Treatment of Varicose Veins/Venous Insufficiency

Description

A variety of treatment modalities are available to treat varicose veins/venous insufficiency, including surgical approaches, thermal ablation, and sclerotherapy. The application of each of these treatment options is influenced by the severity of the symptoms, the type of vein, the source of venous reflux, and the use of other (prior or concurrent) treatments.

Background

The venous system of the lower extremities consists of the superficial veins (this includes the greater and lesser saphenous and accessory, or duplicate veins that travel in parallel with the greater and lesser 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. Since 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 considers the clinical, etiologic, anatomic, and pathologic (CEAP) characteristics of venous insufficiency, ranging from class 0 (no visible sign of disease) to class 6 (active ulceration).

Treatment of venous reflux/venous insufficiency is aimed at reducing 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 in 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 greater or lesser saphenous veins are eliminated and blood flow is diverted through the accessory veins.
Saphenous Veins and Tributaries

Saphenous veins include the greater and lesser saphenous and accessory saphenous veins that travel in parallel with the greater or lesser 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, for example by stripping of the greater and/or lesser 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. These include sclerotherapy, transilluminated powered phlebotomy (TIPP), and thermal ablation using cryotherapy, high frequency radiowaves (200–300 kHz), or laser energy.

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 resulting in the occlusion of the vessel. The success of the treatment 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 to be 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). The foam is produced at the time of treatment. Varithena™ (previously known as Varisolve, BTG PLC, London) is a proprietary microfoam sclerosant that is dispersed from a canister with a controlled density and more consistent bubble size.

Endovenous Mechanochemical Ablation

Endovenous mechanochemical ablation 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 3,500 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, without the need for the tumescent anesthesia used in radiofrequency (RF) ablation or endovenous laser ablation (EVLT).
Thermal Ablation

RFA is performed by means of 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 greater saphenous vein under ultrasound (US) guidance; the laser is activated and slowly removed along the course of the saphenous vein. Cryoablation uses extreme cold to cause injury to the vessel. The objective of endovenous techniques is to cause injury to 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 lesser saphenous vein.

Transilluminated Powered Phlebectomy (TIPP)

TIPP is an alternative to stab avulsion or hook phlebectomy. This procedure uses 2 instruments: an illuminator which also provides irrigation, and a resector, which has an oscillating tip and can perform suction. Following removal of the saphenous vein, the illuminator is introduced via a small incision in the skin and tumescence solution (anesthetic and epinephrine) is infiltrated along the course of the varicosity. The resector is then inserted under the skin from the opposite direction, and the oscillating tip is placed directly beneath the illuminated veins to fragment and loosen the veins from the supporting tissue. Irrigation from the illuminator is used to clear the vein fragments and blood through aspiration and additional drainage holes. The illuminator and resector tips may then be repositioned, thereby reducing the number of incisions needed when compared with stab avulsion or hook phlebectomy. It has been proposed that TIPP might result in decreased operative time, decreased complications such as bruising, and faster recovery compared to the 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 addressed 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 be occasionally utilized for the closure of incompetent perforator veins that cannot be reached by less invasive procedures. Subfascial endoscopic perforator surgery (SEPS) is a less-invasive surgical procedure for treatment of incompetent perforators and has been reported since the mid-1980s. Guided by Duplex US scanning, small incisions are made in the skin, and the perforating veins are clipped or divided by endoscopic scissors. The operation can be performed as an outpatient procedure. Endovenous ablation of incompetent perforator veins with sclerotherapy and RFA has also been reported.
Deep vein valve replacement is being investigated.

Outcomes of interest for venous interventions include healing and recurrence, recannulation of the vein, and neovascularization. Recannulation (recanalization) is the restoration of the lumen of a vein after it has been occluded; this occurs more frequently following treatment with endovenous techniques. Neovascularization is the proliferation of new blood vessels in tissue and occurs more frequently following vein stripping. Direct comparisons of durability for endovenous and surgical procedures are complicated by these different mechanisms of recurrence. Relevant safety outcomes include the incidence of paresthesia, thermal skin injury, thrombus formation, thrombophlebitis, wound infection, and transient neurologic effects.

Regulatory Status

The following devices have received specific FDA marketing clearance for the endovenous treatment of superficial vein reflux:

- In 1999, the VNUS® Closure™ system (a radiofrequency device) received FDA clearance through the 510(k) process for "endovascular coagulation of blood vessels in patients with superficial vein reflux." The VNUS RFS™ and RFSFlex™ devices received FDA clearance in 2005 for "use in vessel and tissue coagulation including: treatment of incompetent (i.e., refluxing) perforator and tributary veins. The modified VNUS® ClosureFAST™ Intravascular Catheter received FDA clearance through the 510(k) process in 2008.

- In 2002, the Diomed 810 nm surgical laser and EVLT™ (endovenous laser therapy) procedure kit received FDA clearance through the 510(k) process, "… for use in the endovascular coagulation of the greater saphenous vein of the thigh in patients with superficial vein reflux."

- A modified Erbe Erbokryo® cryosurgical unit (Erbe USA) received FDA clearance for marketing in 2005. A variety of clinical indications are listed, including cryostripping of varicose veins of the lower limbs.

- The Trivex (InaVein LLC) system is a device for transilluminated powered phlebectomy that received FDA clearance through the 510(k) process in October 2003. According to the label, the intended use is for "ambulatory phlebectomy procedures for the resection and ablation of varicose veins."

