SUBJECT: SAPHENOUS VEIN ABLATION

INCLUDED PRODUCT(S):

- Medicaid
  - BadgerCare Plus
- Commercial
  - Together with CCHP
- Marketplace
  - Together with CCHP
  - Care4Kids Program

PURPOSE OR DESCRIPTION:
The purpose of this policy is to define criteria for the medically necessary use of saphenous vein ablation by radiofrequency or laser for symptomatic saphenous vein incompetence.

POLICY:
CCHP policy will follow MCG guidelines (A-0174 and A-0425) for saphenous vein ablations with one exception regarding conservative therapy. CCHP will only require a trial and failure of 3 months or more of graduated compression stockings. If compression stockings have failed to resolve the symptoms, the rest of the criteria in the MCG guidelines will be required.

Below are the complete criteria for saphenous vein ablations. This includes the MCG guidelines with the modification for the required trial of conservative therapy in the last section, 1.e.:

1. Radiofrequency or endovascular laser saphenous vein ablation may be indicated when **ALL** of the following are present:
a. Saphenofemoral valve incompetence documented by duplex ultrasound or other imaging test with valve closure time of greater than 500 msec
b. Saphenous venous insufficiency symptoms causing functional impairment, including 1 or more of the following:
   i. Bleeding or ruptured superficial varicose veins
   ii. Leg edema
   iii. Leg fatigue
   iv. Leg pain
   v. Persistent or recurrent superficial thrombophlebitis
   vi. Persistent or recurrent venous stasis ulcer
   vii. Skin changes (eg, lipodermatosclerosis, hemosiderosis)
c. No clinically significant lower extremity arterial disease
d. No deep venous thrombosis on duplex ultrasound or other imaging test
e. No significant symptomatic improvement in response to 3-month or longer trial of graduated compression stockings.

REFERENCES