BlueCross BlueShield of Vermont

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Monitored Anesthesia Care (MAC) during Gastrointestinal Endoscopy, Bronchoscopy, or Interventional Pain Procedures in Outpatient Settings Corporate Medical Policy

File Name: Monitored Anesthesia Care (MAC) during Gastrointestinal Endoscopy Bronchoscopy, or Interventional Pain Procedures in Outpatient Settings
File Code: 7.02.VT01
Origination: 07/2009
Last Review: 01/2023
Next Review: 01/2024
Effective Date: 02/01/2023

Description/Summary

Monitored anesthesia care (MAC) refers to a set of physician services, not a particular level of sedation. The services include the ability to convert a patient to general anesthesia if needed and to intervene in the event that a patient's airway becomes compromised. Adequate sedation and analgesia are important parts of diagnostic and therapeutic endoscopic procedures. Various levels of sedation and analgesia (anesthesia) may be used, depending on the patient's status and the procedure being performed. This policy addresses the clinical indications and risk factors that might necessitate the presence of dedicated anesthesia providers during procedures performed in a properly equipped and staffed outpatient setting.

Policy

Coding Information

Click the links below for attachments, coding tables & instructions.
Attachment I- CPT® Coding Table & Instructions

When a service may be considered medically necessary

Use of monitored anesthesia care may be considered **medically necessary** for gastrointestinal endoscopy, bronchoscopy, and interventional pain procedures, when there is documentation by the proceduralist and anesthesiologist that specific risk factors or significant medical conditions are present. Those risk factors or significant medical conditions include any of the following:

- Increased risk for complications due to severe comorbidity (ASA III or greater)*
- Morbid obesity (BMI [body mass index] >40)
- Documented sleep apnea
- Inability to follow simple commands (cognitive dysfunction, intoxication, or psychological impairment)
- Spasticity or movement disorder complicating the procedure
- History or anticipated intolerance to standard sedatives, such as:
  - Chronic opioid use
  - Chronic benzodiazepine use
- Documented history of complication or intolerance to previous procedure performed, necessitating the use of monitored anesthesia care with subsequent procedures
- Patients with history of or active alcohol or substance use, or where it is anticipated by the provider that such conditions will necessitate the use of monitored anesthesia
- Patients younger than 18 years or 70 years or older
- Patients who are pregnant
- Patients with increased risk for airway obstruction due to anatomic variation, such as:
  - History of stridor or
  - Dysmorphic facial features such as Pierre-Robin syndrome or Trisomy 21 or
  - Oral abnormalities including but not limited to a small oral opening (less than 3 cm in an adult), high arched palate, macroglossia, or tonsillar hypertrophy of 4+. Neck abnormalities including but not limited to short neck, obesity involving the neck and facial structures, limited neck extension, decreased hyoid-mental distance (less than 3 cm in an adult) neck mass, cervical spine disease or trauma, tracheal deviation, or advance rheumatoid arthritis; or
  - Jaw abnormalities including but not limited to micrognathia, retrognathia, trismus, or significant malocclusion.
- Acutely agitated, uncooperative patients
- Prolonged or therapeutic gastrointestinal endoscopy procedures requiring deep sedation (see Policy Guidelines section).

*American Society of Anesthesiologists (ASA) Physical Status Classification System for assessing a patient before surgery:

ASA I – A normal, healthy patient
ASA II – A patient with mild systemic disease
ASA III - A patient with severe systemic disease
ASA IV – A patient with severe systemic disease that is a constant threat to life
ASA V – A moribund patient who is not expected to survive without the operation
ASA VI – A declared brain-dead patient whose organs are being harvested

In order to support access to appropriate preventive services we will allow monitored anesthesia care if it is the only form of anesthesia offered within a 60 minute drive of the member's home.

When a service is considered not medically necessary

Use of monitored anesthesia care is considered **not medically necessary** for gastrointestinal endoscopic, bronchoscopic, or interventional pain procedures in patients at average risk related to use of anesthesia and sedation.

Policy Guidelines

Monitored anesthesia care can be provided by qualified anesthesia personnel with training and experience in:

- Patient assessment
- Continuous evaluation and monitoring of patient physiological functions
- Diagnosis and treatment (both pharmacological and non-pharmacological) of any and all deviations in physiological function.

