Anesthesia Services for Gastrointestinal Endoscopic Procedures

I. Description
Sedatives and analgesics are routinely administered intravenously for gastrointestinal endoscopic examinations to help alleviate patient anxiety and discomfort. It is the standard practice for the endoscopist, in conjunction with a registered nurse, to provide the sedation and analgesia. This is usually referred to as moderate or conscious sedation. On occasion, deep sedation may be planned or required for an endoscopic procedure. Payment for moderate or conscious sedation or deep sedation is made to the endoscopist and is included in the payment for the endoscopic procedure.

Under certain circumstances, it is medically appropriate and necessary for a patient to receive an anesthesia service provided by an anesthesiologist or certified registered nurse anesthetist during a gastrointestinal endoscopic procedure. Anesthesia services include monitored anesthesia care (MAC), regional anesthesia and general anesthesia. An anesthesia service may be necessary for extensive endoscopic procedures, for endoscopic procedures that cannot be completed with attempted moderate or deep sedation or for patients with medical conditions that put them at high risk for complications from sedation. Anesthesia services for endoscopy performed on inpatients and those patients undergoing emergency procedures are usually medically appropriate and necessary.

This policy is consistent with the American Society of Anesthesiologists, “Practice Guidelines for Sedation and Analgesia by Non-Anesthesiologists.” The purpose of this practice guideline is to: “allow clinicians to provide their patients with the benefits of sedation/analgesia while minimizing the associated risks.” This policy is also consistent with the guideline developed by the American College of Gastroenterology, American Gastroenterological Association and American Society for Gastrointestinal Endoscopy, “Sedation and Anesthesia in GI Endoscopy.”
II. Criteria/Guidelines
   A. MAC, regional anesthesia or general anesthesia are covered (subject to Limitations/Exclusions and Administrative Guidelines) for endoscopic procedures when one of the following indications is present.
      1. Prolonged or therapeutic endoscopic procedure requiring deep sedation (e.g., endoscopic retrograde cholangiopancreatography, balloon enteroscopy, foreign body extraction from the upper gastrointestinal tract, percutaneous endoscopic gastrojejunostomy and direct percutaneous jejunostomy, esophageal stenting, endoscopic mucosal resection of the upper gastrointestinal tract, esophageal ablation procedures, and endoscopic ultrasound)
      2. History of being difficult to sedate
      3. Anticipation that the patient will be difficult to sedate with the standard sedatives used for moderate sedation due to treatment with opioid analgesics, sedatives or hypnotics, substance abuse/ dependence or alcohol abuse/dependence, i.e., greater than 16 standard drinks per week in men or 10 standard drinks per week in women
      4. History of allergy, intolerance or adverse reaction to standard sedatives or analgesics used for moderate sedation
      5. Increased risk for complications due to severe co-morbidity, i.e., American Society of Anesthesiologists (ASA) class III physical status or greater (see Appendix)
      6. Age less than 18 years or greater than 70 years
      7. Pregnancy
      8. Uncooperative or acutely agitated patient, e.g., due to delirium, dementia, organic brain disease.
      9. Increased risk of aspiration due to foreign bodies, retained food, diabetic with autonomic neuropathy or gastroparesis, achalasia, ascites, swallowing disorders or bulbar neurologic disorders.
      10. Increased risk of airway obstruction due to any of the following:
          a. History of severe problems with anesthesia and sedation
          b. Previous documented episodes of airway obstruction under moderate sedation, administered by an endoscopist
          c. History of tracheal stenosis or previous tracheostomy
          d. Clinically significant obstructive sleep apnea (see HMSA policy for Positive Airway Pressure and Oral Devices for the Treatment of Obstructive Sleep Apnea)

