

Anesthesia for Routine Gastrointestinal Endoscopic Procedures

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Dates Reviewed: 12/2013, 11/2014, 12/2015, 03/2017, 12/2017, 8/2018, 07/2019, 09/2020, 09/2021, 08/2022, 09/2023

Developed By: Medical Necessity Criteria Committee

I. Description

Gastrointestinal endoscopic procedures are routinely performed with the use of intravenous sedation and analgesia. The level of anesthesia required to relieve patient anxiety and discomfort can vary from patient to patient. There are four levels of sedation that have been identified by the American Society of Anesthesiologists. They include:

- Minimal sedation – a drug-induced state in which patients respond normally to verbal commands and airway, ventilation, and cardiovascular function remain unaffected.
- Moderate sedation (conscious sedation) – a drug-induced depressed level of consciousness in which patients can purposefully respond to verbal command or tactile stimulation. No airway intervention is required. Ventilation is adequate and cardiovascular function is usually maintained.
- Deep sedation – a drug-induced depressed level of consciousness in which patients cannot be easily aroused but respond purposefully after repeated or painful stimuli. Airway intervention may be required. Patients may require assistance to maintain a patent airway and spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained.
- General anesthesia – a drug-induced loss of consciousness in which patients are not arousable, even by painful stimuli. Patients require assistance in maintaining a patent airway; positive pressure ventilation may be required due to depressed spontaneous ventilation, drug-induced depression, or neuromuscular function. Cardiovascular function may be impaired.

Typically, screening, diagnostic, and uncomplicated therapeutic upper endoscopy and colonoscopy procedures are successfully performed with moderate sedation to relieve patient anxiety and discomfort. Moderate sedation is usually administered by a licensed registered nurse or physician's assistant under the direction of the gastroenterologist.

Monitored anesthesia care (MAC) refers to anesthesia services administered by anesthesia personnel and is not necessarily related to the level of anesthesia administered. Anesthesia personnel provide a pre-anesthesia evaluation and are present during the entire procedure. They must be prepared to convert the patient to general anesthesia and provide airway management if complications arise.

Deep sedation with propofol is required to be administered by anesthesia services. It has been used more frequently for routine endoscopic procedures. The advantages of using propofol are a short-acting sedation with rapid onset and a shorter recovery time. However, several studies have not demonstrated any clinical benefit in the average risk patient undergoing standard upper and lower endoscopy procedures.

II. Criteria: CWQI HCS-0004

- A. Monitored anesthesia for routine endoscopic procedures policy does **NOT** apply to Medicare members as prior authorization is **NOT** required
- B. Eastern Oregon Coordinated Care Organization (EOCCO) will NOT cover anesthesia services to provide deep sedation and analgesia for routine upper and lower endoscopic procedures for average risk patients (*i.e., ASA Class 1 and Class 2*)
- C. EOCCO will cover anesthesia services for routine upper and lower endoscopic procedure for **1 or more** of the following indications:
 - a. Patient with previous problems with anesthesia or sedation;
 - b. Patient with prescribed or illicit benzodiazepine use;
 - c. Alcohol or drug-addicted patients, or patients with an increased tolerance to sedation and analgesic agents (*i.e., chronic pain patients treated with opioids*) (*occasional marijuana use, does not by itself require MAC Anesthesia*)
 - d. Patient undergoing prolonged or complex procedures,
 - e. Morbidly obese patients with BMI \geq 40,
 - f. Patients with documented severe sleep apnea
 - g. Increased risk for complication due to severe comorbidity (American Society of Anesthesiologists, ASA Class III physical status or greater (see Attachment A – ASA classifications)),
 - h. Patients younger than 18 years and older than 70 years of age,
 - i. Patients with other documented co-morbid conditions that would prevent safe sedation without anesthesia services (*i.e., neurologic conditions such as Parkinson's, cardiac conditions, uncooperative or combative patients*).
 - j. Increased risk of airway obstruction due to anatomic variant including any one of the following;
 - i. History of stridor, or
 - ii. Dysmorphic facial features, such as Pierre-Robin syndrome or trisomy 21, or
 - iii. Jaw abnormalities including but not limited to micrognathia, trismus, retrognathia, or significant malocclusion; or
 - iv. Neck abnormalities e.g., neck mass; or
 - v. Oral abnormalities e.g., macroglossia

