Anesthesia Care with Diagnostic Endoscopy

MEDICAL POLICY NUMBER: 105

Effective Date: 6/1/2023
Last Review Date: 3/2023
Next Annual Review: 3/2024

INSTRUCTIONS FOR USE: Company Medical Policies serve as guidance for the administration of plan benefits. Medical policies do not constitute medical advice nor a guarantee of coverage. Company Medical Policies are reviewed annually and are based upon published, peer-reviewed scientific evidence and evidence-based clinical practice guidelines that are available as of the last policy update. The Company reserves the right to determine the application of medical policies and make revisions to medical policies at any time. The scope and availability of all plan benefits are determined in accordance with the applicable coverage agreement. Any conflict or variance between the terms of the coverage agreement and Company Medical Policy will be resolved in favor of the coverage agreement. Coverage decisions are made on the basis of individualized determinations of medical necessity and the experimental or investigational character of the treatment in the individual case. In cases where medical necessity is not established by policy for specific treatment modalities, evidence not previously considered regarding the efficacy of the modality that is presented shall be given consideration to determine if the policy represents current standards of care.

SCOPE: Providence Health Plan, Providence Health Assurance, Providence Plan Partners, and Ayin Health Solutions as applicable (referred to individually as “Company” and collectively as “Companies”).

PLAN PRODUCT AND BENEFIT APPLICATION

☒ **Commercial** ☒ **Medicaid/OHP*** ☐ **Medicare****

*Medicaid/OHP Members

Oregon: Services requested for Oregon Health Plan (OHP) members follow the OHP Prioritized List and Oregon Administrative Rules (OARs) as the primary resource for coverage determinations. Medical policy criteria below may be applied when there are no criteria available in the OARs and the OHP Prioritized List.

**Medicare Members

This *Company* policy may be applied to Medicare Plan members only when directed by a separate *Medicare* policy. Note that investigational services are considered **"not medically necessary"** for Medicare members.

COVERAGE CRITERIA

Note:

This policy applies to:

- Ambulatory Surgical Centers (ASCs),
- Off Campus-Outpatient Hospital (location 19), and
- Non-Hospital Based Outpatient Surgery Departments

Note: This policy does not address the use of monitored anesthesia care (MAC) or general anesthesia performed as part of a *screening* endoscopy.

I. In members 18 years or younger, monitored anesthesia care (MAC) or general anesthesia, provided by anesthesiology personnel, may be considered **medically necessary** when performed as part of a diagnostic endoscopy.

II. In members 19 years or older, monitored anesthesia care (MAC) or general anesthesia, provided by anesthesiology personnel, may be considered **medically necessary** in specific circumstances, when performed as part of a diagnostic endoscopy and **all** of the following criteria are met:

   A. The anesthesiology care service rendered must be appropriate and medically reasonable and necessary; **and**

   B. MAC or general anesthesia should be provided by qualified anesthesia personnel, (anesthesiologists or qualified anesthetists such as certified registered nurse anesthetists or anesthesia assistants). These individuals must be **continuously** present to monitor the patient and provide anesthesia care; **and**

C. Documentation of **at least one** of the qualifying criteria below (1.-5.) must be submitted with the request for consideration. Patients who meet the following criteria may be considered for approval for anesthesiology specialist care; however, the majority of patients undergoing diagnostic endoscopy will not require the care of an anesthesiology specialist:

1. Members who have had a previous failure to complete the procedure or a procedure completed with great difficulty utilizing standard moderate sedation protocols. Records from the prior procedure and Gastroenterologist notes will be required for review; **and/or**
2. Members who are known to have or are predicted to have documented difficult airways or co-morbidity that would prevent safe sedation without anesthesia services, including, but not limited to the following situations: .. Difficult airways may include, but are not limited to the following:
    a. Reactive airway disease
    b. BMI ≥ 40
    c. Neurologic conditions such as Parkinson's
    d. Cardiac conditions
    e. Uncooperative or combative members
    f. Pregnancy
    g. Asthma or lung disease

    Note: Documentation from previous anesthesia provider may be required for review
3. Members with anticipated intolerance of standard sedatives (e.g., known alcohol or known substance use). Documentation of Medications and substances along with quantities will be required for review. Chronic use of standard doses of sedative medications will not meet criteria; ; **and/or**
4. Members being treated for moderate to severe sleep apnea. Moderate sleep apnea is defined as having an AHI (calculated to Medicare standards) of ≥ 15**.**

III. In members 19 years or older, the following situations do not qualify as necessary for MAC or general anesthesia
    A. Procedural anxiety is not a qualifying condition for the addition of an anesthesiology provider to the care team; **or**
    B. The presence of an underlying condition alone, as reported by an ICD-10-CM code, may not be sufficient evidence that moderate sedation is necessary; **or**
    C. The medical condition is not significant enough to impact the need to provide moderate sedation. The presence of a stable, treated condition of itself is not necessarily sufficient. In the case of members who are significantly impaired or potentially unstable, consideration should be given to performing the procedure in a hospital-based facility.

