

## Quality ID #420: Varicose Vein Treatment with Saphenous Ablation: Outcome Survey

**2025 COLLECTION TYPE:**  
MIPS CLINICAL QUALITY MEASURES (CQMS)

**MEASURE TYPE:**  
Patient Reported Outcome -Based Performance Measure – High Priority

**DESCRIPTION:**  
Percentage of patients treated for varicose veins (CEAP C2-S) who are treated with saphenous ablation (with or without adjunctive tributary treatment) that report an improvement on a disease specific patient reported outcome survey instrument after treatment.

**INSTRUCTIONS:**  
This measure is to be submitted **each time** a saphenous ablation procedure is performed for the treatment of varicose veins during the performance period. This measure may be submitted by Merit-based Incentive Payment System (MIPS) eligible clinicians who perform the quality actions described in the measure based on the services provided and the measure-specific denominator coding.

**Measure Submission Type:**  
Measure data may be submitted by individual MIPS eligible clinicians, groups, or third-party intermediaries. The listed denominator criteria are used to identify the intended patient population. The numerator options included in this specification are used to submit the quality actions as allowed by the measure. The quality data codes listed do not need to be submitted by MIPS eligible clinicians, groups, or third-party intermediaries that utilize this modality for submissions; however, these codes may be submitted for those third-party intermediaries that utilize Medicare Part B claims data. For more information regarding Application Programming Interface (API), please refer to the Quality Payment Program (QPP) website.

**DENOMINATOR:**  
All patients who are treated for varicose veins with saphenous ablation and who receive an outcomes survey before and 3-6 months after treatment

**Denominator Criteria (Eligible Cases):**

All patients, regardless of age

**AND**

Diagnosis for varicose veins (ICD-10-CM): I83.811, I83.812, I83.813, I83.819

**AND**

Patient procedure during the performance period (CPT): 36465, 36473, 36475, 36478, 36482

**WITHOUT**

Telehealth Modifier (including but not limited to): GQ, GT, POS 02, POS 10

**NUMERATOR:**  
Patients whose outcome survey score improved when assessed 3-6 months following treatment

**Definition:**

**Outcome Survey** – A normalized and validated “outcome survey” developed for the patient reported outcomes for saphenous vein ablation. The disease specific standardized outcome survey utilized must be documented in the medical record. Examples of outcome surveys include, but are not limited to:

- Venous Insufficiency Epidemiological and Economic Study-Quality of Life (VEINES-QOL)
- Chronic Venous Insufficiency Questionnaire (CIVIQ)
- Aberdeen Varicose Veins Questionnaire (AVVQ)

- Specific Quality of Life and Outcome Response - Venous (SQOR-V)
- Varicose Veins Symptom Questionnaire (VVSymQ)
- Venous Clinical Severity Score (VCSS)

**Numerator Options:**

***Performance Met:***

Patient survey score improved from baseline following treatment (**G9603**)

**OR**

***Denominator Exception:***

Patient survey results not available (**G9604**)

**OR**

***Performance Not Met:***

Patient survey score did not improve from baseline following treatment (**G9605**)

**RATIONALE:**

Surrogate measures to measure the success of varicose vein treatment with saphenous ablation have numerous flaws. The ultimate measure of success of saphenous ablation for varicose veins is an improved quality of life. This quality measure motivates physicians to assess changes in quality of life after as compared with before an ablation using one of several standardized survey instruments. This enables objective quantification of the improvement in quality of life that saphenous vein ablation provides patients with CEAP C2 disease.

**CLINICAL RECOMMENDATION STATEMENTS:**

The Intersocietal Accreditation Commission (IAC) - Vein Center Division strongly recommends the use of the disease specific patient reported outcome (PRO) instruments before and after ablation and to use the data collected for an analysis of the quality of care being delivered by the center. These guidelines have been created by the IAC and are being implemented by several groups including Society for Vascular Surgery (SVS).

The American Venous Forum recommends the use of PRO instruments before and after vein treatment for all patients.

