Subject: Monitored Anesthesia Care for Gastrointestinal Endoscopic Procedures

Background: Monitored Anesthesia Care (MAC) is anesthesia care involves a drug-induced depression of consciousness during which the patient may respond purposefully to verbal commands (either alone or accompanied by light tactile stimulation), and requires monitoring of the patient by a practitioner who is qualified to administer anesthesia. Typically, cardiovascular function is maintained, and no interventions to maintain a patent airway are required. (Spontaneous ventilation is usually adequate.)

- Indications for MAC depend on the nature of the procedure, the patient’s clinical condition, and/or the potential need to convert to a general or regional anesthetic.

Policy and Coverage Criteria:
Harvard Pilgrim Health Care (HPHC) considers monitored anesthesia care (MAC) for elective upper and lower endoscopy for members with a higher risk for sedation-related complications.

Monitored anesthesia care for upper or lower gastrointestinal (GI) endoscopy is considered medically necessary for members presenting with ANY of the following:

- Member is under 18 years of age; OR
- Member is over 70 years of age; OR
- Member is pregnant; OR
- Increased risk for complications due to severe co-morbidity corresponding to the American Society of Anesthesiologists (ASA) Physical Status Modifier of P2 or greater; OR
- Increased risk for airway obstruction due to anatomic variation, such as:
  - History of stridor;
  - Dysmorphic facial features;
  - Oral abnormalities (e.g. macroglossia);
  - Neck abnormalities (e.g. neck mass);
  - Jaw abnormalities (e.g. micrognathia); OR
- Member has one of the following:
  - History of adverse reaction to sedation;
  - History of inadequate response to sedation;
  - Obstructive sleep apnea;
  - Morbid obesity (e.g. BMI >40)
  - Active or history of alcohol or substance abuse

Exclusions: Harvard Pilgrim Health Care (HPHC) considers Monitored Anesthesia Care for GI endoscopy as not medically necessary when above indications are not met.

Supporting Information:
In 2008, the American Society for Gastrointestinal Endoscopy published a guideline outlining appropriate use of sedation and anesthesia in GI endoscopy, updated in 2018. The guideline notes the routine use of MAC for average-risk patients undergoing standard upper and lower GI endoscopy is not appropriate. Typical patient risk factors indicating monitored anesthesia care lists are significant medical conditions such as extremes of age; severe pulmonary, cardiac, renal, or hepatic diseases; pregnancy; history of substance abuse; uncooperative behavior; potentially difficult airways for positive-pressure ventilation; and anatomy that is associated with more difficult intubation.
The American College of Gastroenterology states that healthy, low risk patients derive no increase in safety or procedural efficacy from anesthesiologist-administered sedation while incurring higher costs.

The American Society of Anesthesiologists Position on Monitored Anesthesia Care (2013) states that use of monitored anesthesia is indicated by a need for deeper sedation/analgesia than moderate sedation, such as with patient condition or nature of a procedure.

**Guidelines:**

**American Society of Anesthesiologists (ASA) Physical Status Modifiers**

- 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 remove for donor purposes

**Coding:**

Codes are listed below for informational purposes only, and do not guarantee member coverage or provider reimbursement. The list may not be all-inclusive. Deleted codes and codes which are not effective at the time the service is rendered may not be eligible.

<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>
</tr>
<tr>
<td>00811</td>
<td>Anesthesia for lower intestinal endoscopic procedures, endoscope introduced distal to duodenum, not otherwise specified</td>
</tr>
<tr>
<td>00813</td>
<td>Anesthesia for combined upper and lower gastrointestinal endoscopic procedures, endoscope introduced both proximal to and distal to the duodenum</td>
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**List of medically necessary ICD-10 Codes**

**Billing Guidelines:**

Member’s medical records must document that services are medically necessary for the care provided. Harvard Pilgrim Health Care maintains the right to audit the services provided to our members, regardless of the participation status of the provider. All documentation must be available to HPHC upon request. Failure to produce the requested information may result in denial or retraction of payment.

**References:**

1. American Society of Anesthesiologists.
   - Position on Monitored Anesthesia Care; 10/17/18
   - Statement on Anesthesia Care for Endoscopic Procedures; 10/15/14
   - Statement on Safe Use of Propofol; 10/15/14
   - Distinguishing Monitored Anesthesia Care from Moderate Sedation Analgesia; 10/16/13

   - Sedation and Anesthesia in GI Endoscopy; 2018
   - Position Statement: Non-Anesthesiologist Administration of Propofol for GI Endoscopy; 2009
   - Modifications in endoscopic practice for pediatric patients; 2014
   - Modifications in endoscopic practice for the elderly; 2013
   - Guideline for Endoscopy in Pregnant and Lactating Women; 2012

Summary of Changes:

<table>
<thead>
<tr>
<th>Date</th>
<th>Change</th>
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<tbody>
<tr>
<td>4/19</td>
<td>Co-morbidity requirement adjusted, supporting information updated</td>
</tr>
<tr>
<td>10/18</td>
<td>Code 00812 was removed from the policy</td>
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<tr>
<td>2/18</td>
<td>Complications risk updated, coding updated</td>
</tr>
<tr>
<td>9/17</td>
<td>Coding update</td>
</tr>
<tr>
<td>8/16</td>
<td>Updated language and members being covered</td>
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Approved by Medical Policy Committee: 4/9/19
Approved by Clinical Policy Operational Committee: 8/16; 9/17, 2/18, 10/18, 4/19
Policy Effective Date: 7/1/2019
Initiated: 1/16