December 11, 2023

Sandhya Rao, MD
Chief Medical Officer
Senior Vice President
Blue Cross Blue Shield of Massachusetts
101 Huntington Avenue,
Suite 1300
Boston, MA 02199

Dear Dr. Rao,

On behalf of the undersigned national organizations representing physicians across the United States in the fields of gastroenterology and anesthesiology, we would like to request a meeting with you before year end to discuss Blue Cross Blue Shield of Massachusetts (BCBSMA) enforcement of medical policy, 154 – Monitored Anesthesia Care (MAC) in Massachusetts, scheduled to go into effect January 1, 2024. Our concern centers on the immediate implications of this policy, specifically its impact on patient access and compliance with care, the safe delivery of moderate sedation, and overall practice operations. Our societies share BCBSMA's commitment to providing high quality safe patient care in GI endoscopy services, and that is why we urge you not to enforce medical policy 154 on January 1, 2024.

Patient Access to Care

Our societies are deeply concerned that the proposed policy change introduces obstacles for BCBSMA patients seeking gold standard colorectal cancer screening services. This comes at a crucial time when there is a rise in the incidence of colon cancer, and an increasing number of individuals are seeking screening following the recommendations of the US Preventive Task Force (USPTF) to initiate colorectal cancer screening at age 45 for average-risk individuals. While noninvasive tests, such as stool-based tests, detect cancer, screening colonoscopy remains the only test capable of preventing, detecting, and treating colon cancer, establishing it as the gold standard among colorectal cancer screening tests.

The potential consequences of missing the opportunity for early detection of polyps and cancer are widely acknowledged, with downstream costs escalating significantly. The enforcement of BCBSMA medical policy 154 threatens numerous preventive and life-saving services precisely when patients are catching up on necessary treatments and services integral to the colorectal cancer screening continuum of care.

Requiring practices to use moderate sedation for certain cases not only diminishes efficiency and appointments per day but also heightens patient apprehension about undergoing this crucial screening if MAC is not a covered option.

Health Inequities and Patient Choice

Moreover, we are concerned that this policy exacerbates health inequities, particularly for populations such as African American men who may harbor stigma or fear associated with colonoscopies. We have been informed that BCBSMA is contemplating offering patients a choice, with the patient bearing the cost difference between receiving moderate sedation or propofol. We believe this approach further compounds disparities in care for underserved populations and sends a message that may not align with BCBSMA's commitment to equitable healthcare.

MAC is the Standard of Care

Furthermore, our organizations find enforcement of this policy perplexing, given that most insurers recognize MAC as the standard of care for GI endoscopy procedures. In 2017, procedural services under the endoscopy CPT codes, which inherently include moderate sedation, saw the removal of time and RVU values associated with moderate sedation. This adjustment was made because MAC had become the established standard practice for these procedures, including screening colonoscopies. Currently, distinct CPT/HCPCS codes exist for reporting either moderate sedation or monitored anesthesia care, reflecting the prevalent use of anesthesia for GI procedures.

The removal of this option for BCBSMA patients places them at a disadvantage, as it denies them access to the same sedation options available to most patients nationwide. Our societies express deep concern about the unnecessary impact this policy will have on patient perception, adoption, access to care, and the efficient functioning of medical practices.

Workforce and Training

As we have noted previously, recently trained endoscopists lack experience administering moderate sedation due to a shift in endoscopist sedation training during fellowship. Consequently, a lot more trained nurses would be needed to handle this aspect of patient care. Compounding this challenge is a severe workforce shortage across the healthcare continuum, particularly affecting nurses trained in administering moderate sedation. This shortage poses a significant obstacle to the effective implementation of the BCBSMA policy, impacting both hospital and freestanding facility settings. Furthermore, the longer recovery time associated with moderate sedation affects throughput, reducing the number of patients that can be seen. This, in turn, leads to extended wait times for appointments, exacerbating an already challenging situation in obtaining timely screening colonoscopies, with wait times extending to at least six months due to increased demand resulting from the pandemic and the lowered screening age to 45 from 50.

Operational Workflow

In a previous meeting, it was noted that a substantial 60% of GI endoscopists in the state utilize MAC for endoscopy procedures. We firmly assert that such a sizable number of providers and facilities cannot feasibly overhaul their sedation protocols within the limited timeframe specified. The complexities of such a change necessitate careful consideration, encompassing outreach to patients already scheduled with propofol, ensuring a stable supply of moderate sedation drugs, and facilitating education and coordination between GI endoscopy and anesthesia billing and coding teams.

