

From the CEO

Blue Cross Blues

By Barbara Baldwin, M.P.H.
Chief Executive Officer



In a letter dated October 28, 2005, Blue Cross shocked anesthesiologists with a new Clinical Practice Guideline for anesthesia services, including those provided with colonoscopies. As stated in the letter from Blue Cross Medical Director Anthony Nguyen, M.D.:

The **routine** assistance of an Anesthesiologist or Certified Registered Nurse Anesthetist (CRNA) for average risk patients undergoing standard upper and/or lower gastrointestinal endoscopic procedures is considered **not medically necessary**...

This letter is to notify you that all claims for CPT codes 00740 and 00810, anesthesia for endoscopic procedures, will now be subject to medical review for compliance with this guideline.

The pertinent language of the Blue Cross policy, entitled Anesthesia Services including MAC, reads as follows:

For surgical procedures which do not usually require anesthesia services, anesthesia services including monitored anesthesia care (MAC) are considered **medically necessary** when the patient's condition requires the presence of qualified anesthesia personnel to perform monitored anesthesia in addition to the physician performing the procedure, and is so documented. The medical condition must be significant enough to impact the need to provide anesthesia services including MAC. Complex procedures and procedures in high-risk patients may justify the use of an anesthesiologist/anesthetist to provide conscious sedation and/or deep sedation. The presence of a stable, treated condition of itself is not necessarily sufficient.

Anesthesia services including monitored anesthesia care (MAC) is considered **medically necessary** during gastrointestinal endoscopic procedures in **any** of the following situations:

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- a. Prolonged or therapeutic endoscopic procedure requiring deep sedation; or
- b. A history of or anticipated intolerance to standard sedatives; or
- c. Increased risk for complication due to severe comorbidity (American Society of Anesthesiologists [ASA] class III physical status or greater. See Appendix for physical status classifications.); or
- d. Patient of extreme age, under one year or over 70; or
- e. Pregnancy; or
- f. History of drug or alcohol abuse; or
- g. Uncooperative or acutely agitated patients (e.g., delirium, organic brain disease, senile dementia); or
- h. Increased risk for airway obstruction due to anatomic variant including any of the following:
 - History of previous problems with anesthesia or sedation; or
 - History of stridor or sleep apnea; or
 - Dysmorphic facial features, such as Pierre-Robin syndrome or trisomy-21; or
 - Presence of oral abnormalities including but not limited to a small oral opening (less than 3 cm in an adult), high arched palate, macroglossia, tonsillar hypertrophy, or a non-visible uvula; or
 - Neck abnormalities including but not limited to short neck, obesity involving the neck and facial structures, limited neck extension, decreased hyoid-mental distance (less than 3 cm in an adult), neck mass, cervical spine disease or trauma, tracheal deviation, or advanced rheumatoid arthritis; or
 - Jaw abnormalities including but not limited to micrognathia, retrognathia, trismus, or significant malocclusion.

The routine assistance of an Anesthesiologist or Certified Registered Nurse Anesthetist (CRNA) for average risk patients undergoing standard

upper and/or lower gastrointestinal endoscopic procedures is considered **not medically necessary**. (The complete policy can be found on the CSA Web Site at www.csaahq.org)

Correcting Implementation Problems

Following Blue Cross' announcement of the new coverage policy, some members urged the CSA to seek repeal of the policy. Because the policy was issued from WellPoint's corporate headquarters as a national policy, Blue Cross of California has no authority to disregard the directive. The CSA does not have the resources to challenge the Goliath of a plan at the national level. In addition, because use of anesthesia with colonoscopies varies widely within and outside of California, it could not be argued that its use is a widely accepted standard of care. Even some Medicare carriers in other states do not cover anesthesia for uncomplicated colonoscopies.

A decision was made to wait until the policy had been in effect for several months in order to gauge whether widespread problems were experienced by anesthesiologists and billing services. A sufficient number reported problems to the extent that we believed the implementation of the policy was inconsistent and, in some cases, incorrect. The CSA requested a meeting with Dr. Nguyen, and billing services were invited to submit claims they believed to be improperly denied.

