LOUISIANA BLUE

Vein Embolization as a Treatment for Pelvic Congestion Syndrome and Varicocele

Policy # 00691
Original Effective Date: 02/01/2020
Current Effective Date: 02/01/2026

Applies to all products administered or underwritten by Blue Cross and Blue Shield of Louisiana and its subsidiary, HMO Louisiana, Inc. (collectively referred to as the "Company"), unless otherwise provided in the applicable contract. Medical technology is constantly evolving, and we reserve the right to review and update Medical Policy periodically.

Note: Treatment of Varicose Veins/Venous Insufficiency is addressed separately in medical policy 00034.

Note: Transcatheter Uterine Artery Embolization is addressed separately in medical policy 00130.

Services Are Considered Investigational

Coverage is not available for investigational medical treatments or procedures, drugs, devices or biological products.

Based on review of available data, the Company considers endovascular occlusion of the ovarian vein and/or internal iliac veins as a treatment of pelvic congestion syndrome to be **investigational.***

Based on review of available data, the Company considers endovascular embolization of the testicular (spermatic) vein for treatment of varicocele to be **investigational.***

Policy Guidelines

Endovascular occlusion of the internal iliac and ovarian veins has been performed on an outpatient basis but may require an overnight hospital stay.

Background/Overview

Pelvic Congestion Syndrome

Pelvic congestion syndrome is a chronic pelvic pain syndrome of variable location and intensity, which is associated with dyspareunia (which may be aggravated by standing) and symptoms suggestive of a venous origin, such as postcoital ache and tenderness over the ovarian point. The syndrome usually occurs before menopause, and pain is often greater before or during menses. The underlying etiology is thought to be related to varices of the pelvic veins, leading to pelvic vascular congestion. The lack of clear diagnostic criteria and overlapping clinical presentation of pelvic congestion syndrome with other potentially related pelvic venous disorders has hindered research progress and contributed to underdiagnosis of these disorders as causes of chronic pelvic pain. In 2021, a multidisciplinary, intersociety working group convened by the American Vein and Lymphatic Society published the Symptoms-Varices-Pathophysiology (SVP) classification of pelvic venous disorders which, in conjunction with the established Clinical-Etiologic-Anatomic-

Physiologic classification for lower extremity venous disorders when applicable, places patients in homogeneous populations based on standardized definitions of presenting symptoms, involved variceal reservoirs, and underlying pathophysiology (including anatomic, hemodynamic, and etiologic disease features). The term pelvic venous disorder, accompanied by the patient-specific SVP classification, has been proposed to replace pelvic congestion syndrome and other historical nomenclature for related diseases (such as May-Thurner syndrome and nutcracker syndrome). As diagnostic criteria remain lacking, pelvic venous disorder as a cause of chronic pelvic pain amounts to a diagnosis of exclusion; evaluation may involve a variety of physical assessments, laboratory measurements, and/or imaging studies to eliminate other etiologies of chronic pelvic pain, such as cystitis or gynecologic malignancy.

Treatment
An initial conservative approach to the treatment of pelvic congestion syndrome may involve analgesics (eg, short-term use of nonsteroidal anti-inflammatory drugs) and hormonal therapy, with or without psychotherapy. The evidence base for medical management consists primarily of 5 clinical trials of hormonal therapy (sample sizes ranging from 22 to 102) in which medroxyprogesterone (in combination with psychotherapy), goserelin, and etonogestrel demonstrated significant improvements in pain scores with up to 13 months of follow-up. Longer-term efficacy of these treatments has not been demonstrated, and the largest trial of medroxyprogesterone indicated rapid recurrence of symptoms with discontinuation. Surgical ligation of pelvic veins may be considered, but is also supported by limited evidence and further limited by need for general anesthesia, duration of hospitalization, recovery time, and associated morbidity. Embolization therapy and/or sclerotherapy of the ovarian and internal iliac veins has been proposed as an alternative to surgical vein ligation. Endovascular occlusion can be performed using a variety of materials including coils, vascular plugs, glue, liquid embolic agents, and gelatin sponge or powder (Gelfoam).