Examples of prolonged (greater than 30 minutes) endoscopy procedures that may require deep sedation include:

- adhesions or strictures post-abdominal surgery or as a result of medical disease
- endoscopic retrograde cholangiopancreatography
- esophageal ultrasound
- history of removal of numerous large (>=10mm in diameter) polyps
- stent placement in the upper GI tract
- complex therapeutic procedures such as plication of the cardioesophageal junction

The Mallampati score is considered a predictor of difficult tracheal intubation and is routinely used in preoperative anesthesia evaluation. The score is obtained by having the patient extend the neck, open the mouth, and extend the tongue while in a seated position. Patients are scored from Class 1-4 as follows:

Class I - the tonsils, uvula and soft palate are fully visible
Class 2 - the hard and soft palate, uvula and upper portion of the tonsils are visible
Class 3 - the hard and soft palate and the uvula base are visible
Class 4 - only the hard palate is visible.

Patients with Class 3 or 4 Mallampati scores are considered to be at higher risk of intubation difficulty. The Mallampati score alone does not determine a need for monitored anesthesia care. The Mallampati score should be used in combination with other factors in determining risk for airway obstruction. Other tests to predict difficult tracheal intubation include the upper lip bite test (scores of 3 or 4 suggest a higher risk for intubation difficulty), the intubation difficulty scale, and the Cormack-Lehane grading system.

For reference, the add-on code for anesthesia for patient of extreme age is:

99100 – Anesthesia for patient of extreme age, younger than 1 year and older than 70 (List separately in addition to code for primary anesthesia procedure).

Background

Monitored anesthesia care (MAC) is a spectrum of anesthesia services defined by the type of anesthesia personnel present during a procedure, not specifically by the level of anesthesia needed. The American Society of Anesthesiologists (ASA) has defined MAC. The following is derived from ASA statements:

"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.

Monitored anesthesia care includes all aspects of anesthesia care— a preprocedure assessment and optimization, intraprocedure care, and postprocedure anesthesia management. During monitored anesthesia care, the anesthesiologist provides or medically directs a number of specific services, including but not limited to:

- Preprocedural assessment and management of patient comorbidity and periprocedural risk
- Diagnosis and treatment of clinical problems that occur during the procedure
- Support of vital functions inclusive of hemodynamic stability, airway management and appropriate management of the procedure induced pathologic changes as they affect the patient's coexisting morbidities
- 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.

MAC may include varying levels of sedation, analgesia, and anxiolysis as necessary. The provider of MAC 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."

Reference Resources

1. Blue Cross and Blue Shield Association: MPRM 7.02.01 - Monitored Anesthesia Care. Reviewed December 2022. Accessed January 2023.
2. ASGE Standards of Practice Committee, Early DS, Lightdale JR, et al. Guidelines for sedation and anesthesia in GI endoscopy. Gastrointest Endosc. Feb 2018; 87 (2):327-337. PMID 29306520
3. UpToDate – Monitored Anesthesia Care in Adults. Literature review current through June 2022. Accessed January 2023.
4. UpToDate – Gastrointestinal Endoscopy in Adults: Procedural Sedation Administered by Endoscopists. Literature review current through December 2022. Accessed January

2023.

Document Precedence

Blue Cross and Blue Shield of Vermont (BCBSVT) Medical Policies are developed to provide clinical guidance and are based on research of current medical literature and review of common medical practices in the treatment and diagnosis of disease. The applicable group/individual contract and member certificate language, or employer's benefit plan if an ASO group, determines benefits that are in effect at the time of service. Since medical practices and knowledge are constantly evolving, BCBSVT reserves the right to review and revise its medical policies periodically. To the extent that there may be any conflict between medical policy and contract/employer benefit plan language, the member's contract/employer benefit plan language takes precedence.

Audit Information

BCBSVT reserves the right to conduct audits on any provider and/or facility to ensure compliance with the guidelines stated in the medical policy. If an audit identifies instances of non-compliance with this medical policy, BCBSVT reserves the right to recoup all non-compliant payments.

Administrative and Contractual Guidance

Benefit Determination Guidance

Prior approval may be required for services as outlined in Attachment I. Benefits are subject to all terms, limitations and conditions of the subscriber contract.

NEHP/ABNE members may have different benefits for services listed in this policy. To confirm benefits, please contact the customer service department at the member's health plan.

Federal Employee Program (FEP): Members may have different benefits that apply. For further information please contact FEP customer service or refer to the FEP Service Benefit Plan Brochure. It is important to verify the member's benefits prior to providing the service to determine if benefits are available or if there is a specific exclusion in the member's benefit.

Coverage varies according to the member's group or individual contract. Not all groups are required to follow the Vermont legislative mandates. Member Contract language takes precedence over medical policy when there is a conflict.

