Anesthesia Services for Gastrointestinal Endoscopic Procedures

Policy Number:        Original Effective Date:        MM.12.001        12/01/2010
Line(s) of Business:        Current Effective Date:        HMO; PPO; QUEST Integration      05/01/2018
Section:        12/01/2018
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 (conditions listed in the ASA table found in the Appendix) 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. Hypertension that is poorly controlled or has complications
      iii. 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
      iii. Spasticity or movement disorder complicating the procedure
      iv. Inability to follow simple commands (cognitive dysfunction, intoxication, or psychological impairment)
   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. OSA treated with UPPP, without a post-procedure sleep study, or with recurrence of symptoms. OSA for which CPAP has been prescribed, but which is not currently being used.
      iii. Suspected OSA, in the absence of a sleep study, in a patient who needs an urgent endoscopic procedure, and has a BMI of at least 30. The patient must have a
“high risk of OSA” as defined by the STOP-Bang criteria. See Appendix. This is applicable only when there is an urgent need for a diagnostic or therapeutic endoscopic procedure, prior to the completion of a sleep study.

d. Psychiatric disorder:
   Chronic severe psychiatric disorder e.g., schizophrenia, bipolar disorder major depressive disorder

g. Patient has increased risk of aspiration due to conditions such as: foreign body, retained food, gastroparesis, achalasia, ascites

h. Type 1 diabetes. Poorly controlled Type 2 diabetes and/or diabetes with complications.

i. Severe liver disease, including cirrhosis

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 jejuno- stomy, 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 anxiolytics or sleeping medication.
      iii. Alcohol and/or drug use:
         1. Chronic and significant substance abuse/dependence documented by the primary care physician in the patient’s medical records.
         2. Alcohol abuse/dependence, i.e., greater than 1614 standard drinks per week in men under 65 years of age or 107 standard drinks per week in women and men 65 years or older, documented by the primary care physician or endoscopist, documented in the patient’s medical records.
         3. Chronic and daily use of marijuana or medical marijuana
      iv. Uncooperative or agitated patient, e.g., due to dementia, organic brain disease
      v. 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).
      v. Inadequate moderate sedation requiring “rescue anesthesia” by an anesthesiologist or CRNA.
   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 or allergies to the drugs of choice for the endoscopist. 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 hyperthermia, 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 in a patient who has the following:
      1. Stridor, dysmorphic facial features, oral abnormalities (eg. macroglossia), neck abnormalities (eg. neck mass), or jaw abnormalities (eg. micrognathia), AND
      2. is expected to require more than moderate procedural sedation; AND
      3. has a BMI of 35 or more
   b. Documented history of tracheal stenosis or previous tracheostomy or radiation to the neck

5. Patient is
   a. Less than 18 years of age or 70 years of age and older
   b. Pregnancy
   c. ASA P4 or P5 patient (conditions listed in the ASA table found in the Appendix)

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.

B. The routine assistance of an anesthesiologist or a certified registered nurse anesthetist (CRNA) for average-risk adult patients undergoing standard upper and/or lower gastrointestinal endoscopic procedures is considered not medically necessary.
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. If necessary documentation from the primary care physician will be reviewed.

   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. The patient must be informed of the financial implications. 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.

   Agreement of Financial Responsibility

   AGREEMENT OF FINANCIAL RESPONSIBILITY

   The purpose of this form is to help HMSA members make an informed choice about whether or not they want to receive the services, items or laboratory tests listed below, knowing that they might have to pay for the services themselves. HMSA members must be given ample opportunity to review this form and discuss it, as well as service options with his/her provider.

   Notice from Provider to Member
   HMSA will only pay for services that meet HMSA’s payment determination criteria as set forth in your health plan. If HMSA determines that a particular service does not meet HMSA’s payment determination criteria, HMSA will not pay for that service. I believe that, in your case, HMSA probably will not pay for:
   (Specify service, item or laboratory test, and provider’s estimated charge for each service on the lines below.)

   | Services(s): | Estimated Charge: |
**Beneficiary Agreement**

This agreement is between me (the HMSA beneficiary whose signature appears below) and my provider, whose name is ____________________________________________.

I have been notified by my provider that he or she believes that, in my case, HMSA will probably not pay for the services, items or laboratory tests identified above. If HMSA denies payment, I agree to be personally and fully responsible for payment of the services, items, or laboratory tests for which the provider’s estimated charge is shown above. I understand that the charge above is only an estimated charge and may not be the actual charge or total amount I will be responsible for.

