ND

Medical Policies

Print

Policy Number:	A-5001		
Policy Name:	Monitored Anesthesia Care		
Policy Type:	Medical	**Policy Subtype:**	Anesthesia
Effective Date:	09-15-2025	**End Date:**	11-02-2025

Description

Monitored Anesthesia Care

Monitored anesthesia care (MAC) is a set 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) defined MAC, and the following is derived from the ASA's 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 individual'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 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 individual safety
- Psychological support and physical comfort
- Provision of other medical services as needed to complete the procedure safely.

Monitored anesthesia care 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 individual loses consciousness and the ability to respond purposefully, the anesthesia care is a general anesthetic, irrespective of whether airway instrumentation is required.

Sedation Depth

In 2004 (amended in 2014), ASA defined 4 levels of sedation and analgesia, as shown in Table 1.

Table 1. ASA's Definitions of General Anesthesia and Levels of Sedation and Analgesia

Terms	Minimal Sedation (Anxiolysis)	Moderate Sedation or Analgesia (Conscious Sedation)	Deep Sedation or Analgesia	General Anesthesia
Responsiveness	Normal response to verbal stimulation	Purposeful response to verbal or tactile stimulation	Purposeful response following repeated or painful stimulation	Unarousable even with painful stimulation
Airway	Unaffected	No intervention required	Intervention may be required	Intervention often required
Spontaneous ventilation	Unaffected	Adequate	May be inadequate	Frequently inadequate
Cardiovascular function	Unaffected	Usually maintained	Usually maintained	May be impaired

Adapted from American Society of Anesthesiologists (2013)

ASA: American Society of Anesthesiologists

Because sedation is a continuum, it is not always possible to predict how an individual will respond. Hence, practitioners intending to produce a given level of sedation should be able to rescue individuals whose level of sedation becomes deeper than initially intended. Individuals administering moderate sedation or analgesia (conscious sedation) should be able to rescue individuals who enter a state of deep sedation or analgesia, while those administering deep sedation or analgesia should be able to rescue individuals who enter a state of general anesthesia.

Sedation for Diagnostic and Therapeutic Procedures

Multiple diagnostic and therapeutic procedures performed in the outpatient setting (e.g., endoscopy, colonoscopy, bronchoscopy, interventional pain management procedures) rely on some degree of sedation for anxiolysis and pain control. Regardless of sedation depth, sedation and anesthesia services provided in outpatient settings should be administered by qualified and appropriately trained personnel. Moderate sedation is generally sufficient for many diagnostic and uncomplicated therapeutic procedures. Moderate sedation using benzodiazepines, with or without narcotics, is frequently administered under the supervision of the proceduralist.

According to the ASA's standard for monitoring, MAC should be provided by qualified anesthesia personnel, including physicians and nurse specialists. By this standard, the personnel must be, in addition to the proceduralist, present continuously to monitor the individual and provide anesthesia care. For individuals at high risk of an unsuccessful procedure under moderate sedation, this allows for the safe continuation of the procedure under deep sedation or general anesthesia by trained personnel.

Moderate sedation can be achieved using pharmacologic agents for sedation, anxiolysis, and analgesia. A frequently used combination is an opioid and benzodiazepine (e.g., fentanyl with midazolam) at doses

individualized to obtain the desired sedative effect. Other combinations have also been used. While benzodiazepines and opioids can cause respiratory depression, effective reversal agents exist for both.

Propofol has increasingly been used to provide sedation for procedures. It is associated with a rapid onset of action and fast recovery from sedation. However, there are concerns about potential adverse effects and safety when used by non-anesthesiologists. Propofol has the potential to induce general anesthesia, and there is no pharmacologic antagonist to reverse its action. When used as moderate sedation, propofol may be administered by anesthesia personnel or under the direction of the proceduralist. ASA has offered practice guidelines for the provision of sedation by non-anesthesiologists, stating that personnel must be prepared to respond to deep sedation and loss of airway protection should these complications inadvertently occur during sedation.

Regulatory Status

In 1989, propofol Diprivan® (AstraZeneca) was approved by the U.S. Food and Drug Administration (FDA) through the premarket approval process for the induction and maintenance of anesthesia. The current FDA-approved label for Diprivan® states that it is indicated for initiation and maintenance of MAC sedation, combined sedation, and regional anesthesia; the label also states that Diprivan® is indicated for the sedation of adults in the intensive care unit who have been intubated or mechanically ventilated. Moreover, Diprivan® is also approved for induction of general anesthesia in individuals three (3) years of age and older and maintenance of general anesthesia in individuals two (2) months of age and older.

Many other FDA-approved medications for pain relief, anxiolysis, and sedation may be used in outpatient sedation.

Policy Application

All claims submitted under this policy's section will be processed according to the policy effective date and associated revision effective dates in effect on the date of service.

