



NHANA Membership **Action Alert**

We are sending out this alert from the NHANA Board to notify our membership of a position statement by Aetna that they will no longer pay for Anesthesia for Colonoscopies.

Included are 3 Items 1. Recent Response from AANA President, Fax of Aetna service notification, and NY Times December Article.

Please take the time to send a letter to Aetna stating your rational justification for your position and displeasure for their decision. Please request that they reverse their decision to stop paying for anesthesia for all endoscopies and colonoscopies.

Letters To:

James D. Cross, MD
Dir. Policy and Program Administration
Aetna Inc.
151 Farmington Ave.
Hartford, CT. 06156

CC a copy to:

Dr. Troyen Brennan MD MPH
Sr. VP and Chief Medical Officer
Aetna Inc.
151 Farmington Ave.
Hartford, CT 06156

We believe this issue of CRNA's to be reimbursed for their services effects you as a CRNA.

The AANA position statement sums up the points well.

Having RN's give conscious sedation is an issue that is encroaching our practice . There have been Advanced Practice RN's approached with questions from the Virginia BON about RN's giving sedation for eye procedures. When you give up one area you invite more of the same. If it is allowable for RN's to begin giving sedation to patients where will it end? RN's are not trained with our expertise.

The problems with this are clearly outlined in the AANA position statement, on being that this is a patient safety issue. Think about how many patients we see with undiagnosed sleep apnea, HTN, HRT Dx and Obesity. We must manage these patients and give a balanced safe anesthetic.

I believe CRNA's must vigorously defend our practice to administer these anesthetics and not allow RNS to practice beyond their scope of practice. We will be facing the issue of RN's giving propofol in NH soon and CRNA's should be on the same page with regard to this issue.

and It is imperative that you stress the importance of Anesthesia providers administering these anesthetics.

Please feel free to contact John Hanlon - johnsrna@aol.com or myself.

Thank you on behalf of the NHANA Board.

Kelly DeFeo CRNA PhD - CRNAsRUS@aol.com

NHANA Sec.-Treasurer

December 28, 2007

Aetna to End Payment for a Drug in Colonoscopies

By [BARNABY J. FEDER](#)

Correction Appended

[Aetna](#), one of the nation's largest private health plan managers, is the latest insurer to clamp down on the use of a powerful anesthetic during an increasingly common form of [colon cancer screening](#).

The company will send a letter to doctors on Friday, saying that it plans to classify the drug as “medically unnecessary” for most such procedures. As of April 1, Aetna plans to stop paying for its use in those cases.

The change by Aetna covers about 16.6 million members and comes on the heels of similar moves last year by [WellPoint](#) and six months ago by [Humana](#). Other insurers say they have no plans to follow their lead, including UnitedHealthcare, which has 26 million members. [Medicare](#) leaves coverage up to local insurers that administer its plans, most of which cover the anesthetic, propofol, only in high-risk cases.

Critics say Aetna's decision would be a step backward in the battle against [cancer of the colon](#) and rectum, which trails only lung and [prostate cancer](#) as a cause of [cancer](#) death among Americans, according to the federal [Centers for Disease Control](#).

The anesthetic eliminates the discomfort of undergoing a [colonoscopy](#), a procedure in which doctors explore the lower intestine to identify — and if necessary remove — developing [tumors](#) before they become dangerous.

But many specialists say there is scant evidence that the anesthetic helps enough to make it worth the cost. Aetna said its billing records showed that 77 percent of colonoscopy patients in the New York metropolitan area were receiving the anesthetic, compared with 10 percent or less in other regions. No data has surfaced linking such regional practice differences to better outcomes.

All three major medical associations for specialists who perform colonoscopies have published guidance statements saying the anesthetic was not needed for routine procedures.

“This is like a lot of hard-to-explain geographical variations in medical practice in this country,” said Aetna's chief medical officer, Dr. Troyen A. Brennan.

A recent book looking at such patterns and at overuse of medical products and procedures — “Overtreated,” by Shannon Brownlee — concluded that they inflate health care spending in the United States by at least 20 percent.

With millions of colonoscopies performed each year and specialists advising all Americans over 50 to be

screened, the proper use of this anesthetic could become a multibillion-dollar point of contention.

“It’s perfectly appropriate to say this doesn’t look like a good place to spend health care dollars,” said Dr. Douglas K. Rex, a colonoscopy specialist at the University of Indiana.

Propofol was originally marketed as Diprivan. It is now relatively cheap because its patent has expired and a generic version is available. But propofol is tricky because it acts rapidly and no rescue drug is available to counteract its effects if a patient begins to have trouble breathing. The [Food and Drug Administration](#) has recommended that it be administered by trained specialists who are not otherwise involved in the procedure.