Testicular varicocele
A varicocele, which is present in 15 to 20 percent of postpubertal males, is caused by dilatation of the pampiniform plexus of spermatic veins. It is generally left sided, may first appear at puberty, and may become larger over time.

A varicocele is diagnosed by its characteristic physical findings, which range from minimal left-sided scrotal fullness on Valsalva maneuver to a large, soft, left-sided scrotal mass ("bag of worms") that decompresses and disappears in the recumbent position. A varicocele may be asymptomatic or present with scrotal pain (typically when standing), atrophy of the left testicle, and/or decreased fertility.

Treatment
Most varicoceles do not require intervention. A practice standard from the Cardiovascular and Interventional Radiological Society of Europe (CIRSE) recommends treatment of varicoceles in specific scenarios: palpable varicocele, pain associated with varicocele, prevention or reversal of testicular atrophy in adolescent patients, documented infertility, abnormal semen parameters or

sperm function test results, elevated sperm DNA fragmentation, or hypogonadism. These recommendations are not specific to embolization, however, and also include open, laparoscopic, and microscopic surgical approaches as well as sclerotherapy.

Regarding outcomes, treatment of varicocele leads to reduction in orchalgia and improved semen parameters (such as sperm concentration, motility, and morphology) in the majority of cases, with variable technical success depending on factors such as anatomy, vascular approach, and laterality (greater success with left-sided than with right-sided varicocele).

Surgery, which is the preferred treatment option for varicoceles, involves ligating the gonadal vein branches so that retrograde blood flow can no longer reach the plexus of veins in the scrotum. This procedure can be performed with inguinal, subinguinal, or retroperitoneal approaches. Some urologists favor laparoscopy or microsurgery, which may have a lower recurrence rate. Percutaneous gonadal vein embolization, with or without sclerotherapy, is an alternative to surgery, however it carries a risk of serious complications including vascular perforation, coil migration, and thrombosis of the pampiniform plexus, and recurrence rates are higher than with traditional surgical approaches.

FDA or Other Governmental Regulatory Approval

U.S. Food and Drug Administration (FDA)

Ovarian and internal iliac vein embolization are surgical procedures and, as such, are not subject to regulation by the U.S. Food and Drug Administration (FDA).

Various products (eg, coils, vascular plugs, glue, liquid embolic agents, Gelfoam) and/or delivery-assist devices would be used to embolize the vein(s), and they would be subject to FDA regulation. Several products have been cleared for marketing by the FDA through the 510(k) process for uterine fibroid embolization (eg, Embosphere®‡ Microspheres, Cook Incorporated Polyvinyl Alcohol Foam Embolization Particles) and/or embolization of hypervascular tumors and arteriovenous malformations (eg, Contour™‡ PVA Embolization particles). Several embolization delivery systems have also been cleared via the 510(k) process for arterial and venous embolization in the peripheral vasculature featuring vascular plugs (eg, ArtVentive Medical Group, Inc. Endoluminal Occlusion System [EOS™‡]) or coils (eg, Cook Incorporated MReye®‡ Flipper®‡). FDA product code: KRD.

In November 2004, the sclerosant agent Sotradecol®‡ (sodium tetradecyl sulfate injection) was approved by the FDA for use in the treatment of small uncomplicated varicose veins of the lower extremities that show simple dilation with competent valves (ANDA 040541).

Rationale/Source

This medical policy was developed through consideration of peer-reviewed medical literature generally recognized by the relevant medical community, U.S. Food and Drug Administration approval status, nationally accepted standards of medical practice and accepted standards of medical practice in this community, technology evaluation centers, reference to regulations, other plan medical policies, and accredited national guidelines.

Description
Pelvic congestion syndrome is characterized by chronic pelvic pain that is often aggravated by standing; diagnostic criteria for this condition are not clearly defined. Endovascular occlusion (eg, embolization, sclerotherapy) of the ovarian and internal iliac veins has been proposed as a treatment for patients who fail medical therapy.

A varicocele may be associated with scrotal pain, testicular atrophy and decreased fertility. Endovascular embolization has been proposed as a treatment for symptomatic patients.

