FEP Medical Policy Manual

FEP 7.01.124 Treatment of Varicose Veins/Venous Insufficiency

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Related Policies:
None

Treatment of Varicose Veins/Venous Insufficiency

Description

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).

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Treatment

Treatment of venous reflux/venous insufficiency seeks to reduce abnormal pressure transmission from the deep to the superficial veins. Conservative medical treatment consists of elevation of the extremities, graded compression, and wound care when indicated. Conventional surgical treatment consists of identifying and correcting the site of reflux by ligation of the incompetent junction followed by stripping of the vein to redirect venous flow through veins with intact valves. While most venous reflux is secondary to incompetent valves at the saphenofemoral or saphenopopliteal junctions, reflux may also occur at incompetent valves in the perforator veins or the deep venous system. The competence of any single valve is not static and may be pressure-dependent. For example, accessory saphenous veins may have independent saphenofemoral or saphenopopliteal junctions that become incompetent when the great or small saphenous veins are eliminated, and blood flow is diverted through the accessory veins.

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 typically includes the following:

1. Identification by preoperative Doppler ultrasonography of the valvular incompetence
2. Control of the most proximal point of reflux, traditionally by suture ligation of the incompetent saphenofemoral or saphenopopliteal junction
3. Removal of the superficial vein from circulation, eg, by stripping of the great and/or small saphenous veins.
4. 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 sclerotherapy, transilluminated powered phlebectomy, and thermal ablation using cryotherapy, high-frequency radio waves (200-300 kHz), or laser energy.

Thermal Ablation

Radiofrequency ablation is performed 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 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 (eg, air or carbon dioxide) with a liquid sclerosant (eg, 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 the need for the tumescent anesthesia used with endovenous thermal ablation techniques (radiofrequency ablation, endovenous laser ablation).

**Cyanoacrylate Adhesive**

A 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 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 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 transilluminated powered phlebectomy might decrease surgical time, decrease complications such as bruising and lead to a faster recovery than established procedures.

**Treatment of Perforator Veins**

Perforator veins cross through the fascia and connect the deep and superficial venous systems. Incompetent perforating veins were originally treated with an open surgical procedure, called the Linton procedure, which involved a long medial calf incision to expose all posterior, medial, and paramedial perforators. While this procedure was associated with healing of ulcers, it was largely abandoned due to a high incidence of wound complications. The Linton procedure was subsequently modified by using a series of perpendicular skin flaps instead of a longitudinal skin flap to provide access to incompetent perforator veins in the lower part of the leg. The modified Linton procedure may occasionally be used to close incompetent perforator veins that cannot be reached by less invasive procedures.

Subfascial endoscopic perforator surgery is a less invasive surgical procedure for the treatment of incompetent perforators and has been reported since the mid-1980s. Guided by Duplex ultrasound scanning, small incisions are made in the skin, and the perforating veins are clipped or divided by endoscopic scissors. The surgery can be performed as an outpatient procedure. Endovenous ablation of incompetent perforator veins with sclerotherapy and radiofrequency ablation has also been reported.

**OBJECTIVE**

The objective of this evidence review is to evaluate whether the use of ablative, chemical, and adhesive technologies to treat varicose veins/venous insufficiency arising from reflux in the saphenous, tributary, and perforator veins improves net health outcomes.

**POLICY STATEMENT**

**Saphenous Veins**

**Great or Small Saphenous Veins**

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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 not medically necessary.

### 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 not medically necessary.

### 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.

### Perforator Veins

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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 **not medically necessary**.

**Telangiectasia**

Treatment of telangiectasia such as spider veins, angiomas, and hemangiomata is considered cosmetic and **not medically necessary**.

**Other Veins**

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.

**POLICY GUIDELINES**

The standard classification of venous disease is the CEAP (Clinical, Etiologic, Anatomic, Pathophysiologic) classification system. Table PG1 provides the Clinical portion of the CEAP.