- Varithena™ (formerly known as Varisolve® (BTG PLC, London) is a sclerosant microfoam made with a proprietary gas mix. It was approved by FDA in 2013 under a new drug application (NDA) 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 ClariVein® Infusion Catheter received marketing clearance through the 510(k) process in 2008 (K071468). It is used for mechanochemical ablation. Predicate devices were listed as 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.
Related Policies

None

Policy

*This policy statement applies to clinical review performed for pre-service (Prior Approval, Precertification, Advanced Benefit Determination, etc.) and/or post-service claims.

Greater or Lesser Saphenous Veins

Treatment of the greater or lesser saphenous veins by surgery (ligation and stripping) or endovenous radiofrequency or laser ablation, or microfoam sclerotherapy may be considered medically necessary for symptomatic varicose veins/venous insufficiency when the following criteria have been met:

There is demonstrated saphenous reflux; AND

There is documentation of one or more of the following indications:

- Ulceration secondary to venous stasis that fails to respond to compressive therapy; OR
- Recurrent superficial thrombophlebitis that fails to respond to compressive therapy; 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 greater or lesser saphenous veins by surgery, endovenous radiofrequency or laser ablation or microfoam sclerotherapy that do 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) or endovenous radiofrequency or laser ablation 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, OR the greater or lesser saphenous veins had been previously eliminated (at least 3 months); AND

There is demonstrated accessory saphenous reflux; AND

There is documentation of one or more of the following indications:

- Ulceration secondary to venous stasis that fails to respond to compressive therapy; OR
• Recurrent superficial thrombophlebitis that fails to respond to compressive therapy; 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 accessory saphenous veins by surgery or endovenous radiofrequency or laser ablation that do 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 noted above is considered investigational.

Perforator Veins

Surgical ligation (including subfascial endoscopic perforator surgery) or endovenous radiofrequency or laser ablation of incompetent perforator veins may be considered medically necessary as a treatment of leg ulcers associated with chronic venous insufficiency when the following conditions have been met:

- There is demonstrated perforator reflux; AND
- The superficial saphenous veins (greater, lesser, 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 Greater of surgery is not medically necessary.
Telangiectasia

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

Other

Techniques for conditions not specifically listed above are **investigational**, including, but not limited to:

- Sclerotherapy techniques, other than microfoam sclerotherapy, of greater, lesser or accessory saphenous veins
- Sclerotherapy of perforator veins
- Sclerotherapy of isolated tributary veins without prior or concurrent treatment of saphenous veins or lesser saphenous, or accessory veins
- Stab avulsion, hook phlebectomy, or transilluminated powered phlebectomy of perforator, greater or lesser saphenous, or accessory saphenous veins
- Endovenous radiofrequency or laser ablation of tributary veins
- Endovenous cryoablation of any vein
- Mechanochemical ablation of any vein

Policy Guidelines

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.

Rationale

Treatment of Saphenous Reflux

Compression Therapy

A 2009 Cochrane review on compression for venous ulcers included a total of 39 randomized, controlled trials (RCTs), with 48 different comparisons. (1) The review was updated in 2012, and included controlled trials (RCTs), with 59 different comparisons. (2) Most of the RCTs were small. Objective measures of healing were the time to complete healing, the proportion of ulcers healed within the trial period (typically 12 weeks), and the change in ulcer size. Evidence from 8 trials indicated that venous ulcers healed more rapidly with compression than without. Findings suggested that multi-component systems (bandages or stockings) were more effective than single-component compression. In addition, multi-component systems containing an elastic bandage appeared more effective than those composed mainly of inelastic constituents. Although this meta-analysis did not include time to
healing, studies included in the review reported that the mean time to ulcer healing was approximately 2 months, while the median time to healing in other reports was 3 to 5 months.

A Cochrane review on compression stockings for the initial treatment of varicose veins in patients without venous ulceration was published in 2011. (3) Included in the review were 7 studies involving 356 participants with varicose veins without healed or active venous ulceration (CEAP [clinical, etiology, anatomy, pathophysiology] classification C2 to C4). Six of the studies compared different types or pressures of stockings. Subjectively, participants' symptoms improved, but results were not compared with a control arm. Due primarily to inadequate reporting, the methodologic quality of the included trials was unclear. Meta-analyses were not performed due to inadequate reporting and suspected heterogeneity. The authors concluded that there is insufficient high-quality evidence to determine whether or not compression stockings are effective as the sole and initial treatment of varicose veins in patients without venous ulceration, or whether any type of stocking is superior to any other type.

**Ligation and Stripping**

Systematic literature reviews published in 2008 indicate a similar healing rate of venous ulcers with superficial vein surgery and conservative compression treatments but a reduction in ulcer recurrence rate with surgery. (4, 5) In general, recurrence rates after ligation and stripping are estimated at around 20%. Jones et al reported on the results of a study that randomized 100 patients with varicose veins to undergo either ligation alone or ligation in conjunction with stripping. (6) At 1 year, reflux was detected in 9% of patients, rising to 26% at 2 years. Rutgers and Kitslaar reported on the results of a trial that randomized 181 limbs to undergo either ligation and stripping or ligation combined with sclerotherapy. (7) At 2 years, Doppler ultrasound (US) demonstrated reflux in approximately 10% of patients after ligation and stripping, increasing to 15% at 3 years.