Summary of Evidence
For individuals who have pelvic congestion syndrome who receive ovarian and/or internal iliac vein endovascular occlusion, the evidence includes randomized studies, comparative cohort studies, non-comparative cohort studies, case series, and systematic reviews. Relevant outcomes are symptoms, quality of life, and treatment-related morbidity. Systematic reviews of prospective and retrospective data, as well as more recently published retrospective cohort studies, indicate consistently high clinical success rates (primarily in the form of significant pain reduction) ranging from 63.7% to 100% after ovarian and/or internal iliac vein endovascular occlusion at short-term, long-term, or overall follow-up. These data support guideline and international consensus recommendations for endovascular occlusion in this setting. In a randomized trial of embolization with vascular plugs or coils in patients with pelvic congestion syndrome, adverse events were reported in 22% and 10% of patients, respectively. A retrospective analysis comparing coil embolization to endoscopic resection indicated significantly greater improvement in pain 1 month post-procedure with resection, but similar improvements in pain between the procedures at 5-year follow-up. Differences between these procedures, particularly the need for general anesthesia with resection versus local anesthesia with embolization, suggest the possibility of selection bias in this study. Randomized controlled trials using well-defined eligibility criteria and relevant comparators are needed. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

For individuals who have testicular varicocele who receive testicular (spermatic) vein embolization the evidence includes a systematic review, prospective studies that are not randomized or blinded, and retrospective studies. The evidence is low or very low level with small number of participants. In 2018, a systematic review was performed to assess clinical outcomes for embolization treatment with different embolic materials for the management of testicular varicoceles. A total of 23 retrospective and 7 prospective clinical studies were included with a total of 3505 individuals. The majority of the studies were retrospective with small sample sizes. Due to the significant heterogeneity between the studies and the small sample sizes, no solid conclusion can be reached and further research is warranted to assess the cost-effectiveness difference between the various embolic materials and their exact effectiveness in terms of fertility and long term pain control. Randomized studies are needed to determine whether embolization of the testicular vein is an effective and safe treatment for testicular varicocele as compared to alternative treatment options. The evidence is insufficient to determine that technology results in an improvement in the net health outcome.

Supplemental Information

Practice Guidelines and Position Statements
Guidelines or position statements will be considered for inclusion in 'Supplemental Information' if they were issued by, or jointly by, a US professional society, an international society with US representation, or National Institute for Health and Care Excellence (NICE). Priority will be given to guidelines that are informed by a systematic review, include strength of evidence ratings, and include a description of management of conflict of interest.

International Union of Phlebology
An international consensus document on the diagnosis and treatment of pelvic congestion syndrome (which acknowledged the suboptimal nature of this terminology and noted that new nomenclature was being proposed at the time of publication) was published by a task force of the International Union of Phlebology in 2019. Key consensus statements include:

- Symptomatic (pain-relief) therapies include analgesics, nonsteroidal anti-inflammatory drugs, and psychotropic drugs, but the effect of such therapy is transient.
- Hormonal therapy seems to have therapeutic effect, but long-term usage is not recommended because of the high risk of osteoporosis.
- Current surgical treatment includes open or laparoscopic surgery to ligate the insufficient veins. However, these procedures are rarely performed as they are more invasive than endovascular embolization procedures and require a general anesthetic and a longer recovery period. Surgery of the reproductive organs is not advised as a treatment option.
- Injecting foam or liquid sclerosant could be used for occlusion of gonadal veins and for the treatment of atypical varicose veins of perineal, vulval, gluteal, or posterior thigh localization.
- Transcatheter embolization therapy is the method of choice for the treatment of pelvic congestion syndrome. The aim of embolization is to occlude insufficient venous axes as close as possible to the origin of the leak. In pelvic venous disorders these will be the gonadal axes, pelvic varicose veins, and insufficient tributary branches of the internal iliac veins. However, published evidence of its effect has been criticized for the lack of validated clinical and imaging criteria for the disorders responsible for pelvic venous disease.
- Treatment of choice for pelvic congestion syndrome is pelvic vein embolization, in the absence of obstructions. Serious complications after this kind of treatment are very rare.

Society for Interventional Radiology
A fact sheet from the Society for Interventional Radiology on chronic pelvic pain in women endorsed ovarian vein embolization as an effective treatment option for pelvic congestion syndrome.