Criteria

Coverage is subject to the specific terms of the member's benefit plan.

The 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 (American Society of Anesthesiologists class III, IV, or V [see Table PG1])
- Morbid obesity (body mass index greater than 40 kg/m2)
- 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
    - Individuals with active medical problems related to drug or alcohol abuse

- Individuals younger than 18 years or 70 years or older
- Individuals who are pregnant
- Individuals with 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)
- Acutely agitated, uncooperative individuals
- Prolonged or therapeutic gastrointestinal endoscopy procedures requiring deep sedation.

Table PG1: ASA's Physical Status Classification System

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

ASA: American Society of Anesthesiologists

The use of monitored anesthesia care is considered investigational for gastrointestinal endoscopic, bronchoscopic, or interventional pain procedures in individuals at average risk related to use of anesthesia and sedation

Procedure Codes

00520	00635	00731	00732	00811	00812	00813
01937	01938	01940	01941	01942	01991	96373
96374						

Summary of Evidence

For individuals who have planned endoscopy and certain risk factors or significant medical conditions who receive MAC, the evidence includes systematic reviews, randomized controlled trials (RCTs) , and observational studies. Relevant outcomes are overall survival (OS), morbid events, hospitalizations, and treatment-related mortality and morbidity. A literature review for the American Gastroenterological Association Institute identified

potential indications requiring an anesthesia specialist. Systematic reviews comparing general anesthesia to MAC in individuals undergoing endoscopic retrograde cholangiopancreatography have found few differences between these modalities. However, the evidence from RCTs is sparse. A RCT comparing propofol administration by anesthesiologists for the purpose of anesthesia with propofol administered by nonanesthesiologists for sedation during colonoscopy reported that individuals receiving propofol from anesthesiologists indicated greater willingness to undergo further colonoscopies under the same conditions. This trial did not show any differences in procedure time or individual satisfaction and reported a higher rate of hypoxia in individuals treated by anesthesiologists with propofol. However, this trial may have been underpowered to detect differences in complication rates. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

For individuals who have planned bronchoscopy and certain risk factors or significant medical conditions who receive MAC, the evidence includes no studies that directly address this issue. Relevant outcomes are OS, morbid events, hospitalizations, and treatment-related mortality and morbidity. There is a lack of published evidence on MAC for bronchoscopy procedures; no RCTs, nonrandomized comparative studies, or large case series were identified. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

For individuals who have planned interventional pain management procedures and certain risk factors or significant medical conditions who receive MAC, the evidence includes no studies that directly address this issue. Relevant outcomes are OS, morbid events, hospitalizations, and treatment-related mortality and morbidity. There is a lack of published evidence on MAC for interventional pain management procedures; no RCTs, nonrandomized comparative studies, or large case series were identified. The evidence is insufficient to determine that the technology results in an improvement in the net health outcome.

National guidelines (e.g., from the American Society of Anesthesiologists) support the use of MAC for individuals undergoing outpatient procedures who have certain risk factors or significant medical conditions. Therefore, MAC is considered medically necessary in these situations.

Professional Statements and Societal Positions Guidelines

Practice Guidelines and Position Statements

American Society of Anesthesiologists

In 2014, the American Society of Anesthesiologists (ASA) updated its statement on the safe use of propofol:

'The Society believes that the involvement of an anesthesiologist in the care of every individual undergoing anesthesia is optimal. However, when this is not possible, non-anesthesia personnel who administer propofol should be qualified to rescue individuals whose level of sedation becomes deeper than initially intended and who enter, if briefly, a state of general anesthesia.'

'Rescue' was defined as correcting 'adverse physiologic consequences of the deeper-than-intended level of sedation (such as hypoventilation, hypoxia, and hypotension) and returns the individual to the originally intended level.'

In 2016, ASA updated its statement on anesthetic care during interventional pain procedures. ASA indicated that:

'Many individuals can undergo interventional pain procedures without the need for supplemental sedation in addition to local anesthesia. For most individuals who require supplemental sedation, the physician performing

the interventional pain procedure(s) can provide moderate (conscious) sedation as part of the procedure. For a limited number of individuals, a second provider may be required to manage moderate or deep sedation or, in selected cases other anesthesia services....

Significant anxiety may be an indication for moderate (conscious) sedation or anesthesia services. In addition, procedures that require the individual to remain motionless for a prolonged period of time and/or remain in a painful position may require sedation or anesthesia services. Examples of such procedures include but are not limited to sympathetic blocks (celiac plexus, paravertebral and hypogastric), chemical or radiofrequency ablation, percutaneous discectomy, trial spinal cord stimulator lead placement, permanent spinal cord stimulator generator and lead implantation, and intrathecal pump implantation. Major nerve/plexus blocks are performed less often in the chronic pain clinic, but the Committee believes that these blocks may more commonly require moderate (conscious) sedation or anesthesia services (e.g., brachial plexus block, sciatic nerve block, and continuous catheter techniques).'