**Comparison of Endovenous Ablation with Ligation and Stripping**

An updated Cochrane review from 2014 compared endovenous ablation (radiofrequency and laser) and foam sclerotherapy versus ligation/stripping for saphenous vein varices. (8) Included in the review were 13 randomized studies with a combined total of 3081 patients. The overall quality of the evidence was moderate. There was no significant difference between sclerotherapy and surgery in the rate of recurrence as rated by clinicians (odds ratio (OR) =1.74, p=0.06) or for symptomatic recurrence (OR=1.28). For endovenous laser ablation (EVLA) versus surgery, there were no significant differences between the treatment groups for clinician noted or symptomatic recurrence, or for recanalization. Neovascularization and technical failure were reduced in the laser group (OR 0.05, p <0.0001 and OR 0.29, p=0.0009, respectively). For endovenous radiofrequency ablation (RFA) versus surgery, there were no significant differences between the groups in clinician noted recurrence, recanalization, neovascularization, or technical failure. The authors concluded that sclerotherapy, EVLA, and RFA are at least as effective as surgery in the treatment of great saphenous varicose veins.

In 2014, Brittenden et al reported a multicenter randomized trial that compared foam sclerotherapy, EVLA, and surgical treatment in 798 patients. (9) The study was funded by U.K.’s Health Technology Assessment Programme of the National Institute for Health Research. Veins greater than 15 mm were
excluded from the study. At the 6-week follow-up visit, patients who were assigned to treatment with foam or laser had the option of treatment with foam for any residual varicosities; this was performed in 38% of patients in the foam group and 31% of patients in the EVLA group. At 6 months following treatment, mean disease-specific quality of life was slightly worse after sclerotherapy than after surgery (p=0.006), and there were more residual varicose veins, although the differences were small. Disease-specific quality of life was similar for the laser and surgery groups. The frequency of procedural complications was similar for the foam sclerotherapy (6%) and surgery (7%) groups, but was lower in the laser group (1%). The rate of complications at 6 months (primarily lumpiness and skin staining), was highest for the sclerotherapy group.

**Endovenous Radiofrequency Ablation (RFA)**

In 2008, Luebke et al reported a meta-analysis of 8 studies that included a total of 224 patients who underwent RFA and 204 patients who underwent stripping. (10) There was no significant difference between RFA and surgery in immediate or complete greater saphenous vein occlusion, incomplete greater saphenous vein closure, freedom from reflux, recurrent varicose veins, recanalization, or neovascularization between the 2 treatments. There were significant reductions in tenderness and ecchymosis at 1 week and fewer hematomas at 72 hours, 1 week, and 3 weeks with RFA. Quality-of-life results, including return to normal activity and return to work, favored RF over surgery. The authors noted that rates of recanalization, retreatment, occlusion, and reflux may alter with longer follow-up and that further RCTs with longer follow-up are needed.

Long-term outcomes of endovenous RFA were reported from the Closure Study Group clinical registry in 2005. (11) Thirty-four centers (1,006 patients, 1,222 limbs) participated in the registry, with 12 centers contributing 5-year data (406 limbs). The registry included data on the treatment of 52 lesser saphenous veins and 16 accessory saphenous veins. Follow-up at 1 week showed a 97% anatomical success rate and a decrease in pain in 50% (from 85% to 30%) of patients. An additional 162 failures were identified over the 5 years of follow-up, 129 veins were found to have recanalization, and 33 limbs had reflux in the groin. Logistic regression analysis (risk factors of gender, age, body mass index [BMI], vein diameter, and catheter pullback speed) showed that BMI was associated with long-term failure. The rate of pull-back speed of the catheter during treatment was associated with failure to occlude or recanalization.

**Endovenous Laser Ablation (EVLA)**

The largest trial on EVLA is the 2012 RELACS study, which was a practical design that randomized 400 patients to EVLA performed by a surgeon at 1 site or to ligation and stripping performed by a different surgeon at a second location. (12) At 2-year follow-up, there was no significant difference between the groups for clinically recurrent varicose veins, medical condition on the Homburg Varicose Vein Severity Score, or disease-related quality of life. Saphenofemoral reflux was detected by ultrasonography more frequently after endovenous laser treatment (EVLT) (17.8% vs 1.3%). This study will follow patients for 5 years. Another trial compared EVLA with ligation and stripping in 200 limbs (100 in each group). (13) At 1-year follow-up, 98% of the limbs were reported to be free of symptoms. At 2-year follow-up, the EVLA group had 2 veins completely reopened and 5 partially reopened, which was significantly greater than in the ligation and stripping group. In the 2013 MAGNA trial, 223
consecutive patients (240 legs) with great saphenous vein reflux were randomized to EVLA, ligation and stripping, or foam sclerotherapy. (14) At 1-year follow-up, the anatomic success rates were similar between EVLA and stripping (88.5% and 88.2%, respectively), which were superior to foam sclerotherapy (72.2%). Ten percent of the stripping group showed neovascularization. Health-related quality of life improved in all groups. The CEAP classification improved in all groups with no significant difference between the groups. Transient adverse events were reported in 11 patients after stripping, 7 after EVLA, and 5 after sclerotherapy.

Literature on isolated treatment of the anterior accessory saphenous vein is limited. In a 2009 study, outcomes from a cohort of 33 patients who underwent EVLA of the anterior accessory saphenous vein were compared with 33 matched controls undergoing EVLA of the greater saphenous vein. (15) In 21 of the patients (64%) in the accessory saphenous vein group, there had been no previous treatment of the greater saphenous vein. At 12-month follow-up, there was no evidence of reflux in these patients, and the treated accessory saphenous vein was not visible with ultrasound. The Aberdeen Varicose Vein Symptom Severity Score had improved in both groups, with no significant difference between the 2 groups. Patient satisfaction scores were also similar.

