Anthem

Clinical UM Guideline

Subject: Monitored Anesthesia Care for Gastrointestinal Endoscopic Procedures
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Description

This document addresses the medical necessity of the use of monitored anesthesia care during gastrointestinal endoscopic procedures. This document does not address whether or not reimbursement is provided for the anesthesia service and it is not intended to guide the billing and reimbursement of anesthesia services.

Note: Please see the following related document for additional information:

- CG-MED-21 Anesthesia Services and Moderate ("Conscious") Sedation

Clinical Indications

Medically Necessary:

Monitored Anesthesia Care (for definition, see Discussion below)

Monitored anesthesia care is considered **medically necessary** during gastrointestinal endoscopic procedures when there is documentation by the operating physician or the anesthesiologist that demonstrates **any** of the following higher risk situations exist:

- Prolonged or therapeutic endoscopic procedure requiring deep sedation such as endoscopic retrograde cholangiopancreatography (ERCP) or repeat colonoscopy due to tortuous colon; **or**
- A history of or anticipated poor response due to cross tolerance or paradoxical reaction to standard sedatives used during moderate (conscious) sedation specifically due to narcotics or benzodiazepines; **or**
- Increased risk for complication due to severe comorbidity (American Society of Anesthesiologists [ASA] class III physical status or greater. See Appendix for physical status classifications); **or**
- Individuals over 70; **or**
- Individuals under the age of 18; **or**
- Pregnancy; **or**
- History of drug or alcohol abuse; **or**
- Uncooperative or acutely agitated individuals (for example, delirium, organic brain disease, senile dementia); **or**
- Increased risk for airway obstruction due to anatomic variant including **any** of the following:
    - History of previous problems with anesthesia or sedation; **or**
    - History of stridor or sleep apnea; **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 3cm in an adult), high arched palate, macroglossia, tonsillar hypertrophy, or a non-visible uvula (not visible when tongue is protruded with individual in sitting position [for example, Mallampati class greater than II]); **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 3cm in an adult), neck mass, cervical spine disease or trauma, tracheal deviation, or advanced rheumatoid arthritis; **or**
    - Jaw abnormalities including but not limited to micrognathia, retrognathia, trismus, or significant malocclusion.

The routine assistance of an Anesthesiologist or Certified Registered Nurse Anesthetist (CRNA) for individuals meeting the above criteria who are undergoing gastrointestinal endoscopic procedures is considered **medically necessary.**

Not Medically Necessary:

Monitored anesthesia care is considered **not medically necessary** when the above criteria are not met.

The routine assistance of an Anesthesiologist or Certified Registered Nurse Anesthetist (CRNA) for individuals not meeting the above criteria who are undergoing gastrointestinal endoscopic procedures is considered **not medically necessary.**

Coding

The following codes for treatments and procedures applicable to this document are included below for informational purposes. Inclusion or exclusion of a procedure, diagnosis or device code(s) does not constitute or imply member coverage or provider reimbursement policy. Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage of these services as it applies to an individual member.

When services may be Medically Necessary when criteria are met:

CPT	
00731	Anesthesia for upper gastrointestinal endoscopic procedures, endoscope introduced proximal to duodenum; not otherwise specified
00732	Anesthesia for upper gastrointestinal endoscopic procedures, endoscope introduced proximal to duodenum; endoscopic retrograde cholangiopancreatography (ERCP)
00811	Anesthesia for lower intestinal endoscopic procedures, endoscope introduced distal to duodenum; not otherwise specified
00812	Anesthesia for lower intestinal endoscopic procedures, endoscope introduced distal to duodenum; screening colonoscopy
00813	Anesthesia for combined upper and lower gastrointestinal endoscopic procedures, endoscope introduced both proximal to and distal to the duodenum

ICD-10 Diagnosis

All diagnoses

When services are Not Medically Necessary:
For the procedure codes listed above when criteria are not met or for situations designated in the Clinical Indications section as not medically necessary.

Discussion/General Information

Anesthesia services include all services associated with the administration and monitoring of analgesia or anesthesia to an individual in order to produce partial or complete loss of sensation. Examples of various methods of anesthesia include moderate sedation ("conscious sedation"), monitored anesthesia care (MAC), regional anesthesia and general anesthesia.

Adequate sedation and analgesia is an integral part of a diagnostic or therapeutic gastrointestinal procedure. Sedation may be defined as a drug-induced depression in the level of consciousness. The purpose of sedation and analgesia is to relieve an individual's discomfort and anxiety, improve the outcome of the examination and diminish the individual's memory of the event. The choice of sedative used during procedures is operator dependent.