Society for Vascular Surgery and American Venous Forum
A clinical practice guideline for the care of patients with varicose veins and related chronic venous disorders was jointly published by the Society for Vascular Surgery and American Venous Forum in 2011. Portions of these guidelines were updated most recently in 2023, although there was no mention of pelvic congestion syndrome.

The 2011 guidelines included the recommendations below related to treatment of pelvic congestion syndrome. Medical management is not included among recommendations; the guideline states that "Pharmacologic agents to suppress ovarian function, such as medroxyprogesterone or gonadotropin-releasing hormone, may offer short-term pain relief, but their long-term effectiveness has not been proven."

- We suggest treatment of pelvic congestion syndrome and pelvic varices with coil embolization, plugs, or transcatheter sclerotherapy, used alone or together (grade 2B: weak recommendation, moderate quality of evidence).
- If less invasive treatment is not available or has failed, we suggest surgical ligation and excision of ovarian veins to treat reflux (grade 2B: weak recommendation, moderate quality of evidence).

American Urology Association and American Society for Reproductive Medicine
2020 Guideline part II on Diagnosis and Treatment of Infertility in men notes following about varicocele repair/varicocelectomy:

- Surgical varicocelectomy should be considered in men attempting to conceive, who have palpable varicocele(s), infertility, and abnormal semen parameters, except for azoospermic men. (Moderate Recommendation; Evidence Level: Grade B)
- Clinicians should not recommend varicocelectomy for men with nonpalpable varicoceles detected solely by imaging. (Strong Recommendation; Evidence Level: Grade C)
- For men with clinical varicocele and non-obstructive azoospermia (NOA), couples should be informed of the absence of definitive evidence supporting varicocele repair prior to ART. (Expert Opinion)

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.

Ongoing and Unpublished Clinical Trials
Some currently unpublished and ongoing trials that might influence this review are listed in Table 1.

Table 1. Summary of Key Trials

NCT No.	Trial Name	Planned Enrollment	Completion Date
Ongoing			
NCT03794466	Quantification of Pain Relief With Gonadal Vein Embolization for Pelvic Congestion Syndrome	30	Dec 2025

NCT05553158[a]	Study to Investigate the Influence of Compression Treatment in Patients with Pelvic Congestion Syndrome (PCS)	172	Nov 2024 (unknown)
Unpublished			
NCT04115137	Multicentric Spanish Record of Pelvic Varicose Veins Treated With Vascular Plugs Type Amplatzer - Pelvic Congestion Syndrome: Study of Efficacy and Safety (REPiVAC)	300	Jan 2021 (unknown)
NCT01909024[a]	A Randomised Controlled Trial Investigating The Use Of Pelvic Vein Embolisation To Reduce Recurrent Varicose Veins Of The Legs In Women With Recurrent Varicose Veins And Associated Pelvic Venous Reflux.	270	Dec 2018 (unknown)
NCT04358497	Endovascular Versus Medical Treatment for the Pelvic Congestion Syndrome (ENDPCS)	120	Oct 2022 (unknown; last reported as not yet recruiting)

NCT: national clinical trial.
[a] Denotes industry-sponsored or cosponsored trial.

References

1. Eyre RC, Farooq A. Nonacute scrotal conditions in adults. In: O'Leary MP, ed. *UpToDate*. UpToDate Inc.; July 15, 2025. Accessed October 20, 2025. https://www.uptodate.com/contents/nonacute-scrotal-conditions-in-adults
2. Phillips K, Olanrewaju RA, Omole F. Infertility: evaluation and management. *Am Fam Physician*. 2023;107(6):623-630. Accessed October 20, 2025. https://www.aafp.org/pubs/afp/issues/2023/0600/infertility.html
3. Pastuszak AW, Kumar V, Shah A, et al. Diagnostic and management strategies for varicocele. *Asian J Androl.* 2016;18(2):161–168. doi:10.4103/1008-682X.172640. Accessed October 20, 2025. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4770492/
4. Makris GC, Efthymiou E, Little M, Boardman P, Anthony S, Uberoi R, Tapping C. Safety and effectiveness of the different types of embolic materials for the treatment of testicular varicoceles: a systematic review. *Br J Radiol.* 2018;91(1088):20170445. doi:10.1259/bjr.20170445 [europepmc.org]
5. Knuttinen MG, Machan L, Khilnani NM, et al. Diagnosis and Management of Pelvic Venous Disorders: AJR Expert Panel Narrative Review. AJR Am J Roentgenol. Nov 2023; 221(5): 565-574. PMID 37095667
6. Meissner MH, Khilnani NM, Labropoulos N, et al. The Symptoms-Varices-Pathophysiology classification of pelvic venous disorders: A report of the American Vein Lymphatic Society

