Varicocele Embolization

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Effective Date	6/1999
Next Review Date	6/15/2024
Coverage Policy	Surgical 209
Version	3

All requests for authorization for the services described by this medical policy will be reviewed per Early and Periodic Screening, Diagnostic and Treatment (EPSDT) guidelines. These services may be authorized under individual consideration for Medicaid members under the age of 21-years if the services are judged to be medically necessary to correct or ameliorate the member's condition. Department of Medical Assistance Services (DMAS), Supplement B - EPSDT (Early and Periodic Screening, Diagnosis and Treatment) Manual.*.

Purpose:

This policy addresses Varicocele Embolization.

- Refer to separate policy for Varicose Vein Treatments.

Description & Definitions:

Varicocele embolization is a procedure used to block blood flow in a painful enlarged vein in a man's scrotum.

Criteria:

Varicocele embolization (balloon or metallic coil) for the treatment a varicocele in a male with **1 or more of the following:**

- Individual with recurrence of varicoceles post surgical (ligation)
- Individual is an adolescent with grade 2 or 3 varicocele related to ipsilateral testicular growth restriction
- Individual with scrotal pain associated with varicoceles
- Individual with infertility problems with **all of the following**:
  - Lower sperm concentration
  - Decreased sperm motility

Varicocele embolization is considered **not medically necessary** for any use other than those indicated in clinical criteria.

Coding:

Medically necessary with criteria:

Coding	Description
37241	Vascular embolization or occlusion, inclusive of all radiological supervision and interpretation, intraprocedural roadmapping, and imaging guidance necessary to complete the intervention; venous, other than hemorrhage (eg, congenital or acquired venous malformations, venous and capillary hemangiomas, varices, varicoceles)

Considered Not Medically Necessary:

Coding	Description
	None

U.S. Food and Drug Administration (FDA) - approved only products only.

Document History:

Revised Dates:

- 2020: January
- 2014: May, June
- 2013: April, October
- 2012: January, April, September
- 2011: December
- 2008: April, October
- 2004: May, July
- 2003: July
- 2001: August
- 1999: September

Reviewed Dates:

- 2023: June
- 2022: June
- 2021: June
- 2020: July
- 2019: April
- 2018: August
- 2017: November
- 2016: June
- 2015: October
- 2011: April
- 2010: April
- 2009: April
- 2007: October
- 2006: June, September
- 2005: July, December
- 2003: June

Effective Date:

- June 1999

References:

Specialty Association Guidelines; Government Regulations; Winifred S. Hayes, Inc; UpToDate; Literature Review; Specialty Advisors; National Coverage Determination (NCD); Local Coverage Determination (LCD).

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Special Notes: *

This medical policy express Sentara Health Plan's determination of medically necessity of services, and they are based upon a review of currently available clinical information. These policies are used when no specific guidelines for coverage are provided by the Department of Medical Assistance Services of Virginia (DMAS). Medical Policies may be superseded by state Medicaid Plan guidelines. Medical policies are not a substitute for clinical judgment or for any prior authorization requirements of the health plan. These policies are not an explanation of benefits.

Medical policies can be highly technical and complex and are provided here for informational purposes. These medical policies are intended for use by health care professionals. The medical policies do not constitute medical advice or medical care. Treating health care professionals are solely responsible for diagnosis, treatment and medical advice. Sentara Health Plan members should discuss the information in the medical policies with their treating health care professionals. Medical technology is constantly evolving and these medical policies are subject to change without notice, although Sentara Health Plan will notify providers as required in advance of changes that could have a negative impact on benefits.

The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) covers services, products, or procedures for children, if those items are determined to be medically necessary to "correct or ameliorate" (make better) a defect, physical or mental illness, or condition (health problem) identified through routine medical screening or examination, regardless of whether coverage for the same service or support is an optional or limited service under the state plan. Children enrolled in the FAMIS Program are not eligible for all EPSDT treatment services. All requests for authorization for the services described by this medical policy will be reviewed per EPSDT guidelines. These services may be authorized under individual consideration for Medicaid members under the age of 21-years if the services are judged to by medically necessary to correct or ameliorate the member's condition. *Department of Medical Assistance Services (DMAS), Supplement B - EPSDT (Early and Periodic Screening, Diagnosis and Treatment) Manual.*

Keywords:

Pelvic embolization, gonadal vein, embolization, varicocele embolization, varicocele, infertility, sperm, scrotal pain, Varicocele Embolization, Surgical 209