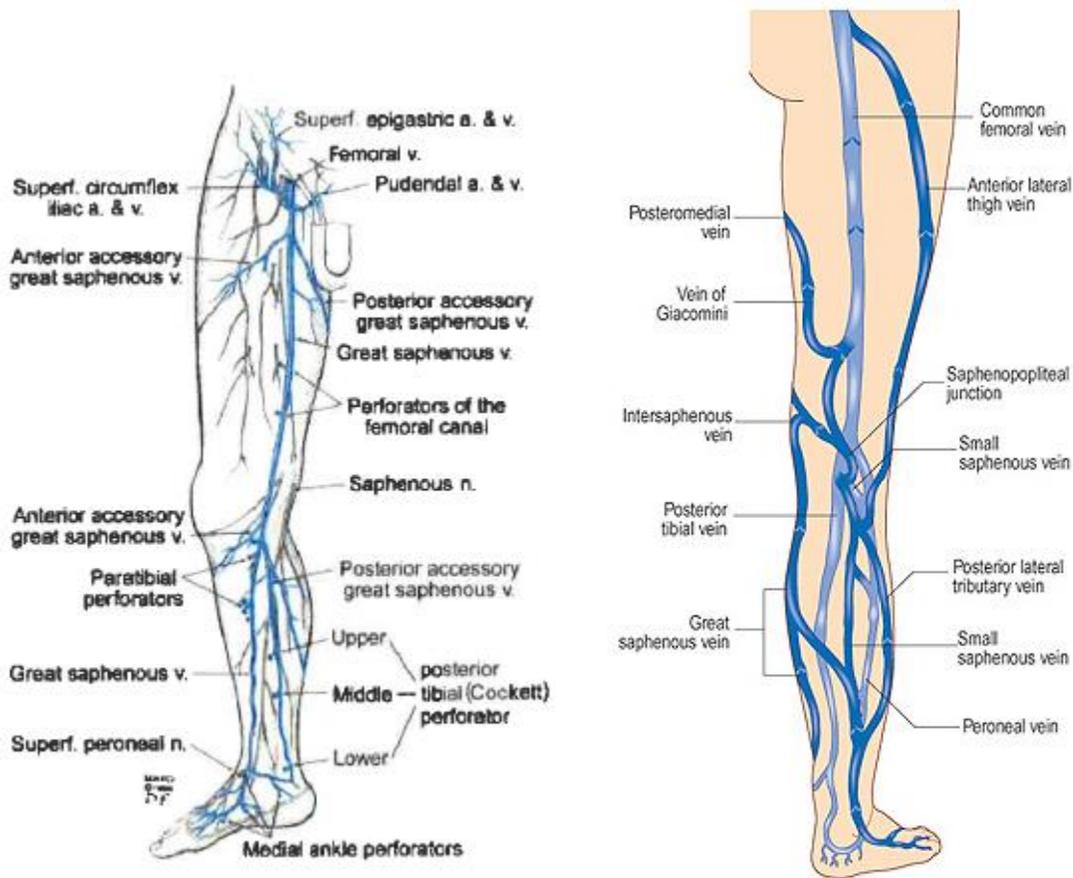
Clinical Classification	
CO	No visible or palpable signs of venous disease
C1	Telangiectasies or reticular veins
C2	Varicose veins
C3	Edema
C4a	Pigmentation and eczema
C4b	Lipodermatosclerosis and atrophie blanche
C5	Healed venous ulcer
C6	Active venous ulcer
S	Symptoms including ache, pain, swelling,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