If the member receives benefits through an Administrative Services Only (ASO) group, benefits may vary or not apply. To verify benefit information, please refer to the member's employer benefit plan documents or contact the customer service department. Language in the employer benefit plan documents takes precedence over medical policy when there is a conflict.

Policy Implementation/Update information

07/2009	New Policy
02/2011	Clarifications to "when services may be covered". Policy guidelines combined into "when services may be covered" section.
09/2012	Minor Format/Font changes. Pg 1- Document Precedence section added. Pg. 3-Change patients of extreme age younger than 12 yrs, now states younger than 19 years. Pg 5-language added by Dr. Borden -"Propofol for pediatric patients". Pg. 6- references added. Pg 7- Audit Information section added. Medical/Clinical Coder reviewed-RLJ.
06/2014	Effective 9/1/2014. Adoption of language from BCBSA policy #7.02.01. Clarification on ASA-P3 status. Clearer definition of conscious sedation versus monitored anesthesia.
08/2015	No language update. Added CPT 00520 for clarification only, does not require PA. Added CPTs: 00635, 01935 & 01936, 01991 & 01992- requires PA.
08/2016	Updates language per updated BCBSA policy
11/2017	Updated description language, updated medical criteria, updated rationale section, updated references, and minor formatting changes. Coding reviewed and no changes to current policy statement.
01/2018	2018 Adaptive Maintenance Effective 01/01/2018: Deleted codes 00740 & 00810 effective 01/01/2018. New codes will require PA 00731, 00732, 00811, 00812, 00813.
05/2018	Added language:" In order to support access to appropriate preventive service we will allow monitored anesthesia care if it is the only form of anesthesia offered within a 60 minute drive of the member's home."
05/2019	Reference 40 added, and minor formatting changes. No changes to current policy statements.
07/2020	Addition of Policy Criteria regarding prior complication/intolerance. Reference List removed as Policy based upon references in BCBSA Policy. Policy guideline language details removed. References reviewed and updated.
03/2021	Policy Reviewed. References Updated. Clarified indication of use in members with alcohol or substance use disorders and prior intolerance with procedures. Clarified language around ASA PS Classification System. Simple formatting changes
04/2021	Reviewed policy added additional clarification under policy statements for dysmorphic facial features, oral abnormalities and Class 3 or 4 Mallampati scores.
12/2021	Adaptive Maintenance Review: Effective 01/01/2022 deleted codes 01935 & 01936.
03/2022	Policy reviewed. Added clarifications on prolonged procedures, upper lip bite score and updated references.
01/2023	Policy reviewed. No change to policy statement. References updated.

Eligible Providers

Qualified healthcare professionals practicing within the scope of their license(s).

Approved by BCBSVT Medical Directors **Date Approved**

Tom Weigel, MD, MBA
Vice President & Chief Medical Officer

Attachment I
CPT® Coding Table & Instructions

Code Type	Number	Description	Policy Instructions
The following codes are considered as medically necessary when applicable criteria have been met.			
CPT®	00520	Anesthesia for closed chest procedures; (including bronchoscopy) not otherwise specified	Prior approval is not required for this code.
CPT®	00635	Anesthesia for procedures in lumbar region; diagnostic or therapeutic lumbar puncture	Prior Approval Required
CPT®	00731	Anesthesia for upper gastrointestinal endoscopic procedures, endoscope introduced proximal to duodenum; not otherwise specified	Prior Approval Required
CPT®	00732	Anesthesia for upper gastrointestinal endoscopic procedures, endoscope introduced proximal to duodenum; endoscopic retrograde	Prior Approval Required
CPT®	00811	Anesthesia for lower intestinal endoscopic procedures, endoscope introduced distal to duodenum; not otherwise specified	Prior Approval Required
CPT®	00812	Anesthesia for lower intestinal endoscopic procedures, endoscope introduced distal to duodenum; screening colonoscopy	Prior Approval Required

CPT®	00813	Anesthesia for combined upper and lower gastrointestinal endoscopic procedures, endoscope introduced both proximal to and distal to the duodenum	Prior Approval Required
CPT®	01991	Anesthesia for diagnostic or therapeutic nerve blocks and injections (when block or injection is performed by a different physician or other qualified health care professional); other than the prone position	Prior Approval Required
CPT®	01992	Anesthesia for diagnostic or therapeutic nerve blocks and injections (when block or injection is performed by a different physician or other qualified health care professional); prone position	Prior Approval Required
The following code is considered Informational and is not reimbursable.			
HCPCS	G9654	Monitored Anesthesia Care (MAC)	Informational