**Table PG1. Clinical Portion of the CEAP Classification System**

<table>
<thead>
<tr>
<th>Class</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>C0</td>
<td>No visible or palpable signs of venous disease</td>
</tr>
<tr>
<td>C1</td>
<td>Telangiectasies or reticular veins</td>
</tr>
<tr>
<td>C2</td>
<td>Varicose veins</td>
</tr>
<tr>
<td>C3</td>
<td>Edema</td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>C4a</th>
<th>Pigmentation and eczema</th>
</tr>
</thead>
<tbody>
<tr>
<td>C4b</td>
<td>Lipodermatosclerosis and atrophie blanche</td>
</tr>
<tr>
<td>C5</td>
<td>Healed venous ulcer</td>
</tr>
<tr>
<td>C6</td>
<td>Active venous ulcer</td>
</tr>
<tr>
<td>S</td>
<td>Symptoms including ache, pain, tightness, skin irritation, heaviness, muscle cramps, as well as other complaints attributable to venous dysfunction</td>
</tr>
<tr>
<td>A</td>
<td>Asymptomatic</td>
</tr>
</tbody>
</table>


CEAP: Clinical, Etiologic, Anatomic, Pathophysiologic classification system.

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 not medically necessary or incidental to the injection procedure.

**BENEFIT APPLICATION**

Experimental or investigational procedures, treatments, drugs, or devices are not covered (See General Exclusion Section of brochure).

Treatment of some varicose veins may be considered cosmetic if not associated with significant clinical symptoms and documented reflux at the saphenofemoral or saphenopopliteal junction, and thus contract exclusions for cosmetic therapies may apply to coverage eligibility. Photographs or chart notes in conjunction with the results of duplex ultrasound scanning demonstrating incompetent veins may be required to establish medical necessity. Note that 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 other symptoms (eg, pain or heaviness), and their treatment is considered cosmetic.

**FDA 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 (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 the FDA through the 501(k) process for endovenous treatment of superficial vein reflux:

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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 VNUS RFS and RFSFlex devices were cleared by the FDA for use in vessel and tissue coagulation including treatment of incompetent (ie, 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: GEX.

In 2002, the Diomed 810 nm surgical laser and EVLT (endovenous laser therapy) procedure kit were 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. A variety of clinical indications are listed, including cryoablation of varicose veins of the lower limbs. FDA product code: GEI.

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 (Vascular Insights) was cleared by the FDA through the 510(k) process (K071468) for mechaenochemical 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 RCTs and systematic reviews of controlled trials. The relevant outcomes are symptoms, change in disease status, morbidity events, QOL, and TRM. 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 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 a meaningful 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. The relevant outcomes are symptoms, change in disease status, morbidity events, QOL, and TRM. 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 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 a meaningful improvement in the net health outcome.

Based on the available evidence, clinical input obtained in 2015, and clinical practice guidelines, the use of endovenous RFA, endovenous laser ablation, and microfoam sclerotherapy are considered to improve outcomes when used in the saphenous veins. For treatment of saphenous tributaries at the same time or following treatment of the saphenous vein, stab avulsion, hook phlebectomy, sclerotherapy, or transilluminated powered phlebectomy improve outcomes.

For individuals who have varicose veins/venous insufficiency and saphenous vein reflux who receive MOCA, the evidence includes two RCTs and case series. The relevant outcomes are symptoms, change in disease status, morbidity events, QOL, and TRM. MOCA is a combination of liquid sclerotherapy with mechanical abrasion. Potential advantages of this procedure compared with thermal ablation are that MOCA does not require multiple needle sticks with tumescent anesthesia and may result in less pain during the procedure. The evidence on MOCA includes an RCT that compared MOCA to thermal ablation with one year results, an RCT with year results, an RCT with...
The short-term results that compared MOCA with RFA, and case series with follow-up out to three years. The short-term results of one RCT suggested that intraprocedural pain is slightly lower with MOCA than with RFA. However, the second RCT showed lower occlusion rates than thermal ablation. MOCA has been assessed in relatively few patients and for short durations. Longer follow-up in RCTs with a larger number of patients is needed to evaluate the efficacy and durability of this procedure compared with established procedures. The evidence is insufficient to determine the effects of the technology on health outcomes.

