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Dear Colleague:

Many of you have received a letter from Aetna concerning payment for sedation and anesthesia services for endoscopy. The crux of the letter is: "For patients age 18 to 65, MAC codes 00740 or 00810 will not be eligible for separate payment for upper and lower endoscopy procedures performed in the physician's office and billed with modifiers PI, P2 or with no modifier." ASA responded to that letter and the response is posted on ASA's Web site.

These letters have caused grave concerns for many of us. I would like to address some of these concerns.

ASA's Communications with Insurance Companies

First, the fact that Aetna or any other carrier consults with ASA **does not and should not suggest ASA's endorsement of Aetna's policy**. Some have questioned the wisdom of communicating with health plans at all and asked about ASA's interactions with these plans. ASA's relations with Aetna are characterized by a willingness to respond to inquiries about medical and policy aspects of anesthesia services. An ASA member serves as one of Aetna's national medical directors and has been eager to solicit ASA input on anesthesia issues and communicate ASA concerns to management. ASA has similar relationships with other private insurance companies as well as with Medicare both in Baltimore and in the local carrier offices. Not having open lines of communication is a "head in the sand" approach and would disappoint many members who expect ASA to be their voice with third-party payers, especially at the national level.

Why doesn't ASA take a harder line? Remember we are constrained by antitrust considerations from discussing boycotts, specific fee amounts, mass contract cancellations, or making threats of concerted action in general. Our choice is to tell health plans that we reject their medical policies and will not talk things over with them or to try to influence such policies for the better. ASA values its relationships with carriers which we have worked hard to establish and appreciates the opportunity to provide input to government and health plans. However, all of us must understand that our wishes may not always prevail.

I can assure you that this issue has not been ignored or given short shrift either by ASA leadership or ASA staff. There are elements to the progressive manipulation of payment policies that represent serious dangers to the specialty and to the safety of our patients. I know that it is a slippery slope and I am trying to stop the slide.

Medical Necessity for Endoscopy Anesthesia Services

We are insisting that Aetna insure that their policies do not provide any obstacles to ready access to anesthesia care for patients needing the services of an anesthesiologist for their endoscopy. The difficult question is how that need is determined. We must recognize that a great many endoscopies are performed safely and satisfactorily without anesthesiologists' involvement. Can we make a case that an anesthesiologist's involvement makes the procedure safer? Intuitively we all believe that is true for some patients, but can we prove it? Some believe that an anesthesiologist's involvement improves the efficacy of the procedure. There is some preliminary unpublished data that the frequency of polyp detection may improve with an anesthesiologist's involvement. Such evidence-based literature would be tremendously helpful and if you have such data please send it to me. We can make the case that an anesthesiologist's involvement makes the procedure more comfortable. In terms of insurance company payment, this is not "medical necessity," the universal requirement for coverage. The AMA's definition of medical necessity is "Health care services or products that a prudent physician would provide to a patient for the purpose of preventing, diagnosing or treating an illness, injury, disease or its symptoms in a manner that is: (a) in accordance with generally accepted standards of medical practice; (b) clinically appropriate in terms of type, frequency, extent, site, and duration; and (c) not primarily for the economic benefit of the health plans and purchasers or for the convenience of the patient, treating physician, or other health care provider." How vigorously can we make the case that the degree of comfort is an issue in terms of the "generally accepted standards" when so many are done without our involvement and the endoscopists have said they don't need us most of the time?

This has become a higher hurdle because the three major gastroenterology organizations issued a position statement in March 2004 stating that (1) there are definitely some patients (albeit a minority) who need to have an anesthesiologist to administer general anesthesia for a colonoscopy; and (2) "The routine assistance of an anesthesiologist/anesthetist for average risk patients undergoing standard upper and lower endoscopic procedures is not warranted."

The complexity of this issue is illustrated by the fact that gastroenterology is divided notwithstanding the joint statement cited above. Many gastroenterologists feel completely competent to administer sedation and some are aggressively pushing the use of propofol by individuals without formal training in the administration of general anesthesia. But there is a sizable group that wants an anesthesiologist involved in the care of all their patients undergoing endoscopy and they are equally unhappy with the various insurance companies' position. Gastroenterology is taking the position that in addition to the above statements, the physician's decision that an anesthesiologist is necessary should be the ultimate criterion for medical necessity.

It is difficult to prove that every patient requires this level of care, but there are patients for whom successful completion of the GI procedure absolutely depends on an anesthesiologist's participation. Identifying these patients is more complex than Aetna's complete reliance on ASA physical status and is one of the areas we are discussing with them.

Payment Methodology Changes

Another very serious concern about the position taken by Aetna is an attempt to fundamentally change payment for anesthesia services. The Aetna letter includes a second paragraph: “MAC codes 00740 or 00810 will be eligible for payment at the moderate sedation rate (CPT4® codes 99149 and 99150 for upper and lower endoscopy procedures performed in an ambulatory surgery center or hospital and billed with modifier PI, P2 or with no modifier when submitted by an anesthesiologist or certified registered nurse anesthetist.” Anesthesiology has the most widely accepted and longest standing payment methodology of any field of medicine. The Relative Value Guide system is a guide and not a standard; ASA members and others including payers are free to use the RVG or any other system, but a mixed method such as that announced by Aetna can be expected to produce strong reactions from our members. Devaluing a physician service to reflect questions about its necessity fails to adequately address both the value and appropriateness of the care. We are extremely concerned about the linkage of sedation payment to anesthesia services and will do everything legally possible to stop this dangerous precedent. Devaluing anesthesia care when provided to selected groups of patients is unprecedented and wholly inconsistent with industry standards.

Anesthesia by Non-Anesthesia Providers

The third major concern raised by this issue is the specter of a spreading belief that “safer” anesthesia drugs can be administered by those who are not anesthesia providers and that insurance carriers may push that spread. Propofol is part of this debate over endoscopies but I don’t think that propofol is the last intravenous anesthetic that will be introduced and successive ones are likely to be “safer and easier to use.” Will this concept be introduced next into the operating room for simple procedures as the procedures are simultaneously becoming less invasive? Is this medical progress or a slippery slope or both? I highly recommend that you read Dr. Mark Warner’s Rovenstine Lecture and the report of the Task Force on the Future Paradigms of Anesthesia Practice.

This is an issue of great concern for us. We understand its significance and are listening to your concerns. But frankly, we also need your ideas and suggestions about how to cope with a changing environment in a way that is best for our patients and the specialty.

Sincerely,

Orin F. Guidry, M.D.
President