IV. The routine assistance of an anesthesiologist/anesthetist for standard diagnostic upper and lower endoscopy procedures is considered **not medically necessary** for average risk members (ASA Class 1 or 2, see Policy Guidelines) who do not need an endoscopic retrograde cholangiopancreatography (ERCP).

POLICY CROSS REFERENCES

None

The full Company portfolio of current Medical Policies is available online and can be accessed here.

POLICY GUIDELINES

DEFINITIONS

ASA Physical Status Classification System (2020)[1]

ASA PS Classification	Definition	Adult Examples, Including, but not Limited to:	Pediatric Examples, Including but not Limited to:	Obstetric Examples, Including but not Limited to:
ASA I	A normal healthy patient	Healthy, non-smoking, no or minimal alcohol use	Healthy (no acute or chronic disease), normal BMI percentile for age	
ASA II	A patient with mild systemic disease	Mild diseases only without substantive functional limitations. Current smoker, social alcohol drinker, pregnancy, obesity (30<BMI<40), well-controlled DM/HTN, mild lung disease	Asymptomatic congenital cardiac disease, well controlled dysrhythmias, asthma without exacerbation, well controlled epilepsy, non-insulin dependent diabetes mellitus, abnormal BMI percentile for age, mild/moderate OSA, oncologic state in remission, autism with mild limitations	Normal pregnancy*, well controlled gestational HTN, controlled preeclampsia without severe features, diet-controlled gestational DM.
ASA III	A patient with severe systemic disease	Substantive functional limitations; One or more moderate to severe diseases. Poorly controlled DM or HTN, COPD, morbid obesity (BMI ≥40), active hepatitis, alcohol dependence or abuse, implanted pacemaker, moderate reduction of ejection fraction, ESRD undergoing regularly scheduled dialysis, history (>3 months) of MI, CVA, TIA, or CAD/stents.	Uncorrected stable congenital cardiac abnormality, asthma with exacerbation, poorly controlled epilepsy, insulin dependent diabetes mellitus, morbid obesity, malnutrition, severe OSA, oncologic state, renal failure, muscular dystrophy, cystic fibrosis, history of organ transplantation, brain/spinal cord malformation, symptomatic hydrocephalus, premature infant PCA <60 weeks, autism with severe limitations, metabolic disease, difficult airway, long term parenteral nutrition. Full term infants <6 weeks of age.	Preeclampsia with severe features, gestational DM with complications or high insulin requirements, a thrombophilic disease requiring anticoagulation.
ASA IV	A patient with severe systemic disease that is a constant threat to life	Recent (<3 months) MI, CVA, TIA or CAD/stents, ongoing cardiac ischemia or severe valve dysfunction, severe reduction of ejection fraction, shock, sepsis, DIC, ARD or ESRD not undergoing regularly scheduled dialysis	Symptomatic congenital cardiac abnormality, congestive heart failure, active sequelae of prematurity, acute hypoxic-ischemic encephalopathy, shock, sepsis, disseminated intravascular coagulation, automatic implantable cardioverter-defibrillator, ventilator dependence, endocrinopathy, severe trauma, severe respiratory distress, advanced oncologic state.	Preeclampsia with severe features complicated by HELLP or other adverse event, peripartum cardiomyopathy with EF <40, uncorrected/decompensated heart disease, acquired or congenital.
ASA V	A moribund patient who is not expected to survive without the operation	Ruptured abdominal/thoracic aneurysm, massive trauma, intracranial bleed with mass effect, ischemic bowel in the face of significant cardiac pathology or multiple organ/system dysfunction	Massive trauma, intracranial hemorrhage with mass effect, patient requiring ECMO, respiratory failure or arrest, malignant hypertension, decompensated congestive heart failure, hepatic encephalopathy, ischemic bowel or multiple organ/system dysfunction.	Uterine rupture.
ASA VI	A declared brain-dead patient whose organs are being removed for donor purposes			

General Anesthesia and Levels of Sedation/Analgesia

According to the 2014 American Society of Anesthesiologists definition guideline:[2]