**Sclerotherapy**

In the 2013 MAGNA trial (previously described), 223 consecutive patients (240 legs) with great saphenous vein reflux were randomized to EVLA, ligation and stripping, or physician compounded foam sclerotherapy (1 cc aethoxysclerol 3%: 3 cc air). (14) At 1-year follow-up, the anatomic success rate of foam sclerotherapy (72.2%) was inferior to both EVLA and stripping (88.5% and 88.2%, respectively). Twenty-one patients in the sclerotherapy group had partial occlusion with reflux, though the clinical complaint was completely relieved. A 2012 study was a noninferiority trial of foam sclerotherapy versus ligation and stripping in 430 patients. (16) Analysis was per protocol. Forty patients (17%) had repeat sclerotherapy. At 2 years, the probability of clinical recurrence was similar in the 2 groups (11.3% sclerotherapy vs 9.0% ligation and stripping), although reflux was significantly more frequent in the sclerotherapy group (35% vs 21%). Thrombophlebitis occurred in 7.4% of patients after sclerotherapy. There were 2 serious adverse events in the sclerotherapy group (deep venous thrombosis and pulmonary emboli) that occurred within 1 week of treatment.

In 2013, Varithena™ microfoam was approved under a new drug application (NDA) for the treatment of varicose veins. Efficacy data were from 2 randomized, blinded, multicenter studies. (17) One evaluated Varithena™ at 0.5%, 1.0%, and 2.0% polidocanol and the second evaluated Varithena™ at 0.5% and 1.0% polidocanol compared with endovenous placebo or a subtherapeutic dose of polidocanol foam. The primary end point was improvement in symptoms at week 8, as measured by the Varicose Vein Symptoms Questionnaire. The improvement in symptoms was greater in the pooled Varithena™ treatment group (p<0.0001) and in each of the individual dose-concentration groups compared with vehicle alone. Secondary and tertiary end points (appearance, duplex ultrasound response, quality of life) were also significantly better for the Varithena™ groups compared with controls. This second study, called VANISH-2, was published in 2014. (18) At the 8-week assessment, there was elimination of reflux and/or occlusion of the previously incompetent vein in 85.6% of the combined 0.5% and 1.0% groups, 59.6% of patients in the 0.125% group, and 1.8% of the placebo group. Analysis of data from both studies showed a dose response from 0.5% to 2.0% for improvement in appearance and from
0.5% to 1.0% for Duplex responders. The 1.0% dose of Varithena™ was selected for the FDA approval. Safety analysis found deep vein thrombosis detected by ultrasound in 2.8% of Varithena™-treated patients with 1% of patients having proximal symptomatic thrombi; these were treated with anticoagulants. There was no signal of an increase in neurological adverse events, and there were no adverse cardiac or cardiopulmonary effects following treatment with Varithena™ injectable foam. Rates of occlusion with Varithena™ are similar to those reported for EVLA or stripping. A randomized trial comparing EVLA and stripping with this new preparation of foam sclerotherapy is needed to evaluate its comparative effectiveness. Evaluation out to 5 years is continuing.

**Mechanochemical Ablation**

Several prospective series and cohort studies have been reported. One prospective multicenter series evaluated the efficacy of mechanochemical ablation (MCA) of the great saphenous vein in 126 patients in a community setting. (19) Veins were selected that were greater than 4 mm and less than 12 mm in diameter, with an average diameter of 7.3 mm. Closure rates were 100% at 1 week, 98% at 3 months, and 94% at 6 months. The venous clinical severity score decreased from a score of approximately 9 pretreatment to about 3 at 6 months. In 2012, Elias and Raines reported an industry-sponsored safety and efficacy study of MCA with the ClariVein® system. (20) Thirty greater saphenous veins in 29 patients were treated with this device. Greater saphenous veins with diameters greater than 12 mm were excluded. At 6-month follow-up, 1 vein had recanalized, for a primary closure rate of 96.7%. No pain during the procedure or adverse events were reported. Another prospective series evaluated MCA of the small saphenous vein in 50 consecutive patients. (21) Only patients with a vein diameter of 2.5 to 11 mm were included. The dose of sclerosant was increased after the first 15 patients. At the 6-week assessment, all treated veins were occluded and at 1-year follow-up, 94% remained occluded. The median visual analog scale score for pain during the procedure was 2 of 10. There were no major complications. Controlled studies with a greater number of subjects and longer follow-up are needed.

A 2013 review of MCA notes that a 5-year 840 patient randomized trial comparing ClariVein with RFA began in 2012 in Europe. (22) This trial will provide needed data on the comparative effectiveness of MCA, measured at a longer duration and in a larger population. Early results from this trial (119 patients) indicate that intra-procedural pain is slightly lower with mechanochemical ablation (13.4 mm on a 100-mm scale) compared with RFA (24.4, p=0.001). (23)

**Endovenous Cryoablation**

Klem et al reported a randomized trial in 2009 that found endovenous cryoablation (n=249) to be inferior to conventional stripping (n=245) for treating patients with symptomatic varicose veins. (24) The percentage of patients with greater saphenous vein remaining was 44% in the endovenous cryoablation group and 15% in the conventional stripping group. The Aberdeen Varicose Vein Questionnaire also showed better results for conventional stripping (score of 11.7) in comparison with cryoablation (score of 8.0). There were no differences between the groups in Short-Form-36 (SF-36) subscores, and neural damage was the same (12%) in both groups.