III. Information Submitted with the Prior Authorization Request (if available):

1. Pre-procedure history and physical
2. Pre-anesthesia evaluation
3. Provider notes documenting any co-morbid medical condition.
4. Sleep study documenting significant obstructive sleep apnea if that is the condition requiring anesthesia services.

IV. Applicable CPT or HCPC codes covered:

Codes	Description
00731	Anesthesia for upper endoscopic procedures, endoscope introduced proximal to duodenum; not otherwise specified.
00740	Anesthesia, Upper GI endoscopy procedure, proximal duodenum
00811	Anesthesia for lower intestinal endoscopic procedures, endoscope introduced distal to duodenum; not otherwise specified.
00812	Anesthesia for lower intestinal endoscopic procedures, endoscope introduced distal to duodenum; screening colonoscopy
00813	Anesthesia for combined upper and lower endoscopic procedures, endoscope introduced both proximal to and distal to the duodenum

V. Anesthesia Modifiers:

Modifier	Description
P1	A normal healthy patient (ASA Class I)
P2	A patient with mild systemic disease (ASA Class II)
P3	A patient with severe systemic disease (ASA Class III)
P4	A patient with severe systemic disease that is a constant threat to life (ASA Class IV)
P5	A moribund patient who is not expected to survive without the operation (ASA Class V)

*American Society of Anesthesiologist (ASA) physical status classification system for assessing a patient before surgery. (See Attachment A)

VI. Annual Review History

Review Date	Revisions	Effective Date
02/2013	New criteria approved	02/2013
12/2013	Annual Review: Added description of MAC, added table with revision dates.	12/19/2013
12/2014	Annual Review: No change	12/03/2014
12/2015	Annual Review: Added BMI, Increased documentation, removed AHI	12/02/2015
03/2017	Annual Review: Updated to new template, no content changes	03/22/2017
12/06/2017	Updated with new codes for 2018.	01/01/2018
8/2018	Annual Review: Updated Medicare does not apply	08/22/2018
07/2019	Annual Review: No content changes	08/01/2019
09/2020	Annual Review: added; Marijuana use for drug-addicted patients is not considered a requirement for MAC anesthesia	10/01/2020

12/2020	Update: Section III: - Added 'if available' for documentation requirement	
09/2021	Annual review: Replaced 'intermittent or frequently' with 'occasional' marijuana use	10/01/2021
08/2022	Annual Review: No changes	09/01/2022
09/2023	Annual Review: added coverage requirements anesthesia use for increased risk airway obstruction, ICD 10 codes added, see appendix	10/01/2023

Attachment A – ASA Classifications

ASA Class	Description
Class I	The patient is normal and healthy
Class II	The patient has mild systemic disease that does not limit activities (i.e., controlled hypertension or controlled diabetes without systemic sequelae)
Class III	The patient has moderate or severe systemic disease that does not limit the activities (i.e., stable angina or diabetes with systemic sequelae)
Class IV	The patient has severe systemic disease that is a constant threat to life (i.e., severe congestive heart failure, end-stage renal disease)
Class V	The patient is morbid and is at a substantial risk of death within 24 hours (with or without procedure)
Class E	Emergency status: in addition to indicating the underlying ASA status (1-5), any patient undergoing an emergency procedure is indicated by suffix "E."