In 2014, ASA updated its statement on respiratory monitoring during endoscopic procedures. The statement advised that 'Monitoring for exhaled carbon dioxide should be conducted during endoscopic procedures in which sedation is provided with propofol alone or in combination with opioids and/or benzodiazepines, and especially during these procedures on the upper gastrointestinal tract.'

American Society for Gastrointestinal Endoscopy

Guidelines on sedation during gastrointestinal endoscopy were released in 2018 by the American Society for Gastrointestinal Endoscopy (ASGE). The guidelines stated that anesthesia provider assistance during gastrointestinal endoscopy should be considered in the following situations: prolonged or therapeutic endoscopic procedures requiring deep sedation, anticipated intolerance to standard sedatives, increased risk for adverse event because of severe comorbidity (ASA class IV or V), and increased risk for airway obstruction because of anatomic variant. The guidelines made the following recommendations for the use of propofol during endoscopies:

- 'A sedation team with appropriate education and training [including] at least one (1) person ... qualified in advanced life support skills....
- Trained personnel [for] uninterrupted monitoring of individual's clinical and physiologic parameters....
- Physiologic monitoring must include pulse oximetry, electrocardiography, and intermittent blood pressure measurement. Monitoring oxygenation by pulse oximetry is not a substitute for monitoring ventilatory function. Capnography should be considered because it may decrease the risks during deep sedation...
- Personnel should have the ability to rescue a individual who becomes unresponsive or unable to protect his or her airway or who loses spontaneous respiratory or cardiovascular function.
- Age-appropriate equipment for airway management and resuscitation must be immediately available.
- A physician should be present throughout propofol sedation and remain immediately available until the individual meets discharge criteria.'

In 2015, ASGE published quality indicators for all gastrointestinal endoscopic procedures. Specific to this evidence review, ASGE stated: 'Individuals administering moderate sedation should be able to rescue individuals who enter a state of deep sedation, whereas those administering deep sedation should be able to rescue individuals who enter a state of general anesthesia.'

In 2013, ASGE published guidelines for endoscopic modification for geriatric individuals. Specific to this evidence review, ASGE recommended 'standard monitoring procedures in the elderly during moderate sedation with heightened awareness of this population's increased response to sedatives.'

In 2014, ASGE issued guidelines on the safety of the endoscopy unit, which made several recommendations on procedural sedation: 'Staff Recommendations for intra-procedure care based on level of sedation

- No sedation-One assistant ...other than the physician performing the procedure should be present to assist with the technical aspects of the procedure.
- Moderate sedation (also known as conscious sedation)-Sedation should be directed by a physician who is credentialed and privileged to do so and can be administered by an RN. During the period in which the individual is sedated, the RN must monitor the individual for vital sign changes, hypoxemia and comfort. The RN may assist with minor, interruptible tasks. In the event that more intense technical assistance is required, a second assistant (RN, LPN, or UAP [unlicensed assistive personnel]) should be available to join the care team for the technical aspects of the procedure.
- Deep sedation-Most institutions require that deep sedation be administered by an anesthesia professional such as an anesthesiologist, Certified Registered Nurse Anesthetist (CRNA), or Anesthesiologist Assistant who is credentialed and privileged to do so. In this situation, the anesthesia provider should be responsible for administering sedation and monitoring the individual. A second staff person (RN, LPN, or UAP) is required to assist with technical aspects of the procedure.'

'Recommendations for Individual Monitoring'

- All individuals undergoing endoscopy should be monitored, the frequency of which depends on procedural and individual factors (e.g., type of sedation, duration and complexity of procedure, individual's condition). At a minimum, monitoring should be performed before the procedure, after administration of sedatives, at regular intervals during the procedure, during initial recovery, and just before discharge.
- Units should have procedures in place to rescue individuals who are sedated deeper than intended.
- When the target level is moderate sedation (also known as conscious sedation):
    - The individual assigned responsibility for individual monitoring may perform brief, interruptible tasks.
    - Minimal monitoring requirements include electronic assessment of blood pressure, respiratory rate, heart rate, and pulse oximetry combined with visual monitoring of the individual's level of consciousness and discomfort.
- Currently, there are inadequate data to support the routine or required use of capnography during endoscopic procedures in adults when moderate sedation is the target.
- When deep sedation is targeted:
- The individual responsible for individual monitoring must be dedicated solely to that task and may not perform any other function during the procedure.
- The use of capnography in EUS [endoscopic ultrasound], ERCP [endoscopic retrograde cholangiopancreatography], and colonoscopy to assess the adequacy of ventilation may reduce the incidence of hypoxemia and apnea, but its impact on the frequency of other sedation-related adverse events such as bradycardia and hypotension is unknown. As such, capnography may be considered for the performance of endoscopy under deep sedation. However, there is no safety data to date to support the universal use of capnography in such cases.
- Documentation of the clinical assessments and monitoring data during sedation and recovery is required.'