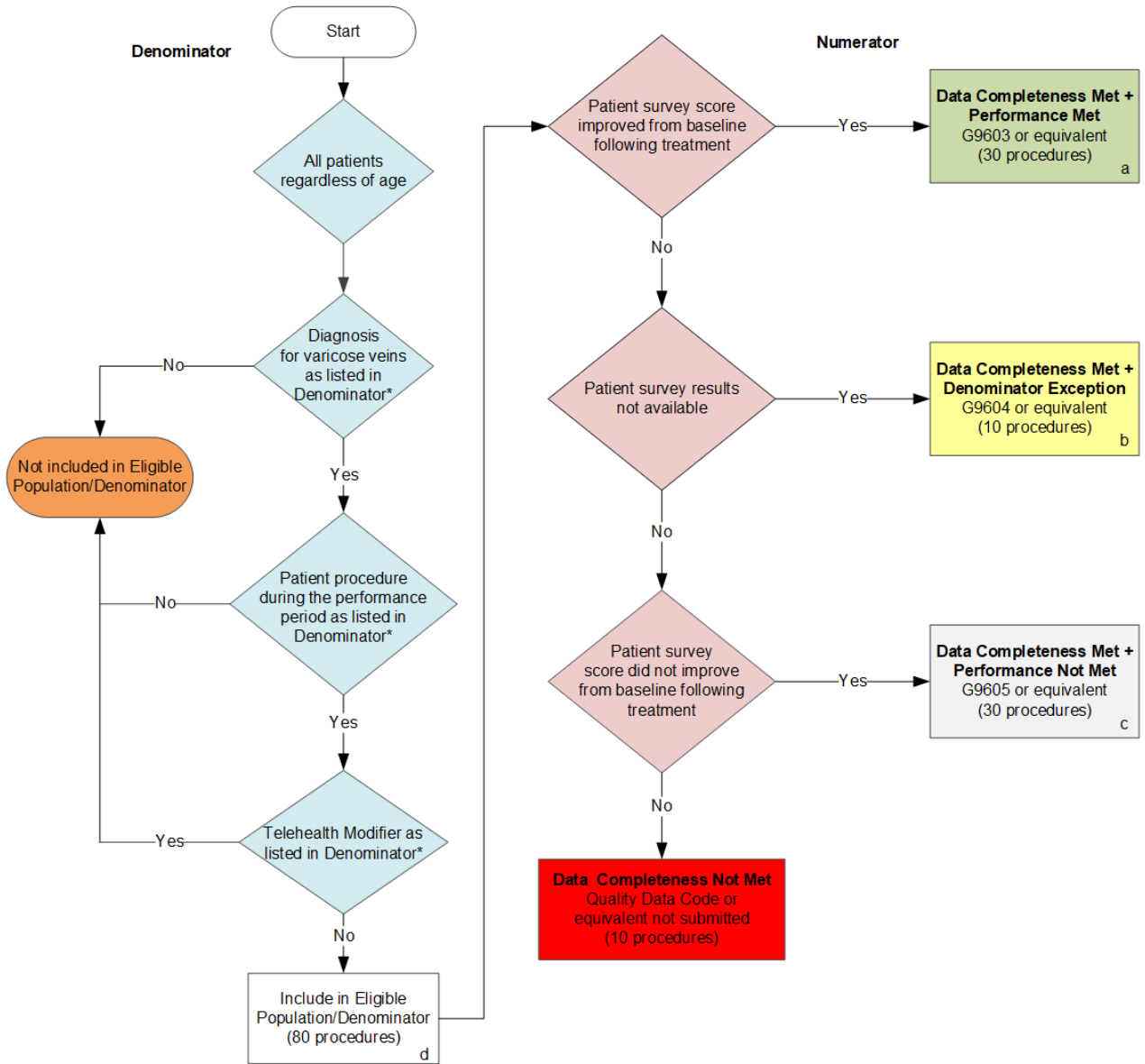
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**2025 Clinical Quality Measure Flow for Quality ID #420:  
Varicose Vein Treatment with Saphenous Ablation: Outcome Survey**

*Disclaimer: Refer to the measure specification for specific coding and instructions to submit this measure.*



**SAMPLE CALCULATIONS**

**Data Completeness=**  

$$\frac{\text{Performance Met (a=30 procedures)} + \text{Denominator Exception (b=10 procedures)} + \text{Performance Not Met (c=30 procedures)}}{\text{Eligible Population / Denominator (d=80 procedures)}} = \frac{70 \text{ procedures}}{80 \text{ procedures}} = 87.50\%$$

**Performance Rate=**  

$$\frac{\text{Performance Met (a=30 procedures)}}{\text{Data Completeness Numerator (70 procedures) - Denominator Exception (b=10 procedures)}} = \frac{30 \text{ procedures}}{60 \text{ procedures}} = 50.00\%$$

\* See the posted measure specification for specific coding and instructions to submit this measure.