**Beneficiary: Please write your initials in the boxes above for those services in which you agreeing to pay the provider as appropriate.**

I understand that for each service listed above, the Hawaii Medical Service Association (HMSA) may not pay for the service because the service may not meet HMSA’s payment determination criteria. By signing below, I request that each service which I have initialed in the boxes above be rendered. If HMSA denies payment for the service, I agree to pay my provider in full for each service.

<table>
<thead>
<tr>
<th>CPT Codes</th>
<th>Description</th>
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<tbody>
<tr>
<td>00731</td>
<td>ANESTHESIA FOR UPPER GASTROINTESTINAL ENDOSCOPIC PROCEDURES, ENDOSCOPE INTRODUCED PROXIMAL TO DUODENUM; NOT OTHERWISE SPECIFIED</td>
</tr>
<tr>
<td>00732</td>
<td>ANESTHESIA FOR UPPER GASTROINTESTINAL ENDOSCOPIC PROCEDURES, ENDOSCOPE INTRODUCED PROXIMAL TO DUODENUM; ENDOSCOPIC RETROGRADE CHOLANGIOPANCREATOGRAPHY (ERCP)</td>
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<tr>
<td>00811</td>
<td>ANESTHESIA FOR LOWER INTESTINAL ENDOSCOPIC PROCEDURES, ENDOSCOPE INTRODUCED DISTAL TO DUODENUM; NOT OTHERWISE SPECIFIED</td>
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</table>
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.

**ASA Physical Classification System**

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<tr>
<th>ASA PS Classification</th>
<th>Definition</th>
<th>Examples, including, but not limited to:</th>
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<tr>
<td>ASA I</td>
<td>A normal healthy patient</td>
<td>Healthy, non-smoking, no or minimal alcohol use</td>
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<tr>
<td>ASA II</td>
<td>A patient with mild systemic disease</td>
<td>Mild diseases only without substantive functional limitations. Examples include (but not limited to): current smoker, social alcohol drinker, pregnancy, obesity (30&lt;BMI&lt;40), well-controlled DM/HTN, mild lung disease</td>
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<tr>
<td>ASA III</td>
<td>A patient with severe systemic disease</td>
<td>Substantive functional limitations; One or more moderate to severe diseases. Examples include (but not limited to):</td>
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<tr>
<td>ASA IV</td>
<td>A patient with severe systemic disease that is a constant threat to life</td>
<td>Examples include, (but not limited to): recent (&lt;3 months) MI, CVA, TIA, or CAD/stents, ongoing cardiac ischemia or severe valve dysfunction, severe reduction of ejection fraction, sepsis, DIC, ARD or ESRD not undergoing regularly scheduled dialysis</td>
</tr>
<tr>
<td>ASA V</td>
<td>A moribund patient who is not expected to survive without the operation</td>
<td>Examples include (but not limited to): 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</td>
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<tr>
<td>ASA VI</td>
<td>A declared brain-dead patient whose organs are being removed for donor purposes</td>
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*The edition of “E” denotes Emergency surgery: (An emergency is defined as existing when delay in treatment of the patient would lead to a significant increase in the threat to life or body part)*
### STOP-Bang questionnaire

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<tr>
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<th>Yes</th>
<th>No</th>
<th>Question</th>
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|   |     |    | **Snoring?**  
| Box| Yes | No | Do you **snore loudly** (loud enough to be heard through closed doors, or your bed partner elbows you for snoring at night)? |
|   | Yes | No | **Tired?**  
| Box|     |    | Do you often feel **tired, fatigued, or sleepy** during the daytime (such as falling asleep during driving)? |
|   | Yes | No | **Observed?**  
| Box|     |    | Has anyone **observed** you **stop breathing** or **choking/gasping** during your sleep? |
|   | Yes | No | **Pressure?**  
| Box|     |    | Do you have or are being treated for **high blood pressure**? |
|   | Yes | No | **Body mass index more than 35 kg/m²?** |
|   | Yes | No | **Age older than 50 years old?** |
|   | Yes | No | **Neck size large? (measured around Adam's apple)**  
| Box|     |    | For male, is your shirt collar 17 inches or larger?  
| Box|     |    | For female, is your shirt collar 16 inches or larger? |
|   | Yes | No | **Gender = Male?** |

**Scoring criteria***

For general population

- **Low risk of OSA:** Yes to 0 to 2 questions
- **Intermediate risk of OSA:** Yes to 3 to 4 questions
- **High risk of OSA:** Yes to 5 to 8 questions