As a result, most doctors want an anesthesiologist to assist them when propofol is used. That is especially true in areas like New York City, where many colonoscopies are performed in doctor’s offices. But using an anesthesiologist can add \$300 to \$1,000 to the cost of a colonoscopy, according to insurers.

Aetna’s policy is a slightly revised version of one it tried to introduce in 2006 but withdrew in the face of strong resistance. It includes an expanded list of exceptions where Aetna will pay for use of propofol and an anesthesiologist, including patients over 65, pregnant women and patients with illnesses that make the use of other drugs more risky.

Dr. Brennan said that Aetna believed the exceptions would cover 10 percent to 20 percent of colonoscopy screenings.

The data showing no advantage in typical screenings is “probably true,” said Dr. David H. Finley, United Healthcare’s senior medical director responsible for quality and affordability programs in the Northeast. “But we ended up after a lot of discussion last year deciding we didn’t want to intervene in the decision as to which patient gets the anesthetic,” he said.

Many doctors say that the freedom to choose the treatments used is an important principle to preserve no matter what the cost to insurers because there is little agreement on what really amounts to a medical necessity.

“The term ‘medical necessity’ leaves out psychological conditions,” said Dr. Ervin Moss, executive medical director of the New Jersey State Society of Anesthesiologists, who said patient comfort can play a role in the success of colonoscopies. A few doctors have reported that they found more polyps, which can be precursors to cancerous tumors, after they began using anesthesiologists to administer propofol.

Patients who fear the procedure often opt for less invasive screening techniques, including CT scanning (known as virtual colonoscopies), testing of feces and sigmoidoscopy (which exams less of the intestine). But those tests are less effective and do not allow doctors to deal immediately with any problems.

The propofol conflict is particularly challenging for gastroenterologists, the specialists who perform colonoscopies and other endoscopic procedures that involve snaking devices into the digestive system.

“There’s no doubt patients prefer propofol,” said Dr. Lawrence B. Cohen, a gastroenterologist in New York. Many doctors favor propofol because it can make procedures move more quickly and because patients are

usually more relaxed, which can lead to a more thorough exam.

Using an anesthesiologist also shifts a potentially distracting task normally handled by the doctor or a nurse at no extra cost — administering drugs that keep the patient comfortable — to a third party. In the traditional colonoscopy, patients are given a combination of a sedative, like Versed, and a tranquilizer, like Valium.

Dr. Cohen has tried to find a middle ground with a procedure that uses small doses of propofol that he and his staff administer along with the other drugs. “It adds an extra 60 seconds to the front end of the procedure, but we’ve been doing it in our group of three gastroenterologists for six years with no complications,” he said. Data for results with 16,000 endoscopic patients, most of them colonoscopies, will be presented at a scientific meeting in May.

Such results are not surprising. While propofol has been linked to patient deaths in unrelated procedures, Dr. Rex said estimates that it has been administered “off label” by gastroenterologists and trained nurses in more than 450,000 colonoscopy screenings without a single major adverse outcome being reported.

Despite that record, many [hospitals](#) and clinics have rules forbidding the off-label use. The number of states restricting nurses from administering the anesthetic has grown to 22 from 12, said Deborah A. Krohn, a lawyer and part-time [endoscopy](#) nurse in Towson, Md., who has advised nurses and hospital risk managers about potential liability.

Specialists see no end to the two-pronged battle over whether to use propofol routinely in colonoscopies and, if so, who should administer it.

“There are so many layers of controversy and unsettled science in this it isn’t surprising we’ve struggled for so many years, and are likely to for many more,” said Dr. Alexander A. Hannenberg, an anesthesiologist in Newton, Mass., who is in line to become president of the American Society of Anesthesiology in two years.

Correction: December 29, 2007

An article in Business Day on Friday about a health insurer’s decision to curtail payment for propofol, an anesthetic sometimes used in colonoscopies, misstated the class of Versed, another drug often administered for the procedure. Versed is a sedative, not a narcotic.

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151 Farmington Avenue
Hartford, CT 06156

December 2007

Dear Physician and/or Practice Manager:

We're implementing a new clinical policy for monitored anesthesia care (MAC) for GI endoscopy

Effective April 1, 2008, we will implement a new clinical policy for anesthesia services for upper and lower gastrointestinal (GI) endoscopy. A summary of the coverage guidelines is provided below.

Please review the policy and, where applicable, inform your patients as described later in this letter. The policy will be posted on our public website, www.aetna.com, once it becomes effective.

MAC will only be covered under certain circumstances

Under this policy, we will no longer routinely cover MAC for patients with no sedation-related risk factors who are undergoing GI endoscopy. We will, however, continue to cover conscious sedation (as part of the GI endoscopy) for patients with no sedation-related risk factors.