NOTE: Submission Frequency: Procedure

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 The measure diagrams were developed by CMS as a supplemental resource to be used in conjunction with the measure specifications. They should not be used alone or as a substitution for the measure specification.  
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**2025 Clinical Quality Measure Flow Narrative for Quality ID #420:  
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1. Start with Denominator
2. Check *All patients regardless of age*.
3. Check *Diagnosis for varicose veins as listed in the Denominator\**:
  - a. If *Diagnosis for varicose veins as listed in the Denominator\** equals No, do not include in *Eligible Population/Denominator*. Stop processing.
  - b. If *Diagnosis for varicose veins as listed in the Denominator\** equals Yes, proceed to check *Patient procedure during the performance period as listed in the Denominator\**.
4. Check *Patient procedure during the performance period as listed in the Denominator\**:
  - a. If *Patient procedure during the performance period as listed in the Denominator\** equals No, do not include in *Eligible Population/Denominator*. Stop processing.
  - b. If *Patient procedure during the performance period as listed in the Denominator\** equals Yes, proceed to check *Telehealth Modifier as listed in Denominator\**.
5. Check *Telehealth Modifier as listed in Denominator\**:
  - a. If *Telehealth Modifier as listed in Denominator\** equals Yes, do not include in *Eligible Population/Denominator*. Stop processing.
  - b. If *Telehealth Modifier as listed in Denominator\** equals No, include in *Eligible Population/Denominator*.
6. Denominator Population:
  - Denominator population is all Eligible Procedures in the denominator. Denominator is represented as Denominator in the Sample Calculation listed at the end of this document. Letter d equals 80 procedures in the Sample Calculation.
7. Start Numerator
8. Check *Patient survey score improved from baseline following treatment*:
  - a. If *Patient survey score improved from baseline following treatment* equals Yes, include in *Data Completeness Met and Performance Met*.
    - *Data Completeness Met and Performance Met* letter is represented in the Data Completeness and Performance Rate in the Sample Calculation listed at the end of this document. Letter a equals 30 procedures in the Sample Calculation.
  - b. If *Patient survey score improved from baseline following treatment* equals No, proceed to check *Patient survey results not available*.
9. Check *Patient survey results not available*:
  - a. If *Patient survey results not available* equals Yes, include in *Data Completeness Met and Denominator Exception*.

- *Data Completeness Met and Denominator Exception* letter is represented in the Data Completeness and Performance Rate in the Sample Calculation listed at the end of this document. Letter b equals 10 procedures in the Sample Calculation.
- b. If *Patient survey results not available* equals No, proceed to check *Patient survey score did not improve from baseline following treatment*.
10. Check *Patient survey score did not improve from baseline following treatment*:
- a. If *Patient survey score did not improve from baseline following treatment* equals Yes, include in *Data Completeness Met and Performance Not Met*.
- *Data Completeness Met and Performance Not Met* letter is represented in the Data Completeness in the Sample Calculation listed at the end of this document. Letter c equals 30 procedures in the Sample Calculation.
- b. If *Patient survey score did not improve from baseline following treatment* equals No, proceed to check *Data Completeness Not Met*.
11. Check *Data Completeness Not Met*:
- If *Data Completeness Not Met*, the Quality Data Code or equivalent was not submitted. 10 procedures have been subtracted from the Data Completeness Numerator in the Sample Calculation.

### Sample Calculations

Data Completeness equals Performance Met (a equals 30 procedures) plus Denominator Exception (b equals 10 procedures) plus Performance Not Met (c equals 30 procedures) divided by Eligible Population/Denominator (d equals 80 procedures). All equals 70 procedures divided by 80 procedures. All equals 87.50 percent.

Performance Rate equals Performance Met (a equals 30 procedures) divided by Data Completeness Numerator (70 procedures) minus Denominator Exception (b equals 10 procedures). All equals 30 procedures divided by 60 procedures. All equals 50.00 percent.

\* See the posted measure specification for specific coding and instructions to submit this measure.

NOTE: Submission Frequency: Procedure

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