In 2009, ASGE-along with the American Association for the Study of Liver Diseases, American College of Gastroenterology, and American Gastroenterological Association-issued a joint position statement on non-anesthesiologist administration of propofol (NAAP) for gastrointestinal endoscopy. The societies found that

NAAP was as safe and effective as anesthesiologist-administered propofol. They asserted that proper training and proper individual selection were necessary for the safe practice of NAAP sedation.

European Society of Gastrointestinal Endoscopy et al

The European Society of Gastrointestinal Endoscopy, as well as the European Society of Gastroenterology and Endoscopy Nurses and Associates, updated their guidelines on NAAP in 2015. Table 2 summarizes the main recommendations.

Table 2. Recommendations on NAAP for GI Endoscopy

Recommendation	SOR	QOE
1. Before NAAP, individual assessment of physical status, age, body mass index, Mallampati's classification, and obstructive sleep apnea risk factors	Strong	Moderate
2. Primary involvement of an anesthesiologist for high risk individuals	Weak	Low
3. Capnographic monitoring in high risk individuals, intended deep sedation, and long procedures	Weak	High
4. Propofol monotherapy except in particular situations	Weak	High
5. Administration of propofol through intermittent bolus infusion or perfusor systems, including target-controlled infusion and individual-controlled sedation	Strong	High
6. Individual listen to self-selected music during upper and lower GI endoscopy procedures	Weak	Moderate
7. Do not use pharyngeal anesthesia during propofol sedation for upper GI endoscopy	Weak	Moderate
8. Use post-anesthetic discharge scoring system to determine individual discharge	Weak	Low
9. For individuals of ASA class greater than (>) two (2), upon discharge, individual should be accompanied by a responsible person and refrain from driving, drinking alcohol, operating heavy machinery, or engaging in legally binding decisions for 24 hours. Advice should be provided verbally and in written form	Strong	Low
10. For individuals of ASA classes 1-2 who have received low-dose propofol monotherapy, a 6-hour limit is suggested	Weak	Low

ASA: American Society of Anesthesiologists; GI: gastrointestinal; NAAP: non-anesthesiologist-administered propofol; QOE: quality of evidence; SOR: strength of recommendation.

ASA class greater than or equal to (≥) three (3), with a Mallampati's class greater than or equal to (≥) three (3) or other conditions that put them at risk of airway obstruction, in individuals receiving significant amounts of narcotic analgesics, or in long-lasting procedures.

Diagnosis Codes

C15.3	C15.4	C15.5	C15.8	C15.9	C16.0	C16.1
C16.2	C16.3	C16.4	C16.5	C16.6	C16.8	C16.9
C17.0	C17.1	C17.2	C17.3	C17.8	C17.9	C18.0
C18.1	C18.2	C18.3	C18.4	C18.5	C18.6	C18.7
C18.8	C18.9	C19	C20	C21	C21.0	C21.1
C21.2	C21.8	C22.0	C22.1	C22.2	C22.3	C22.4
C22.7	C22.8	C22.9	C23	C24.0	C24.1	C24.8
C24.9	C25.0	C25.1	C25.2	C25.3	C25.4	C25.7
C25.8	C25.9	C26.0	C26.1	C26.9	C34.00	C34.01
C34.02	C34.10	C34.11	C34.12	C34.2	C34.3	C34.30
C34.31	C34.32	C34.80	C34.81	C34.82	C34.90	C34.91
C34.92	D01.0	D01.1	D01.2	D01.3	D01.40	D01.49
D01.5	D01.7	D01.9	D02.20	D02.21	D02.22	D12.0
D12.1	D12.2	D12.3	D12.4	D12.5	D12.6	D12.7
D12.8	D12.9	D13.0	D13.1	D13.2	D13.30	D13.39
D13.4	D13.5	D13.6	D13.7	D14.30	D14.31	D14.32
G56.40	G56.41	G56.42	G56.43	G57.70	G57.71	G57.72
G57.73	G89.0	G89.11	G89.12	G89.18	G89.21	G89.22
G89.28	G89.29	G89.3	G89.4	G90.50	G90.511	G90.512
G90.513	G90.519	G90.521	G90.522	G90.523	G90.529	G90.59
J40	J41.0	J41.1	J41.8	J42	J43.0	J43.1
J43.2	J43.8	J43.9	J44.0	J44.1	J44.81	J44.9
J45.20	J45.21	J45.22	J45.30	J45.31	J45.32	J45.40

