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**ST. JOHN'S MERCY
MEDICAL CENTER**

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Troyen A. Brennan, M.D., M.P.H.
Senior Vice President
Chief Medical Officer
Aetna
1151 Farmington Avenue
Hartford, CT 06156

RE: Who needs anesthesia?

Dear Dr. Brennan,

With surprise and great disappointment I reviewed communication from Aetna proposing to reverse current policy and prevent patient access to anesthesiology services during diagnostic and therapeutic endoscopy.

The policy change proposed by Aetna sets an ominous precedent. It alters the role of health insurance organizations in patient care by stepping squarely over the line into the doctor - patient relationship. I believe this policy change results in Aetna making a medical decision on behalf of doctors and patients that will dictate who can and cannot receive the services of an anesthesiologist. The American Medical Association believes that patients should have access to equivalent health care regardless of healthcare setting, patient health or the ability to pay. I am concerned that your Company cannot be in a position to make an informed judgment based on a generalized policy that overrides the treating physician's decision regarding use of anesthesiology services. Your policy very easily may miss patients who, because of age, co-morbidities, extreme anxiety, and community standard of care or other reasons require anesthesiology care, including, but not limited to, medications, techniques and monitoring skills during the endoscopic procedure. That you have singled out endoscopy patients for uniquely restrictive access to anesthesiology services means that: Aetna patients requiring endoscopy are subjected to a different standard of care than Aetna patients requiring other diagnostic and therapeutic procedures; in addition, Aetna endoscopy patients are subjected to a different standard of care than the remainder of patients presenting for endoscopy.

The fundamental flaw in substituting corporate policy for clinical judgment is the basis for the Statement on Medical Necessity of Anesthesia Services that the American Society of Anesthesiologists adopted in 2006. Key elements of this statement include:

"The decision as to the medical necessity of anesthesiology services for a particular patient is a medical judgment that must consider all patient factors, procedure requirements, potential risks and benefits, requirements or preferences of a physician performing the surgery/procedure and competencies of the involved practitioners."

"The ASA does not support the determinations of medical necessity of anesthesiology services made independently by other organizations, such as healthcare specialty organizations or health insurance plans."

Your Guideline appears to rest largely upon the 2002 American Society of Gastrointestinal Endoscopists statement which relied upon then available clinical experience and suggested that anesthesiology services are unnecessary for healthy patients undergoing endoscopy procedures. The subsequent experience of increasing demand by gastroenterologists and patients for anesthesiology care during endoscopy questions the validity of this dated ASGE document. In addition, both the American Society of Anesthesiologists and the American Gastroenterological Association have asked that you defer and reconsider the implementation of your proposed Guideline.

The advent of fast-acting anesthetics, such as propofol (administered by qualified anesthesia providers), permits enhanced patient comfort and drastically fewer side-effects as compared with traditional sedation methods such as Valium/Midazolam and Demerol/Fentanyl. Historically, Gastroenterologists in the United States have sedated patients as a part of the endoscopic service. Current survey data confirms that propofol administered by anesthesiology professionals is the preferred sedation method for gastroenterological procedures. Commonly cited reasons include the safety benefits provided through the judgment and skill of anesthesiologists, higher cecal

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intubation rates and improved quality of exams and superior patient comfort and recovery attributes which has led to a much higher degree of patient satisfaction with endoscopy.

Patients at St. John's Mercy Health Care have told us: 1. The confidence that one could be safely asleep in the care of a qualified anesthesia provider and completely unaware during the endoscopy is often the deciding factor to schedule and complete the endoscopic examination.; 2. Having first undergone colonoscopy or upper endoscopy under historical sedation methods and recently under anesthesia by an anesthesia provider patients recognize the difference. When provided with anesthesia care, they express strong satisfaction with their lack of awareness during the test and the quality of their recovery. Patients who have had anesthesia for endoscopy continue to demand anesthesia for subsequent tests.

Not surprisingly, availability of anesthesiology services has been accepted as necessary in contemporary endoscopy practice by physicians in this region in order to avoid: 1. incomplete exams due to the patient's inability to tolerate the procedure without anesthesia; 2. failure to detect colon cancer; 3. necessary additional examinations; 4. significant patient discomfort; 5. significant side effects with alternate regimens.

Against this backdrop, it would be interesting to speculate how Aetna, if you existed in the nineteenth century, would have reacted to the discovery of anesthesia and the reality that a leg could be amputated pain free but at a cost. Would we hear that biting the bullet or a stiff drink of whiskey had sufficed for years? In my career I have seen progress in insurance companies relenting after efforts to limit access to anesthesiology services for labor analgesia and post-operative pain management among other reversals of restrictive coverage decisions. Your decision to reverse your policy of coverage for anesthesiology services for endoscopy is a sad departure from experience that the insurance industry can adapt to the evolution of care, particularly in response to safety and satisfaction concerns. There seems little doubt in my mind that your move is motivated by an interest in containing easily measured costs. I, like most other physicians, endorse cost containment. But it should be rational and not lead to suboptimal care.

We remain encouraged that other health insurance plans agree that the treating physician should determine if anesthesiology services are required to maintain current standards of patient care and safety in the pursuit of colon cancer detection and the treatment of other medical conditions.

My simple question regarding your proposal is, "Why?"

I understand that you plan to travel to St. Louis to meet with interested members of the medical community later this month. I look forward to meeting you and the opportunity to address this matter with you directly.

Sincerely yours,



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Director, Missouri
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