



Anesthesia Assistance with Gastrointestinal Endoscopic Procedures

Clinical Coverage Criteria

Overview

All patients undergoing planned gastrointestinal (GI) endoscopic procedures require a pre-procedural evaluation to assess the risks of the procedure and manage problems related to preexisting medical conditions. Selected patients may undergo GI endoscopic procedures without sedation, analgesia, or both however the majority of patients receive some level of sedation and analgesia. The purpose of sedation and analgesia provided with GI endoscopic procedures is to relieve patient anxiety and discomfort and improve the outcome of the examination. The level of sedation and analgesia required to perform endoscopic procedures varies. Patient age, health status, concurrent medications, pre-procedural anxiety, and pain tolerance influence the level of sedation required to achieve the desired result, as do procedural variables such as the degree of invasiveness and the duration of the procedure. Patients should be informed of and agree to the administration of sedation and analgesia with endoscopic procedures, including a discussion of the benefits, risks, limitations, and possible alternatives.

Procedural (standard) sedation refers to the administration of intravenous medications, usually a benzodiazepine and a narcotic, by or under the supervision of the physician performing the procedure. A moderate level of sedation/analgesia is targeted. Most gastrointestinal endoscopic procedures can be performed adequately and safely under standard sedation. At the level of moderate sedation/analgesia, the patient is able to make purposeful responses to verbal or tactile stimulation. Moderate sedation/analgesia is not expected to induce depths of sedation that would impair a patient's cardiovascular function or ability to maintain the integrity of his or her own airway. Because sedation is a continuum, it is not always possible to predict how an individual patient will respond. Non-anesthesiologists providing moderate sedation must be capable of rescuing a patient who unintentionally transitions to deep sedation. Most gastroenterologists in the U.S. administer moderate sedation/analgesia to their patient's undergoing office-based or outpatient endoscopic procedures.

Deep sedation/analgesia may be medically necessary for patients with risk factors for sedation related complications and for patients undergoing prolonged or complex GI endoscopic procedures. The same combinations of medications that are used to achieve moderate sedation/analgesia can be used to achieve deep sedation/analgesia (but in higher doses). In addition, other agents, such as droperidol and propofol, may be used to achieve deep sedation. Because sedation is a continuum, it is not always possible to predict how an individual patient will respond. Practitioners administering deep sedation/analgesia should be trained to rescue patients who enter a state of general anesthesia.

Propofol is an ultra-short acting sedative agent with no analgesic properties which provides sedative and amnesic effects. Propofol is FDA-approved for the induction and maintenance of anesthesia and should be administered only by persons trained in the administration of general anesthesia. Since its introduction in the 1980s, its clinical applications have expanded to include procedural sedation and monitored anesthesia care. Compared to standard sedatives, propofol provides a more rapid onset of action and considerably shorter recovery time.

Monitored anesthesia care (MAC) is a specific anesthesia service provided to a patient undergoing a planned diagnostic or therapeutic procedure. In such a case, the anesthesiologist is in control of the patient's vital signs, and is available to administer general anesthesia or provide other medical care as appropriate. The standard of care for patients receiving MAC is the same as for patients undergoing general anesthesia, and should include a complete preoperative assessment, intraoperative monitoring, and postoperative in the recovery room prior to discharge. The administration of sedation/analgesia is often, but not always, the reason MAC is indicated. In some patients who may only require moderate sedation/analgesia, MAC may be medically necessary because even small doses of sedatives could precipitate adverse responses that would necessitate acute intervention.

Many factors may contribute to the decision to have anesthesiologist-directed sedation for endoscopic procedures. Procedure-related factors include prolonged or therapeutic procedures requiring deep sedation and/or general anesthesia. Patient-related factors are also important. Chief among these are increasing levels of adverse physiology and uncooperative patients. An ASA Physical Status of 4 or greater has been associated with an increased risk of cardiopulmonary complications. The use of sedatives, analgesics, and alcohol can also increase sedation-related risk.

Definitions

Endoscope: A lighted optical instrument used to examine internal organs. An endoscope can be rigid or flexible. Endoscopes are named depending where they are intended to look. Examples include: cystoscope (bladder), nephroscope (kidney), bronchoscope (bronchi), laryngoscope (larynx + the voice box), otoscope (ear), arthroscope (joint), laparoscope (abdomen), and gastrointestinal endoscope.

Minimal sedation: 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 (conscious sedation): A drug-induced depression of consciousness during which patients respond purposefully (reflex withdrawal from a painful stimulus is not considered a purposeful response) 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: 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 respiratory 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: A drug-induced loss of consciousness during which patients are not arousable, even with painful stimulation. The ability to independently maintain respiratory 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.

Policy

Fallon Health requires Prior Authorization for anesthesia assistance for upper GI endoscopy (CPT code 00740) and/or lower GI endoscopy (CPT code 00810).

Anesthesia assistance for plan members without risk factors for sedation-related complications undergoing routine endoscopic procedures has not been shown to improve safety or procedural outcome, Fallon Health considers anesthesia assistance in these circumstances not medically necessary.