J45.41	J45.42	J45.50	J45.51	J45.52	J45.901	J45.902
J45.909	J45.990	J45.991	J45.998	J47.0	J47.1	J47.9
J96.0	J96.00	J96.01	J96.02	J96.10	J96.11	J96.12
J96.20	J96.21	J96.22	J96.90	J96.91	J96.92	J98.01
J98.09	J98.11	J98.19	J98.2	J98.3	J98.4	J98.51
J98.59	J98.6	J98.8	J98.9	J99	K80.00	K80.01
K80.10	K80.11	K80.12	K80.13	K80.18	K80.19	K80.20
K80.21	K80.30	K80.31	K80.32	K80.33	K80.34	K80.35
K80.36	K80.37	K80.40	K80.41	K80.42	K80.43	K80.44
K80.45	K80.46	K80.47	K80.50	K80.51	K80.60	K80.61
K80.62	K80.63	K80.64	K80.65	K80.66	K80.67	K80.70
K80.71	K80.80	K80.81	K81.0	K81.1	K81.2	K81.9
K82.0	K82.1	K82.2	K82.3	K82.4	K82.8	K82.9
K82.A1	K82.A2	K83.0	K83.01	K83.09	K83.1	K83.2
K83.3	K83.4	K83.5	K83.8	K83.9	K85	K85.00
K85.01	K85.02	K85.10	K85.11	K85.12	K85.20	K85.21
K85.22	K85.30	K85.31	K85.32	K85.80	K85.81	K85.82
K85.90	K85.91	K85.92	K86.0	K86.1	K86.2	K86.3
K86.81	K86.89	K86.9	K87	M25.50	M25.511	M25.512
M25.519	M25.521	M25.522	M25.529	M25.531	M25.532	M25.539
M25.541	M25.542	M25.549	M25.551	M25.552	M25.561	M25.562
M25.571	M25.572	M25.579	M54.00	M54.01	M54.02	M54.03
M54.04	M54.05	M54.06	M54.07	M54.08	M54.09	M54.10
M54.11	M54.12	M54.13	M54.14	M54.15	M54.16	M54.17

M54.18	M54.2	M54.30	M54.31	M54.32	M54.40	M54.41
M54.42	M54.50	M54.51	M54.59	M54.6	M54.81	M54.89
M54.9	M79.601	M79.602	M79.603	M79.604	M79.605	M79.606
M79.609	M79.621	M79.622	M79.629	M79.631	M79.632	M79.639
M79.641	M79.642	M79.643	M79.644	M79.645	M79.646	M79.651
M79.652	M79.659	M79.661	M79.662	M79.669	M79.671	M79.672
M79.673	M79.674	M79.675	M79.676	R52	Z12.0	Z12.1
Z12.10	Z12.11	Z12.12	Z12.13	Z13.811	Z13.83	Z80.0
Z80.2	Z82.5	Z83.6	Z83.710	Z83.711	Z83.718	Z83.719
Z83.79	Z85.00	Z85.01	Z85.020	Z85.028	Z85.030	Z85.038
Z85.040	Z85.048	Z85.07	Z85.09	Z85.110	Z85.118	Z86.010

CURRENT CODING

CPT:

00520	ANESTHESIA CLOSED CHEST PX W/BRONCHOSCOPY NOS	Commercial
00635	ANES DIAGNOSTIC/THERAPEUTIC LUMBAR PUNCTURE	Commercial
00731	ANESTHESIA UPPER GI ENDOSCOPIC PX NOS	Commercial
00732	ANESTHESIA UPPER GI ENDOSCOPIC PX ERCP	Commercial
00811	ANESTHESIA LOWER INTST ENDOSCOPIC PX NOS	Commercial
00812	ANESTHESIA LOWER INTST ENDOSCOPIC PX SCR COLSC	Commercial
00813	ANESTHESIA COMBINED UPPER&LOWER GI ENDOSCOPIC PX	Commercial
01937	ANES PERQ IMG NJX DRG/ASPIR PX SPI/SP CRV/THRC	Commercial

