

Venous Insufficiency: Insurance Companies imposing difficult rules as ObamaCare effect looms

By Joseph Magnant, MD, FACS

Of the estimated 35-40 million adult Americans who suffer from significant superficial venous insufficiency, or venous reflux disease, the majority do not present with ulceration or external bleeding as their initial complaint. Until the year 2000, the only treatments for venous insufficiency (manifest as large varicose veins, skin ulcerations or bleeding varicose veins) were compression hose or vein stripping. Due to the invasive and painful nature of this procedure, surgical treatment for venous insufficiency was limited to patients with recurrent ulcerations around the ankles or bleeding episodes. Fortunately, endovenous closure, which was introduced in 2000, has forever changed the landscape for patients with venous insufficiency. Since introduced, endovenous closure (sealing of the leaky veins with a small catheter) has been used successfully to treat patients with painful varicose veins, skin dis-

coloration, venous ulcerations, bleeding varicose veins, and a host of other symptoms related to and caused by leaky veins including swollen legs, restless legs syndrome, nocturnal leg cramps and frequent nighttime urination and a number of more obscure foot and leg problems such as tarsal tunnel syndrome. Patients have been able to have successful treatment of their venous insufficiency and relief from their disabling symptoms prior to developing the end result complications of venous ulceration or hemorrhage. These complications require emergency room visits and frequent hospitalizations and thus the goal should be the avoidance of these serious complications. It seems only logical to offer earlier, effective, minimally invasive treatment when possible, rather than to demand presence of the end complications to justify therapy. The reader of this article is likely to wonder where Dr. Magnant is going with this discussion.

The point here is that over the past several months commercial insurance companies have instituted new regulations and requirements making it much more difficult to obtain preauthorization for endovenous ablation therapy for patients with symptomatic, severe venous insufficiency. High resolution digital photographs are no longer adequate for United Healthcare unless the patient's name and date is taped to the leg on a sticky note with a ruler placed next to the varicose vein to confirm the varicose vein is large enough to justify treatment. If no varicose veins are present, then the patient must fill out a separate questionnaire confirming severity, frequency and length of pain, as well as response to hose therapy. Where patients previously were considered candidates for treatment only if their response to compression hose was inadequate, the correct new required response here is patient is improved with hose. Other insurance companies (Cigna) now may reject requests based on arbitrary vein measurements on ultrasound testing (vein diameter <3mm) rather than severity of reflux in the veins as measured in number of seconds (normal <0.5 sec, abnormal range from 0.5-10 sec or greater). Our latest denial letter from this same insurance company noted the reason was that there was no documented evidence of ulceration or history of external bleeding. Read that line again... "there was no documented evidence of ulceration or history of external bleeding". There is something terribly wrong with this picture.



UHC has launched an aggressive PR campaign as they have tightened restrictions and regulations and made documentation a nightmare for clinicians to take proper care of their patients. These new rules are not based on scientific data, and appear to be arbitrarily derived. It is the severity of reflux (measured in seconds) not the absolute size of the veins (which is influenced by patient position, hydration and other hormonal factors) which should be considered in determining which veins will benefit from sealing or endovenous closure. The committees responsible for the criteria are unreachable and medical directors responsible for the denials often have no specialty training in Phlebology or vein diseases and have commented that "it is out of their hands".

Appeals are required after denials and peer to peer phone conferences with medical directors are time consuming and this type of micromanagement of medical care by a distant impersonal algorithm does not result in improved patient care, rather it results in restricting of benefits and services. Physicians may grow weary of the appeal process and may not take the time or have the time to conduct the numerous peer to peer phone conferences with the medical directors of as many as 50 different insurance carriers to obtain preauthorizations for their patients. Patients do not have the technical knowledge or data to independently present their cases on appeal to the medical directors. Insurance companies appear to be trying to wear down the physicians and patients by mandating excessive and arbitrary new documentation methods which have little or no objective relationship to the actual clinical severity of the condition. More concerning is the restriction of effective, minimally invasive therapy for severe venous insufficiency by at least one insurance company unless the end complications of either

ulceration or external hemorrhage (bleeding) has occurred. This is equivalent to withholding coverage for diabetes or high cholesterol medicines until patients develop diabetic neuropathy or retinopathy or arterial blockages causing stroke, heart attack or gangrene. Why these new rules and denials? Uncertainty and the bottom line. Improving the bottom line as the uncertain effects of ObamaCare approach. Maximize profits through the minimization of services approved and performed. "Request denied for vein too small, no ulcer, no bleeding, name not on sticky note, hose did not improve pain, hose did improve pain, timely appeal, appeal lost, photos not received", the list goes on. Patient gets weary of waiting and Physician of calling and expense of appeal process in terms of human resource capital. Rather than providing services for their clients who pay premiums, they have restricted the very services for which they are insuring their patients.

Our goal in medicine should be to improve the well being and functional quality of life of our patients by offering evidence based treatments directed at prevention of the end complications of the disease process. Regarding venous insufficiency this translates into offering treatment to patients with ultrasound documented, severe insufficiency of the superficial venous system including one of, or a combination of the great saphenous vein, small saphenous vein, anterior accessory saphenous vein, posterior accessory saphenous vein, intersaphenous vein and/or perforating veins or branch veins. In addition to the finding of severe insufficiency, patients must have symptoms referable to the distribution of the abnormal veins (such as painful varicose veins, venous ulceration, bleeding history from veins, recurrent superficial venous thrombosis, severe limb swelling without any other identifiable cause, skin discoloration in the ankle region, severe restless legs syndrome, nighttime leg cramps, nocturnal urination without urologic/metabolic/cardiovascular expla-

nation, or a number of other more obscure presentations of venous insufficiency) and have had a trial of conservative therapy consisting of elevation, compression hose and analgesics.

Rather than have a different set of rules from each insurance company, insurance companies should trust their contracted physician members to take proper care of their patients and allow physicians to practice that which they spent many years training for, medicine. If our experiences of the last few months, denials for anything less than extreme complications, micromanagement of photo style and layout, arbitrary varicose vein diameter measurements by a nurse, from a digital photo, with a paper ruler taped to the leg in question, and nearly impossible appeals processes, are a window into the future of the health exchanges and President Obama's healthcare plan, I am afraid it is a rear facing window. Patients and physicians need to be educated and make their voices heard with their insurance carriers as the process of delivering and receiving health care is further encumbered by bureaucratic regulations and arbitrary mandates. The cost of healthcare is already on the rise, more staff to manage the denials, arrange the conference calls, mail the photos and records for preauthorization, follow-up on the status of the requests or denials and physician time spent educating primary care (or non Vein Specialist) medical directors on the modern treatment of venous disease.

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