Fallon Health expects that physicians and other providers will inform plan members of services they did not know or could not reasonably have been expected to know were not medically necessary (informed consent). Fallon Health recognizes the right of any plan member to receive the services of an anesthesiologist if they desire. Such plan member should sign a statement accepting financial responsibility prior to the procedure.

Fallon Health urges referring physicians to submit a request for prior authorization for anesthesia assistance before scheduling GI endoscopy for a plan member who requires anesthesia assistance with GI endoscopy.

1. Fallon Health considers anesthesiologist-directed sedation medically necessary for GI endoscopic procedures when there is objective evidence in the medical record that demonstrates one of the following patient-related risk factors or significant medical conditions exists:
 - ASA Class III-IV (see below), i.e., severe systemic disease that limits physical activity
 - Anticipated intolerance to regimens used for moderate sedation (i.e., benzodiazepines and/or narcotics), e.g., plan members with a history of long-term use/abuse of benzodiazepines, narcotics, alcohol, or neuropsychiatric medications
 - Age under 18 years (i.e., to the 18th birthday)
 - Uncooperative or extremely agitated plan members, such as plan members with senile dementia
 - Pregnancy
 - Previous problems with anesthesia or sedation
 - Increased risk for airway obstruction or anatomic variant associated with difficult intubation
 - History of stridor or sleep apnea
 - Dysmorphic facial features, such as Pierre-Robin syndrome or Trisomy 21
 - Oral abnormalities, such as a small opening (< 3 cm in an adult), edentulous, protruding incisors, high arched palate, macroglossia, tonsillar hypertrophy, or a nonvisible uvula
 - Neck abnormalities, such as obesity involving the neck and facial structures, short neck, limited neck extension, decreased hyoid-mental distance (< 3 cm in an adult), neck mass, cervical spine disease or trauma, tracheal deviation, or advanced rheumatoid arthritis
 - Jaw abnormalities such as micrognathia, retrognathia, trismus, or significant malocclusion
2. Plan members undergoing prolonged or complex endoscopic procedures requiring deep sedation, such as endoscopic retrograde cholangiopancreatography (ERCP) and endoscopic ultrasoundography (EUS).

ASA Physical Status Classification System

ASA I

Patients are considered to be normal and healthy. Patients are able to walk up one flight of stairs or two level city blocks without distress. Little or no anxiety. Little or no risk.

ASA II

Patients have mild to moderate systemic disease or are healthy ASA I patients who demonstrate a more extreme anxiety and fear toward dentistry. Patients are able to walk up one flight of stairs or two level city blocks, but will have to stop after completion of the exercise because of distress. Minimal risk during treatment. Examples: History of well-controlled disease states including diabetes, hypertension, obesity, epilepsy, asthma, or thyroid conditions; ASA I with a respiratory condition, pregnancy, and/or active allergies.

ASA III

Patients have severe systemic disease that limits physical activity, but is not incapacitating. Patients are able to walk up one flight of stairs or two level city blocks, but will have to stop enroute because of distress. Examples: History of angina pectoris, myocardial infarction, or cerebrovascular accident, congestive heart failure over six months ago, and diabetes with vascular complications, poorly controlled hypertension, morbid obesity.

ASA IV

Patients have severe systemic disease that limits physical activity and is a constant threat to life. Patients are unable to walk up one flight of stairs or two level city blocks. Distress is present even at rest. Patients pose significant risk since patients in this category have a severe medical problem of greater importance to the patient than the planned dental treatment. Whenever possible, elective dental care should be postponed until such time as the patient's medical condition has improved to at least an ASA III classification. Examples: History of unstable angina pectoris, myocardial infarction or cerebrovascular accident within the last six months, severe congestive heart failure, severe chronic obstructive pulmonary disease, uncontrolled diabetes, hypertension, epilepsy, or thyroid condition, advanced pulmonary, renal or hepatic dysfunction.

ASA V

Patients are moribund and are not expected to survive more than 24 hours with or without an operation. These patients are almost always hospitalized, terminally ill patients. Examples: ruptured abdominal aneurysm, pulmonary embolus, head injury with increased intracranial pressure.

ASA VI

Clinically dead patients being maintained for harvesting of organs.

Exclusions

- Propofol administered during a gastrointestinal endoscopic procedures that do not meet Fallon Health's criteria.

Codes

Code type	Code	Description
CPT	00740	Anesthesia for upper gastrointestinal endoscopic procedures, endoscope introduced proximal to duodenum
	00810	Anesthesia for lower intestinal endoscopic procedures, endoscope introduced distal to duodenum

References

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5. Vargo JJ, Bramley T, Meyer K, et al. Practice Efficiency and Economics: The Case for Rapid Recovery Sedation Agents for Colonoscopy in a Screening Population. J Clin Gastroenterol. 2007;41:591-8.
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8. A Joint Statement of a Working Group from the American College of Gastroenterology (ACG), the American Gastroenterological Association (AGA), and the American Society for Gastrointestinal Endoscopy (ASGE). Recommendations on the Administration of Sedation for the Performance of Endoscopic Procedures. March 8, 2004. Available at: <http://www.gastro.org>.
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Policy History

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