


UCLA MEDICAL GROUP / Managed Care Operations		
DEPARTMENT:	Utilization Management	POLICY NUMBER: TBD
SECTION:	UM Policy	
TITLE:	Policy on Monitored Anesthesia Care (MAC) for Gastrointestinal Endoscopic Procedures	ISSUE: 08/2017 EFFECTIVE: 08/2017
Date Revised:	4/18/2018	
APPROVED BY UMC: August 16, 2017		

The intent of this policy is to address anesthesia services for diagnostic and therapeutic procedures performed in an outpatient setting. Various levels of anesthesia, including sedation and analgesia, may be used depending on the patient's condition and the procedure being performed. This policy addresses the need for Monitored anesthesia care (MAC).

Monitored Anesthesia (00100-01999) or Moderate Conscious Sedation (99148-99150) codes provided by a second physician or other qualified health care professional other than the health care professional performing the procedure, **may** be considered medically necessary during gastrointestinal endoscopic procedures when there is documentation by the operating physician and the anesthesiologist that demonstrates any of the following higher risk situations exist:

- Prolonged or therapeutic endoscopic procedure requiring deep sedation**; or
- A history of or anticipated intolerance to standard sedatives (e.g., patient on chronic high dose narcotics or high dose benzodiazepines, or has an unstable neuropsychiatric disorder which would prevent cooperation); or
- Increased risk for complication due to severe comorbidity. American Society of Anesthesiologists ASA class III physical status or greater (as documented by Anesthesia)
- Pediatric age group (16 years and younger); or
- Aged 70 or greater
- Pregnancy; or
- History of active drug or alcohol abuse; or
- Morbid obesity (BMI>40); or
- Uncooperative or acutely agitated patients (e.g., delirium, organic brain disease, senile dementia); or
- Spasticity or movement disorder complicating procedure; or
- Increased risk for airway obstruction due to anatomic variant including any of the following:
 - Documented history of previous problems with anesthesia or sedation; or
 - History of stridor or severe sleep apnea requiring oxygen and bipap; or
 - Dysmorphic facial features, such as:
 - Pierre-Robin syndrome or trisomy-21; or
 - Presence of oral abnormalities including but not limited to a small oral opening (less than 3 cm in an adult), high arched palate, macroglossia, tonsillar hypertrophy, or a non-visible uvula (not visible when tongue is protruded with patient in sitting position e.g., Mallampati class greater than II) as documented by Anesthesia; or
 - 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 advanced rheumatoid arthritis as documented by Anesthesia; or
 - Jaw abnormalities including but not limited to micrognathia, retrognathia, trismus, or significant malocclusion as documented by Anesthesia (ASA, 2002; American Society for Gastrointestinal Endoscopy [ASGE], 2002, 2003, 2012)

DEPARTMENT:	Utilization Management	POLICY NUMBER:	TBD
TITLE:		Page 2 of 3	**

Having consecutive upper and lower scopes on the same day does not in and of itself qualify as a prolonged endoscopic procedure

Not Medically Necessary:

The routine assistance of an anesthesiologist or Certified Registered Nurse Anesthetist (CRNA) for patients not meeting the above criteria who are undergoing standard upper or lower gastrointestinal endoscopic procedures is considered not medically necessary. (American College of Gastroenterology [ACG], American Gastroenterological Association [AGA] & ASGE, 2004; ASGE, 2002, 2003, 20012).

Additional Information:

In 2004, the ASA defined 4 levels of sedation/analgesia as follows:

I. **Minimal sedation (anxiolysis)** is a drug-induced state during which patients respond normally to verbal commands. Although cognitive function and coordination may be impaired, ventilator and cardiovascular function are unaffected.

II. **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.

III. **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.

IV. **General anesthesia** is a drug-induced depression of consciousness during which patients are not arousable, even by painful stimulation. The ability to independently maintain ventilator 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.

According to the American Society of Anesthesiologists' (ASA) 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 and must be present continuously to monitor the patient and provide anesthesia care. For patients 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.

Sedation and anesthesia services that are 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 usually administered by, or under the supervision of, the proceduralist.

Moderate sedation can be achieved using pharmacologic agents for sedation, anxiolysis, and analgesia. A frequently used combination is an opioid and benzodiazepine, for example fentanyl with midazolam, at doses individualized to obtain the desired sedative effect. Other combinations have also been utilized for this purpose. While both benzodiazepines and opioids can cause respiratory depression, effective reversal agents exist for both.

Propofol is an agent that has been increasingly used to provide sedation for procedures. Propofol is associated with a rapid onset of action and fast recovery from sedation. However, there have been concerns about potential side 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,

DEPARTMENT:	Utilization Management	POLICY NUMBER: TBD
TITLE:		Page 3 of 3

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.

REFERENCES

1. American Society of Anesthesiologists. Position on monitored anesthesia care. Amended October 2013. Available online at: <http://www.asahq.org/For-Members/Standards-Guidelines-and-Statements.aspx>. Last accessed January 23, 2014.
2. American Society of Anesthesiologists. Levels of sedation/analgesia. Amended October 29, 2009. Available online at: <http://www.asahq.org/For-Members/Clinical-Information/~media/For%20Members/documents/Standards%20Guidelines%20Stmts/Continuum%20of%20Depth%20of%20Sedation.aspx>. Last accessed January 23, 2014.
3. American Society of Anesthesiologists. Distinguishing monitored Anesthesia care ("MAC") from moderate sedation/analgesia. Amended October 21, 2009 and reaffirmed October 2013. Available online at: <http://www.asahq.org/For-Members/Standards-Guidelines-and-Statements.aspx>. Last accessed January 23, 2014.
4. American Society of Anesthesiologists. Statement on qualifications of anesthesia provided in the office-based setting. Amended October 21, 2009. Available online at: <http://www.asahq.org/For-Members/Clinical-Information/~media/For%20Members/documents/Standards%20Guidelines%20Stmts/Qualifications%20of%20Anesthesia%20Providers%20in%20the%20Office.aspx>. Last accessed January 23, 2014.
5. Liu H, Waxman DA, Main R et al. Utilization of anesthesia services during outpatient endoscopies and colonoscopies and associated spending in 2003-2009. JAMA 2012; 307(11):1178-84.
6. Fleisher LA. Assessing the value of "discretionary" clinical care: the case of anesthesia services for endoscopy. JAMA 2012; 307(11):1200-1.
7. Mallampati SR, Gatt SP, Gugino LD et al. A clinical sign to predict difficult tracheal intubation: a prospective study. Canadian Anaesthetists Society Journal 1985; 32(4):429-34.
8. American Society of Anesthesiologists. Statement on nonoperating room anesthetizing locations. Amended October 2013. Available online at: <http://www.asahq.org/For-Members/Standards-Guidelines-and-Statements.aspx>. Last accessed January 23, 2014.
9. American Society of Anesthesiologists. Guidelines for ambulatory anesthesia and surgery. Amended October 2008 and reaffirmed October 2013. Available online at: <http://www.asahq.org/For-Members/Standards-Guidelines-and-Statements.aspx>. Last accessed January 23, 2014.
10. 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. Archives of Surgery 2004; 139(1):67-72.