International Working Group on Pelvic Venous Disorders. J Vasc Surg Venous Lymphat Disord. May 2021; 9(3): 568-584. PMID 33529720
7. Borghi C, Dell'Atti L. Pelvic congestion syndrome: the current state of the literature. Arch Gynecol Obstet. Feb 2016; 293(2): 291-301. PMID 26404449
8. Bendek B, Afuape N, Banks E, et al. Comprehensive review of pelvic congestion syndrome: causes, symptoms, treatment options. Curr Opin Obstet Gynecol. Aug 2020; 32(4): 237-242. PMID 32487799
9. Tu FF, Hahn D, Steege JF. Pelvic congestion syndrome-associated pelvic pain: a systematic review of diagnosis and management. Obstet Gynecol Surv. May 2010; 65(5): 332-40. PMID 20591203
10. Farquhar CM, Rogers V, Franks S, et al. A randomized controlled trial of medroxyprogesterone acetate and psychotherapy for the treatment of pelvic congestion. Br J Obstet Gynaecol. Oct 1989; 96(10): 1153-62. PMID 2531611
11. Antignani PL, Lazarashvili Z, Monedero JL, et al. Diagnosis and treatment of pelvic congestion syndrome: UIP consensus document. Int Angiol. Aug 2019; 38(4): 265-283. PMID 31345010
12. Brown CL, Rizer M, Alexander R, et al. Pelvic Congestion Syndrome: Systematic Review of Treatment Success. Semin Intervent Radiol. Mar 2018; 35(1): 35-40. PMID 29628614
13. Mahmoud O, Vikatmaa P, Aho P, et al. Efficacy of endovascular treatment for pelvic congestion syndrome. J Vasc Surg Venous Lymphat Disord. Jul 2016; 4(3): 355-70. PMID 27318059
14. Chung MH, Huh CY. Comparison of treatments for pelvic congestion syndrome. Tohoku J Exp Med. Nov 2003; 201(3): 131-8. PMID 14649734
15. Guirola JA, Sánchez-Ballestin M, Sierre S, et al. A Randomized Trial of Endovascular Embolization Treatment in Pelvic Congestion Syndrome: Fibered Platinum Coils versus Vascular Plugs with 1-Year Clinical Outcomes. J Vasc Interv Radiol. Jan 2018; 29(1): 45-53. PMID 29174618
16. Emad El Din M, Soliman M, El Kiran Y, et al. Ovarian vein surgical ablation versus endovascular technique for treatment of pelvic vein incompetence. J Vasc Surg Venous Lymphat Disord. Jul 2023; 11(4): 801-808. PMID 37003463
17. Gavrilov SG, Sazhin AV, Akhmetzianov R, et al. Surgical and endovascular treatment of pelvic venous disorder: Results of a multicentre retrospective cohort study. J Vasc Surg Venous Lymphat Disord. Sep 2023; 11(5): 1045-1054. PMID 37150252
18. Chen H, Wu Z, Wu Z, et al. Proximal coil occlusion preceding distal sclerotherapy in patients with pelvic congestion syndrome: A multicenter, retrospective study. J Vasc Surg Venous Lymphat Disord. Jan 2023; 11(1): 149-155. PMID 36183962
19. Shahat M, Hussein RS, Ahmed AKS. Foam Sclerotherapy in Pelvic Congestion Syndrome. Vasc Endovascular Surg. Jul 2023; 57(5): 456-462. PMID 36692078
20. Sozutok S, Piskin FC, Balli HT, et al. Efficacy of the endovascular ovarian vein embolization technique in pelvic venous congestion syndrome. Pol J Radiol. 2022; 87: e510-e515. PMID 36250142
21. Jambon E, Le Bras Y, Coussy A, et al. Embolization in pelvic venous disorders using ethylene vinyl alcohol copolymer (Onyx®) and Aetoxysclerol: a prospective evaluation of safety and long-term efficacy. Eur Radiol. Jul 2022; 32(7): 4679-4686. PMID 35137302

