Anesthesia-Assisted Sedation Getting Notice by Medicare

To the Editor: In their article "Preprocedural Considerations in Gastrointestinal Endoscopy" published in the September 2013 issue of *Mayo Clinic Proceedings*, Gorospe and Oxentenko[1] make note of data indicating an increasing percentage of "indiscriminate use of anesthesia-assisted sedation," also known as monitored anesthesia care (MAC), for endoscopic procedures, referring to data that suggest that 60% of the anesthesia-assisted procedures are performed in low-risk patients. The issue of the added costs of anesthesia-assisted sedation was also highlighted by an article in *The New York Times*[2] discussing a patient who was faced with a $2800 bill for anesthesia-assisted sedation services that were not covered by her insurance because, even though the gastroenterologist and facility were in the approved provider network, the anesthesiologist was not.

As defined in the Social Security Act, "no [Medicare] payment may be made for…items or services… [which] are not reasonable and necessary for the diagnosis or treatment of illness or injury…."[3] When the Centers for Medicare & Medicaid Services or one of the Medicare Administrative Contractors notes an increasing use of services that are inappropriately used, which they define as overused, underused, or misused, they often develop a National Coverage Determination or Local Coverage Determination (LCD) to better define medical necessity.

Novitas Solutions, Inc, one of the Medicare Administrative Contractors, has developed such an LCD for MAC.[4] They note in the discussion section of the LCD that anesthesia services are included in the global fee paid to the attending physician and are not generally separately reimbursable, and therefore anesthesia-assisted sedation service rendered must be reasonable, appropriate, and medically necessary. Furthermore, the LCD specifies, "The medical condition must be significant enough to impact on the need to provide MAC such as the patient being on medication or being symptomatic, etc. The presence of a stable, treated condition, of itself, is not necessarily sufficient." While it is common for the physician to note the indication for the endoscopy, it is rare to see discussion about the stability of the patient's medical conditions and the indications for the type of anesthesia support planned.

Articles such as the one by Gorospe and Oxentenko,[1] the articles cited by the authors, the increasing expenditures by an already financially stressed health care system, and the media attention to this issue, along with the safety issues cited by the authors, are sure to get the Centers for Medicare & Medicaid Services' attention. I would not be surprised to see a reduction in payment to the physician performing the endoscopy when anesthesia is administered by another physician, at which point we may see the pendulum swing back in favor of conscious sedation.

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1. Gorospe EC, Oxentenko AS. Preprocedural considerations in gastrointestinal endoscopy. *Mayo Clin Proc*. 2013;88(9):1010-1016.
2. Rabin RC. Waking up to major colonoscopy bills. *The New York Times* website. http://well.blogs.nytimes.com/2012/05/28/waking-up-to-major-colonoscopy-bills/?_r=0. Published May 28, 2012. Accessed October 13, 2013.
3. Social Security Act, 42 USC 1395y §1862 (a) (1)(A).
4. Local Coverage Determination (LCD): Monitored Anesthesia Care (L32628). Centers for Medicare & Medicaid Services website. http://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=32628&ContrId=255&ver=27&ContrVer=1&Date=03%2f18%2f2013&DocID=L32628&bc=AAAAAAgAAAAAAA%3d%3d&. Updated March 17, 2013. Accessed October 13, 2013.

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In reply—Anesthesia-Assisted Sedation Getting Notice by Medicare

We thank Dr Hirsch for his letter in response to our article on preprocedural considerations in gastrointestinal endoscopy. We are delighted in his interest to encourage further discussion about the current state of anesthesia-assisted sedation in routine endoscopy. These are timely and controversial issues given the media's increasing scrutiny of the economics of endoscopy and other preventive services in health care.[1]

We fully agree with Dr Hirsch's observation that the need and indication for anesthesia-assisted sedation are rarely documented in patients' medical records. Dr Hirsch accurately states that "while it is common for the physician to note the indication for the endoscopy, it is rare to see discussion about the stability of the patient's medical conditions and the indications for the type of anesthesia support planned."

In our article, we went further in stating that the preoperative evaluation of patients for any endoscopic procedure should be a shared responsibility between the referring clinician and the endoscopist, especially in open-access endoscopy practices. We believe that a conscious effort in assessing perioperative medical issues and sedation requirements may decrease the inappropriate use of anesthesia-assisted sedation. We recognize that anesthesia services can be costly, but they are essential in the provision of safe and effective endoscopic services for selected patients. Inappropriate use of anesthesia-assisted sedation includes both indiscriminate use in low-risk patients and underutilization in high-risk patients undergoing complicated endoscopic procedures.

Dr Hirsch raises concern about the possible reduction in reimbursement for endoscopy that may result from