Study could lead to more scrutiny of anesthesia staffing for GI cases

Who should be giving sedation to low-risk patients having colonoscopies and upper GI endoscopies?

This question may get a new look with a large new study in the March 21, 2012, JAMA.

Researchers found use of anesthesia services for these cases has more than doubled over 7 years, jumping from about 14% of patients in 2003 to more than 30% in 2009. The study analyzed claims for 6.6 million GI endoscopy patients covered by Medicare or commercial insurance.

The lion’s share—about $1.1 billion of the $1.3 billion spent on anesthesia care for GI patients—was spent on low-risk patients.

“This is a pretty dramatic increase, given that this is quite expensive,” one of the researchers, Soeren Mattke, MD, of the RAND Corporation, told OR Manager. Use of anesthesia services adds about $500 to the procedure charge for patients with commercial insurance and $150 for Medicare patients.

There were also big regional differences. In the West, only 14% of GI endoscopies for Medicare patients used anesthesia providers, compared with 48% in the Northeast.

Why regional variation?

The regional variation is a well-known phenomenon for a number of procedures, such as cardiac surgery and cesarean section, Dr Mattke observes. Some of the variation has to do with the practice style in the local area, he notes. Physicians who train in an area tend to settle there and inherit practice patterns of their professors.

Insurers’ payment policies also vary. The West, where use of anesthesia services was lowest, has more managed care, which maintains a tighter grip on costs and discretionary care.

Nationally, however, many large insurers tend to pay those claims, he notes, even though their policies say anesthesia services will be covered only for high-risk GI procedures.

This suggests the variation “is driven a lot by financial motivation,” says Lee A. Fleisher, MD, chair of anesthesiology and critical care for the University of Pennsylvania Health System in Philadelphia, who wrote an accompanying JAMA editorial.

State patchwork

Another reason for regional variation could be the patchwork of state regulations, which have varying rulings on the role of RNs in giving and monitoring sedation. The Society of Gastroenterology Nurses and Associates (SGNA) has a rundown on state regulations at www.sgna.org/Issues/SedationFactsorg/StandardsRegulations/StateRegulations.aspx

Propofol controversy

Endoscopists’ preference for propofol sedation is another factor that has likely fueled greater use of anesthesia providers, though that was not analyzed in the study, Dr Mattke says.
During the 2003 to 2009 study period, there was heated debate about propofol being given by nonanesthesia providers such as GI endoscopists and RNs.

With propofol, patients can be sedated and wake up quickly with little after-effect. Yet the drug is tricky to administer because patients can slip into deep sedation more easily than with other drugs, and there is no reversal agent. Plus, the package insert says propofol sedation should be given only by persons trained in general anesthesia.

With current payment policies, there is no reason for endoscopists not to use anesthesia support in giving propofol. It doesn’t affect their fee, and there is an extra margin of medical-legal protection.

Yet recent studies have shown propofol can be given safely by endoscopists. One review led by Douglas Rex, MD, of 649,000 cases with endoscopist-directed propofol sedation found it had a lower mortality rate than for endoscopist-delivered benzodiazepines and opioids. Still, the package insert has not changed in response to the new evidence.

**What CMS says**

Facilities that scrutinize their use of anesthesia providers for low-risk GI endoscopy need to be careful that they are meeting the latest requirements for GI endoscopists and RNs who give sedation.

The Centers for Medicare and Medicaid Services (CMS), after much discussion with the American Society of Anesthesiologists (ASA), updated its interpretive guidelines for anesthesia services in January 2011.

CMS continues to specify that anesthesia services policies and procedures be overseen by the anesthesia service. But it opens the door for nonanesthesiologists to be able to be privileged (permitted by the hospital) to provide deep sedation if they are qualified, notes John Rosing, MHA, FACHE, of Patton Healthcare Consulting, who consults on CMS and Joint Commission issues.

“‘To be qualified, a physician needs to be able to ‘rescue’ a patient from a deeper level of sedation than intended, which requires expertise in airway management and advanced life support,’” Rosing says.

Practically speaking, this requires certification in Advanced Cardiac Life Support (ACLS). Thus, residency-trained emergency physicians who maintain ACLS would be deemed qualified to give propofol, he notes. But fewer GI physicians are thus qualified. Also, if the state nurse practice act prohibits RNs from being involved in deep sedation, then RNs cannot administer propofol.

In brief, the CMS guidelines, which include moderate sedation/analgesia, specify that:

- all anesthesia services must be organized under one director of anesthesia services
- hospitals must have anesthesia policies and procedures that follow national guidelines
- these must address qualifications and supervision for each category of practitioner permitted to provide anesthesia services, particularly moderate sedation.

Some questions CMS surveyors would ask regarding the anesthesia services policies and procedures:

- Do they apply to all hospital locations where anesthesia services are provided?
- Do they indicate qualifications each practitioner must meet to give anesthesia as well as moderate sedation?
- Do they address what clinical applications are considered to involve analgesia, in particular moderate sedation, based on national guidelines?
- What national guidelines are they following, and how is that documented?
What guidelines say

A brief look at professional recommendations on sedation/analgesia by nonanesthesia providers.

**American Society of Anesthesiologists**
The American Society of Anesthesiologists (ASA) in a 2011 update to its statement on granting privileges for moderate sedation to nonanesthesia practitioners, outlines a formal training program on sedation/analgesia that covers 11 subject areas, among them:
- proficiency in airway management with a facemask and positive pressure ventilation
- physiologic monitoring
- advanced life support skills with a current certificate.

Education and training are also outlined for RNs and other practitioners who monitor patients under sedation given by a nonanesthesiologist.

---

**Gastroenterology societies**
A 2009 joint position statement on nonanesthesiologist administration of propofol for GI endoscopy by the American Society of Gastrointestinal Endoscopy and other GI societies states, among other recommendations, that:
- administration and standard sedation by nonanesthesiologists is comparable in efficacy and safety, with proper training and patient selection being critical
- use of anesthesiologist-administered propofol for healthy patients having elective endoscopy without risk factors “is very costly, with no demonstrated improvement in patient safety or procedural outcome.”

---

ASA outlined recommendations for granting privileges for nonanesthesiologists giving moderate and deep sedation in 2011 and 2010 statements. GI societies also have recently updated their guidelines (sidebar).

**Staffing for sedation**
When an anesthesia provider gives sedation, SGNA recommends that an RN be in the room to assist the endoscopy team, even if the anesthesia provider is a CRNA (certified registered nurse anesthetist).

Facilities that assign a GI technician rather than an RN to these cases are not in compliance with national guidelines, notes Kathryn Snyder, BSN, RN, MM, CGRN. She is nurse manager of the endoscopy/bronchoscopy/motility departments for the University of Virginia Health System in Charlottesville.

**The big picture on costs**
Discretionary services like anesthesia services for low-risk GI endoscopy patients are likely to see greater scrutiny as the nation grapples with health care costs

“My hope is there will be a closer look at who needs anesthesia services and who doesn’t,” Dr Mattke says.

One possible approach, Dr Fleisher suggests, is bundled payment; that is, a single payment for the procedure “that would force the endoscopists, anesthesiologists, and/or nurse anesthetists to determine the value of the various aspects of the service.”
The alternative to not addressing services like this that don’t add value, says Dr Mattke, could be across-the-board cuts that would slash services regardless of clinical need.

The study was funded by Ethicon Endo-Surgery, which has a propofol delivery device, Sedasys, under review by the Food and Drug Administration. The authors state that the company had no involvement in the design of the study or analysis of the results.

—Pat Patterson

References