Paspatis and colleagues (2011) reported on 520 individuals undergoing colonoscopy for the detection of polyps and were randomized to either deep sedation (n=258) or moderate sedation (n=262) with the hypothesis that deep sedation may increase the rate of polyp detection compared to moderate sedation which would enhance the quality of the colonoscopy. The degree of sedation was assessed by a research nurse using the modified assessment of alertness/sedation (MOAA/S) scale. Each participant's satisfaction with the sedation was assessed 2 hours after the procedure in the recovery area. The endoscopist's satisfaction concerning the sedation during the procedure was also assessed immediately following the procedure. There was no difference between the two groups in regards to the overall rate of polyps detected. There was no difference in the level of participant satisfaction between the two groups. However, the endoscopist's satisfaction rating was greater in the deep sedation group compared to the moderate sedation group.

In a 2018 study by Behrens and colleagues, the authors reported on sedation-assisted complications during GI endoscopic procedures. A total of 368,206 endoscopies were recorded; 11% were without sedation. Of the individuals who received sedation, 38 suffered a major complication with overall mortality 0.005% and minor complications occurred in 0.3%. Across 39 facilities, when compared with hospitals, tertiary referral centers had higher complication rates. Also of note is that when another person (nurse or physician) was added to provide sedation during a two-person endoscopy team (endoscopist/assistant), a higher complication rate occurred. The authors note that this higher complication rate could have been attributed to a higher complexity of the procedure. Overall sedation-related complications during GI endoscopy procedures are rare with a very low mortality rate.

In a 2019 retrospective cohort study by Edelson and colleagues, the authors examined the safety of moderate sedation and MAC in individuals with cirrhosis. The primary outcome was safety, defined as the absence of adverse events. In a cohort of 2618 participants, 1157 underwent MAC anesthesia and 1461 underwent benzodiazepine/narcotic-based moderate sedation. The participants in the MAC group had less severe liver disease compared to the moderate sedation group as evidenced by higher MELD and Child–Pugh scores, a higher prevalence of ascites, and more frequent hepatic encephalopathy. The individuals who received moderate sedation had higher ASA scores and Charlson Comorbidity Index (CCI) severity scores. Esophagogastroduodenoscopy (EGD) was performed most commonly, 679/1157 participants in the MAC group which was comparable to 988/1461 participants in the moderate sedation group. Other procedures included endoscopic ultrasound and/or ERCP, colonoscopy, percutaneous endoscopic gastrostomy/percutaneous endoscopic jejunostomy placement, flexible sigmoidoscopy, and ileoscopy. There were 15 adverse events overall, 7 in the MAC group and 8 in the moderate sedation group. Hypoxia was the most common adverse event followed by bleeding and hypotension. The authors note that moderate sedation appears to be as safe as MAC in persons with cirrhosis. Limitations of the study include its retrospective design, provider discretion regarding which individuals received MAC or moderate sedation, and possible ascertainment bias in the assignment of ASA scores which were assigned by different providers.

Smith and colleagues (2019) reported on a randomized controlled trial which evaluated safety of general anesthesia versus propofol-based MAC in individuals undergoing ERCP. Eligible participants had planned ERCP and at least one established risk factor for sedation-related adverse events. A 1:1 randomization was performed in the preprocedure area and all participants were sedated by 1 of 5 nurse anesthetists under the direction of an anesthesiologist. ERCP was performed by 1 of 4 experienced interventional endoscopy attending physicians. Ultimately 200 individuals completed the study and were included in the analysis; 101 in the general anesthesia arm and 99 in the MAC arm. Sedation-related adverse events included hypoxemia, the use of airway maneuvers, conversion to general anesthesia, hypotension requiring vasopressors, sedation-related procedure interruption or termination, cardiac arrhythmia, and respiratory failure. In the MAC group, 51/99 individuals experienced a sedation-related adverse event compared to 10/101 in the general anesthesia group, primarily based on the incidence of hypoxemia and the need for airway maneuvers such as nasal airway, oral airway, chin lift, jaw thrust, or bag max ventilation. In the MAC group there were 45 airway maneuvers used with a total of 19 participants who experienced hypoxemia compared to none in the general anesthesia group. The results of this study may not be generalizable. While the results suggest that general anesthesia is the preferred method for those undergoing ERCP who are at high risk for sedation-related adverse events, it should be noted that the use of airway maneuvers were defined as sedation-related adverse events. Other institutions may consider airway maneuvers a standard part of maintaining a patent airway during MAC and should not be classified as a sedation-related adverse effect. The nurse anesthetists in this study were very experienced in sedating individuals for ERCP. There may be limitations for anesthesia providers in other facilities. Larger sample sizes at multiple facilities may be necessary to generalize results.

