Priority Health	BILLING POLICY No. 145
Varicose Vein Treatment	
Date of origin: September 2025	**Review dates: July 2026**

DEFINITION

Varicose vein treatments are medical procedures or interventions used to manage enlarged, twisted veins caused by weakened vein walls and faulty valves. These treatments aim to relieve symptoms such as pain, swelling, and heaviness, improve appearance, and prevent complications like ulcers or blood clots. This policy defines the criteria, procedures, and documentation required for reimbursement.

MEDICAL POLICY

Varicose Vein - # 91326

For Medicare

For indications that do not meet criteria of NCD, local LCD or specific medical policy a Pre-Service Organization Determination (PSOD) will need to be completed. Click here for additional details on PSOD.

POLICY SPECIFIC INFORMATION

Documentation requirements

Complete and thorough documentation to substantiate the procedure performed is the responsibility of the Provider. In addition, the Provider should consult any specific documentation requirements that are necessary of any applicable defined guidelines.

Coding specifics

- Unlisted CPT code 37799 should be submitted when less than 10 stab phlebectomies are done. Please review our unlisted code policy for details on reported unlisted codes.
- For sclerotherapy procedures only one service should be reported for each leg regardless of number of veins treated
- CPT code 36470 should be used when only one vein is injected
- 36474, 36476, 36479, 36483 for subsequent vein(s) treated in the same extremity may only be reported once per extremity, regardless of the number of additional vein(s) treated
- CPT codes 36465, 36466, 36470, 36471, 36473, and 36474 include the reimbursement for the sclerosant. Sclerosant should not be separately reported. Similarly, CPT 36482 and 36483 contain the reimbursement for the chemical adhesive, and this should not be separately reported.
- Report CPT code 36483 for the second and subsequent veins treated in a single extremity only when treated through separate access sites
- For endoluminal radiofrequency ablation (ERFA), use CPT code 36475 for the first vein on each extremity. CPT code 36476 should be used for the second and subsequent veins treated in a single extremity only when treated through separate access sites.

Modifiers

Priority Health follows standard billing and coding guidelines which include CMS NCCI. Modifiers should be applied when applicable based on this guidance and only when supported by documentation.

Incorrect application of modifiers will result in denials. The modifier list below may not be an all-inclusive list. Please see our provider manual page for modifier use here.

- **Modifier 79**: use when performing ligation/ablation on the opposite leg during the postoperative period
- **Modifier 50**: for bilateral services
- **Modifiers RT/LT:** when reporting any combination of procedures performed on opposite legs, report the appropriate CPT codes with appropriate modifier on separate lines

Place of Service

Coverage will be considered for services furnished in the appropriate setting to the patient's medical needs and condition. Authorization may be required. Click here for additional information.

Reimbursement rates

Find reimbursement rates for the codes listed on this page in our standard fee schedules for your contract. Go to the fee schedules (login required).

REFERENCES

CMS LCD L33575
CMS Article A52870

DISCLAIMER

CMS and/or MDHHS guidelines apply unless otherwise specified in this policy or provider manual. Where such guidance is absent, this policy applies. Priority Health's billing policies outline our guidelines to assist providers in accurate claim submissions and define reimbursement or coding requirements if the service is covered by a Priority Health member's benefit plan. The determination of visits, procedures, DME, supplies and other services or items for coverage under a member's benefit plan or authorization isn't being determined for reimbursement. Authorization requirements and medical necessity requirements appropriate to procedure, diagnosis and frequency are still required. We use Current Procedural Terminology (CPT), Centers for Medicare and Medicaid Services (CMS), Michigan Department of Health and Human Services (MDHHS) and other defined medical coding guidelines for coding accuracy.

An authorization isn't a guarantee of payment when proper billing and coding requirements or adherence to our policies aren't followed. Proper billing and submission guidelines must be followed. We require industry standard, compliant codes defined by CPT, HCPCS and revenue codes for all claim submissions. CPT, HCPCPS, revenue codes, etc., can be reported only when the service has been performed and fully documented in the medical record to the highest level of specificity. Failure to document for services rendered or items supplied will result in a denial. To validate billing and coding accuracy, payment integrity pre- or post-claim reviews may be performed to prevent fraud, waste and

abuse. Unless otherwise detailed in the policy, our billing policies apply to both participating and non-participating providers and facilities.

If guidelines detailed in government program regulations, defined in policies and contractual requirements aren't followed, Priority Health may:

- Reject or deny the claim
- Recover or recoup claim payment

An authorization on file for an item or services doesn't supersede coding, billing or reimbursement requirements.

These policies may be superseded by mandates defined in provider contracts or state, federal or CMS contracts or requirements. We make every effort to update our policies in a timely manner to align to these requirements or contracts. If there's a delay in implementation of a policy or requirement defined by state or federal law, as well as contract language, we reserve the right to recoup and/or recover claim payments to the effective dates per our policy. We reserve the right to update policies when necessary. Our most current policy will be made available in our Provider Manual.

CHANGE / REVIEW HISTORY

Date	Revisions made
11/17/2025	New policy effective
07/06/2026	Reviewed, no updates