According to the FDA label indications, VNUS® Closure™ System can be used for endovascular coagulation of blood vessels in patients with superficial vein reflux. VNUS® RFS and RFS Flex can be used in vessel and tissue coagulation including treatment of incompetent (i.e., refluxing) perforator and tributary veins. EVLT™ Diomed 810nm diode laser can be used for endovascular coagulation of the greater saphenous vein of the thigh in patients with superficial vein reflux. The 810 nm Diomed Laser and EVLT Procedure Kit can be used in the treatment of superficial vein reflux of the greater saphenous vein associated with varicosities. EVLT™ Kit and the D15 Plus and D30 Plus Diode Lasers can be used for treatment of incompetence and reflux of superficial veins in the lower extremity. ELVeS® Ceralas D 10-60 810nm diode laser (VenaCure™) can be used for endovascular coagulation of the greater saphenous vein of the thigh in individuals with superficial vein reflux. Angiodynamics Inc. 600 um Fiber and Venacure Procedure Kit can be used for endovascular coagulation of the great saphenous vein in individuals with superficial vein reflux for the treatment of varicose veins and varicosities associated with superficial reflux of the great saphenous vein, and for the treatment of incompetence and reflux of superficial veins of the lower extremity. Powered surgical laser instrument devices include, *but are not limited to*, Medilas™ D Fibertom Laser (Medilas D), Medilas™ D SkinPulse Laser (SkinPulse) and Medilas™ D SkinPulse S (SkinPulse S) and can be used for endovascular coagulation of the greater saphenous vein of the thigh in individuals with superficial vein reflux.

VARICOSE VEIN TREATMENTS (cont.)

Description: (cont.)

Vein Anatomy:





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VARICOSE VEIN-TREATMENTS (cont.)

Criteria:

A. Varicose Vein Treatment General Criteria:

- Treatment of varicose veins is considered **medically necessary** with documentation of **ALL** of the following:
 1. At least **ONE** of the following indications must be present:
 - Functional impairment, attributed to varicose veins, which limits performance of activities of daily living (ADLs). ADLs are defined as feeding, bathing, dressing, grooming, meal preparation, household chores, and occupational tasks that are required as a daily part of job functioning. Clinical records must specifically document **ALL** of the following:
 - a. The specific ADL (s) that is impaired
 - b. A description of how performance of the ADL is limited
 - Ultrasound documented recurrent attacks of superficial thrombophlebitis
 - Recurrent or persistent hemorrhage from ruptured varix
 - Ulceration from venous stasis where incompetent varices are a significant contributing factor
 2. There is clinical documentation that ongoing medically supervised conservative therapy, including use of compression stockings (or compression wrap when stockings cannot be utilized), has been utilized for a minimum of three months, is currently being utilized and did not successfully treat the individual's indication(s) or clinical condition. Clinical documentation must include **ALL** of the following:
 - Unna boot or compression bandaging or compressive device should be the first line of treatment when moderate to severe edema is identified, regardless of whether ulceration is present or not
 - History of present illness, physical examination, and conservative therapy treatment plan
 - Progress notes from a treating provider of at least 1 office visit after at least 3 months of conservative therapy documenting individual compliance with conservative therapy, including the use of compression stockings is currently being utilized and the individual's response



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VARICOSE VEIN-TREATMENTS (cont.)

Criteria: (cont.)

A. Varicose Vein Treatment General Criteria: (cont.)

- Treatment of varicose veins is considered **medically necessary** with documentation of **ALL** of the following: (cont.)
 2. There is clinical documentation that ongoing medically supervised conservative therapy, including use of compression stockings (or compression wrap when stockings cannot be utilized), has been utilized for a minimum of three months, is currently being utilized and did not successfully treat the individual's indication(s) or clinical condition. Clinical documentation must include **ALL** of the following: (cont.)
 - For requests for additional treatment sessions, three months of conservative therapy must have been utilized after the most recent varicose vein procedure and have not successfully treated the individual's symptom
 - Complete duplex studies including vein names with measurements of seconds of reflux and average vein diameters. A complete venous study includes a minimum of the following:
 - a. Deep veins: common femoral, mid-femoral and popliteal
 - b. Great saphenous vein: saphenofemoral junction (SFJ), mid-thigh, knee and mid-calf
 - c. Small saphenous vein: saphenopopliteal junction (SPJ) and mid-calf
 - d. Perforators: site with seconds of reflux and diameters
 - e. Tributaries: site with seconds of reflux and diameters.
 - f. Varicose veins (varices): diameters
 - Conservative therapy treatment plan (including use of compression stockings)
 - Results of monitoring conservative therapy, including documentation of medical supervision and timeframe of conservative therapy
 - Procedures requested:
 - a. Specific veins to be treated
 - b. Number of treatment sessions(s) being requested
 - c. Specify the veins to be treated in each session
 - d. For thermal ablation, all segments of the same truncal vein are treated in the same session unless there is documentation the practitioner is not able to advance the thermal ablation device all the way along the length of the truncal vein and must treat that vein in two segments in the same session



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VARICOSE VEIN-TREATMENTS (cont.)

