Anthem Now Wants Your Eye Surgeon To Double As Your Anesthesiologist

By Jamie Wells, M.D. — February 21, 2018

Sad and scary times are upon us if patient safety is your priority. Assuring medical care delivery is in a patient’s best interest while being as cost-effective as possible should be the goal of a health insurer. Unfortunately, new policy measures by Anthem call such a notion into question.

Here are some recent examples that hit the news:

- See New Anthem anesthesia policy can have blinding consequences: Physicians’ groups call for immediate halt to recent policy limiting use of anesthesia during cataract surgery [2]
- See Anthem insurance might not pay for ER visits in Ohio and Kentucky [3]

Is Anthem’s goal to amplify physician shortages or become the de facto treating eye surgeon?

Last I checked, patients don’t seek out their insurers opinion as to what is in their best interest for their health care let alone for the preservation of their sight. If insurance carriers now wish to be doctors, then let them be beholden to the strict rules and regulations of the profession. For starters, they should actually examine the patients themselves and review their complete medical record - something insurance behemoth Aetna is now in hot water over with multi-state investigations in progress. (See Is It Even Ethical For a Doctor To Work At An Aetna? [4])

As per the California Medical Association [2]

“The California Academy of Eye Physicians and Surgeons (CAEPS) and the
California Society of Anesthesiologists (CSA) have sent letters to Anthem Inc. requesting that they immediately rescind a new policy that deems Monitored Anesthesia Care (MAC) “not medically necessary” during “routine” cataract surgery – a move seen as endangering patients. These were followed up with complaints to the California Department of Managed Health Care (DMHC) and the California Department of Insurance by the California Medical Association (CMA), and supported by the other groups."

The company’s latest policy puts the onus of performing and monitoring not only the cataract surgery, but also the anesthesia on the ophthalmologist in a number of situations. A surgeon should be focused on surgery and the body part on which he or she is operating and should not be having to monitor and sedate the patient while performing complex and delicate ocular procedures. This is especially disturbing since many of these operations occur in the elderly population who typically have complicating co-morbidities and are more clinically fragile.

Sedating patients in these circumstances is often required to reduce risk given the delicate nature of the surgery itself - it is frequently essential to relaxing the patient and impeding their movement in a procedure where margins for error are minute to avoid causing near or complete blindness. It is also important to recognize that even those cases that seem cut and dry can take unexpected turns when operations are underway. Should such a bad turn of events occur, waiting to find an anesthesiologist seems particularly cruel and egregious.

The increased burden on eye surgeons is below the standard of care for their patients and will likely further contribute to “burnout” a leading cause of those leaving medical practice (see Want to Fix Health Care? Start Valuing Doctors! [5]). Plus, patients may not seek the proper care they deserve because they can’t pay for the anesthesia or will place themselves in suboptimal positions.

Placing the burden on a patient to self-diagnose what is a true emergency endangers them

Anthem is not unfounded in their desire to curtail well-known abuse of the emergency room for non-emergent conditions. However, their approach to limiting their coverage to those who turn out not to have a true emergency, for example, is a bit misguided. Abdominal pain, for instance, in a female can be quite complicated as the origin can range from the gastrointestinal to reproductive systems. Certain conditions like an ovarian torsion which warrants urgent surgical intervention should never be delayed to the point the ovary loses such blood flow it begins to die. Such an occurrence could lead to loss of the organ thereby impairing fertility or even incurring sepsis. The pain experienced can mimic other things. There is no way a patient can know what the origin of their discomfort is without proper testing and the stakes with a condition like this are too high.
Playing Monday morning quarterback with these and other complaints like chest pain could compel those who absolutely need care to avoid seeking it. Adding an inclusion of coverage criteria to those sent to the ER by ambulance will likely amount to more individuals tying up emergency services to guarantee their ER visit is covered which in the end only contributes to greater expense.

Asking a patient to discern what is life-threatening and what isn’t without any medical education is ill-conceived on many fronts. First, it is dangerous. Second, it can contribute to longer term disability and escalate the interventions necessary to treat a condition that might have been more easily managed if delays in seeking care result. Third, maybe start focusing on more ideal measures like ones that encourage expanding urgent care facilities adjacent to emergency rooms or in close proximity so they can best triage the situation or incentivize and support practitioners to extend their office hours when possible.

After all, we know altering executive salaries will never be a consideration for change.

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