22. Liu J, Han L, Han X. The Effect of a Subsequent Pregnancy After Ovarian Vein Embolization in Patients with Infertility Caused by Pelvic Congestion Syndrome. Acad Radiol. Oct 2019; 26(10): 1373-1377. PMID 30660471
23. Hocquelet A, Le Bras Y, Balian E, et al. Evaluation of the efficacy of endovascular treatment of pelvic congestion syndrome. Diagn Interv Imaging. Mar 2014; 95(3): 301-6. PMID 24183954
24. Nasser F, Cavalcante RN, Affonso BB, et al. Safety, efficacy, and prognostic factors in endovascular treatment of pelvic congestion syndrome. Int J Gynaecol Obstet. Apr 2014; 125(1): 65-8. PMID 24486124
25. Laborda A, Medrano J, de Blas I, et al. Endovascular treatment of pelvic congestion syndrome: visual analog scale (VAS) long-term follow-up clinical evaluation in 202 patients. Cardiovasc Intervent Radiol. Aug 2013; 36(4): 1006-14. PMID 23456353
26. Gandini R, Chiocchi M, Konda D, et al. Transcatheter foam sclerotherapy of symptomatic female varicocele with sodium-tetradecyl-sulfate foam. Cardiovasc Intervent Radiol. 2008; 31(4): 778-84. PMID 18172712
27. Kwon SH, Oh JH, Ko KR, et al. Transcatheter ovarian vein embolization using coils for the treatment of pelvic congestion syndrome. Cardiovasc Intervent Radiol. 2007; 30(4): 655-61. PMID 17468903
28. Kim HS, Malhotra AD, Rowe PC, et al. Embolotherapy for pelvic congestion syndrome: long-term results. J Vasc Interv Radiol. Feb 2006; 17(2 Pt 1): 289-97. PMID 16517774
29. Society of Interventional Radiology (SIR). Diseases and conditions: Pelvic venous disease (pelvic congestion syndrome or chronic pelvic pain) [Patient Center]. n.d.; https://www.sirweb.org/patient-center/pelvic-venous-disease/https://www.sirweb.org/patient-center/conditions-and-treatments/pelvic-venous-disease/.
30. Gloviczki P, Comerota AJ, Dalsing MC, et al. The care of patients with varicose veins and associated chronic venous diseases: clinical practice guidelines of the Society for Vascular Surgery and the American Venous Forum. J Vasc Surg. May 2011; 53(5 Suppl): 2S-48S. PMID 21536172
31. Gloviczki P, Lawrence PF, Wasan SM, et al. The 2023 Society for Vascular Surgery, American Venous Forum, and American Vein and Lymphatic Society clinical practice guidelines for the management of varicose veins of the lower extremities. Part II: Endorsed by the Society of Interventional Radiology and the Society for Vascular Medicine. J Vasc Surg Venous Lymphat Disord. Jan 2024; 12(1): 101670. PMID 37652254
32. Schlegel PN, Sigman M, Collura B, et al. Diagnosis and treatment of infertility in men: AUA/ASRM guideline part II. *Fertil Steril.* 2021;115(1):62-69. doi:10.1016/j.fertnstert.2020.11.017. Accessed October 20, 2025. https://www.asrm.org/practice-guidance/practice-committee-documents/diagnosis-and-treatment-of-infertility-in-men-aua-asrm-guideline-part2/ [asrm.org]

Policy History

Original Effective Date: 02/01/2020
Current Effective Date: 02/01/2026
11/07/2019 Medical Policy Committee review
11/13/2019 Medical Policy Implementation Committee approval. New policy.

