Blue Cross and Blue Shield of [state]
Second Level Claim Appeal
Member name: [member name]
Service Request: Preferred Benefits for out-of-network service

To whom it may concern:

We are appealing BCBS's decision to deny preferred benefits for [Member name]'s bilateral Nd:YAG laser vitreolysis of his vitreous floaters by Dr. James Johnson of Irvine, CA. Since BCBS has already agreed to cover the laser vitreolysis at the standard benefit rate, the issue is not whether this type of treatment is coverable or whether [member name] needed treatment, but rather is whether a comparable treatment option was available in-area.

Our appeal is based on the following facts:

1) [Member name] had bilateral posterior vitreous detachment, resulting in large, dense vitreous floaters centrally located in both eyes that significantly impaired his vision. This was not only very disruptive to his life (e.g., when trying to read) but in some cases also endangered his safety (e.g., when driving or operating table saw during his work as a remodeler). [Member name]'s visual impairment was significant and warranted treatment, as evidenced by [member's in-network eye doctor]'s diagnosis. This diagnosis was not contested by BCBS, which agreed to cover the laser vitreolysis at the standard benefit rate in response to our request for pre-approval of treatment.
2) The only in-area available treatment for such floaters in pars plana vitrectomy (PPV), an invasive and risky surgical procedure requiring general anesthesia in which the eye is opened up and the floaters and surrounding vitreous are sucked out and replaced with fluid.
3) Because of the significant risks of PPV, [member's in-network eye doctor] did not want to recommend this surgery (see letter from him that was treated as our first level of appeal, even though we did not realize his letter would supplant our right to a first level of appeal). Among these well-documented risks are:
    a. All of the risks of general anesthesia, which I'm sure you're aware of;
    b. Risk of infection during the surgery, since, as [member's in-network eye doctor] put it to us, "You're opening up parts of the body that are never meant to be opened up";
    c. Significant risks of retinal breaks (10-14%) during surgery as well as retinal detachment (over 2%) in the months following surgery (refs 1- 4);
    d. Rare but serious complication of suprachoroidal hemorrhage (ref 5);

e. Extremely high risk (reports range from 68-100%) of cataract formation within 2 years after PPV (e.g., refs 6-11);
f. Greater complications incurred by cataract surgery for post-vitrectomy than non-post-vitrectomy patients (refs 13-15).

4) An alternative treatment for vitreous floaters is laser vitreolysis. However this treatment is only currently available outside our plan area. Laser vitreolysis has been repeatedly shown to be safe and effective (refs 16-21). In a recent FDA approved study of 200 patients, laser vitreolysis was shown to have zero significant complications and a 92% overall success rate, with an even higher success rate (97%) for patients with PVD, such as [member name] had (ref 21). The procedure is reimbursable by insurance companies, including Vermont BCBS, which granted pre-approval for reimbursement of [member name]'s laser vitreolysis at the standard rate when we requested pre-approval. (Please note that insurance code 67031 for "Laser Severing of Vitreous Strands" refers to brief 2-3 minute laser procedure that is used after a complication of cataract surgery where a thin strand of vitreous gets stuck in the cornea incision; this code does not re-flect the complexity, intensity, time requirements, and the skill set needed for laser treatment of vitreous –floaters).

   The Neodymium Yttrium-Aluminum-Garnet Laser (Nd:YAG) has been used in ophthalmology since the early 1980's. Like other forms of laser light it is coherent, and monochromatic. This means the light energy can be focused into a very small spot size. In addition, modern YAG lasers use an electronic "Q-switch" that limits the exposure time to very short duration of a few nanoseconds. Modern ophthalmic YAG lasers can focus the spot beam to about 4 microns. The highly concentrated energy over such a short durations creates very high, but localized temperatures that are high enough to vaporize vitreous floaters, even though there is a short total cumulative laser time exposure (around 0.000008 seconds per treatment session). The gas vapor is then naturally reabsorbed by the body. With the skillful use of a handheld contact focusing lens, even microscopic threads and strands can be vaporized.