To date, we are not aware of any additional guidance that has been provided to providers or education that has been sent to enrollees / patients on BCBSMA enforcement of this policy.

Adding to the complexity, a severe workforce shortage persists throughout the healthcare continuum, particularly impacting nurses trained in administering moderate sedation. This shortage significantly impedes the implementation of the BCBSMA policy in both hospitals and freestanding facilities.

Prepayment Review

Previously, the concept of prepayment review for MAC was introduced by BCBSMA. This process could potentially have a devastating impact on the operation of a practice. Most services provided by GI endoscopy unit require some level of sedation. BCBSMA review of all claims identified with some level of MAC before payment is made will stagnate the already overwhelmed practices with staffing shortages, capacity issues and post pandemic backlogs. Prepayment review processes that include submission of medical records for every patient are untenable to providers. Coupled with the need to match the documentation from the gastroenterology practice and the anesthesia practice, it creates a recipe for disaster. Endoscopy providers will have to have two different yet simultaneous standards of documentation, staffing, and care for moderate sedation and general anesthesia. Practices will almost need to run two different practices in one site, one for moderate sedation patients and one for monitored anesthesia patients. We request that you outline the steps in your prepayment review process, clarify how a prepayment review will be triggered and activities for completion to move forward with the medically necessary service(s).

Society Practice Guidelines

Guidelines from the American Society for Gastrointestinal Endoscopy (ASGE) on sedation and anesthesia in GI Endoscopy were cited by BCBSMA as a basis for enforcement. As discussed during the May 2023 meeting, it is crucial to understand that ASGE guidelines serve as educational resources, offering information to assist endoscopists in delivering patient care. These guidelines do not function as strict rules and should not be interpreted as establishing a legal standard of care or endorsing, advocating, mandating, or discouraging any specific treatment. ASGE disapproves of BCBSMA employing its guidelines in this manner and for this purpose.

Clinical decisions in each case necessitate a nuanced analysis of the patient's condition, clinical variables, and available courses of action. Consequently, endoscopists may deviate from these guidelines for valid reasons and in the best interest of the patient, as the decision-making process involves a comprehensive evaluation of individual circumstances. The ASGE guideline provides statements on how to safely deliver sedation but are not meant as a rule or requirement for the best type of sedation. Such decisions are made by the clinician and patient, together, on a case-by-case basis, always keeping in mind the best interest of the patient.

Patient Care

The reality is that BCBSMA's policy will result in delays or even abandonment of medically necessary procedures due to patient decisions. Individuals who are already apprehensive about undergoing endoscopy or have high-risk social determinants of health may opt not to proceed when confronted with the challenging choice between moderate sedation and MAC. Gastroenterologists commonly encounter patients with symptoms, like rectal bleeding, requiring substantial counseling from primary care physicians or gastroenterologists to persuade them to undergo essential endoscopic procedures.

Additionally, there is documented evidence that individuals with high-risk polyps, such as those with high-grade dysplasia, large adenomas, or large flat polyps with endoscopic mucosal resection (EMR), may not adhere to recommended follow-up intervals. This becomes critically significant, given that patients who fail to undergo a colonoscopy following a positive non-invasive colorectal cancer-screening test face a 103% higher risk of death compared to those who undergo the procedure. Surveillance colonoscopy, as endorsed by the U.S. Multi-Society Task Force (USMTF) guidelines, reduces the risk of colorectal cancer incidences by 43% – 48%. The implementation of the MAC medical policy by BCBSMA introduces barriers, and data indicate that a substantial number of patients may forego necessary care due to these impediments.

Conclusion

Both BCBSMA and the GI, Surgical and Anesthesia communities want what is best for the patient. At the national and state level we welcome the opportunity to partner with you on issues important to our members and the patients we serve. We also request you to reconsider implementing this policy as planned, for all the reasons stated above, but above all to ensure patient safety and to avoid serious disruptions to practice operations across GI and Anesthesia practices throughout the state of Massachusetts.

Thank you in advance for your prompt attention and consideration of our meeting request.

American College of Gastroenterology

American College of Surgeons

American Gastroenterological Association

American Society Anesthesiology

American Society for Gastrointestinal Endoscopy