



Anesthesia Services for Gastrointestinal Endoscopic Procedures

I. Policy

University Health Alliance (UHA) will reimburse for anesthesia services for gastrointestinal endoscopic procedures when it is determined to be medically necessary and when it meets the medical criteria guidelines (subject to limitations and exclusions) indicated below.

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. 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."

II. Criteria/Guidelines

- A. Monitored anesthesia care (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. ASA P3 (see ASA table) 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. 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
 - 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. Criteria applies regardless if the CPAP is currently being used by the patient.
 - iii. Suspected OSA, in the absence of a sleep study, in a patient who requires an endoscopic procedure, and has a BMI of at least 30. The patient must have a "high risk of OSA" as defined by generally accepted objective criteria and such criteria must be documented in the medical record..
 - f. Chronic severe psychiatric disorder, e.g., schizophrenia, bipolar disorder major depressive disorder that impedes ability to safely cooperate with procedure
 - g. Patient has increased risk of aspiration due to foreign body, retained food, gastroparesis, achalasia or ascites.
 - h. Type 1 diabetes or 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 jejunostomy, esophageal stenting, endoscopic mucosal resection of the upper gastrointestinal tract, esophageal ablation procedures, endoscopic ultrasound of the upper GI tract, and colonic stenting.
 - a. 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. Chronic use of benzodiazepines is defined as use for two months or more at therapeutic dose.

- iii. Chronic and significant substance abuse/dependence documented in the patient's medical records
 - Alcohol abuse/dependence, i.e., greater than 14 standard drinks per week in men under age 65, or 7 standard drinks per week in women and in men age 65 and older, documented in the patient's medical records
 - Chronic 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)
- 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.
- i. 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 documented prolonged vomiting requiring hospitalization or an extended outpatient stay. .
4. Documented history of severe problems with anesthesia and sedation (e.g., malignant hyperthermia, difficult intubation, difficult mask ventilation) Risk of airway obstruction
- a. Increased risk of airway obstruction in a patient who has documentation of the following:
 - i. Stridor, dysmorphic facial features, oral abnormalities (e.g. macroglossia), neck abnormalities (e.g. neck mass), or jaw abnormalities (e.g. micrognathia),
 - ii. Is expected to require more than moderate procedural sedation; or
 - b. Is at increased risk for sedation due to obesity with a BMI of 35 or more, 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
7. ASA P4 or P5 (see ASA table)
- B. General anesthesia with endotracheal intubation may be medically necessary for many advanced endoscopic procedures, including peroral endoscopic myotomy (POEM), endoscopic drainage of a pancreatic pseudocyst, and application of clips or glue for treatment of gastroesophageal fistulae, endoscopic retrograde cholangiopancreatography (ERCP), endoscopic ultrasound, esophageal stricture dilatation and stenting, treatment of esophageal varices, and various other specialized procedures.

NOTE:

This UHA payment policy is a guide to coverage, the need for prior authorization and other administrative directives. It is not meant to provide instruction in the practice of medicine and it should not deter a provider from expressing his/her judgment.

Even though this payment policy may indicate that a particular service or supply is considered covered, specific provider contract terms and/or members' individual benefit plans may apply, and this policy is

not a guarantee of payment. UHA reserves the right to apply this payment policy to all UHA companies and subsidiaries.

UHA understands that opinions about and approaches to clinical problems may vary. Questions concerning medical necessity (see Hawaii Revised Statutes §432E-1.4) are welcome. A provider may request that UHA reconsider the application of the medical necessity criteria in light of any supporting documentation.

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 that is not expected to limit patient's ability to safely cooperate with the procedure.
 - 2. Patients with a low pain threshold.
 - 3. Anticipated requirement for "deep sedation", difficulty in sedation, or the need for general anesthesia in a routine endoscopic procedure in a low risk patient, with no prior history of difficulty with sedation and/or no supporting documentation.
 - 4. Expected consequences of routine gastrointestinal preparation, e.g., mild volume depletion from the 'nothing by mouth' (NPO) status or colonoscopy prep.
- 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. Prior authorization for anesthesia services for endoscopic procedures is not required.
- B. When anesthesia services are coordinated by the gastroenterologist or his/her support staff and the criteria for coverage as stated in this policy are clearly not met, it is expected that the anesthesia provider will be informed that their services do not meet UHA criteria for payment.
- C. Documentation supporting the medical necessity should be legible, maintained in the patient's medical record, and must be made available to UHA upon request. UHA reserves the right to perform retrospective review using the above criteria to validate if services rendered met payment determination criteria and to ensure proper reimbursement is made.
- D. Member Agreement of Financial Responsibility – If there is a reasonable expectation that the criteria in this policy are/will not be met, and the member requests anesthesia services from an anesthesiologist or certified registered nurse anesthetist (CRNA), or the endoscopist routinely utilizes such anesthesia service, the patient must be informed of the financial implications. UHA will process the claim to indicate member responsibility for payment for this separate anesthesia service.
- E. **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

CPT Code	Description
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
00812	Anesthesia for lower intestinal endoscopic procedures, endoscope introduced distal to duodenum; screening colonoscopy
00813	Anesthesia for combined upper and lower gastrointestinal endoscopic procedures, endoscope introduced both proximal to and distal to the duodenum

V. Policy History

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