   This is a painless and low risk out-patient procedure, using only local gel anesthetic. It is not easily performed, and not programmed in and computer controlled like LASIK and excimer laser vision correction. Each laser shot is individually assessed, aimed, focused and applied. Patients typically require an initial treatment lasting about an hour per eye, with 1-3 follow-up treatments that can be performed in the following days. ([member name]'s treatment took about 45 minutes per eye for the initial treatment and about 30 minutes per eye for each of the two follow-up treatments).

The required Nd:YAG laser is already approved for ophthalmologic use, and the procedure for laser vitreolysis has been around for about 20 years and is not considered experimental. While virtually every ophthalmologist has used the YAG laser to accurately break up membranes and or vitreous material following cataract surgery, only 3 doctors in the U.S. currently perform Nd:YAG Laser Photodisruption Vitreolysis for vitreous floater ablation on a regular basis; Dr. James Johnson (Irvine, CA; this is the only practice that is exclusively dedicated to this treatment, and is the doctor being referred to in this case), Dr. John Karickhoff (Virginia), and Dr. Geller (Florida). *No in network providers offer laser vitreolysis*.

Because there is no abrasion or breach in the defenses of the eye during Nd:YAG Laser Photodisruption Vitreolysis, there is no increased risk of infection and so no need for antibiotics, nor does the procedure increase the risk of subsequent cataracts, as in PPV. In the 20 year history of this procedure, there have been no retinal detachments, no apparent vision loss, and no vision threatening complications. Temporary elevations in eye pressure (that respond well to eye drops and are resolved within a few to several weeks) are observed in 3 to 5 out of every 1000 patients (<0.5% risk of occurrence). Minor and reversible complications to the retina via laser "shock-wave" could occur if working in close proximity to the retina, but Dr. Johnson avoids these risks by simply not treating floaters that are too close to the retina or the lens; in any case, [member name]'s floaters were not located in these risky places.

In summary, laser vitreolysis has the following advantages over PPV:

a. It requires only a topical anesthetic (so no risks of general anesthesia);
b. It removes the floaters but not the vitreous;
c. The eye is not opened (no cataract formation, retinal detachments, infections or bleeding);
d. Laser vitreolysis is much less expensive than surgical PPV, especially when one considers the likelihood of cataract formation following PPV and its associated costs and risks;
e. There are no restrictions on activities, and the patient's eyesight is fully functional as soon as the dilating drops wear off (well within 24 hours).

In conclusion, although PPV is an *effective* in-area treatment of vitreous floaters, this form of treatment is *associated with extremely high risks,* including a significant risk of retinal detachment and an almost certain risk of cataract formation. *Laser vitreolysis, on the other hand, is equally effective but much safer, with none of the risks of PPV, and in addition is much cheaper*. We understand that BCBS prefers in-area treatments, and had laser vitreolysis been available in-area we would have been more than happy to have sought it out (and saved the

couple of thousand we had to spend in travel expenses to get treated in California). However, in this case of vitreous floater treatment, it would be medically irresponsible for BCBS to deny preferred benefits to the out-of-area laser vitreolysis treatment that is equally effective as surgical PPV but has none of the very high and significant risks of PPV. In addition, since PPV not only costs more but will almost surely require subsequent expensive cataract surgery; covering in-area PPV but not out-of-area laser vitreolysis at preferred rates would therefore needlessly contribute to escalating health care costs. BCBS could improve patient care and outcomes, while at the same time saving money, by offering preferred benefits for the safe and effective laser vitreolysis out-of-area, as opposed to the risky and expensive pars plana vitrectomy in-area, and we urge you to consider this, not only for us, but for future patients as well.

In closing, we are delighted to report that (as expected) [member name]'s bilateral laser vitreolysis was highly effective, ablated essentially all of his large dense and vitreous floaters, and restored his vision to 100% of what it had been prior to his posterior vitreous detachments. He experienced no pain or side effects during or after the procedures and as soon as the dilation of his pupils wore off he was able to see clearly and function normally. Dr. Johnson is an amazing and careful physician, and charged a very reasonable rate. Patients like [member name] should not have to choose between a highly-efficacious no-risk procedure that is only offered at the standard out-of-network reimbursement rate and a very high-risk in-network procedure that is offered at the preferred benefit rate.

Thank you for considering this appeal,

Signed,

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