The American College of Gastroenterology (ACG) released a Position Statement (Vargo, 2009) which recommends that "the use of anesthesiologist-administered sedation for healthy, low-risk patients undergoing routine GI endoscopy results in higher costs with no proven benefit with respect to patient safety or procedural efficacy."

The American Society of Anesthesiologists (ASA) Statement on Distinguishing Monitored Anesthesia Care ("MAC") from Moderate Sedation/Analgesia (Conscious Sedation) (2023) states:

> The American Society of Anesthesiologists has defined Monitored Anesthesia Care (MAC) as a specific anesthesia service performed by a qualified (trained) anesthesia provider, for a diagnostic or therapeutic procedure. Indications for MAC include, but are not limited to, the nature of the procedure, the patient's clinical condition and/or the need for deeper levels of analgesia and sedation than can be provided by moderate sedation (including potential conversion to a general or regional anesthetic). Monitored anesthesia care includes all aspects of anesthesia care – a preprocedure assessment and optimization, intraprocedure care and postprocedure management that is inherently provided by a qualified anesthesia provider as part of the bundled specific service. During MAC, 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
- Postoperative medical and pain management

MAC may include varying levels of sedation, awareness, analgesia and anxiolysis as necessary. The qualified anesthesiologist provider of monitored anesthesia care must be prepared to manage all levels of sedation up to and including general anesthesia and respond to the pathophysiology (airway and hemodynamic changes) of procedure and patient positioning..

In 2018 the American Society for Gastrointestinal Endoscopy released guidelines for sedation and anesthesia in GI endoscopy and stated that individuals with medical comorbidities may require MAC. Many factors go into determining whether the assistance of MAC is necessary. Risk factors include:

> Significant medical conditions such as extremes of age; severe pulmonary, cardiac, renal, or hepatic disease; pregnancy; the abuse of drugs or alcohol; uncooperative patients; a potentially difficult airway for positive-pressure ventilation; and individuals with anatomy that is associated with more difficult intubation.

The guideline also lists situations when anesthesia provider assistance should be consulted to provide sedation. These situations include:

- 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)
- Increased risk for airway obstruction because of anatomic variant

There is no single age cut-off for individuals in a pediatric age group that would clearly determine an individual to be at higher risk. Several organizations have proposed age cut-offs for monitored sedation ranging from 19 to 21 years and other organizations are silent regarding at what age an individual is no longer considered to be in the pediatric age group. In a 2017 statement by the American Academy of Pediatrics (Hardin, 2017), it is noted that limits that affect care should not be placed solely based on age, but rather take into consideration the physical and psychosocial needs of pediatric members. Typically by the age of 18, an individual will have finished growing in regards to facial structures and airway size.

In a 2019 retrospective chart review by Najafi and colleagues, the authors determined the prevalence of adverse events during MAC. Children up to age 16 years who underwent elective or diagnostic gastrointestinal endoscopy were included (n=3435). Children who presented with ASA physical status of at least 4, those who required mechanical ventilation, and those undergoing therapeutic or urgent gastrointestinal endoscopy were not included in the review. There were 64% of children with ASA physical status of 1 or 2 and 36% with ASA 3. The comorbid breakdown is as follows: respiratory comorbidities (n=1299), recent respiratory infection (n=799), both respiratory comorbidity and infection (n=736), psychological disorders (n=605), neurological comorbidities (n=505), history of prematurity (n=219), and congenital cardiac abnormalities (n=106). Upper gastrointestinal endoscopy, with or without lower gastrointestinal endoscopy, was performed in 87.1% of children. There were 116 overall adverse events, including 113 adverse respiratory events reported, with 55 documented as minor, 58 as intermediate and 3 as sentinel events. MAC failed in 11 children. An unplanned tracheal intubation was necessary for 3 sentinel events (apnea and severe laryngospasm). Review of the charts showed 19 potential predictors found to be significantly associated with the occurrence of adverse events, which included ASA physical status; age; weight; height; children's size; the presence of respiratory comorbidities, or recent respiratory infection, or both; neurological comorbidities; history of prematurity; psychological disorders; gastroesophageal reflux disease; allergy to food; upper versus lower gastrointestinal endoscopy; respiratory reason for endoscopy with or without gastrointestinal problems; induction dose of propofol; induction dose of ketamine; co-administration of ketamine and propofol and propofol administration after sevoflurane induction. This chart review showed very few sedation-related adverse effects, with the exception of adverse respiratory events. The study limitations include the retrospective design and single-center nature which could reduce generalizability of the results. There may have been minor interventions performed by anesthesiology staff such as airway positioning that may not have been documented, leading to underreporting of minor adverse events.