Criteria: (cont.)

A. Varicose Vein Treatment General Criteria: (cont.)

- Treatment of varicose veins is considered **medically necessary** with documentation of **ALL** of the following: (cont.)
 3. Incompetence in the superficial system veins, (e.g., great and small saphenous veins, perforator veins, and saphenous tributaries) must be supported by complete venous imaging study, documentation obtained no more than 6 months prior to the request for coverage with the diameter of the vein and reflux in seconds measured at multiple levels in the thigh and calf
- Treatment of varicose veins for all other indications not previously listed or if above criteria not met is considered **cosmetic** and **not medically necessary**.

B. Treatment Sessions:

- Plan will consider requests for coverage of initial treatment sessions as follows:
 1. Initial treatment, single session, unilateral or bilateral leg(s)
 2. Initial treatment bilateral, 2 sessions, one for each leg
 3. Subsequent treatment when the clinical outcome of prior treatment(s) during three months subsequent to prior treatment(s) has been established and documented and varicose veins general criteria listed above are met with documentation of **ONE** of the following:
 - Subsequent treatment single session, unilateral or bilateral leg(s)
 - Subsequent treatment, bilateral, 2 sessions, one for each leg
 4. Each treatment session should address as much abnormality as is appropriate and reasonable and may include more than one modality

VARICOSE VEIN-TREATMENTS (cont.)

Criteria: (cont.)

C. Imaging:

- A Doppler ultrasound or duplex study to map the venous system and evaluate for deep and superficial venous incompetence is considered **medically necessary**.
- Ultrasound guidance for liquid, foam, or microfoam sclerotherapy (echosclerotherapy) for the small saphenous vein and saphenous tributaries including accessory saphenous veins is considered **medically necessary**.
- Ultrasound guidance for liquid, foam, or microfoam sclerotherapy for all other veins not listed above is considered **not medically necessary** based upon insufficient evidence to support improvement of the net health outcome.
- Follow-up venous studies performed within six months following the most recent ipsilateral treatment, in the absence of complications, including but not limited to routine confirmation studies following endovenous ablation is considered **not medically necessary** based upon insufficient evidence to support improvement of the net health outcome.
- Follow-up venous studies performed six months or longer following the most recent ipsilateral treatment when criteria above are met is considered **medically necessary**.

D. Procedures:

Ligation, Stripping and Phlebectomy: (i.e., stab, hook, transilluminated powered)

- Ligation/stripping and phlebectomy treatment of the incompetent, superficial system veins (including the great and small saphenous veins and saphenous tributaries including accessory saphenous veins) and varicose veins 4 mm or greater in diameter is considered **medically necessary** with documentation of **ALL** of the following:
 1. The incompetent superficial veins proximal to the vein to be treated either have been treated or are being treated concurrently
 2. Treatment of varicose veins general criteria listed above are met
- Ligation, stripping and phlebectomy for all indications not previously listed or above criteria not met is considered **not medically necessary** based upon insufficient evidence to support improvement of the net health outcome.

VARICOSE VEIN TREATMENTS (cont.)

Criteria: (cont.)

D. Procedures: (cont.)

Endovenous Ablation:

- Endovenous radiofrequency or laser ablation treatment of incompetent great or small saphenous veins is considered **medically necessary** with documentation of **ALL** of the following:
 1. Minimum vein diameters where treatment is requested with documentation of **ONE** of the following:
 - Great saphenous vein diameter 5.5 mm or greater throughout the segment to be ablated, measured via ultrasound at the saphenofemoral junction (SFJ) (or proximal thigh), med-thigh, and knee (or above knee); (If below knee ablation requested mid-calf measurement also necessary)
 - Small saphenous vein diameter is 4 mm or greater throughout the segment to be ablated, measured via ultrasound at the saphenopopliteal junction (SPJ)
 2. Significant incompetence exceeding a duration of 0.5 seconds or a peak reflux velocity greater than 30 cm/sec is demonstrated at the saphenofemoral junction (SFJ), or at the saphenopopliteal junction (SPJ)
 3. Treatment of varicose veins general criteria listed above are met
- Endovenous radiofrequency or laser ablation of incompetent great or small saphenous veins for all indications not previously listed or above criteria not met is considered **not medically necessary** based upon insufficient evidence to support improvement of the net health outcome.
- Endovenous laser or radiofrequency ablation of the entire incompetent saphenous vein usually can be accomplished in a single treatment session. Endovenous laser or radiofrequency ablation of multiple separate sessions for ablation of segments of a continuous vein are considered **not medically necessary** based upon insufficient evidence to support improvement of the net health outcome. Although additional procedures, including ligation or sclerotherapy, performed in the same treatment session on the same ablated saphenous vein are considered included components of the ablation procedure, procedures on other saphenous venous systems may be distinct procedural services.