01938	ANES PERQ IMG NJX DRG/ASPIR PX SPI/SP LMBR/SAC	Commercial
01939	ANES PERQ IMG DSTRJ PX NULYT AGT SPI/SP CRV/THRC	Commercial
01940	ANES PERQ IMG DSTRJ PX NULYT AGT SPI/SP LMBR/SAC	Commercial
01941	ANES PERQ IMG NEUROMD/NTRVRT PX SPI/SP CRV/THRC	Commercial
01942	ANES PERQ IMG NEUROMD/NTRVRT PX SPI/SP LMBR/SAC	Commercial
01991	ANES DX/THER NRV BLK&NJX OTH/THN PRONE POS	Commercial
96373	THERAPEUTIC PROPHYLACTIC/DX NJX INTRA-ARTERIAL	Commercial
96374	THER PROPH/DX NJX IV PUSH SINGLE/1ST SBST/DRUG	Commercial
00520	ANESTHESIA CLOSED CHEST PX W/BRONCHOSCOPY NOS	Medicaid Expansion
00635	ANES DIAGNOSTIC/THERAPEUTIC LUMBAR PUNCTURE	Medicaid Expansion
00731	ANESTHESIA UPPER GI ENDOSCOPIC PX NOS	Medicaid Expansion
00732	ANESTHESIA UPPER GI ENDOSCOPIC PX ERCP	Medicaid Expansion
00811	ANESTHESIA LOWER INTST ENDOSCOPIC PX NOS	Medicaid Expansion
00812	ANESTHESIA LOWER INTST ENDOSCOPIC PX SCR COLSC	Medicaid Expansion
00813	ANESTHESIA COMBINED UPPER&LOWER GI ENDOSCOPIC PX	Medicaid Expansion
01937	ANES PERQ IMG NJX DRG/ASPIR PX SPI/SP CRV/THRC	Medicaid Expansion
01938	ANES PERQ IMG NJX DRG/ASPIR PX SPI/SP LMBR/SAC	Medicaid Expansion
01939	ANES PERQ IMG DSTRJ PX NULYT AGT SPI/SP CRV/THRC	Medicaid Expansion
01940	ANES PERQ IMG DSTRJ PX NULYT AGT SPI/SP LMBR/SAC	Medicaid Expansion

01941	ANES PERQ IMG NEUROMD/NTRVRT PX SPI/SP CRV/THRC	Medicaid Expansion
01942	ANES PERQ IMG NEUROMD/NTRVRT PX SPI/SP LMBR/SAC	Medicaid Expansion
01991	ANES DX/THER NRV BLK&NJX OTH/THN PRONE POS	Medicaid Expansion
96373	THERAPEUTIC PROPHYLACTIC/DX NJX INTRA-ARTERIAL	Medicaid Expansion
96374	THER PROPH/DX NJX IV PUSH SINGLE/1ST SBST/DRUG	Medicaid Expansion

References

1. American Society of Anesthesiologists (ASA). Position on monitored anesthesia care (Amended October 17, 2018). 2018; https://www.asahq.org/standards-and-guidelines/position-on-monitored- anesthesia-care. Accessed October 3, 2022.
2. American Society of Anesthesiologists (ASA). Distinguishing monitored Anesthesia care (MAC) from moderate sedation/analgesia (Last Amended October 17, 2018). 2018; https://www.asahq.org/standards-and-guidelines/distinguishing-monitored-anesthesia-care-mac-from-moderate-sedationanalgesia-conscious-sedation. Accessed October 2, 2022.
3. American Society of Anesthesiologists (ASA). Continuum of Depth of Sedation: Definition of General Anesthesia and Levels of Sedation/Analgesia (Last Amended on October 23, 2019). 2019; https://www.asahq.org/standards-and-guidelines/continuum-of-depth-of-sedation-definition-of-general-anesthesia-and-levels-of-sedationanalgesia Accessed October 1, 2022.
4. American Society of Anesthesiologists Task Force on Sedation and Analgesia by Non-Anesthesiologists. Practice guidelines for sedation and analgesia by non-anesthesiologists. Anesthesiology. Apr 2002; 96(4): 1004-17. PMID 11964611
5. American Society of Anesthesiologists (ASA). Guidelines for ambulatory anesthesia and surgery (Reaffirmed October 2018). 2018; American Society of Anesthesiologists (ASA). Guidelines for ambulatory anesthesia and surgery. https://www.asahq.org/standards-and-guidelines/guidelines-for-ambulatory-anesthesia-and-surgery. Accessed October 4, 2022.
6. American Society of Anesthesiologists (ASA). Statement on safe use of propofol (Amended October 2019). 2019; https://www.asahq.org/standards-and-guidelines/statement-on-safe-use-of-propofol. Accessed September 25, 2022.
7. Whippey A, Kostandoff G, Paul J, et al. Predictors of unanticipated admission following ambulatory surgery: a retrospective case-control study. Can J Anaesth. Jul 2013; 60(7): 675-83. PMID 23606232
8. Fleisher LA, Pasternak LR, Herbert R, et al. Inpatient hospital admission and death after outpatient surgery in elderly patients: importance of patient and system characteristics and location of care. Arch Surg. Jan 2004; 139(1): 67-72. PMID 14718279
9. Mazze RI, Kallen B. Reproductive outcome after anesthesia and operation during pregnancy: a registry study of 5405 cases. Am J Obstet Gynecol. Nov 1989; 161(5): 1178-85. PMID 2589435
10. ACOG Committee on Obstetric Practice. ACOG Committee Opinion Number 284, August 2003: Nonobstetric surgery in pregnancy. Obstet Gynecol. Aug 2003; 102(2): 431. PMID 12907126
11. Higuchi H, Adachi Y, Arimura S, et al. Early pregnancy does not reduce the C(50) of propofol for loss of consciousness. Anesth Analg. Dec 2001; 93(6): 1565-9, table of contents. PMID 11726445