For patients who have sedation-related risk factors, we will continue to cover MAC, which requires the attendance of an anesthesiologist or anesthetist. This includes patients who are:

- Pregnant
- 18 years of age or younger
- 65 years of age or older
- At increased risk for complications due to certain classes of physical status according to the American Society of Anesthesiologists
- In danger of airway compromise, including those with oral, neck or jaw abnormalities; sleep apnea; or those who are morbidly obese
- Uncooperative or combative
- Dependent on opiates or sedatives
- Scheduled for certain complex or prolonged GI endoscopic procedures
- Diagnosed with epilepsy
- Identified as having a history of drug or alcohol abuse, or previous problems with sedation or with an endoscopic procedure

Conscious sedation is safe and frequently used

Conscious sedation is a safe and well-tolerated choice for most patients undergoing GI endoscopy. There is no generally accepted evidence demonstrating that average-risk patients require MAC for routine GI endoscopy. Therefore, we will cover MAC only for patients undergoing GI endoscopy with sedation-related risk factors, as listed above.

(over)

610-366-9538

Our clinical policy is consistent with the positions of professional organizations
 Our clinical policy is consistent with the following statement on sedation for performing GI endoscopic procedures: The statement was issued jointly in 2004 by the American College of Gastroenterology, the American Gastroenterological Association and the American Society for Gastrointestinal Endoscopy.

"The routine assistance of an anesthesiologist/anesthetist for average risk patients undergoing standard upper and lower endoscopic procedures is not warranted."

We have also reviewed our policy throughout its development with the American Society of Anesthesiologists.

Before routine GI endoscopy is performed with planned MAC, let the patient know that MAC will likely not be covered

We do not expect any patient to have a GI endoscopy without sedation. However, if a patient at average risk requests MAC, you should tell him/her before the procedure that the service(s) of an anesthesiologist or anesthetist will likely not be covered under the terms of his/her benefits plan. Also, let the patient know he/she may be responsible for payment of any anesthesia services that are not covered. Informing the patient of his/her financial responsibility in these circumstances is consistent with the obligations set forth in your participation agreement with Aetna.

Enclosed is a sample acknowledgement form that a patient may sign before a GI endoscopy to acknowledge his/her understanding. If the patient is informed before the procedure that anesthesia services may not be covered and that he/she may be financially responsible, the provider may bill the patient for these services following receipt of a coverage determination from Aetna. Please keep a copy of this acknowledgement in your files. Please note that even if a member signs an acknowledgement form, he/she still has the right to appeal our determination to deny coverage and that the provider is expected to cooperate in any such appeal.

Preventive care screenings are recommended

We strongly advocate preventive care, including recommended cancer screenings like colonoscopy. We cover screening colonoscopies in all plans that include preventive care benefits.

Contact us if you have questions

You can call our Provider Service Center at 1-800-624-0756 for questions related to HMO-based benefits plans or 1-888-632-3862 for questions related to indemnity and PPO-based benefits plans. Or, you can contact your Aetna network representative.

Sincerely,



James D. Cross, M.D.
 Head of Medical Policy and Program Administration

Enclosure

Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies. The Aetna companies that offer, underwrite or administer benefit coverage include Aetna Health Inc., Aetna Health of California Inc, Aetna Health of the Carolinas Inc., Aetna Health of Illinois Inc., Aetna Life Insurance Company, Aetna Health Insurance Company of New York, Corporate Health Insurance Company, Aetna Health Management, LLC, Aetna Health Administrators, LLC, PPOM, L.L.C., Sloan Lake Management Corp, and Strategic Resource Company.



February 5, 2008

Dr. Troyen Brennan MD MPH
Senior VP and Chief Medical Officer
Aetna
151 Farmington Ave.
Hartford, CT 06156

Dear Dr. Brennan:

On behalf of the 37,000 members of the American Association of Nurse Anesthetists (AANA), I want to express our serious concerns with Aetna's new clinical policy issued December 2007 on monitored anesthesia care (MAC) for gastrointestinal (GI) endoscopy, denying coverage in most cases for propofol MAC by an anesthesia professional.

We believe Aetna's new policy puts patient safety and outcomes at risk. It erects new barriers between patients and the safest, most comfortable, most thorough and efficient method for delivering life-saving diagnostic GI endoscopy screenings. Further, the new policy inappropriately reserves for Aetna medical necessity decision-making that rightfully belongs with patients and healthcare providers such as Certified Registered Nurse Anesthetists (CRNAs) and physicians. Taking at face value Aetna's demonstrated interest in applying payment systems to spur higher quality and more efficient care, we request Aetna withdraw this new policy, and to meet with us to address our common interests in delivering our patients and your beneficiaries safe and high quality healthcare.