VARICOSE VEIN TREATMENTS (cont.)

Criteria: (cont.)

D. Procedures: (cont.)

Endovenous Ablation: (cont.)

- Endovenous laser or radiofrequency ablation treatment for all of the following is considered **experimental or investigational** based upon:
 1. Lack of final approval from the Food and Drug Administration, and
 2. Insufficient scientific evidence to permit conclusions concerning the effect on health outcomes, and
 3. Insufficient evidence to support improvement of the net health outcome, and
 4. Insufficient evidence to support improvement of the net health outcome as much as, or more than, established alternatives, and
 5. Insufficient evidence to support improvement outside the investigational setting.

These indications include, *but are not limited to*:

- Cryoablation of any vein
- Radiofrequency or laser ablation of veins other than the great or small saphenous veins, including but not limited to the following:
 - a. Accessory saphenous veins
 - b. Branch tributaries
 - c. Varicose veins
 - d. Perforator veins
- Ablation of saphenous and other veins for the treatment of pelvic congestion syndrome
- Mechanochemical ablation of any vein
- Microwave ablation of any vein
- Stem injection ablation of any vein

VARICOSE VEIN TREATMENTS (cont.)

Criteria: (cont.)

D. Procedures: (cont.)

Sclerotherapy:

- Sclerotherapy (liquid, foam, or microfoam) treatment of the superficial system veins, the small saphenous vein and saphenous tributaries including accessory saphenous veins, varicose veins 4mm or greater in diameter and perforator veins greater than 5 mm in individuals with C4b disease or greater following truncal ablation is considered **medically necessary** with documentation of **ALL** of the following:
 1. If related superficial system veins proximal to the incompetent vein to be treated are incompetent, those incompetent proximal veins either have been treated or are being treated concurrently
 2. Treatment of varicose veins general criteria listed above are met
- Sclerotherapy for all indications not previously listed including the greater saphenous vein or above criteria not met is considered **not medically necessary** based upon insufficient evidence to support improvement of the net health outcome.
- Sclerotherapy of small (less than 4mm in diameter) superficial reticular veins and /or telangiectasia's (spider veins) is considered **cosmetic** and **not eligible for coverage**.

Other Treatments:

- Endovenous glue/adhesive (e.g. cyanoacrylate adhesives) is considered **experimental or investigational** based upon:
 1. Lack of final approval from the Food and Drug Administration, and
 2. Insufficient scientific evidence to permit conclusions concerning the effect on health outcomes, and
 3. Insufficient evidence to support improvement of the net health outcome, and
 4. Insufficient evidence to support improvement of the net health outcome as much as, or more than, established alternatives, and
 5. Insufficient evidence to support improvement outside the investigational setting



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VARICOSE VEIN-TREATMENTS (cont.)

Resources:

Literature reviewed 01/11/18. We do not include marketing materials, poster boards and non-published literature in our review.

The BCBS Association Medical Policy Reference Manual (MPRM) policy is included in our guideline review. References cited in the MPRM policy are not duplicated on this guideline.

Resources prior to 2013 may be requested from the BCBSAZ Medical Policy and Technology Research Department.