For individuals who have varicose veins/venous insufficiency and saphenous vein reflux who receive CAC, the evidence includes two RCTs and a prospective cohort. The relevant outcomes are symptoms, change in disease status, morbid events, QOL, and TRM. Evidence includes a multicenter noninferiority trial with follow-up through 36 months, an RCT 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. A second RCT (n=525) with the same 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. A prospective cohort reported 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 a meaningful 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 and multicenter series. The relevant outcomes are symptoms, change in disease status, morbid events, QOL, and TRM. 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 the effects of the technology on 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, QOL, and TRM. 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). 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 a meaningful improvement in the net health outcome.

Perforator Veins

For individuals who have perforator vein reflux who receive ablation (eg, subfascial endoscopic perforator surgery) of perforator veins, the evidence includes RCTs and systematic reviews of RCTs. The relevant outcomes are symptoms, change in disease status, morbid events, QOL, and TRM. 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 (ie, ulcers), treatment of perforator vein reflux may be as beneficial as an alternative (eg, 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 has been shown to be as effective as the Linton procedure with a reduction in adverse events. Although only one case series has been identified showing an improvement in health outcomes, 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 a meaningful improvement in the net health outcome.

SUPPLEMENTAL INFORMATION

Practice Guidelines and Position Statements

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**Table 12. Guidelines on Management of Varicose Veins and Associated Chronic Venous Diseases**

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Grade</th>
<th>SOR</th>
<th>QOE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Compression therapy for venous ulcerations and varicose veins</td>
<td>1B</td>
<td>Strong</td>
<td>Moderate</td>
</tr>
<tr>
<td>Compression therapy is recommended as the primary treatment to aid healing of</td>
<td>1B</td>
<td>Strong</td>
<td>Moderate</td>
</tr>
<tr>
<td>venous ulceration</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>To decrease the recurrence of venous ulcers, ablation of the incompetent</td>
<td>1A</td>
<td>Strong</td>
<td>High</td>
</tr>
<tr>
<td>superficial veins in addition to compression therapy is recommended</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Use of compression therapy for patients with symptomatic varicose veins is</td>
<td>2C</td>
<td>Weak</td>
<td>Low</td>
</tr>
<tr>
<td>recommended</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Compression therapy as the primary treatment if the patient is a candidate for</td>
<td>1B</td>
<td>Strong</td>
<td>Moderate</td>
</tr>
<tr>
<td>saphenous vein ablation is not recommended</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Treatment of the incompetent great saphenous vein</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Endovenous thermal ablation (radiofrequency or laser) is recommended over</td>
<td>1B</td>
<td>Strong</td>
<td>Moderate</td>
</tr>
<tr>
<td>chemical ablation with foam or high ligation and stripping</td>
<td>1B</td>
<td>Strong</td>
<td>Moderate</td>
</tr>
<tr>
<td>due to reduced convalescence and less pain and morbidity. Cryoablation is a</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>technique that is new in the United States, and it has not been fully evaluated.</td>
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<tr>
<td>Varicose tributaries</td>
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<tr>
<td>Phlebectomy or sclerotherapy are recommended to treat varicose tributaries</td>
<td>1B</td>
<td>Strong</td>
<td>Moderate</td>
</tr>
<tr>
<td>Transillumination powered phlebectomy using lower oscillation speeds and</td>
<td>2C</td>
<td>Weak</td>
<td>Low</td>
</tr>
<tr>
<td>extended tumescence is an alternative to traditional phlebectomy</td>
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<tr>
<td>Perforating vein incompetence</td>
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</table>

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Selective treatment of perforating vein incompetence in patients with simple varicose veins is not recommended

| Treatment of pathologic perforating veins (outward flow of ≥500 ms duration, with a diameter of ≥3.5 mm) located underneath healed or active ulcers (CEAP class C5-C6) is recommended | 1B | Strong | Moderate |

QOE: quality of evidence; SOR: strength of recommendation.

