Clinical Policy: Monitored Anesthesia Care for Gastrointestinal Endoscopy

Reference Number: CP.MP.161 Coding Implications
Last Review Date: 05/18 Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description

Administering conscious sedation for gastrointestinal (GI) endoscopic procedures is standard of care to relieve patient anxiety and discomfort, improve outcomes of the examination, and decrease the memory of the procedure. Generally, the gastroenterologist performing the procedure and/or his/her qualified assistant can adequately manage the administration of conscious sedation and monitoring of the patient. However there are cases when additional assistance from an anesthesia team member is required to perform monitored anesthesia care (MAC) to ensure the safest outcome for the patient. This policy outlines the indications for when MAC is considered medically necessary.

Policy/Criteria

I. It is the policy of health plans affiliated with Centene Corporation® that MAC for GI endoscopic procedures is considered **medically necessary** for the following indications:

A. Age < 18 years or > 70 years;
B. Pregnancy;
C. Increased risk of complications due to physiological status as identified by the American Society of Anesthesiologist (ASA) physical status classification of ASA III or higher;
D. Increased risk for airway obstruction because of anatomic variants such as dysmorphic facial features, oral abnormalities, neck abnormalities, or jaw abnormalities;
E. History of or anticipated intolerance to conscious sedation (i.e. chronic opioid or benzodiazepine use);
F. History of drug or alcohol abuse;
G. Morbid obesity (BMI > 40);
H. Documented sleep apnea;
I. Other surgery scheduled on same day of procedure;
J. Prolonged or therapeutic endoscopic procedure requiring deep sedation (examples include patients with adhesions after abdominal surgery, stent placement in the upper GI tract, and complex therapeutic procedures such as plication of the cardioesophageal junction. Polyp removal would not be considered a prolonged procedure).

Background

Monitored anesthesia care has been defined by the American Society of Anesthesiologist (ASA). "Monitored anesthesia care is a specific anesthesia service for a diagnostic or therapeutic procedure. Indications for monitored anesthesia care include the nature of the procedure, the patient's clinical condition and/or the potential need to convert to a general or regional anesthetic." It includes a preprocedure consult, intraprocedure care, and postprocedure management. "The provider of monitored anesthesia care must be prepared and qualified to convert to general anesthesia when necessary. If a patient loses consciousness and the ability to respond purposefully, the anesthesia care is a general anesthetic, irrespective of whether airway instrumentation is required."

During moderate sedation/analgesia, also known as conscious sedation, a physician administers or supervises the administration of the sedation used during a diagnostic or therapeutic procedure. The sedation is intended to depress the level of consciousness to a moderate level of sedation to allow for comfort and cooperation of the patient, as well as the successful performance of a diagnostic or therapeutic procedure. The physician administering or overseeing the conscious sedation must be qualified to identify sedation that is to "deep" and manage the consequences and adjust the sedation to a lesser level.

While both conscious sedation and MAC require the administration of sedation and monitoring of cardiac and respiratory function, the administrator of MAC must be prepared and qualified to convert to general anesthesia as well as support the patient's airway from any sedation-induced compromise. Patients at increased risk for the need to convert to general anesthesia or for airway support include those with significant comorbidities, increased sensitivity to sedative and analgesic medications, and those undergoing prolonged or complex therapeutic procedures.

American Society of Anesthesiologists classification system for assessing a patient before surgery:
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 harvested

American Society for Gastrointestinal Endoscopy (ASGE)[6]
Anesthesia provider assistance should be considered in the following situations:
- Prolonged or therapeutic endoscopic procedures requiring deep sedation
- Anticipated intolerance to standard sedatives
- Increased risk for adverse event because of severe comorbidity (ASA class IV or V)
- Increased risk for airway obstruction because of anatomic variant

Several factors that may determine whether the assistance of anesthesia providers is needed include patient specific risk factors for sedation, the planned depth of sedation, and the urgency and type of endoscopic procedure performed. Patient risk factors include significant medical conditions such as extremes of age; severe pulmonary, cardiac, renal, or hepatic disease; pregnancy; the abuse of drugs or alcohol; uncooperative patients; a potentially difficult airway for positive-pressure ventilation; and individuals with anatomy that is associated with more difficult intubation.

For lower-risk patients (ASA I-III) undergoing non-advanced endoscopic procedures such as elective colonoscopy and EGD, recent large population–based studies found a higher risk of aspiration and other unplanned cardiopulmonary events in patients receiving deep sedation with propofol as administered by anesthesiologists, when compared with patients who received lighter sedation as administered by endoscopists.[7]

Coding Implications

This clinical policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT codes and descriptions are copyrighted 2018, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from the current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this clinical policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

CPT® Codes	Description
00731	Anesthesia for upper gastrointestinal endoscopic procedures, endoscope introduced proximal to duodenum; not otherwise specified
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