Policy # 00691
Original Effective Date: 02/01/2020
Current Effective Date: 02/01/2026

11/05/2020	Medical Policy Committee review
11/11/2020	Medical Policy Implementation Committee approval. Coverage eligibility unchanged.
11/04/2021	Medical Policy Committee review
11/10/2021	Medical Policy Implementation Committee approval. Coverage eligibility unchanged.
11/03/2022	Medical Policy Committee review
11/09/2022	Medical Policy Implementation Committee approval. Coverage eligibility unchanged.
11/02/2023	Medical Policy Committee review
11/08/2023	Medical Policy Implementation Committee approval. Coverage eligibility unchanged.
11/07/2024	Medical Policy Committee review
11/13/2024	Medical Policy Implementation Committee approval. Coverage eligibility unchanged.
07/01/2025	Coding update.
11/06/2025	Medical Policy Committee review
11/12/2025	Medical Policy Implementation Committee approval. Title changed from "Ovarian and Internal Iliac Vein Endovascular Occlusion as a Treatment of Pelvic Congestion Syndrome" to "Vein Embolization as a Treatment for Pelvic Congestion Syndrome and Varicocele". Added an investigational statement for endovascular embolization of the testicular (spermatic) vein for treatment of varicocele.

Next Scheduled Review Date: 11/2026

Coding

The five character codes included in the Louisiana Blue Medical Policy Coverage Guidelines are obtained from Current Procedural Terminology (CPT®)‡, copyright 2024 by the American Medical Association (AMA). CPT is developed by the AMA as a listing of descriptive terms and five character identifying codes and modifiers for reporting medical services and procedures performed by physician.

The responsibility for the content of Louisiana Blue Medical Policy Coverage Guidelines is with Louisiana Blue and no endorsement by the AMA is intended or should be implied. The AMA disclaims responsibility for any consequences or liability attributable or related to any use, nonuse or interpretation of information contained in Louisiana Blue Medical Policy Coverage Guidelines. Fee schedules, relative value units, conversion factors and/or related components are not assigned by the AMA, are not part of CPT, and the AMA is not recommending their use. The AMA does not directly or indirectly practice medicine or dispense medical services. The AMA assumes no liability for data contained or not contained herein. Any use of CPT outside of Louisiana Blue Medical Policy Coverage Guidelines should refer to the most current Current Procedural Terminology which contains the complete and most current listing of CPT codes and descriptive terms. Applicable FARS/DFARS apply.

Policy # 00691
Original Effective Date: 02/01/2020
Current Effective Date: 02/01/2026

Codes used to identify services associated with this policy may include (but may not be limited to) the following:

Code Type	Code
CPT	36011, 36012, 37241, 75894
HCPCS	No codes
ICD-10 Diagnosis	I86.1, I86.2, I86.3, I87.2, N94.89, R10.20-R10.24

*Investigational – A medical treatment, procedure, drug, device, or biological product is Investigational if the effectiveness has not been clearly tested and it has not been incorporated into standard medical practice. Any determination we make that a medical treatment, procedure, drug, device, or biological product is Investigational will be based on a consideration of the following:

A. Whether the medical treatment, procedure, drug, device, or biological product can be lawfully marketed without approval of the U.S. Food and Drug Administration (FDA) and whether such approval has been granted at the time the medical treatment, procedure, drug, device, or biological product is sought to be furnished; or
B. Whether the medical treatment, procedure, drug, device, or biological product requires further studies or clinical trials to determine its maximum tolerated dose, toxicity, safety, effectiveness, or effectiveness as compared with the standard means of treatment or diagnosis, must improve health outcomes, according to the consensus of opinion among experts as shown by reliable evidence, including:
    1. Consultation with technology evaluation center(s);
    2. Credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community; or
    3. Reference to federal regulations.

NOTICE: If the Patient's health insurance contract contains language that differs from the BCBSLA Medical Policy definition noted above, the definition in the health insurance contract will be relied upon for specific coverage determinations.

NOTICE: Medical Policies are scientific based opinions, provided solely for coverage and informational purposes. Medical Policies should not be construed to suggest that the Company recommends, advocates, requires, encourages, or discourages any particular treatment, procedure, or service, or any particular course of treatment, procedure, or service.

NOTICE: Federal and State law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over Medical Policy and must be considered first in determining eligibility for coverage.