



## 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.

### **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 or P4 (see Item D under Administrative Guidelines for definitions) 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 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
    - 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 generally accepted objective criteria and such criteria must be documented in the medical record. This is applicable only when there is an urgent need for a diagnostic or therapeutic endoscopic procedure.
  - f. Psychiatric disorder: 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. 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
      - 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
      - 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)
  - 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 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 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

- 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. For other advanced endoscopic procedures, practice varies (e.g., for ERCP). Advanced endoscopic procedures include 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 without supporting documentation 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" or general anesthesia in a routine endoscopic procedure in a low risk patient, with no prior history of difficulty with sedation.
  - 4. Expected consequences of routine gastrointestinal preparation, e.g., mild volume depletion from the nothing by mouth (NPO) status or colonoscopy prep.
  - 5. Anticipated difficulty to sedate without supporting documentation.
- 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 is not required.
- B. UHA reserves the right to perform retrospective review using the above criteria to validate that services rendered met payment determination.
- C. 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 requires an anesthesia service, the member should complete and sign the **Agreement of Financial Responsibility** at least 24 hours prior to the procedure. 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. The Member Agreement of Financial Responsibility needs to be kept on file by the endoscopist and anesthesia provider. If the Member Agreement of Financial Responsibility is completed on the day of service, UHA will not consider it to be valid and the patient will not be financially responsible for the anesthesia service.
- D. **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**

**Policy Number:** MPP-0033-120301

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