VII. References

1. Carlsson U, and Grattidge P. *Sedation for upper gastrointestinal endoscopy: a comparative study of propofol and midazolam*. Endoscopy 1995; 27: 240-243.
2. Cohen LB, Hightower CD, Wood DA, et al. *Moderate level sedation during endoscopy: a prospective study using low dose propofol, meperidine/fentanyl, and midazolam*. Gastrointestinal Endoscopy 2004; 59(7):795-803.
3. Faigel DO, Baron TH, Goldstein JL, et al. Standards Practice Committee, American Society for Gastrointestinal Endoscopy: guidelines for the use of deep sedation and anesthesia for GI endoscopy. Gastrointest Endosc 2002; 56: 613-7.
4. Gross JB, Bailey PL, Epstein BS, et al. *Practice guidelines for sedation and analgesia by non-anesthesiologist*. American Society of Anesthesiologists 2001.

5. Lee KK, Anderson MA, Baron TH, et al. Standards of Practice Committee, American Society for Gastrointestinal Endoscopy: Modifications in endoscopic practice for pediatric patients. *Gastrointest Endosc* 2008; 67:1-9.
6. Nelson DB, Barkun AN, Block KP, et al. *Guidelines: Propofol use during gastrointestinal endoscopy*. *Gastrointestinal Endoscopy* 2001; 53(7).
7. Standards of Practice Committee of the American Society for Gastrointestinal Endoscopy, Lichtenstein DR, Jagannath S, Baron TH, Anderson MA, Banerjee S, Dominitz JA, Fanelli RD, Gan SI, Harrison ME, Ikenberry SO, Shen B, Stewart L, Khan K, Vargo JJ., *Sedation and Anesthesia in GI Endoscopy*, *Gastrointest Endosc*. 2008 Nov; 68(5):815-26.
8. Sipe BW, Rex DK, Latinovich D. *Propofol versus midazolam/meperidine for outpatient colonoscopy: administration by nurses supervised by endoscopist*. *Gastrointestinal Endoscopy* 2002; 55:815-825.
9. Guidelines to the Practice of Anesthesia - Revised Edition 2018. – NCBI, by G Dobson - 2018 - Cited by 8 - Related articles; *Can J Anaesth*. 2018 Jan;65(1):76-104. doi: 10.1007/s12630-017-0995-9. Epub 2017 Dec 14.; <https://www.ncbi.nlm.nih.gov/pubmed/29243160>
10. American Society of Anesthesiologists; ASA Practice Guidance Resources; <https://www.asahq.org/education-and-career/clinical-resources>
11. American Society for Gastrointestinal Endoscopy; Guidelines for sedation and anesthesia in GI endoscopy; Prepared by: ASGE STANDARDS OF PRACTICE COMMITTEE; Volume 87, No. 2 : 2018 GASTROINTESTINAL ENDOSCOPY; <http://dx.doi.org/10.1016/j.gie.2017.07.018>
12. Centers for Medicare and Medicaid; Noridian LCD L34100; RETIRED Local Coverage Determination for Monitored Anesthesia Care (MAC) (L34100); Revised effective date 1/01/2018; Retirement Date 04/09/2018 at <https://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=34100>.
13. Physician Advisors

Appendix 1 – Centers for Medicare and Medicaid Services (CMS)

Medicare coverage for outpatient (Part B) drugs is outlined in the Medicare Benefit Policy Manual (Pub. 100-2), Chapter 15, §50 Drugs and Biologicals. In addition, National Coverage Determination (NCD) and Local Coverage Determinations (LCDs) may exist and compliance with these policies is required where applicable. They can be found at: <http://www.cms.gov/medicare-coverage-database/search/advanced-search.aspx>. Additional indications may be covered at the discretion of the health plan.

Medicare Part B Covered Diagnosis Codes (applicable to existing NCD/LCD):

Jurisdiction(s): F	NCD/LCD Document (s): L35049
Noridian Local Coverage Determination (LCD) Monitored Anesthesia Care (MAC) (L34100)	
NCD/LCD Document (s):	
https://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=34100...	

Medicare Part B Administrative Contractor (MAC) Jurisdictions		
Jurisdiction	Applicable State/US Territory	Contractor
F (2 & 3)	AK, WA, OR, ID, ND, SD, MT, WY, UT, AZ	Noridian Healthcare Solutions, LLC