Disselhoff et al reported 2 and 5 year outcomes from a randomized trial that compared cryoablation with EVLA. (25, 26) Included were 120 patients with symptomatic uncomplicated varicose veins (CEAP
C2) with saphenofemoral incompetence and greater saphenous vein reflux. At 10 days after treatment, EVLA had better results than cryostripping with respect to pain score over the first 10 days (2.9 vs. 4.4), resumption of normal activity (75% vs. 45%) and induration (15% vs. 52%). At 2-year follow-up, freedom from recurrent incompetence was observed in 77% of patients after EVLA and 66% of patients after cryostripping (not significantly different). At 5 years, 36.7% of patients were lost to follow-up; freedom from incompetence and neovascularization was found in 62% of patients treated with EVLA and 51% of patients treated with cryostripping (not significantly different). Neovascularization was more common after cryostripping, but incompetent tributaries were more common after EVLA. There was no significant difference between groups in the Venous Clinical Severity Score or Aberdeen Varicose Vein Severity Score at either 2 or 5 years.

Other treatments

Both steam injection and microwave ablation for endovenous treatment of varicose veins were reported outside of the U.S. (27-29) These procedures have not been approved or cleared for marketing by the FDA.

Section Summary

There are a number of large randomized trials on endovenous ablation of the saphenous veins. Comparison with ligation and stripping at 2-year follow-up supports use of both RFA and EVLT. Evidence suggests that ligation and stripping may lead to neovascularization, while thermal ablation may lead to recanalization. Controlled studies with longer follow-up are needed to determine the long-term efficacy of these treatments with greater certainty. Two RCTs suggest that cryotherapy is not as effective as available alternatives. For physician-compounded sclerotherapy, there is high variability in success rates of the procedure and reports of serious adverse events. Rates of occlusion with the FDA-approved microfoam sclerotherapy are similar to those reported for EVLA or stripping. MCA is a combination of liquid sclerotherapy with mechanical abrasion. A potential advantage of this procedure compared to thermal ablation techniques is that it does not require tumescent anesthesia and may result in less post-operative pain. To date, the ClariVein procedure has been assessed in relatively few patients and for short durations. Thus, there is insufficient evidence to permit conclusions regarding the safety and efficacy of mechanochemical ablation.

Treatment of Tributary Varicosities

Sclerotherapy and Phlebectomy

Early studies established ligation and stripping as the criterion standard for the treatment of saphenofemoral incompetence based on improved long-term recurrence rates, with sclerotherapy used primarily as an adjunct to treat varicose tributaries. A 2006 Cochrane Review, based primarily on RCTs from the 1980s, concluded that, “The evidence supports the current place of sclerotherapy in modern clinical practice, which is usually limited to treatment of recurrent varicose veins following surgery and thread veins.” (30) Sclerotherapy and phlebectomy are considered appropriate in the absence of reflux of the saphenous system, eg, post- or adjunctive treatment to other procedures such as surgery. (31) In 2014, El-Sheikha et al reported a small randomized trial of concomitant or sequential (if needed) phlebectomy following EVLA for varicose veins. (32) Quality of life and clinical severity scores were
similar between the groups by 1 year, with 16 of 24 patients (67%) in the sequential phlebectomy group receiving a secondary intervention.

A small proportion of patients may present with tributary varicosities in the absence of saphenous reflux. For example, of 1,009 patients recruited for an RCT, 64 patients were found to have minor varicose veins without reflux, 34 of whom agreed to be randomized to sclerotherapy or conservative treatment. At baseline, 92% had symptoms of heaviness, 69% had cosmetic concerns, 53% reported itching, and 30% reported relief of symptoms through the use of compression hosiery. At 1 year follow-up, there was an improvement in clinicians’ assessment of the anatomical extent of varicose veins, with 85% of patients in the sclerotherapy group improved compared to 29% of patients in the conservative-therapy group. Symptoms of aching were better or eliminated in 69% of the sclerotherapy group and 28% of the group treated with conservative therapy. Cosmetic concerns were improved in 85% of the sclerotherapy patients and 14% of controls.

The bulk of the literature discussing the role of ultrasound guidance refers to sclerotherapy of the saphenous vein, as opposed to the varicose tributaries. In 2012, Yamaki et al reported a prospective randomized controlled trial that compared visual foam sclerotherapy vs. ultrasound-guided foam sclerotherapy of the greater saphenous vein together with visual foam sclerotherapy for varicose tributary veins. A total of 51 limbs in 48 patients were treated with ultrasound-guided foam sclerotherapy plus visual foam sclerotherapy of the varicose tributaries, and 52 limbs in 49 patients were treated with foam sclerotherapy alone. At 6-month follow-up, complete occlusion was found in 23 limbs (45.1%) treated with ultrasound-guided and visual-guided foam sclerotherapy and in 22 limbs (42.3%) treated with visual guidance alone (not significantly different). The authors note that for the treatment of tributary veins in clinical practice, most patients receive direct injection of foam without ultrasound guidance.