12. Cohen LB, Delegge MH, Aisenberg J, et al. AGA Institute review of endoscopic sedation. Gastroenterology. Aug 2007; 133(2): 675-701. PMID 17681185
13. McCarty TR, Hathorn KE, Creighton DW, et al. Safety and sedation-associated adverse event reporting among patients undergoing endoscopic cholangiopancreatography: a comparative systematic review and meta-analysis. Surg Endosc. Dec 2021; 35(12): 6977-6989. PMID 33966121
14. Dhaliwal A, Dhindsa BS, Saghir SM, et al. Choice of sedation in endoscopic retrograde cholangiopancreatography: is monitored anesthesia care as safe as general anesthesia? A systematic review and meta-analysis. Ann Gastroenterol. Nov-Dec 2021; 34(6): 879-887. PMID 34815655
15. Enestvedt BK, Eisen GM, Holub J, et al. Is the American Society of Anesthesiologists classification useful in risk stratification for endoscopic procedures?. Gastrointest Endosc. Mar 2013; 77(3): 464-71. PMID 23410699
16. Agostoni M, Fanti L, Gemma M, et al. Adverse events during monitored anesthesia care for GI endoscopy: an 8-year experience. Gastrointest Endosc. Aug 2011; 74(2): 266-75. PMID 21704990
17. Berzin TM, Sanaka S, Barnett SR, et al. A prospective assessment of sedation- related adverse events and patient and endoscopist satisfaction in ERCP with anesthesiologist-administered sedation. Gastrointest Endosc. Apr 2011; 73(4): 710-7. PMID 21316669
18. Cote GA, Hovis RM, Ansstas MA, et al. Incidence of sedation-related complications with propofol use during advanced endoscopic procedures. Clin Gastroenterol Hepatol. Feb 2010; 8(2): 137-42. PMID 19607937
19. Singh H, Poluha W, Cheung M, et al. Propofol for sedation during colonoscopy. Cochrane Database Syst Rev. Oct 08 2008; (4): CD006268. PMID 18843709
20. Poincloux L, Laquiere A, Bazin JE, et al. A randomized controlled trial of endoscopist vs. anaesthetist-administered sedation for colonoscopy. Dig Liver Dis. Jul 2011; 43(7): 553-8. PMID 21450542
21. Shen XC, Ao X, Cao Y, et al. Etomidate-remifentanil is more suitable for monitored anesthesia care during gastroscopy in older patients than propofol- remifentanil. Med Sci Monit. Jan 01 2015; 21: 1-8. PMID 25553506
22. Treeprasertsuk S, Rerknimitr R, Angsuwatcharakon P, et al. The safety of propofol infusion compared to midazolam and meperidine intravenous bolus for patients undergoing double balloon enteroscopy. J Med Assoc Thai. May 2014; 97(5): 483-9. PMID 25065086
23. de Paulo GA, Martins FP, Macedo EP, et al. Sedation in gastrointestinal endoscopy: a prospective study comparing nonanesthesiologist-administered propofol and monitored anesthesia care. Endosc Int Open. Feb 2015; 3(1): E7- E13. PMID 26134777
24. Sieg A, Beck S, Scholl SG, et al. Safety analysis of endoscopist-directed propofol sedation: a prospective, national multicenter study of 24 441 patients in German outpatient practices. J Gastroenterol Hepatol. Mar 2014; 29(3): 517- 23. PMID 24716213
25. Silvestri GA, Vincent BD, Wahidi MM, et al. A phase 3, randomized, double- blind study to assess the efficacy and safety of fospropofol disodium injection for moderate sedation in patients undergoing flexible bronchoscopy. Chest. Jan 2009; 135(1): 41-47. PMID 18641105
26. Bernards CM, Hadzic A, Suresh S, et al. Regional anesthesia in anesthetized or heavily sedated patients. Reg Anesth Pain Med. Sep-Oct 2008; 33(5): 449-60. PMID 18774514
27. Neal JM, Bernards CM, Hadzic A, et al. ASRA Practice Advisory on Neurologic Complications in Regional Anesthesia and Pain Medicine. Reg Anesth Pain Med. Sep-Oct 2008; 33(5): 404-15. PMID 18774509
28. American Society of Anesthesiologists (ASA). Statement on anesthetic care during interventional pain procedures for adults. Amended October 13, 20. 2021; https://www.asahq.org/standards-and-guidelines/statement-on-anesthetic-care-during-interventional-pain-procedures-for-adults. Accessed September 21, 2022.
29. American Society of Anesthesiologists (ASA). Statement on Respiratory Monitoring during Endoscopic Procedures (Amended October 2019). 2019; https://www.asahq.org/standards-and-guidelines/statement-on- respiratory-monitoring-during-endoscopic-procedures. Accessed September 30, 2022.