Grading: strong = 1 or weak = 2, based on a level of evidence that is either high quality = A, moderate quality = B, or low quality = C.

### Society of Interventional Radiography

The Society of Interventional Radiography (2003) published a position statement that considered endovenous ablation therapy, using either laser or radiofrequency devices under imaging guidance and monitoring, an effective treatment of extremity venous reflux and varicose veins under the following conditions:

"The endovenous treatment of varicose veins may be medically necessary when:

1. one of the following indications (A - E) is present:
   - Persistent symptoms interfering with activities of daily living in spite of conservative/nonsurgical management. Symptoms include aching, cramping, burning, itching, and/or swelling during activity or after prolonged standing.
   - Significant recurrent attacks of superficial phlebitis
   - Hemorrhage from a ruptured varix
   - Ulceration from venous stasis where incompetent varices are a contributing factor
   - Symptomatic incompetence of the great or small saphenous veins (symptoms as in A above)
   and;
   - A trial of conservative, nonoperative treatment has failed. This would include mild exercise, avoidance of prolonged immobility, periodic elevation of legs, and compressive stockings.
   and;
   - The patient's anatomy is amenable to endovenous ablation."

In a joint statement, American Venous Forum and Society of Interventional Radiography (2007) recommended reporting standards for endovenous ablation for the treatment of venous insufficiency. They recommended that reporting in clinical studies should include the symptoms of venous disease, history of the disease and prior treatment, the presence of major comorbidities, and any exclusion criteria. It was noted that potential candidates for endovenous ablation might include patients with reflux in an incompetent great saphenous vein or smaller saphenous vein or a major tributary branch of the great or smaller saphenous veins such as the anterior thigh circumflex vein, posterior thigh circumflex vein, or anterior accessory great saphenous vein. The presence of reflux in these veins is important to document using duplex ultrasound imaging, and the ultrasound criteria used to define reflux should be indicated. It was also stated that, in current practice, most vascular laboratories consider the presence of venous flow reversal for greater than 0.5 to 1.0 second with proximal compression, Valsalva maneuver, or distal compression and release to represent pathologic reflux.

### American College of Phlebology

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The American College of Phlebology (2017) published guidelines on the treatment of refluxing accessory saphenous veins. The College gave a Grade 1 recommendation based on level C evidence that patients with symptomatic incompetence of the accessory saphenous veins be treated with endovenous thermal ablation or sclerotherapy to reduce symptomatology. The guidelines noted that although accessory saphenous veins may drain into the great saphenous vein before it drains into the common femoral vein, they can also empty directly into the common femoral vein.

**National Institute for Health and Care Excellence**

The NICE (2013) updated its guidance on ultrasound-guided foam sclerotherapy for varicose veins. NICE stated that:

1. Current evidence on the efficacy of ultrasound-guided foam sclerotherapy for varicose veins is adequate. The evidence on safety is adequate, and provided that patients are warned of the small but significant risks of foam embolization (see section 1.2), this procedure may be used with normal arrangements for clinical governance, consent and audit.

2. During the consent process, clinicians should inform patients that there are reports of temporary chest tightness, dry cough, headaches and visual disturbance, and rare but significant complications including myocardial infarction, seizures, transient ischaemic attacks and stroke.

The NICE (2016) revised its guidance on endovenous mechanochemical ablation, concluding that current evidence on the safety and efficacy of endovenous mechanochemical ablation for varicose veins appears adequate to support the use of this procedure.


**U.S. Preventive Services Task Force Recommendations**

Not applicable.

**Medicare National Coverage**

There is no national coverage determination. In the absence of a national coverage determination, coverage decisions are left to the discretion of local Medicare carriers.

