November 30, 2020

Von Nguyen, MD, MPH
Senior Vice President and Chief Medical Officer
Blue Cross/Blue Shield of North Carolina
4615 University Drive
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Sent electronically via providerupdates@BCBSNC.com

RE: Treatment for Varicose Veins of the Lower Extremity, Corporate Medical Policy

Dear Dr. Nguyen,

The American Venous Forum (AVF), American Venous and Lymphatic Society (AVLS) and the Society for Vascular Surgery (SVS) appreciate the opportunity to comment on the Blue Cross/Blue Shield of North Carolina Corporate Medical Policy regarding Treatment for Varicose Veins of the Lower Extremity, which is up for CAP review this month. These national societies representing vascular surgeons and other practitioners who provide care of patients with venous disease in North Carolina and around the country have collaborated and reviewed the BCBS policy. Our comments are summarized below.

At the outset we would like to commend your group for including up to date references and coverage for the many modalities available to the modern physician treating venous disease. The introductory paragraph describing "Conventional surgical treatment", i.e ligation and stripping is seldom performed in the 21st century, with shift of therapy to less invasive techniques via catheter based platforms. Albeit surgical procedures on occasion are still indicated in some patients and surely deserve continued coverage.

Your plan accurately describes the various constituents of the superficial venous system including the Great, Small, Accessory, and duplicated saphenous veins. Your policy presents data demonstrating benefits to eliminating these venous segments when they are incompetent and symptomatic and provides a reasonable set of criteria for when treatment of these axial veins is "medically necessary". However patients with more advanced venous disease as evidenced by advanced skin changes, ulceration, bleeding, and severe symptoms (as measured by rVCSS scores) clearly benefit from early venous interventions and therefore we recommend providing an exemption to the compression trial requirement. In these patients, timely interventions can limit the limb threatening specter of infection, blood transfusion and ongoing requirements for extensive wound care. While our organizations espouse the clinical benefit of compression garments we believe that mandating compression use for a fixed period of time simply delays therapy in those with advanced disease described above. (EVRA trial. N Engl J Med 2018; 378:2105-2114). We recommend an exemption to the stocking trial mandate in these patients.

Despite your reasonable medical analysis, your Benefits Application which includes the following statement: "**Coverage is provided for endovenous procedures used to support the normal function of your veins, and is limited to one procedure per limb per lifetime.**" has no support in your policy analysis and is not consistent with standard venous practice. While our organizations understand the necessity of cost containment practices and the need to control inappropriate use, we contend that this limit of one treatment per leg is completely unfounded. Your own review recognizes the Great, Small, Accessory, and duplicated Saphenous veins as potentially medically necessary targets for treatment. In addition although GSV ablations are quite successful immediately and in the long term, the nature of venous disease to recur results in a small but real number or patients presenting for repeat treatments. While the majority of patients undergoing venous ablation do receive treatment of a single axial vein, the need for treatment of a second or third vein during a lifetime is common and excluding that coverage without exception does not meet the standard of care in the United States today. Your policy provides robust data supporting the benefits of venous ablations in symptomatic patients including faster time to healing of leg ulcers and decreased ulcer recurrence rates. To our knowledge there is no evidence to support limiting treatment to a single vein of a limb. These patients requiring additional treatments may have synchronous axial vein dysfunction, duplicated systems or additional axial veins which progress to incompetency.

We therefore urge Blue Cross Blue Shield to remove this limit on coverage of only one ablation treatment per leg per life and to instead apply your medical necessity determination outlined above to each application for treatment of additional pathologic veins in a limb. The SVS, AVLS, and AVF support efforts to provide medically appropriate levels of care with reasonable coverage determinations but feel that this current policy will cause untoward consequences for patients with multiple veins in need of intervention. We would however support efforts to reign in outliers and to review inappropriate use if it occurs. Our national leadership and local members would welcome the opportunity to work with you on this important issue. If additional information is required, please contact trishacrishock@gmail.com.

Regards,

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Chair, AVF Health Policy Committee

Sunita Srivastava, MD
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Stephen F. Daugherty, FACS, FAVLS, RVT, RPhS
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cc Bill Marston, MD (UNC)
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