STATE OF IOWA DEPARTMENT OF
Health AND Human
SERVICES

Varicose Vein Treatment
SRG-019

Iowa Medicaid Program:	Prior Authorization	**Effective Date:**	7/1/2008
Revision Number:	5	**Last Rev Date:**	1/19/2024
Reviewed By:	Medicaid Medical Director	**Next Rev Date:**	1/17/2025
Approved By:	Medicaid Clinical Advisory Committee	**Approved Date:**	5/23/2018

Criteria

Treatments for varicose veins include phlebectomy, ligation and excision, endovenous laser therapy (EVLT), sclerotherapy, and radiofrequency ablation (RFA).

1. There must be documentation of at least **ONE** of the following:
   a. Leg ulcerations that are due to saphenous vein insufficiency and are refractory to conservative management; **OR**
   b. Recurrent bleeding from the saphenous vein or other varicosities; **OR**
   c. History of a single, significant episode of bleeding, especially if transfusion is required; **AND**
2. There is documentation of **ALL** the following:
   a. Incompetence/reflux with doppler evaluation and/or duplex ultrasound of the symptomatic varicosity, and documented vessel size >3mm; **AND**
   b. Failure of conservative management (e.g., leg elevation, compression therapy) for 6 consecutive months; **AND**
   c. At least **ONE** of the following associated clinical conditions:
      1) Pain in the affected extremity, resulting in impaired mobility or inability to perform ADLs; **OR**
      2) Recurrent phlebitis or thrombophlebitis; **OR**
      3) Refractory dependent edema; **OR**
      4) Persistent stasis dermatitis.

Treatments for varicose veins are **not covered** when performed primarily for cosmetic purposes. Treatment is not covered for varicose veins <3mm in diameter as this is considered cosmetic in nature.

Coding

The following list of codes is provided for reference purposes only and may not be all inclusive. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment, nor does the exclusion of a code imply that its association to the HCPCS/CPT code is inappropriate.

CPT	Description
36468	Injection(s) of sclerosant for spider veins (telangiectasia), 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.
36475	Endovenous ablation therapy of incompetent vein, extremity, inclusive of all imaging guidance and monitoring, percutaneous, radiofrequency; first vein treated.
37700	Ligation and division of long saphenous vein at saphenofemoral junction, or distal interruptions.
37780	Ligation and division of short saphenous vein at saphenopopliteal junction (separate procedure).
37765	Stab phlebectomy of varicose veins, 1 extremity; 10-20 stab incisions.

Compliance

1. Should conflict exist between this policy and applicable statute, the applicable statute shall supersede.
2. Federal and State law, as well as contract language, including definitions and specific contract provisions or exclusions, take precedence over medical policy and must be considered first in determining eligibility for coverage.
3. Medical technology is constantly evolving, and Iowa Medicaid reserves the right to review and update medical policy on an annual and as-needed basis.

Medical necessity guidelines have been developed for determining coverage for member benefits and are published to provide a better understanding of the basis upon which coverage decisions are made. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in the service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. Criteria are revised and updated annually, or more frequently if new evidence becomes available that suggests needed revisions.

References

Development of utilization management criteria may also involve research into other state Medicaid programs, other payer policies, consultation with experts and review by the Medicaid Clinical Advisory Committee (CAC). These sources may not be referenced individually unless they are specifically published and are otherwise applicable to the criteria at issue.

Criteria Change History

Change Date	Changed By	Description of Change	Version

Signature

Change Date	Changed By	Description of Change	Version

Signature

Change Date	Changed By	Description of Change	Version
1/19/2024	CAC	Annual review.	5

Signature
William (Bill) Jagiello, DO

Change Date	Changed By	Description of Change	Version
1/20/2023	CAC	Annual review.	4

Signature
William (Bill) Jagiello, DO

Change Date	Changed By	Description of Change	Version
10/20/2022	CAC	Annual review. Formatting changes. Added Compliance section.	3

Signature
William (Bill) Jagiello, DO

Change Date	Changed By	Description of Change	Version
4/17/2015	CAC	Added paragraph in References.	2

Signature
C. David Smith, MD

Change Date	Changed By	Description of Change	Version
4/18/2014	Medical Director	Formatting changes. Added CPT codes.	1

Signature