See Policy CPT/HCPCS CODE section below for any prior authorization requirements

**SCOPE:**

Providence Health Plan, Providence Health Assurance, Providence Plan Partners, and Ayin Health Solutions as applicable (referred to individually as “Company” and collectively as “Companies”).

**APPLIES TO:**

All lines of business

**BENEFIT APPLICATION**

Medicaid Members

*Oregon*: Services requested for Oregon Health Plan (OHP) members follow the OHP Prioritized List and Oregon Administrative Rules (OARs) as the primary resource for coverage determinations. Medical policy criteria below may be applied when there are no criteria available in the OARs and the OHP Prioritized List.

**POLICY CRITERIA**

**Note:**

This policy applies to:

- Ambulatory Surgical Centers (ASCs),
- Off Campus-Outpatient Hospital (location 19), and
- Non-Hospital Based Outpatient Surgery Departments

**Note:** This policy does not address the use of monitored anesthesia care (MAC) or general anesthesia performed as part of a *screening* endoscopy.

1. In patients 18 years or younger, monitored anesthesia care (MAC) or general anesthesia, provided by anesthesiology personnel, may be considered **medically necessary and covered** when performed as part of a diagnostic endoscopy.
II. In patients 19 years or older, monitored anesthesia care (MAC) or general anesthesia, provided by anesthesiology personnel, may be considered medically necessary and covered in specific circumstances, when performed as part of a diagnostic endoscopy and all of the following criteria are met (A.-D.):

A. The anesthesiology care service rendered must be appropriate and medically reasonable and necessary; and

B. MAC or general anesthesia should be provided by qualified anesthesia personnel, (anesthesiologists or qualified anesthetists such as certified registered nurse anesthetists or anesthesia assistants). These individuals must be continuously present to monitor the patient and provide anesthesia care; and

C. Documentation of at least one of the qualifying criteria below (1.-5.) must be submitted with the request for consideration. Patients who meet the following criteria may be considered for approval for anesthesiology specialist care; however, the majority of patients undergoing diagnostic endoscopy will not require the care of an anesthesiology specialist.:

1. Patients who have had a previous failure to complete the procedure or a procedure completed with great difficulty utilizing standard moderate sedation protocols. Records from the prior procedure and Gastroenterologist notes will be required for review; and/or

2. Patients who are known to have or are predicted to have documented difficult airways. Documentation from previous anesthesia provider may be required for review. Difficult airways may include, but are not limited to the following:
   - Reactive airway disease
   - BMI ≥ 40
   - STOP-BANG score of 4 or higher; and/or

3. Patients with anticipated intolerance of standard sedatives (e.g., known alcohol or known substance use). Documentation of Medications and substances along with quantities will be required for review. Chronic use of standard doses of sedative medications will not meet criteria; and/or

4. Patients being treated for moderate to severe sleep apnea. Moderate sleep apnea is defined as having an AHI (calculated to Medicare standards) of ≥ 15; and/or

5. Patients with asthma or lung disease; and

D. The patient has none of the following contraindications (1.-3.):

1. Procedural anxiety is not a qualifying condition for the addition of an anesthesiology provider to the care team; or

2. The presence of an underlying condition alone, as reported by an ICD-10-CM code, may not be sufficient evidence that moderate sedation is necessary; or

3. The medical condition is not significant enough to impact the need to provide moderate sedation. The presence of a stable, treated condition of itself is not necessarily sufficient. In the case of patients who are significantly impaired or potentially unstable, consideration should be given to performing the procedure in a hospital based facility.
III. The routine assistance of an anesthesiologist/anesthetist for average risk patients undergoing standard diagnostic upper and lower endoscopy procedures is not medically necessary and not covered.

BILLING GUIDELINES

- This policy applies to:
  - Ambulatory Surgical Centers (ASCs),
  - Off Campus-Outpatient Hospital (location 19), and
  - Non-Hospital Based Outpatient Surgery Departments
- Off-Campus locations, including portions of an off-campus hospital provider based department which provides diagnostic, therapeutic (both surgical and non-surgical), services to sick or injured persons who do not require hospitalization or institutionalization, require prior authorization.
- The Prior-authorization request must be submitted by a gastroenterology clinic.
- Please see “Providence Health Plans Payment Policy (09.0) – Anesthesia” for additional information.

CPT CODES

<table>
<thead>
<tr>
<th>All Lines of Business</th>
<th>Prior Authorization Required</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>00731</strong></td>
<td>Anesthesia for upper gastrointestinal endoscopic procedures, endoscope introduced proximal to duodenum; not otherwise specified</td>
</tr>
<tr>
<td><strong>00732</strong></td>
<td>Anesthesia for upper gastrointestinal endoscopic procedures, endoscope introduced proximal to duodenum; endoscopic retrograde cholangiopancreatography (ERCP)</td>
</tr>
<tr>
<td><strong>00811</strong></td>
<td>Anesthesia for lower intestinal endoscopic procedures, endoscope introduced distal to duodenum; not otherwise specified</td>
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</tbody>
</table>

| No Prior Authorization Required |
| **00813** | Anesthesia for combined upper and lower gastrointestinal endoscopic procedures, endoscope introduced both proximal to and distal to the duodenum |

DESCRIPTION

Monitored anesthesia care does not describe the continuum of depth of sedation; rather it describes “a specific anesthesia service in which an anesthesiologist has been requested to participate in the care of a patient undergoing a diagnostic or therapeutic procedure.”¹

According to the 2013 American Society of Anesthesiologists position statement on monitored anesthesia care:
“Monitored anesthesia care includes all aspects of anesthesia care – a pre-procedure visit, intra-
procedure care and post procedure anesthesia management. During monitored anesthesia care, the
anesthesiologist provides or medically directs a number of specific services, including but not limited to:

- Diagnosis and treatment of clinical problems that occur during the procedure
- Support of vital functions
- Administration of sedatives, analgesics, hypnotics, anesthetic agents or other
- Medications as necessary for patient safety
- Psychological support and physical comfort
- Provision of other medical services as needed to complete the procedure safely.