III. Limitations/Exclusions
   A. The routine use of anesthesia services is not covered for the following:
      1. Procedural anxiety, situational anxiety or severe anxiety with respect to an endoscopic procedure
      2. Patients with a low pain threshold
      3. Anticipated requirement for “deep sedation” or general anesthesia in a routine endoscopic procedure in a low risk patient
      4. Expected consequences of routine gastrointestinal preparation, e.g., mild volume depletion
5. The occurrence of partial airway obstruction or hemodynamic instability secondary to anesthesia or sedation administered by an anesthesiologist or CRNA is not an indication for anesthesia services

IV. Administrative Guidelines
   A. Precertification is required and must be obtained by the provider performing the endoscopy procedure. For some providers, the precertification requirement may be waived under a variable intensity review program.
      1. When precertification is required, documentation from the medical record explaining the high risk indicators, previous treatment, current medications and patient response must be included. See Criteria/Guidelines and Exclusions/Limitations. To precertify, please complete HMSA's Precertification Request and mail or fax the form as indicated along with the required documentation.
      2. When a gastroenterologist is waived from precertification, anesthesiology claims are still subject to the high risk criteria system edits and billing requirements. Claims will not automatically pay if the high risk criteria are not met. Documentation supporting high risk criteria should be legible, maintained in the patient’s medical record and available upon request.
      3. Paid claims with high risk indicators for anesthesia services for gastrointestinal endoscopic procedures may be subject to post-payment review. HMSA will from time to time perform retrospective reviews using the above criteria to validate if services rendered meet payment determination criteria. Documentation supporting high risk criteria should be legible, maintained in the patient’s medical record and available upon request.
   B. Member Agreement of Financial Responsibility - If there is no “high risk indication” for an anesthesia service, and the member requests anesthesia services from an anesthesiologist or certified registered nurse anesthetist (CRNA), or the endoscopist routinely requires an anesthesia service, the member should complete and sign the Member Agreement of Financial Responsibility at least 24 hours prior to the procedure. The patient must be informed of the financial implications. HMSA will process the claim to indicate member responsibility for payment for this separate anesthesia service. The Member Agreement of Financial Responsibility needs to be kept on file by the endoscopist and anesthesia provider. If the Member Agreement of Financial Responsibility is completed on the day of service, HMSA will not consider it to be valid and the patient will not be financially responsible for the anesthesia service. To view, please see Agreement of Financial Responsibility for Anesthesia for Colonoscopy or Upper Endoscopy.

<table>
<thead>
<tr>
<th>CPT Codes</th>
<th>Description</th>
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<tbody>
<tr>
<td>00740</td>
<td>Anesthesia for upper gastrointestinal endoscopic procedures, endoscope introduced proximal to duodenum</td>
</tr>
<tr>
<td>00810</td>
<td>Anesthesia for lower intestinal endoscopic procedures, endoscope introduced distal to duodenum</td>
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V. Important Reminder

The purpose of this Medical Policy is to provide a guide to coverage. This Medical Policy is not intended to dictate to providers how to practice medicine. Nothing in this Medical Policy is intended to discourage or prohibit providing other medical advice or treatment deemed appropriate by the treating physician.

Benefit determinations are subject to applicable member contract language. To the extent there are any conflicts between these guidelines and the contract language, the contract language will control.

This Medical Policy has been developed through consideration of the medical necessity criteria under Hawaii’s Patients’ Bill of Rights and Responsibilities Act (Hawaii Revised Statutes §432E-1.4), generally accepted standards of medical practice and review of medical literature and government approval status. HMSA has determined that services not covered under this Medical Policy will not be medically necessary under Hawaii law in most cases. If a treating physician disagrees with HMSA’s determination as to medical necessity in a given case, the physician may request that HMSA consider the application of this Medical Policy to the case at issue.

VI. References


VII. Appendix

ASA CLASSIFICATION

P1   A normal healthy patient
P2   A patient with mild systemic disease
P3   A patient with severe systemic disease
P4   A patient with severe systemic disease that is a constant threat to life
P5   A moribund patient who is not expected to survive without the operation
P6   A declared brain-dead patient whose organs are being removed for donor purposes.