- **Minimal Sedation (Anxiolysis)** is a drug-induced state during which patients respond normally to verbal commands. Although cognitive function and physical coordination may be impaired, airway reflexes, and ventilatory and cardiovascular functions are unaffected.
- **Moderate Sedation/Analgesia ("Conscious Sedation")** is a drug-induced depression of consciousness during which patients respond purposefully** to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained.
- **Deep Sedation/Analgesia** is a drug-induced depression of consciousness during which patients cannot be easily aroused but respond purposefully** following repeated or painful stimulation. The ability to independently maintain ventilatory function may be impaired. Patients may require assistance in maintaining a patent airway, and spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained.
- **General Anesthesia** is a drug-induced loss of consciousness during which patients are not arousable, even by painful stimulation. The ability to independently maintain ventilatory function is often impaired. Patients often require assistance in maintaining a patent airway, and positive pressure ventilation may be required because of depressed spontaneous ventilation or drug-induced depression of neuromuscular function. Cardiovascular function may be impaired.
  Because sedation is a continuum, it is not always possible to predict how an individual patient will respond. Hence, practitioners intending to produce a given level of sedation should be able to rescue patients whose level of sedation becomes deeper than initially intended. Individuals administering Moderate Sedation/Analgesia ("Conscious Sedation") should be able to rescue patients who enter a state of Deep Sedation/Analgesia, while those administering Deep Sedation/Analgesia should be able to rescue patients who enter a state of General Anesthesia."[2]

BACKGROUND

Monitored anesthesia care does not describe the continuum of depth of sedation; rather it describes "a specific anesthesia service in which an anesthesiologist has been requested to participate in the care of a patient undergoing a diagnostic or therapeutic procedure."[2]

According to the 2013 American Society of Anesthesiologists position statement on monitored anesthesia care:
"Monitored anesthesia care includes all aspects of anesthesia care – a pre-procedure visit, intra-procedure care and post procedure anesthesia management. During monitored anesthesia care, the anesthesiologist provides or medically directs a number of specific services, including but not limited to:

- Diagnosis and treatment of clinical problems that occur during the procedure
- Support of vital functions
- Administration of sedatives, analgesics, hypnotics, anesthetic agents or other
- Medications as necessary for patient safety
- Psychological support and physical comfort
- Provision of other medical services as needed to complete the procedure safely.

Monitored anesthesia care (MAC) may include varying levels of sedation, analgesia and anxiolysis as necessary. The provider of monitored anesthesia care must be prepared and qualified to convert to

general anesthesia when necessary. If the patient loses consciousness and the ability to respond purposefully, the anesthesia care is a general anesthetic, irrespective of whether airway instrumentation is required."[3]

MAC as well as general and regional anesthesia should be provided by qualified anesthesiology personnel, (anesthesiologists or qualified anesthetists such as certified registered nurse anesthetists or anesthesia assistants).

REGULATORY STATUS

U.S. FOOD AND DRUG ADMINISTRATION (FDA)

Approval or clearance by the Food and Drug Administration (FDA) does not in itself establish medical necessity or serve as a basis for coverage. Therefore, this section is provided for informational purposes only.

CLINICAL EVIDENCE AND LITERATURE REVIEW

CLINICAL PRACTICE GUIDELINES

American Society for Gastrointestinal Endoscopy (ASGE)

In 2018, the ASGE published evidence-based guidelines for sedation and anesthesia in GI endoscopy.[4] Investigators made the following recommendations:

1. We recommend that all patients undergoing endoscopic procedures be evaluated to assess their risk of sedation related to pre-existing medical conditions. (*high quality evidence*)
2. We recommend that the combination of an opioid and benzodiazepine is a safe and effective regimen for achieving minimal to moderate sedation for upper endoscopy and colonoscopy in patients without risk factors for sedation-related adverse events. (*high quality evidence*)
3. We suggest using an appropriate adjunctive agent (e.g., diphenhydramine, promethazine, or droperidol) in combination with conventional sedative drugs in select clinical circumstances. (*low quality evidence)*
4. We recommend that providers undergo specific training in the administration of endoscopic sedation and possess the skills necessary for the diagnosis and management of sedation-related adverse events, including rescue from a level of sedation deeper than that intended. (*high quality evidence)*
5. We recommend the routine monitoring of blood pressure, oxygen saturation, and heart rate in addition to clinical observation for changes in cardiopulmonary status during all endoscopic procedures using sedation. Supplemental oxygen administration should be considered for moderate sedation and should be administered during deep sedation. Supplemental oxygen should be administered if hypoxemia is anticipated or develops. (*high quality evidence*).