**Transilluminated Powered Phlebectomy (TIPP)**

A 2008 meta-analysis included 5 studies that compared TIPP with conventional surgery. Results showed a significant advantage of TIPP over the conventional treatment for number of incisions, mean cosmetic score, and duration of the procedure. However, TIPP also increased the incidence of hematoma and resulted in worse mean pain scores. Included in the meta-analysis was a randomized clinical trial by Chetter et al that compared TIPP (n=29) with a multiple stab incision procedure (n=33). A single surgeon performed all but 2 of the procedures, and there was no difference in operating time. Patients treated with TIPP had an average of 5 incisions, compared with 20 for the multiple stab procedure. However, blinded evaluation revealed that bruising or discoloration was higher for the TIPP group at both 1 and 6 weeks after surgery. At 6 weeks after surgery, patients in the TIPP group showed no improvement in pain (-2 points on the Burford pain scale), while patients in the multiple stab incision group had a significant improvement in pain score compared with presurgical baseline (-20 points). At 6 weeks after surgery, quality-of-life measures had improved in the multiple-stab incision group but not in the TIPP group. Thus, although TIPP had the advantage of fewer surgical incisions, in this single-center study, it was associated with a more prolonged recovery due to more extensive bruising, prolonged pain, and reduced early postoperative quality of life. The current literature does not show an advantage of TIPP over conventional treatment.
Section Summary
Evidence indicates that both sclerotherapy and TIPP are as effective as stab phlebectomy in eliminating varicose tributaries. However, there is limited evidence that TIPP is associated with more pain, bruising, discoloration, and a longer recovery.

Treatment of Perforator Reflux

A systematic literature review published in 2008 indicates insufficient evidence for the role of incompetent perforator vein surgery. (5) These conclusions were based on 4 RCTs published since 2000 that compared superficial vein surgery with conservative therapy in advanced chronic venous insufficiency (CEAP category C5/6). The 4 trials included 2 level I (large subject population) and 2 level II (small subject population) studies. Two of the trials combined surgical treatment of the incompetent perforator veins with concurrent or prior treatment of the superficial saphenous veins; the other 2 treated the greater saphenous vein alone. The 2 randomized studies in which the greater saphenous vein alone was treated (including the ESCHAR trial) showed a significant reduction in ulcer recurrence in comparison with conservative therapy. (37, 38) A 2011 community hospital-based multicenter, double-blind, randomized trial found no clinical benefit (self-reported symptoms) from adding subfascial endoscopic perforator surgery (SEPS) to saphenous surgery in 75 patients with varicose ulcers (CEAP C5 or C6) and incompetent perforators. (39)

Treatment of the great saphenous vein alone has been reported to improve perforator function. For example, 1 study showed that reversal of perforator vein incompetence (41% of 68 previously incompetent perforators) was more common than new perforator vein incompetence (22% of 183 previously competent perforators) following superficial vein surgery. (40) O’Donnell discusses additional (lower quality) evidence to suggest deep venous valvular involvement rather than incompetent perforators in venous insufficiency. (5) Thus, although incompetence of perforator veins is frequently cited as an important etiologic factor in the pathogenesis of venous ulcer, current evidence does not support the routine ligation or ablation of perforator veins.

Subfascial Endoscopic Perforator Surgery (SEPS)

In 2004, Tenbrook et al published a review of the literature of SEPS, which included 19 case series and one randomized trial. (41) In total, the reviewed studies included 1,031 patients with 1140 treated limbs. The authors concluded that SEPS was associated with excellent results in terms of ulcer healing and prevention of recurrence. However, the authors also noted that randomized trials are required to define the relative contributions of compression therapy, superficial venous surgery, and SEPS in the management of severe venous disease. A 2009 meta-analysis of SEPS for chronic venous insufficiency concludes that “Its [SEPS] use should not be employed routinely and could only be justified in patients with persistent ulceration thought to be of venous origin, and in whom any superficial reflux has already been ablated and post-thrombotic changes excluded.” (42) The authors also state that “introduction of less invasive techniques for perforator vein ablation, such as ultrasound-guided sclerotherapy or radiofrequency ablation, may diminish the role of SEPS in the future.”
Other Treatments

A 2008 review of procedures for management of varicose veins recommends duplex-guided foam sclerotherapy, microincision phlebectomy, or thermal ablation using a new short RFA catheter for the treatment of symptomatic residual perforator vein incompetence. (43) Ablation of incompetent perforator veins with laser or RFA had been shown to be technically feasible, although no studies had been identified that showed an improvement in clinical outcomes (eg, ulcer healing or recurrence). The 2011 literature update identified one study of EVLA for perforating veins in 33 patients with a CEAP classification of 4 (skin changes), 5 (healed ulcer) or 6 (active ulcer). (44) All incompetent saphenous trunks were treated simultaneously (63% of limbs). At 3-month follow-up, occlusion was achieved in 78% of the perforating veins. Five patients (15%) had active ulcers at baseline; 4 of the 5 ulcers had healed by 6 weeks after EVLA. Evidence regarding the treatment of perforator veins with US-guided sclerotherapy is limited, and there is a risk of deep venous occlusion. (45)

Practice Guidelines and Position Statements

The Society for Vascular Surgery and the American Venous Forum published clinical practice guidelines in 2011. (46) The recommendations are rated as strong=1 or weak=2, based on a level of evidence that is either high quality=A, moderate quality=B, or low quality=C, and include the following:

- **Compression therapy for venous ulcerations and varicose veins**: Compression therapy is recommended as the primary treatment to aid healing of venous ulceration (GRADE 1B, strong recommendation, moderate quality evidence). To decrease the recurrence of venous ulcers, they recommend ablation of the incompetent superficial veins in addition to compression therapy (GRADE 1A, strong recommendation, high-quality evidence). They recommend use of compression therapy for patients with symptomatic varicose veins (GRADE 2C, weak recommendation, low-quality evidence) but recommend against compression therapy as the primary treatment if the patient is a candidate for saphenous vein ablation (GRADE 1B, strong recommendation, moderate quality evidence).