New Policy Puts Patient Safety and Outcomes at Risk

Our professional judgment as nurse anesthetists leads us to conclude that the new Aetna policy places a new and inappropriate barrier between patients and the most effective, safe and efficient method for securing a personally uncomfortable, life-saving GI procedure – and thus puts at risk patient safety and quality outcomes.

The value of GI endoscopy is well understood. The American Cancer Society (ACS) reports colorectal cancer is the second-leading cause of cancer deaths in the

United States, and an estimated 153,000 Americans would be diagnosed with cancers of the colon or rectum in 2007. ACS further reports the five-year survivability of colorectal cancers diagnosed early exceeds 90 percent, but that only 39 percent of colorectal cancers are found early. For detecting colorectal cancers early, GI endoscopy screening is the sole, reliable method. Clearly too few people avail themselves of GI endoscopy screening, on account of several factors including discomfort and out-of-pocket cost.

The value of having a CRNA provide propofol MAC for GI endoscopy is that it enables a more thorough, higher quality procedure in less time, a distinctly superior outcome relative to other methods of sedation for GI endoscopy. Propofol MAC enables the patient to recover more quickly, with fewer after-effects of sedation. The FDA-required labeling for propofol indicates the drug must be administered by a professional skilled in general anesthesia, such as a CRNA. The demonstrated high-quality care as delivered by a CRNA adds an additional layer of patient safety during GI endoscopy over that provided by an unassisted proceduralist in the unfortunate event complications arise.

Having established the benefits that CRNA-provided propofol MAC provides in safe GI endoscopy, we see that Aetna's denial of coverage of a drug that makes patients more comfortable and thus enhances patient compliance with GI screenings intended to secure life-saving early detection of colorectal cancers could expose Aetna to liability. Aetna's new policy inappropriately inserts the insurer into the decision of whether the patient should have the procedure under MAC with a CRNA or anesthesiologist delivering propofol, or under sedation with the procedural physician or other professional administering midazolam and fentanyl or meperidine. While Aetna may regard its action represents a payment policy not a medical decision, permitting CRNAs to provide Aetna beneficiaries a form indicating the company is unlikely to pay a claim for MAC, we regard this option as a barrier to care.

Aetna Policy Discourages Safest, Most Efficient Means of GI Endoscopy Delivery, Limiting Patients' Access to Services

Because patients recover more quickly from MAC than from other sedation, the availability of a CRNA delivering MAC enables GI endoscopy proceduralists to provide a dramatically greater number of procedures, of higher quality, than can proceduralists using alternative forms of sedation. Our members involved in GI endoscopy practices report what recent research confirms: holding time and facility resources constant, a proceduralist can deliver about twice as many GI endoscopies with a CRNA administering propofol MAC than can a proceduralist using midazolam and fentanyl sedation. The rapid onset of propofol, and patients' rapid recovery from its effects, enables patients to move safely and efficiently through the GI endoscopy, postoperative recovery and discharge. By contrast, a proceduralist administering other types of sedation to stop the patient from reacting to the procedure may result in delayed recovery from sedation when compared to the use of propofol.

The ability of a proceduralist to deliver a greater volume of services in a facility correlates with enhanced patient access to healthcare – a crucial factor in a matter as uncomfortable and lifesaving as GI endoscopy. We believe it is in Aetna’s interest to encourage safer and more efficient care rather than the alternative.

Aetna Should Withdraw and Reconsider Its Policy, and Meet with AANA

Finally, we are concerned that though Aetna reports it developed its policy under the review of the American Society of Anesthesiologists (ASA), the company did not consult with the American Association of Nurse Anesthetists whose members are likely the majority of anesthesia professionals providing care in GI endoscopy settings. Aetna’s statement that its new clinical policy is “consistent with the positions of professional organizations” thus deceptively misleads physicians and practice managers that healthcare professional organizations support Aetna’s policy, when Aetna did not consult once with AANA, and ASA outright opposes it.

We would welcome the opportunity to meet with you to share our interests in improving patient outcomes by delivering GI endoscopy services more safely, comfortably and efficiently. To inform your review, we have attached for you the relevant AANA policy statements and policy considerations documents.

Thank you for your attention to this important patient safety issue. On behalf of the 37,000 CRNA and student nurse anesthetist members in the United States and the millions of patients for whom they provide care, I look forward to hearing back from you.

Sincerely,



Wanda O. Wilson CRNA PhD
President

Cc: American Cancer Society

Attachments:

- AANA Policy Statement on Patients’ Access to Anesthesia Services for Gastrointestinal Procedures and Colorectal Cancer Screening, June 2007
- AANA-ASA Joint Statement on Propofol Administration, April 2004