**REFERENCES**


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19. Todd KL, 3rd, Wright D, for the Vanish-Investigator Group. The VANISH-2 study: a randomized, blinded, multicenter study to evaluate the efficacy and safety of polidocanol endovenous microfoam 0.5% and 1.0% compared with placebo for the treatment of saphenofemoral junction incompetence. Phlebology. Oct 2014;29(9):608-618. PMID 23864535

20. Eroglu, EE, Yasim, AA. A Randomised Clinical Trial Comparing N-Butyl Cyanoacrylate, Radiofrequency Ablation and Endovenous Laser Ablation for the Treatment of Superficial Venous Insufficiency: Two Year Follow up Results. Eur J Vasc Endovasc Surg, 2018 Jul 26;56(4). PMID 30042039


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34. Morrison, NN, Kolluri, RR, Vasquez, MM, Madsen, MM, Jones, AA, Gibson, KK. Comparison of cyanoacrylate closure and radiofrequency ablation for the treatment of incompetent great saphenous veins: 36-Month outcomes of the VeClose randomized controlled trial. Phlebology, 2018 Nov 8;268355518810259;268355518810259. PMID 30403154


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POLICY HISTORY - THIS POLICY WAS APPROVED BY THE FEP® PHARMACY AND MEDICAL POLICY COMMITTEE ACCORDING TO THE HISTORY BELOW:

<table>
<thead>
<tr>
<th>Date</th>
<th>Action</th>
<th>Description</th>
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<tr>
<td>December 2011</td>
<td>New policy</td>
<td>Policy updated with literature review, References added,renumbered or removed. New information added to policy regarding endovenous mechanochemical ablation and policy statement under “Other” as considered investigational. Addition to policy statement under Accessory Saphenous Veins: “Incompetence of the accessory saphenous vein is isolated, OR”. New product information added under Regulatory Status on ClariVein® Infusion Catheter.</td>
</tr>
<tr>
<td>June 2013</td>
<td>Replace policy</td>
<td>Policy updated with literature review, references added, policy statements unchanged</td>
</tr>
<tr>
<td>March 2014</td>
<td>Replace policy</td>
<td>Policy updated with literature review; references 8-9, 18, 24, 33 added and some references removed; microfoam sclerotherapy considered medically necessary.</td>
</tr>
<tr>
<td>March 2015</td>
<td>Replace policy</td>
<td>Policy updated with literature review; references updated through July 7, 2015; references 15, 25-28, 47, and 61 added; reference 52 updated; clinical input reviewed. The requirement of failure of compression therapy was removed from the policy statement on ulceration secondary to venous stasis and recurrent superficial thrombophlebitis; terminology was changed from greater and lesser to great and small saphenous veins.</td>
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<tr>
<td>March 2016</td>
<td>Replace policy</td>
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<tr>
<td>September 2018</td>
<td>Replace policy</td>
<td>Policy updated with literature review through March 5, 2018; references 9, 12, 18, 20-21, 24-27, and 30-31 added; references 52, 54 and 56 updated. Policy statements unchanged.</td>
</tr>
<tr>
<td>December 2018</td>
<td>Replace policy</td>
<td>Removed “not medically necessary” from policy statement: “Treatment of telangiectasia such as spider veins, angiomata, and hemangioma is considered cosmetic.”</td>
</tr>
<tr>
<td>March 2019</td>
<td>Replace policy</td>
<td>Policy updated with literature review through November 18, 2018; references 16, 19, 33-34 added. Policy statements unchanged except Cyanoacrylate adhesive changed from investigational to not medically necessary.</td>
</tr>
<tr>
<td>September 2019</td>
<td>Replace policy</td>
<td>Policy updated with literature review through March 26, 2019, references 60, and 65-67 added. Cyanoacrylate adhesive may be considered medically necessary. A statement was added on concurrent treatment of the accessory saphenous veins.</td>
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</tbody>
</table>

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