Anesthesia services are provided by or under the supervision of a physician. Services consist of the administration of an anesthetic agent in various types of anesthesia.

Definitions

General Anesthesia: A reversible state of unconsciousness and the inability to perceive pain, produced by anesthetic agents, with absence of pain sensation over the entire body and a greater or lesser degree of muscular relaxation; the drugs producing this state can be administered by inhalation, intravenously, intramuscularly, rectally, or via the gastrointestinal tract.

Moderate Sedation: Involves the administration of medication with or without analgesia to achieve a state of depressed consciousness while maintaining the individual's ability to respond to stimulation. Moderate sedation is administered by the surgeon or physician performing the procedure or an independent trained practitioner for the purpose of assisting the physician in monitoring the individual's level of consciousness and physiological status. It includes pre- and post- sedation evaluations, administration of the sedation and monitoring of the cardiorespiratory function. Cardiorespiratory functions monitored include heart rate, blood pressure and oxygen level.

Monitored Anesthesia Care (MAC)*: MAC was developed in response to the shift to providing more surgical and diagnostic services in an ambulatory, outpatient or office setting without the use of the traditional general anesthetic. Accompanying this, there has been a change in the provision of anesthesia services from the traditional general anesthetic to a combination of local, regional and certain conscious altering drugs. This type of anesthesia is referred to as MAC if directly provided by anesthesia personnel. Based on the ASA's standards for monitoring, MAC should be provided by qualified anesthesia personnel (anesthesiologists or qualified anesthetists such as CRNA). These personnel must be continuously present to monitor the individual and provide anesthesia care.

American Society of Anesthesiologists Levels of Sedation/Analgesia (2019)

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.

American Society of Anesthesiologists Definition of General Anesthesia (2019)

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*** individuals 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.
*Monitored Anesthesia Care ("MAC) does not describe the continuum of depth of sedation, rather it describes "a specific anesthesia service performed by a qualified anesthesia provider, for a diagnostic or therapeutic procedure." Indications for monitored anesthesia care include "the need for deeper levels of analgesia and sedation that can be provided by moderate sedation (including potential conversion to general or regional anesthetic)."
**Reflex withdrawal from a painful stimulus is NOT considered a purposeful response.
***Rescue of an individual from a deeper level of sedation than intended is an intervention by a practitioner proficient in airway management and advanced life support. The qualified practitioner corrects adverse physiologic consequences of the deeper-than-intended level of sedation (such as hypoventilation, hypoxia and hypotension) and returns the patient to the originally intended level of sedation. It is not appropriate to continue the procedure at an unintended level of sedation.

References

Peer Reviewed Publications:

1. Adams MA, Saleh A, Rubenstein JH. A systematic review of factors associated with utilization of monitored anesthesia care for gastrointestinal endoscopy. Gastroenterol Hepatol (N Y). 2016; 12(6):361-370.
2. Behrens A, Kreuzmayr A, Manner H, et al. Acute sedation-associated complications in GI endoscopy (ProSed 2 Study): results from the prospective multicentre electronic registry of sedation-associated complications. Gut. 2019 Mar;68(3):445-452.
3. Edelson J, Suarez AL, Zhang J, Rockey DC. Sedation during endoscopy in patients with cirrhosis: safety and predictors of adverse events. Dig Dis Sci. 2020 Apr;65(4):1258-1265.
4. Najafi N, Veyckemans F, Vanhonacker D, et al. Incidence and risk factors for adverse events during monitored anaesthesia care for gastrointestinal endoscopy in children: A prospective observational study. Eur J Anaesthesiol. 2019; 36(6):390-399.
5. Paspatis GA, Tribonias G, Manolaraki MM, et al. Deep sedation compared with moderate sedation in polyp detection during colonoscopy: a randomized controlled trial. Colorectal Dis. 2011; 13(6):e137-144.
6. Rex DK, Overley CA, Walker J. Registered nurse-administered propofol sedation for upper endoscopy and colonoscopy: Why? When? How? Rev Gastroenterol Disord. 2003; 3(2):70-80.
7. Smith ZL, Mullady DK, Lang GD, et al. A randomized controlled trial evaluating general endotracheal anesthesia versus monitored anesthesia care and the incidence of sedation-related adverse events during ERCP in high-risk patients. Gastrointest Endosc. 2019; 89(4):855-862.