30. Early DS, Lightdale JR, Vargo JJ, et al. Guidelines for sedation and anesthesia in GI endoscopy. Gastrointest Endosc. Feb 2018; 87(2): 327-337. PMID 29306520
31. Rizk MK, Sawhney MS, Cohen J, et al. Quality indicators common to all GI endoscopic procedures. Am J Gastroenterol. Jan 2015; 110(1): 48-59. PMID 25448874
32. Chandrasekhara V, Early DS, Acosta RD, et al. Modifications in endoscopic practice for the elderly. Gastrointest Endosc. Jul 2013; 78(1): 1-7. PMID 23664042
33. Calderwood AH, Chapman FJ, Cohen J, et al. Guidelines for safety in the gastrointestinal endoscopy unit. Gastrointest Endosc. Mar 2014; 79(3): 363-72. PMID 24485393
34. Vargo JJ, Cohen LB, Rex DK, et al. Position statement: nonanesthesiologist administration of propofol for GI endoscopy. Gastrointest Endosc. Dec 2009; 70(6): 1053-9. PMID 19962497

ND Committee Review

Internal Medical Policy Committee 11-14-2019 Annual Review ***Effective January 6, 2020***

Internal Medical Policy Committee 03-17-2021 *Coding update* : ***Effective May 3, 2021***

- ***Removed*** 00810; **and**
- ***Added*** 00811; 00812; & 00813; **and**
- ***Added*** these Diagnosis Codes:

C16	C17	C18	C22	C24	C26	C34.1
C34.3	C34.8	C34.9	D01.4	D13	G89.1	G89.2
G90.51	G90.52	J43	J44	J45	J45.2	J45.3
J45.4	J45.5	J45.9	J45.90	J45.990	J45.991	J47
J96.0	J96.01	J96.1	J96.2	J96.9	J98	J98.0
J98.1	J98.5	K80.1	K80.2	K80.3	K80.4	K80.5
K80.6	K80.7	K80.8	K81	K82	K82.A	K83
K83.0	K83.5	K85	K85.0	K85.1	K85.1	K85.2
K85.3	K85.8	K85.9	K86	K86.8	M25.51	M25.512
M25.52	M25.54	M25.55	M25.56	M25.57	M54.1	M54.3
M54.8	M79.62	M79.63	M79.64	M79.65	M79.66	Z85.03
Z85.04						

Internal Medical Policy Committee 3-23-2022 Coding update - ***Effective May 2, 2022***

- ***Added*** Procedure codes 00731; and 00732; **and**
- ***Removed*** Procedure code 00740; **and**
- ***Added*** Diagnosis codes M54.50; M54.51; M54.59; Z12.1; and Z85.02.

Internal Medical Policy Committee 3-23-2023 Revision - *Effective May 1, 2023*

- *Added* Summary of Evidence; and
- *Changed* Not medically necessary language to investigational; and
- *Updated* with clarifying language throughout; and
- *Updated* References

Internal Medical Policy Committee 5-14-2024 Coding update- *Effective July 01, 2024*

- *Removed* Procedure Code 01936; and
- *Added* Procedure Codes 01937; 01938; 01939; 01940; 01941; & 01942; and
- *Removed* Diagnosis Codes C16; C17; C18; C22; C24; C25; C26; C34.1; C34.8; C34.9; D01.4; D13; D13.3; D13.9; G89.1; G89.2; G90.51; G90.52; J41; J43; J44; J45; J45.2; J45.3; J45.4; J45.5; J45.9; J45.90; J45.99; J47; J96; J96.1; J96.2; J96.9; J98; J98.0; J98.1; J95.5; K80.1; K80.2; K80.3; K80.4; K80.5; K80.6; K80.7; K80.8; K81; K82; K82.A; K83; K85.0; K85.1; K85.2; K85.3; K85.8; K85.9; K86; K86.8; M25.51; M25.52; M25.53; M25.54; M25.55; M25.57; M54.3; M54.4; M54.5; M54.8; M79.60; M79.62; M79.63; M79.64; M79.65; M79.66; M79.67; Z12.2; Z83.71; Z85.02; Z85.03; & Z85.04; and
- *Added* Diagnosis Codes: J44.81; J44.9; M25.552; M25.261; M25.562; M54.08; M54.09; M54.10; M54.11; M54.12; Z12.0; Z83.710; Z83.711; Z83.718; Z83.719; Z85.07; and Z85.09; and
- *Added* Policy Application

Disclaimer

Current medical policy is to be used in determining a Member's contract benefits on the date that services are rendered. Contract language, including definitions and specific inclusions/exclusions, as well as state and federal law, must be considered in determining eligibility for coverage. Members must consult their applicable benefit plans or contact a Member Services representative for specific coverage information. Likewise, medical policy, which addresses the issue(s) in any specific case, should be considered before utilizing medical opinion in adjudication. Medical technology is constantly evolving, and the Company reserves the right to review and update medical policy periodically.