HCPCS Codes	Description
N/A	

ICD-10-CM Diagnosis Codes that Support Coverage Criteria

ICD-10-CM Code	Description
E66.01-E66.09	Obesity due to excess calories
F01.50-F09	Mental disorders due to known physiological conditions
F10.10-F19.99	Mental and behavioral disorders due to psychoactive substance use
F20.0-F29	Schizophrenia, schizotypal, delusional, and other non-mood psychiatric disorders
F30.10-F39	Mood (affective) disorders
F40.00-F48.9	Anxiety, dissociative, stress –related, somotoform and other nonpsychotic mental disorders
F50.00-F59	Behavioral syndromes associated with physiological disturbances and physical factors
F60.0-F69	Disorders of adult personality and behavior
F70-F79	Intellectual Disabilities
F80.0-F89	Pervasive and specific developmental disorders
F90.0-F99	Behavioral and emotional disorders with onset usually occurring in childhood and adolescence
G30.0-G30.9	Alzheimer's disease
G31.01	Pick's disease
G31.09	Other frontotemporal dementia

ICD-10-CM Code	Description
G31.1	Senile degeneration of brain, not elsewhere classified
G31.83	Dementia with Lewy bodies
G47.30	Sleep apnea, unspecified
G47.31	Primary central sleep apnea
G47.33	Obstructive sleep apnea (adult) (pediatric)
G47.37	Central sleep apnea in conditions classified elsewhere
G47.39	Other Sleep apnea
G62.1	Alcoholic polyneuropathy
I42.6	Alcoholic cardiomyopathy
K29.20	Alcoholic gastritis without bleeding
K29.21	Alcoholic gastritis with bleeding
K70.0-K70.40	Alcoholic liver disease
K70.9	Alcoholic liver disease, unspecified
M26.02	Maxillary hypoplasia
M26.04	Mandibular hypoplasia
O09.00-O09.93	Supervision of high risk pregnancy
O10.011-O16.9	Edema, Proteinuria and hypertensive disorders in pregnancy, childbirth and the puerperium
O20.0-O29.93	Other maternal disorders predominately related to pregnancy
O30.001-O48.1	Maternal care related to the fetus and amniotic cavity and possible delivery problems
O98.011-O9A.	Maternal infectious and parasitic diseases classifiable elsewhere but complicationg pregnancy, childbirth and the puerperium
P04.3	Newborn affected by maternal use of alcohol
P04.41	Newborn affected by maternal use of cocaine
P04.49	Newborn affected by maternal use of other drugs of addiction
P28.3	Primary sleep apnea of newborn
P96.1	Neonatal withdrawal symptoms from maternal use of drugs of addiction
P96.2	Withdrawal symptoms from therapeutic use of drugs in newborn
Q18.9	Congenital malformation of face and neck, unspecified
Q38.2	Macroglossia
Q86.0	Fetal alcohol syndrome (dysmorphic)
R06.1	Stridor
R22.1	Localized swelling, mass and lump, neck
R41.81	Age-related cognitive decline
R41.83	Borderline intellectual functioning
R45.0-R45.7	Symptoms and signs involving emotional state
R45.89	Other symptoms and signs involving emotional state
R46.0-R46.89	Symptoms and signs involving appearance and behavior
R48.81-R45.89	Other symptoms and signs involving emotional state
R46.0-R46.89	Symptoms and signs involving appearance and behavior

ICD-10-CM Code	Description
R54	Age-related physical debility
T14.91	Suicide attempt
T36.0X1+-T50.996	Poisoning by, adverse effects of and underdosing of drugs, medicaments and biological substances
T51.0X1+-T65.94	Toxic effects of substances chiefly nonmedicinal as to source
T71.111+-T71.9	Asphyxiation
X71.0XX+-X83.8XX+	Intentional self-harm
Z72.810	Child and adolescent antisocial behavior
Z72.811	Adult antisocial behavior
Z86.59	Personal history of other mental and behavioral disorders
Z87.891	Personal history of nicotine dependence
Z91.5	Personal history of self-harm
Z91.83	Wandering in diseases classified elsewhere

Reviews, Revisions, and Approvals	Date	Approval Date
Policy developed and approved	05/18	05/18

References

1. American Society of Anesthesiologist (ASA). ASA physical status classification system. Last approved Oct 15, 2014. https://www.asahq.org/resources/clinical-information/asa-physical-status-classification-system
2. American Society of Anesthesiologist. Distinguishing monitored anesthesia care ("MAC") from moderate sedation/analgesia (conscious sedation). Reaffirmed Oct 16, 2013.
3. Lichtenstein DR et al, Guideline from the Standards of Practice Committee of the American Society for Gastrointestinal Endoscopy, "Sedation and Anesthesia in GI Endoscopy," Gastrointestinal Endoscopy, Vol 68, #5 2008.
4. National Guideline Clearinghouse. Sedation and anesthesia in GI endoscopy. Accessed on November 14, 2013 at https://www.asge.org/docs/default-source/education/practice_guidelines/piis0016510717321119.pdf?sfvrsn=4.
5. ASGE Standards of Practice Committee, Early DS, Lightdale JR, et al. Guidelines for sedation and anesthesia in GI endoscopy. Gastrointest Endosc. 2018 Feb;87(2):327-337. doi: 10.1016/j.gie.2017.07.018.
6. Vargo JJ, Niklewski PJ, Williams JL, et al. Patient safety during sedation by anesthesia professionals during routine upper endoscopy and colonoscopy: an analysis of 1.38 million procedures. Gastrointest Endosc. 2017 Jan;85(1):101-108. doi: 10.1016/j.gie.2016.02.007.

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and

accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

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Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs, LCDs, and Medicare Coverage Articles should be reviewed prior to applying the criteria set forth in this clinical policy. Refer to the CMS website at http://www.cms.gov for additional information.