1. 7.01.124 BCBS Association Medical Policy Reference Manual. Treatment of Varicose Veins/Venous Insufficiency. Re-issue date 05/08/2017, issue date 03/10/2011.
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3. Deijen CL, Schreve MA, Bosma J, et al. Clarivein mechanochemical ablation of the great and small saphenous vein: Early treatment outcomes of two hospitals. *Phlebology*. Apr 2016;31(3):192-197.
4. Elias S, Lam YL, Wittens CH. Mechanochemical ablation: status and results. *Phlebology*. Mar 2013;28 Suppl 1:10-14.
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6. External Consultant Review. *Vascular Surgeon*. 06/28/2017.
7. Gibson K, Minjarez R, Ferris B, et al. Clinical presentation of women with pelvic source varicose veins in the perineum as a first step in the development of a disease-specific patient assessment tool. *Journal of vascular surgery. Venous and lymphatic disorders*. Jul 2017;5(4):493-499.
8. InterQual® Care Planning Procedures Adult. Ligation and Stripping, Varicose Veins.
9. InterQual® Care Planning Procedures Adult. Sclerotherapy, Varicose Veins.
10. InterQual® Care Planning Procedures Adult. Endovenous Ablation, Varicose Veins.
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Resources: (cont.)

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13. Labropoulos N, Kokkosis AA, Spentzouris G, Gasparis AP, Tassiopoulos AK. The distribution and significance of varicosities in the saphenous trunks. *J Vasc Surg*. Jan 2010;51(1):96-103.
14. Mueller RL, Raines JK. ClariVein mechanochemical ablation: background and procedural details. *Vasc Endovascular Surg*. Apr 2013;47(3):195-206.
15. National Institute for Health and Care Excellence. Endovenous mechanochemical ablation for varicose veins. May 25 2016.
16. Rabe E, Pannier F. Indications, contraindications and performance: European Guidelines for Sclerotherapy in Chronic Venous Disorders. *Phlebology*. May 2014;29(1 suppl):26-33.
17. Rami Tadros Italina Journal of Vascular and Endovascular Surgery. A novel technique for closure of the perforator vein using the ClariVein Occlusion Catheter March 2016;23 number 1.
18. Regence Surgery Policy 104. Varicose Vein Treatment. Re-issue date 09/01/2017, issue date October 1999.
19. Sullivan LP, Quach G, Chapman T. Retrograde mechanico-chemical endovenous ablation of infrageniculate great saphenous vein for persistent venous stasis ulcers. *Phlebology*. Dec 2014;29(10):654-657.
20. Tang TY, Kam JW, Gaunt ME. ClariVein(R) - Early results from a large single-centre series of mechanochemical endovenous ablation for varicose veins. *Phlebology*. Feb 22 2016.
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VARICOSE VEIN-TREATMENTS (cont.)

Non-Discrimination Statement:

Blue Cross Blue Shield of Arizona (BCBSAZ) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. BCBSAZ provides appropriate free aids and services, such as qualified interpreters and written information in other formats, to people with disabilities to communicate effectively with us. BCBSAZ also provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages. If you need these services, call (602) 864-4884 for Spanish and (877) 475-4799 for all other languages and other aids and services.

If you believe that BCBSAZ has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with: BCBSAZ's Civil Rights Coordinator, Attn: Civil Rights Coordinator, Blue Cross Blue Shield of Arizona, P.O. Box 13466, Phoenix, AZ 85002-3466, (602) 864-2288, TTY/TDD (602) 864-4823, crc@azblue.com. You can file a grievance in person or by mail or email. If you need help filing a grievance BCBSAZ's Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD). Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>

Multi-Language Interpreter Services:

Spanish: Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de Blue Cross Blue Shield of Arizona, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 602-864-4884.

Navajo: Díí kwe'é atah nilinígíí Blue Cross Blue Shield of Arizona haada yit'éego bina'idílkidgo éí doodago Háida bíjá anilyeedígíí t'áadoo le'é yina'idílkidgo beehaz'áanii hólo díí t'áa hazaadk'ehjí háká a'doowolgo bee haz'ą doo baqah ilínígóó. Ata' halne'ígíí kojí' bich'í' hodílnih 877-475-4799.

Chinese: 如果您，或是您正在協助的對象，有關於插入項目的名稱 Blue Cross Blue Shield of Arizona 方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥電話 在此插入數字 877-475-4799。

Vietnamese: Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Blue Cross Blue Shield of Arizona quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 877-475-4799.

Arabic:

إن كان لديك أو لدى شخص تساعد أسئلة بخصوص Blue Cross Blue Shield of Arizona، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون أية تكلفة. للتحدث مع مترجم اتصل بـ 877-475-4799.