- **Treatment of the incompetent great saphenous vein**: Endovenous thermal ablation (radiofrequency or laser) is recommended over chemical ablation with foam (GRADE 1B, strong recommendation, moderate quality evidence) or high ligation and stripping (GRADE 1B, strong recommendation, moderate quality evidence) due to reduced convalescence and less pain and morbidity. Cryostripping is a technique that is new in the United States, and it has not been fully evaluated.

- **Varicose tributaries**: Phlebectomy or sclerotherapy are recommended to treat varicose tributaries (GRADE 1B, strong recommendation, moderate quality evidence). Transilluminated powered phlebectomy using lower oscillation speeds and extended tumescence is an alternative to traditional phlebectomy (GRADE 2C, weak recommendation, low-quality evidence).

- **Perforating vein incompetence**: Selective treatment of perforating vein incompetence in patients with simple varicose veins is not recommended (CEAP class C2; GRADE 1B, strong recommendation, moderate quality evidence), but there is a GRADE 2B recommendation (weak
recommendation, moderate quality evidence) for 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) by subfascial endoscopic perforating vein surgery, sclerotherapy, or thermal ablations (GRADE 1C, weak recommendation, low-quality evidence).

In 2009, the American College of Radiology published appropriateness criteria for the treatment of lower-extremity venous insufficiency. (47) The following is a summary of treatment options:

- **Compression Stockings**: Graduated compression stockings are routinely used to control venous insufficiency symptoms. They provide external support that can constrict dilated veins and restore competence to incompetent valves. Compression stockings are particularly helpful during pregnancy, and they are frequently used following venous ablation treatment.

- **Surgery**: Great saphenous vein (GSV) stripping with branch ligation had historically been the primary treatment option for venous insufficiency. The GSV is ligated near the groin. Ligation alone can preserve the vein for subsequent harvesting in case of arterial bypass; however, ligation alone has proven unsatisfactory for preventing the occurrence of reflux, so it is often supplemented by vein stripping. Ambulatory phlebectomy is primarily used to treat surface varicose veins. It can be performed as an adjunct to endovenous ablation or stripping. This procedure involves making tiny punctures or incisions through which the varicose veins are removed. Other surgical methods to treat venous insufficiency have been described, including SEPS for treating venous ulcers and valvular surgery for treating reflux caused by incompetent valves of the deep veins.

- **Injection Sclerotherapy**: Injection sclerotherapy is a common treatment for telangiectasias and can be used to treat smaller varicose veins. The sclerotherapy solution can be in liquid form or can be injected as "foam" (mixed with a gas such as air). Sclerotherapy has not been shown to have long-term effectiveness for large veins, such as the GSV.

- **Endovenous Ablation**: Endovenous ablation is a minimally invasive alternative to surgery. It is a percutaneous procedure that can be used to treat the GSV, small saphenous vein (SSV), and other superficial veins. Endovenous ablation uses RFA or laser energy (EVLA) applied inside the vein to cause occlusion. Small prospective trials comparing EVLA and RFA with conventional surgery in patients with GSV reflux have shown favorable results. One study demonstrated that EVLA is comparable to surgery in abolishing reflux and improving disease-specific quality of life and that it allows earlier return to normal activity. A recent systematic literature review comparing the safety and efficacy of EVLA and surgery involving saphenous ligation and stripping as treatments for varicose veins showed few differences in clinical effectiveness outcomes, although long-term follow-up was lacking. A meta-analysis suggested that EVLA and RFA are at least as effective as surgery in treating lower-extremity varicose veins. After 3 years, the estimated pooled success rates for treatment were 78% for surgical stripping, 77% for foam sclerotherapy, 84% for RFA, and 94% for laser therapy.

- **Adjunctive Treatments**: Adjunctive treatments may be required to help eliminate venous insufficiency. Patients with venous insufficiency and associated venous occlusion or stenosis of
the common iliac vein (e.g., May-Thurner syndrome) may require venous recanalization with angioplasty and stenting to achieve a patent conduit for venous return. Patients with pelvic venous insufficiency may require percutaneous embolization of the ovarian veins. Patients with deep venous thrombosis are typically treated with anticoagulation to reduce the risk of thrombus propagation, embolization, and post-thrombotic syndrome. One study suggested that endovenous ablation of the saphenous vein can be considered as a viable treatment alternative in patients with venous insufficiency and previous deep venous thrombosis.

- **Complications:** All forms of lower-extremity venous insufficiency treatment are subject to recurrence. Additional risks of vein ligation and stripping surgery include: anesthetic risk, scarring, pain, bleeding, deep venous injury or thrombosis, nerve injury, and infection. Complications of the endovenous ablation procedure include bruising, swelling, transient numbness, and rarely deep venous thrombosis.