Monitored anesthesia care (MAC) may include varying levels of sedation, analgesia and anxiolysis as
necessary. The provider of monitored anesthesia care must be prepared and qualified to convert to
general anesthesia when necessary. If the patient loses consciousness and the ability to respond
purposefully, the anesthesia care is a general anesthetic, irrespective of whether airway instrumentation
is required.”

MAC as well as general and regional anesthesia should be provided by qualified anesthesiology
personnel, (anesthesiologists or qualified anesthetists such as certified registered nurse anesthetists or
anesthesia assistants).

Definitions of General Anesthesia and Levels of Sedation/Analgesia

According to the 2014 American Society of Anesthesiologists definition guideline:

- **Minimal Sedation (Anxiolysis)** is a drug-induced state during which patients respond normally to
  verbal commands. Although cognitive function and physical coordination may be impaired, airway
  reflexes, and ventilatory and cardiovascular functions are unaffected.

- **Moderate Sedation/Analgesia (“Conscious Sedation”)** is a drug-induced depression of
  consciousness during which patients respond purposefully** to verbal commands, either alone
  or accompanied by light tactile stimulation. No interventions are required to maintain a patent
  airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained.

- **Deep Sedation/Analgesia** is a drug-induced depression of consciousness during which patients
  cannot be easily aroused but respond purposefully** following repeated or painful stimulation.
  The ability to independently maintain ventilatory function may be impaired. Patients may require
  assistance in maintaining a patent airway, and spontaneous ventilation may be inadequate.
  Cardiovascular function is usually maintained.

- **General Anesthesia** is a drug-induced loss of consciousness during which patients are not
  arousable, even by painful stimulation. The ability to independently maintain ventilatory function
  is often impaired. Patients often require assistance in maintaining a patent airway, and positive
  pressure ventilation may be required because of depressed spontaneous ventilation or drug-
  induced depression of neuromuscular function. Cardiovascular function may be impaired.
Because sedation is a continuum, it is not always possible to predict how an individual patient will respond. Hence, practitioners intending to produce a given level of sedation should be able to rescue patients whose level of sedation becomes deeper than initially intended. Individuals administering Moderate Sedation/Analgesia (“Conscious Sedation”) should be able to rescue patients who enter a state of Deep Sedation/Analgesia, while those administering Deep Sedation/Analgesia should be able to rescue patients who enter a state of General Anesthesia.”

**CLINICAL PRACTICE GUIDELINES**

American Society for Gastrointestinal Endoscopy (ASGE)

In 2018, the ASGE published evidence-based guidelines for sedation and anesthesia in GI endoscopy. Investigators made the following recommendations:

1. We recommend that all patients undergoing endoscopic procedures be evaluated to assess their risk of sedation related to pre-existing medical conditions. (*high quality evidence*)

2. We recommend that the combination of an opioid and benzodiazepine is a safe and effective regimen for achieving minimal to moderate sedation for upper endoscopy and colonoscopy in patients without risk factors for sedation-related adverse events. (*high quality evidence*)

3. We suggest using an appropriate adjunctive agent (e.g., diphenhydramine, promethazine, or droperidol) in combination with conventional sedative drugs in select clinical circumstances. (*low quality evidence*)

4. We recommend that providers undergo specific training in the administration of endoscopic sedation and possess the skills necessary for the diagnosis and management of sedation-related adverse events, including rescue from a level of sedation deeper than that intended. (*high quality evidence*)

5. We recommend the routine monitoring of blood pressure, oxygen saturation, and heart rate in addition to clinical observation for changes in cardiopulmonary status during all endoscopic procedures using sedation. Supplemental oxygen administration should be considered for moderate sedation and should be administered during deep sedation. Supplemental oxygen should be administered if hypoxemia is anticipated or develops. (*high quality evidence*).

6. We suggest that capnography monitoring be considered for patients undergoing endoscopy targeting deep sedation. (*low quality evidence*).

7. We recommend anesthesia provider–administered sedation be considered for complex endoscopic procedures or patients with multiple medical comorbidities or at risk for airway compromise. (*moderate quality evidence*)

8. We suggest that endoscopists use propofol-based sedation (endoscopist-directed or anesthesia-provider administered) when it is expected to improve patient safety, comfort, procedural efficiency, and/or successful procedure completion. (*low quality evidence*)

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MED108
INSTRUCTIONS FOR USE

Company Medical Policies serve as guidance for the administration of plan benefits. Medical policies do not constitute medical advice nor a guarantee of coverage. Company Medical Policies are reviewed annually and are based upon published, peer-reviewed scientific evidence and evidence-based clinical practice guidelines that are available as of the last policy update. The Companies reserve the right to determine the application of Medical Policies and make revisions to Medical Policies at any time. Providers will be given at least 60-days notice of policy changes that are restrictive in nature.

The scope and availability of all plan benefits are determined in accordance with the applicable coverage agreement. Any conflict or variance between the terms of the coverage agreement and PHP and PHA Medical Policy will be resolved in favor of the coverage agreement.

REGULATORY STATUS

Mental Health Parity Statement

Coverage decisions are made on the basis of individualized determinations of medical necessity and the experimental or investigational character of the treatment in the individual case.

REFERENCES