

Medicare reimbursement for monitored anesthesia care (MAC) for pain management spinal interventions

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The specialty of pain management includes the utilization of many spinal interventional procedures including intralaminar and transforaminal epidural injections, facet joint and medical branch nerve blocks, radiofrequency neurolysis of nerves, sympathetic nerve blocks, implantation of spinal cord stimulators and intrathecal pumps, as well as intradiscal procedures. Although considered minimally invasive these procedures possess inherent potential danger. Pain management procedures involve manipulation of needles and devices very near spinal neural structures including the spinal cord, nerve roots and their blood supply. As a result, there is intrinsic danger involved in these procedures that can be induced by patient movement during critical points of the procedure. In addition, cardiac abnormalities such as local anesthetic induced hypotension, local anesthetic toxicity due to vascular absorption, vasovagal reactions, and cardiac arrhythmias and ST wave depression due to cardiac ischemia may occur during these procedures. The latter potential cardiac events many times are induced by fear and anxiety felt by patients presenting for these procedures.

Many patients who suffer from chronic pain and present for these therapies happen to be elderly and often times are Medicare patients. The advanced age of these patients is associated with co-morbid medical conditions such as hypertension, coronary artery disease, diabetes, obesity, sleep apnea, pulmonary, renal, and liver disease. Medical co-morbidities are associated with increased perioperative complications and thus warrant additional anesthetic attention.

In addition to the medical evidence supporting anesthesia monitoring during spinal procedures, one must take into account the overall patient experience. In fact, in my current practice an informal survey was conducted among patients who had their spinal procedures delivered to them with and without MAC anesthesia. The results were overwhelming in support (98%) of MAC. Anecdotally, in my practice, I see fewer complications including cardiac arrhythmia and ST changes warranting hospital admission since I have utilized MAC anesthesia services as a standard of care.

I realize that there are physicians who choose not to utilize this service and their patients, by and large, do okay. There are also endoscopists who perform colonoscopies and EGDs without MAC anesthesia. Those patients are usually overdosed on Versed and Demerol and suffer for hours and sometimes days after their procedures with sedation, nausea and vomiting. Just because something can be done does not mean it is the best way or the most appropriate way to do it.

I do not support general or deep anesthesia for many pain management spinal procedures as it is critical to maintain responsiveness from the patient to ensure no spinal injury. Utilizing MAC anesthesia does not equate to deep sedation. I am very aware of the anesthesia closed claims data regarding sedation during pain management spinal procedures. This further supports having an anesthesia professional experienced in administering light to moderate conscious sedation to patients undergoing spinal procedures. A skilled professional may relax the patient while maintaining responsiveness from the patient. Without skilled anesthesia providers, many pain practitioners are administering IV conscious sedation medications themselves without the same level of patient monitoring or management. These IV drugs have longer half-lives and are associated with post-procedure side effects like nausea, vomiting and sedation, especially in the elderly who often have delayed renal and liver clearance. As you know

propofol, when titrated appropriately is an excellent alternative, as it is rapidly metabolized and eliminated completely from the body within fifteen to twenty minutes.

I strongly support maintaining the opportunity to utilize MAC anesthesia for pain management spinal interventions. I believe that it is safer as well as more acceptable by the patients. Consequently, I believe it to be a better standard of care to which Medicare patients should have access. I realize that, in the era of cost containment, all medical services are being evaluated. I agree that there are certainly incidences where a patient may not have co-morbid medical conditions, may not possess procedural anxiety and be relatively healthy and, as a result, may not require MAC anesthesia on the basis of medical indication. I believe that the decision to or not to utilize MAC anesthesia should be left to the physician and should be an integral part of the patient-physician relationship.

If FCSO decides to implement policies regarding clinical guidelines for Monitored Anesthesia Care (MAC) I suggest the following:

Medical indications for MAC anesthesia should be documented within the patient's medical record and listed again as an indication within the procedure note. Medical indications should include the presence of medical co-morbidities such as hypertension, coronary artery disease, diabetes, obesity, sleep apnea, pulmonary disease, renal disease, liver disease, anxiety disorder, or severe procedural fear/anxiety. Any other condition that would prevent the complete cooperation from the patient would warrant anesthesia care as well.