Meeting with Blue Cross

On January 12, 2007, CSA President Mark Singleton, M.D., and I, along with billing company representatives, met with Blue Cross Medical Director Anthony Nguyen, M.D., and other Blue Cross senior staff regarding problems related to payments for anesthesia for colonoscopy.

The discussion about claims processing for anesthesia with colonoscopy was very productive. Having reviewed several denied claims prior to the meeting, the Blue Cross representatives understood the concerns raised regarding implementation of the medical review criteria for anesthesia with colonoscopy. We arrived at the following agreements related to documenting medical necessity, informing physicians, and claims processing:

1. CSA will further inform its members about the medical necessity criteria and that it should be supported and documented by the referring endoscopist. Denied claims often do not have any reference to medical necessity criteria in the anesthesia record.
2. Blue Cross will urge referring physicians to obtain pre-approval for anesthesia services with colonoscopy. This is particularly important

- if any uncertainty exists as to meeting the medical review criteria. CSA will urge its members to be alert for this.
3. Blue Cross will process claims that have appropriate medical necessity criteria checked off on a form derived from the Blue Cross policy, and, if necessary, conduct post-payment review.
 4. Physicians should not submit claims to Blue Cross that do not meet the medical review criteria, although Blue Cross recognizes the right of any patient to receive the services of an anesthesiologist if they desire. Such a patient should sign a statement of financial responsibility (a sample of such a form is on the CSA Web Site at www.csahq.org) prior to the procedure and can submit an appeal of financial responsibility to Blue Cross after the procedure, if desired.
 5. Blue Cross will further educate referring physicians on the need to be judicious about requesting anesthesiologists' services only when medically necessary.
 6. Blue Cross will ensure that its customer service representatives do not tell patients they have no obligation to pay for anesthesia services after the patient has been told that those services may not be covered and that patient signs a financial responsibility form.

These changes should greatly reduce denials and appeals, resulting in more claims being paid. Of equal importance is that we agreed to work in collaboration on addressing this and other issues that arise in the future.

Blue Cross officials noted that the vast majority of anesthesia claims received by Blue Cross are paid and that the rate of anesthesiologist-attended colonoscopies is about 3 percent to 5 percent throughout the state. Some facilities have a rate of up to 25 percent of cases including an anesthesiologist, and where significant differences in the frequency exist, claims may be subject to greater scrutiny.

A Win-Win Relationship

A few years ago, a few billing services were invited to join an informal group to share information and seek solutions to common problems. The group has grown and become a great resource for the CSA leadership and me to understand problems they face in billing for anesthesia services. In turn, I research possible solutions to problems they present to the CSA and provide information of interest to them. The generous sharing of their time, knowledge and collaboration that we have enjoyed for the past few years has helped greatly in addressing some of the problems anesthesiologists face with payer practices in

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many venues. We have made progress in, if not completely solved, some vexing issues. I thank all of them for this mutually beneficial relationship.*

* Finally, I want to thank Dale Zeh and Erika Lieberman from Pasadena Billing Associates for supplying claims and lending their expertise at the meeting at Blue Cross. In addition, I thank the following billing representatives for submitting examples of improperly denied claims for the Blue Cross meeting: Kelly Baldwin from MEDAC, Shelly Levenstein from Anesthesia Limited, and Pattie Parker from RC McLean.

CSA Hawaiian Seminar

October 29-November 2, 2007

Grand Hyatt Kauai Resort & Spa, Poipu Beach, Kauai



Faculty

Richard L. Applegate, II, M.D., Program Chair
Zeev N. Kain, M.D., MBA, M.A. (Hon), FAAP
Steven N. Konstadt, M.D.
Joseph M. Neal, M.D.
Randolph H. Steadman, M.D.

www.csahq.org

Secure online registration is available
or call the CSA office at (800) 345-3691.

• Hyatt Regency Hotel		(808) 742-1234
• Air Travel/Auto Rental:	Barbara Riccetti, Connie Maciel cmtravel@sbcglobal.net	(800) 396-6993
Alamo-Rent-A-Car	Group ID #7013325 Rate Code GR	(800) 732-3232
Aloha Airlines	Group 5 Code G/SPE/CSE	(800) 367-5250
• Educational Credits	20 CME credits for physicians	

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