Anesthesia Care with Diagnostic Endoscopy

MEDICAL POLICY NUMBER: 105

Effective Date: 6/1/2022

Last Review Date: 5/2022

Next Annual Review: 5/2023

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

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 patients 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 patients 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.-D.):

   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. Patients 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. Patients who are known to have or are predicted to have documented difficult airways. Documentation from previous anesthesia provider may be required for review. Difficult airways may include, but are not limited to the following:
   - Reactive airway disease
   - BMI ≥ 40
   - STOP-BANG score of 4 or higher; **and/or**
3. Patients 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. Patients being treated for moderate to severe sleep apnea. Moderate sleep apnea is defined as having an AHI (calculated to Medicare standards) of ≥ 15; **and/or**
5. Patients with asthma or lung disease; **and**

D. The patient has none of the following contraindications (1.-3.):

1. Procedural anxiety is not a qualifying condition for the addition of an anesthesiology provider to the care team; **or**
2. 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**
3. 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 patients who are significantly impaired or potentially unstable, consideration should be given to performing the procedure in a hospital-based facility.

E. The routine assistance of an anesthesiologist/anesthetist for average risk patients undergoing standard diagnostic upper and lower endoscopy procedures is **not medically necessary and not covered**.

POLICY CROSS REFERENCES

None

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

POLICY GUIDELINES

DEFINITIONS

General Anesthesia and Levels of Sedation/Analgesia

According to the 2014 American Society of Anesthesiologists definition guideline:[1]

- **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."[1]

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."[1]

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."[2]

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.[3] 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*).[3]

MEDICARE ADVANTAGE

Note: The Company policy for *PHA Medicare Medical Policy Development and Application* (MP50) provides details regarding Medicare's definition of medical necessity and the hierarchy of Medicare references and resources during the development of medical policies, as well as the Plan's use of evidence-based processes for policy development.

As of 5/2022, no specific Medicare coverage policy or guidance (e.g., manual, national coverage determination [NCD], local coverage determination [LCD] article [LCA], etc.) was identified which addresses anesthesia care with diagnostic endoscopy. In the absence of a NCD, LCD, or other Medicare policy, Medicare regulatory guidelines do allow Medicare Advantage Organizations (MAOs) to make their own coverage determinations, as long as the MAO applies an objective, evidence-based process, based on authoritative evidence. *(Medicare Managed Care Manual, Ch. 4, §90.5)* Thus, the Company medical policy criteria may be applied for medical necessity decision-making.

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

***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. 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 4/12/2022.
2. 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 4/12/2022.
3. 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