6. We suggest that capnography monitoring be considered for patients undergoing endoscopy targeting deep sedation. (*low quality evidence*).
7. We recommend anesthesia provider–administered sedation be considered for complex endoscopic procedures or patients with multiple medical comorbidities or at risk for airway compromise. (*moderate quality evidence*).
8. We suggest that endoscopists use propofol-based sedation (endoscopist-directed or anesthesia-provider administered) when it is expected to improve patient safety, comfort, procedural efficiency, and/or successful procedure completion. (*low quality evidence*).[4]

BILLING GUIDELINES AND CODING

- This policy applies to:
  - Ambulatory Surgical Centers (ASCs),
  - Off Campus-Outpatient Hospital (location 19), and
  - Non-Hospital Based Outpatient Surgery Departments
- Off-Campus locations, including portions of an off-campus hospital provider-based department which provides diagnostic, therapeutic (both surgical and non-surgical), services to sick or injured persons who do not require hospitalization or institutionalization, require prior authorization.
- The Prior-authorization request must be submitted by a gastroenterology clinic.
- Please see "Providence Health Plans Payment Policy (09.0) – Anesthesia" for additional information.

CODES*		
CPT	00731	Anesthesia for upper gastrointestinal endoscopic procedures, endoscope introduced proximal to duodenum; not otherwise specified
	00732	Anesthesia for upper gastrointestinal endoscopic procedures, endoscope introduced proximal to duodenum; endoscopic retrograde cholangiopancreatography (ERCP)
	00811	Anesthesia for lower intestinal endoscopic procedures, endoscope introduced distal to duodenum; not otherwise specified
	00813	Anesthesia for combined upper and lower gastrointestinal endoscopic procedures, endoscope introduced both proximal to and distal to the duodenum
HCPCS	None	

***Coding Notes:**

- The above code list is provided as a courtesy and may not be all-inclusive. Inclusion or omission of a code from this policy neither implies nor guarantees reimbursement or coverage. Some codes may not require routine review for medical necessity, but they are subject to provider contracts, as well as member benefits, eligibility and potential utilization audit.
- All unlisted codes are reviewed for medical necessity, correct coding, and pricing at the claim level. If an unlisted code is submitted for non-covered services addressed in this policy then it will be **denied as not covered**. If an unlisted code is submitted for potentially covered services addressed in this policy, to avoid post-service denial, **prior authorization is recommended**.

- **See the non-covered and prior authorization lists on the Company Medical Policy, Reimbursement Policy, Pharmacy Policy and Provider Information website for additional information.**
- HCPCS/CPT code(s) may be subject to National Correct Coding Initiative (NCCI) procedure-to-procedure (PTP) bundling edits and daily maximum edits known as "medically unlikely edits" (MUEs) published by the Centers for Medicare and Medicaid Services (CMS). This policy does not take precedence over NCCI edits or MUEs. Please refer to the CMS website for coding guidelines and applicable code combinations.

REFERENCES

1. American Society of Anesthesiologists. ASA Physical Status Classification System. Amended December 13, 2020. https://www.asahq.org/standards-and-guidelines/asa-physical-status-classification-system. Accessed 2/26/2023.
2. American Society of Anesthesiologists. Continuum of Depth of Sedation: Definition of General Anesthesia and Levels of Sedation/Analgesia. https://www.asahq.org/standards-and-guidelines/continuum-of-depth-of-sedation-definition-of-general-anesthesia-and-levels-of-sedationanalgesia. Published 1999 (amended 2019). Accessed 2/26/2023.
3. American Society of Anesthesiologists. Position on Monitored Anesthesia Care. https://www.asahq.org/standards-and-guidelines/position-on-monitored-anesthesia-care. Published 2005 (amended 2018). Accessed 2/26/2023.
4. Early DS, Lightdale JR, Vargo JJ, et al. Guidelines for sedation and anesthesia in GI endoscopy. *Gastrointestinal endoscopy.* 2018;87(2):327-337. https://www.asge.org/docs/default-source/education/practice_guidelines/piis0016510717321119.pdf?sfvrsn=4

POLICY REVISION HISTORY

DATE	REVISION SUMMARY
2/2023	Updated format
6/2023	Annual Update. Criterion II.C.2 expanded to include more comorbidities, STOP BANG score was removed, and criterion IV clarified that average risk members are ASA Class 1 or 2 who do not need ERCP