Anesthesia Services for Gastrointestinal Endoscopic Procedures

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Original Effective Date: 12/01/2010

Line(s) of Business: HMO; PPO; QUEST Integration
Current Effective Date: 10/28/2016

Section: Other/Miscellaneous
Place(s) of Service: Outpatient

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, with the assistance of a registered nurse, to provide the sedation and analgesia. This is usually referred to as conscious, moderate or procedural 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 necessary.

This policy is consistent with the American Society of Anesthesiologists’ (ASA), “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.”

A review of recent studies concerning sedation for endoscopy, continue to support the limited use of anesthesia services and propofol for sedation when it is medically necessary. “Moderate sedation using midazolam and an opioid represents the standard method of sedation, although propofol is increasingly used in many countries.” Complications from deep sedation for endoscopic procedures were evaluated and it was found that “Although the absolute risk of complications is
low, the use of anesthesia services for colonoscopy is associated with a somewhat higher frequency of complications, specifically aspiration pneumonia”.

II. Criteria/Guidelines

A. Monitored anesthesia care (MAC), regional anesthesia or general anesthesia are covered (subject to Limitations and Administrative Guidelines) for endoscopic procedures when one or more of the following indications is present:

1. ASA P3 or P4 (see Appendix) patient with increased risk for complications due to one or more of the following conditions:
   a. Morbid obesity:
      i. BMI greater than or equal to 40
      ii. BMI greater than or equal to 35 and significant co-morbid conditions, e.g., coronary artery disease, diabetes mellitus, high blood pressure, abnormal airway findings
   b. Cardiac disease:
      i. Cardiac disease that is clinically significant and for which the patient is receiving treatment, e.g., coronary artery disease, valvular heart disease, congestive heart failure, arrhythmia
      ii. History of myocardial infarction, angioplasty, coronary stents, coronary artery bypass graft surgery, pacemaker, automatic implanted cardioverter defibrillator
   c. Kidney disease:
      i. End stage renal disease
      ii. Chronic kidney disease requiring the routine care of a nephrologist
   d. Neurologic disorders:
      i. History of stroke or transient ischemic attack requiring hospitalization and/or an evaluation and treatment by a neurologist
      ii. Severe neuromuscular disorder, e.g., Parkinson’s disease, amyotrophic lateral sclerosis, multiple sclerosis, muscular dystrophy
   e. Respiratory disease:
      i. Respiratory disease that is clinically significant and for which the patient is receiving chronic daily treatment with medication and/or oxygen, e.g., chronic obstructive pulmonary disease, moderate persistent asthma, interstitial lung disease, pulmonary hypertension
      ii. Documented obstructive sleep apnea requiring treatment with a positive airway pressure or oral device
   f. Psychiatric disorder:
      Chronic severe psychiatric disorder e.g., schizophrenia, bipolar disorder major depressive disorder
   g. Patient has increased risk of aspiration due to foreign body, retained food, gastroparesis, achalasia or ascites

2. Increased risk due to 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, endoscopic ultrasound of the upper GI tract and colonic stenting. The combination of an upper endoscopy and colonoscopy is not a prolonged procedure requiring an anesthesia service.

3. Problems with sedation
   a. Difficulty or anticipated difficulty with sedation due to one or more of the following conditions:
      i. Chronic treatment with opioid analgesics.
      ii. Chronic treatment with benzodiazepines in excess of occasional or nightly
          anxiolytics or sleeping medication.
      iii. Chronic and significant substance abuse/dependence documented by the
           primary care physician in the patient’s medical records.
      iv. Alcohol abuse/dependence, i.e., greater than 16 standard drinks per week in
          men or 10 standard drinks per week in women documented by the primary care
          physician in the patient’s medical records.
      v. Uncooperative or agitated patient, e.g., due to dementia, organic brain disease
      vi. Documented history of being difficult to sedate during a prior procedure (e.g., an
          anesthesiologist or CRNA was urgently consulted, the patient was very
          uncomfortable, or a large dose of sedation was required).
   b. Allergy to fentanyl and/or midazolam which is documented in the patient’s medical
      records or in a prior anesthesia record or post-op report. Allergy to other narcotic
      analgesics or benzodiazepines is not a high risk indication for an anesthesia service.
      Generally speaking nausea and/or vomiting following an anesthetic, sedation, or
      procedure, for which fentanyl and/or midazolam were given, are not indications for
      an anesthesia service for endoscopy. However, an anesthesia service may be
      required for patients with prolonged vomiting requiring hospitalization or an
      extended outpatient stay, following an anesthetic, sedation, or procedure, for which
      fentanyl and/or midazolam were administered. Such prolonged vomiting must be
      documented by the primary care physician in the patient’s medical record, or in a
      prior anesthesia record or post-operative report.
   c. History of severe problems with anesthesia and sedation (e.g., malignant hyper-
      thermia, difficult intubation, difficult mask ventilation) which is documented by the
      primary care physician in the patient’s medical record, or in a prior anesthesia record
      or post-op report.