In 2003, the Society of Interventional Radiography (SIR) published a position statement (48) 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:

1. The endovenous treatment of varicose veins may be medically necessary when one of the following indications (a-e) is present:
   a) 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.
   b) Significant recurrent attacks of superficial phlebitis
   c) Hemorrhage from a ruptured varix
   d) Ulceration from venous stasis where incompetent varices are a contributing factor
   e) Symptomatic incompetence of the great or small saphenous veins (symptoms as in (a) above) and;

2. 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;

3. The patient's anatomy is amenable to endovenous ablation.

In a joint statement published in 2007, the American Venous Forum and SIR recommended reporting standards for endovenous ablation for the treatment of venous insufficiency. (49) The document recommended that reporting in clinical studies should include the symptoms of venous disease, history of disease and prior treatment, the presence of major comorbidities, and any exclusion criteria. It was noted that potential candidates for endovenous ablation may include patients with reflux in an incompetent greater saphenous vein or smaller saphenous vein or in a major tributary branch of the greater or smaller saphenous veins such as the anterior thigh circumflex vein, posterior thigh circumflex vein, or anterior accessory greater 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.

In 2003 and 2004, the U.K.’s National Institute for Health and Clinical Excellence (NICE) published guidance on radiofrequency ablation of varicose veins and on endovenous laser treatment of the long saphenous vein. (50, 51) NICE concluded that the evidence on the safety and efficacy appeared adequate to support the use of these procedures provided that the normal arrangements were in place for consent, audit, and clinical governance. The evidence on efficacy at this time was limited to case series with limited follow-up. Clinicians were encouraged to collect longer-term follow up data.

NICE issued updated guidance on ultrasound-guided foam sclerotherapy for varicose veins in 2013. (52) The guidance states that

“1.1 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.

1.2 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.”

NICE issued guidance on endovenous mechanochemical ablation in 2013, concluding that current evidence on the safety and efficacy of endovenous mechanochemical ablation for varicose veins is inadequate in quantity and quality. (53) Therefore this procedure should only be used with special arrangements for clinical governance, consent, and audit or research.

In 2013, NICE published practice guideline on the diagnosis and management of varicose veins in the leg. (54) NICE recommends a study of the clinical and cost effectiveness of

- Concurrent phlebectomies or foam sclerotherapy for varicose tributaries during truncal endothermal ablation for varicose veins
- Truncal endothermal ablation without concurrent phlebectomies or foam sclerotherapy
- Truncal endothermal ablation with phlebectomies or foam sclerotherapy, if needed, 6–12 weeks later

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

The U.S. Preventive Services Task Force has not addressed the treatment of varicose veins/venous insufficiency.

**Summary**

Although randomized, controlled trials (RCTs) with longer follow-up are needed to evaluate long-term durability, and repeat treatments may be required, evidence indicates that endovenous treatment of saphenous veins with radiofrequency or laser ablation improves short-term clinical outcomes (eg, pain...
and return to work) in comparison with surgery. Ultrasound-guided foam sclerotherapy (physician compounded) leads to success rates that approach that of surgery. There are no trials comparing the recently U.S. Food and Drug Administration (FDA)-approved microfoam sclerotherapy with other treatments of varicose veins. Results from a recent RCT of cryoablation indicate that this therapy is inferior to conventional stripping. There is insufficient evidence on mechanochemical ablation.

The literature indicates that sclerotherapy of tributaries following occlusion of the saphenofemoral or saphenopopliteal junction and saphenous veins may be considered medically necessary. Evidence is insufficient to evaluate the health benefit of sclerotherapy as a sole treatment of varicose tributaries without prior or concurrent treatment of the saphenous veins. No studies have been identified that compare radiofrequency or laser ablation of tributary veins with standard procedures (microphlebectomy and/or sclerotherapy). Transilluminated powered phlebectomy is effective at removing varicosities; outcomes are comparable to available alternatives such as stab avulsion and hook phlebectomy.

The literature indicates that the routine ligation/ablation of incompetent perforator veins is not medically necessary for the treatment of varicose veins/venous insufficiency at the time of superficial vein procedures. However, when combined superficial vein procedures and compression therapy have failed to improve symptoms (i.e., ulcers), treatment of perforator vein reflux may be as beneficial as any alternative (eg, deep vein valve replacement). Therefore, treatment of incompetent perforator veins may be considered medically necessary in this specific situation.

Comparative studies are needed to determine the most effective method of ligating/ablating incompetent perforator veins. SEPS has been shown to be as effective as the Linton procedure with a reduction in adverse events. Although only 1 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 in comparison with surgical interventions. For sclerotherapy, concerns have been raised about the risk of deep vein occlusion, and evidence is currently insufficient to evaluate the safety or efficacy of this treatment for incompetent perforator veins.

**Medicare National Coverage**
There is no national coverage determination (NCD).

**References**


19. Todd KL, 3rd, Wright D, for the V-IG. 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


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<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>
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March 2015 Update Policy  Policy updated with literature review; references 8-9, 18, 24, 33 added and some references removed; microfoam sclerotherapy considered medically necessary.

Keywords

ClariVein®
Cryoablation
Diomed 810
Endoluminal Radiofrequency
Endoluminal Laser Ablation
Endovenous Radiofrequency
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TRIVEX™
Varicose Veins
Varisolve®
Venous Insufficiency
VNUS® Closure™ system
VNUS® ClosureFAST™ Intravascular Catheter

This policy was approved by the FEP® Pharmacy and Medical Policy Committee on March 20, 2015 and is effective April 15, 2015.

Signature on file

Deborah M. Smith, MD, MPH