4. Risk of airway obstruction
   a. Increased risk of airway obstruction as determined, prior to the day of the procedure,
      by a specialist qualified to make such a determination in a patient who:
      i. is expected to require more than moderate procedural sedation; and
      ii. is at increased risk for sedation due to obesity with a BMI of 35 or more, or an
          above listed medical condition; or
      iii. will be having a prolonged procedure (not including a combined upper endoscopy
          and colonoscopy).
   b. Documented history of tracheal stenosis or previous tracheostomy or radiation to the
      neck
5. Less than 18 years of age or 70 years of age and older
6. Pregnancy

III. Limitations
   A. Routine use of anesthesia services without supporting documentation 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, with no prior history of difficulty with sedation.
      4. Anticipated difficulty to sedate without supporting documentation.
      5. Expected consequences of routine gastrointestinal preparation, e.g., mild volume depletion from the nothing by mouth (NPO) status or colonoscopy prep.
      6. Patients that have previously undergone a successful endoscopic procedure using conscious sedation.

IV. Administrative Guidelines
   A. Precertification is not required, but a payment determination may be requested by the endoscopist or anesthesia provider. When the endoscopist or anesthesia provider elects to obtain a payment determination, documentation from the medical record supporting the high risk indication, previous treatment, and current medications and patient response must be included. See I. Criteria/Guidelines and II. Limitations.
   B. Claims with high risk indicators for anesthesia services for gastrointestinal endoscopic procedures may be subject to review following claim submission and/or post-payment review. HMSA will from time to time perform reviews using the policy criteria to validate if services rendered meet payment determination criteria. Documentation supporting high risk criteria should be legible, maintained in the patient’s records and available upon request.
   C. Member Agreement of Financial Responsibility – If there is no “high risk indication” for anesthesia services, and the member requests anesthesia services from an anesthesiologist or a certified registered nurse anesthetist (CRNA), or the endoscopist routinely requires 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. If a phone conversation takes place 24 hours prior to the procedure, in which the anesthesiologist or certified registered nurse anesthetist (CRNA) informs the patient of the Member Agreement of Financial Responsibility, the agreement may be signed on the day of the procedure. A copy of the agreement does not need to be submitted with the claim however, the service should be appended with the appropriate modifier. A signed copy of the agreement should be kept in the patient’s records by the endoscopist and the anesthesiologist.
and available upon request. 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.

**Agreement of Financial Responsibility**

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<tr>
<th>CPT Codes</th>
<th>Description</th>
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<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**

5. Gross JB. Bachenberg KL. Benumof JL. Caplan RA. Connis RT. Cote CJ. Nickinovich DG. Prachand V. Ward DS. Weaver EM. Ydens L. Yu S. American Society of Anesthesiologists Task
Anesthesia Services for Gastrointestinal Endoscopic Procedures


VII. Appendix

**ASA CLASSIFICATION**

<table>
<thead>
<tr>
<th>Class</th>
<th>Description</th>
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<tbody>
<tr>
<td>P1</td>
<td>A normal healthy patient</td>
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<tr>
<td>P2</td>
<td>A patient with mild systemic disease</td>
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<tr>
<td>P3</td>
<td>A patient with severe systemic disease</td>
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<tr>
<td>P4</td>
<td>A patient with severe systemic disease that is a constant threat to life</td>
</tr>
<tr>
<td>P5</td>
<td>A moribund patient who is not expected to survive without the operation</td>
</tr>
<tr>
<td>P6</td>
<td>A declared brain-dead patient whose organs are being removed for donor purposes</td>
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