Government Agency, Medical Society, and Other Authoritative Publications:

1. American Society for Gastrointestinal Endoscopy. Guideline for modifications in endoscopic practice for the elderly. Gastrointestinal Endoscopy. 2013; 78(1):1-7.
2. American Society for Gastrointestinal Endoscopy. Guideline for modifications in endoscopic practice for pediatric patients. Gastrointestinal Endoscopy. 2014; 79(5):699-710.
3. American Society for Gastrointestinal Endoscopy. Guideline for sedation and anesthesia in GI endoscopy. Gastrointestinal endoscopy. 2018; 87(2):327-337.
4. American Society of Anesthesiologists. ASA physical status classification system. Original approval October 15, 2014; last amended December 13, 2020. For additional information visit the ASA website: http://www.asahq.org. Accessed on January 9, 2024.
5. American Society of Anesthesiologists. Continuum of depth of sedation definition of general anesthesia and levels of sedation/analgesia. Approved by the ASA House of Delegates October 13, 1999; amended October 23, 2019. For additional information visit the ASA website: http://www.asahq.org. Accessed on January 9, 2024.
6. American Society of Anesthesiologists. Distinguishing monitored anesthesia care ("MAC") from moderate sedation/analgesia (conscious sedation). Original approval October 18, 2023; last updated October 18, 2023. For additional information visit the ASA website: http://www.asahq.org. Accessed on January 9, 2024.
7. American Society of Anesthesiologists. Statement on practice recommendations for pediatric anesthesia. Approved by the ASA House of Delegates October 19, 2011; reaffirmed October 13, 2021. For additional information visit the ASA website: http://www.asahq.org. Accessed on January 9, 2024.
8. American Society of Anesthesiologists. Statement on respiratory monitoring during endoscopic procedures. Approved by the ASA House of Delegates October 21, 2009; last amended October 23, 2019. For additional information visit the ASA website: http://www.asahq.org. Accessed on January 9, 2024.
9. Apfelbaum JL, Hagberg CA, Connis RT, et al. 2022 American Society of Anesthesiologists practice guidelines for management of the difficult airway. Anesthesiology. 2022 Jan 1;136(1):31-81.
10. Cohen LB, Delegge MH, Aisenberg J, et al. AGA Institute review of endoscopic sedation. Gastroenterology. 2007; 133(2):675-701.
11. Coté CJ, Wilson S, 1. American Academy of Pediatrics, American Academy of Pediatric Dentistry. Guidelines for monitoring and management of pediatric patients before, during, and after sedation for diagnostic and therapeutic procedures. Pediatrics. 2019; 143(6):e20191000.
12. Hardin AP, Hackell JM; Committee on Practice and Ambulatory Medicine. Age limit of pediatrics. Pediatrics. 2017; 140(3):e20172151.
13. Vargo JJ, Cohen LB, Rex DK, Kwo PY. Position statement: Nonanesthesiologist administration of propofol for GI endoscopy. Am J Gastroenterol 2009; 104(12):2886–2892.

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History

Status	Date	Action
Reviewed	02/15/2024	Medical Policy & Technology Assessment Committee (MPTAC) review. Updated Discussion/General Information and References sections.
Reviewed	02/16/2023	MPTAC review. Updated References section.
Reviewed	02/17/2022	MPTAC review. Updated References section.
Reviewed	02/11/2021	MPTAC review. Updated Discussion/General Information and References sections. Reformatted Coding section.
Reviewed	02/20/2020	MPTAC review. Updated Discussion/General Information and References sections.
Reviewed	03/21/2019	MPTAC review. Updated Discussion/General Information and References sections.
Reviewed	03/22/2018	MPTAC review. Updated Discussion/General Information and References sections.
	12/27/2017	The document header wording updated from “Current Effective Date” to “Publish Date.” Updated Coding section with 01/01/2018 CPT changes; added codes 00731, 00732, and 00811-00813; removed 00740 and 00810 deleted 12/31/2017.
Reviewed	05/04/2017	MPTAC review. Updated Description, Discussion/General Information, References and Index sections.
Reviewed	05/05/2016	MPTAC review. Removed ICD-9 codes from Coding section.
Reviewed	05/07/2015	MPTAC review. Updated Discussion/General Information, Definitions, and References.
Revised	05/15/2014	MPTAC review. Clarification to Clinical Indications section about prolonged or therapeutic endoscopic procedure and clarification about anticipated intolerance to sedatives. Updated Discussion/General Information and References.
Revised	05/09/2013	MPTAC review. Clinical Indication statement edited to allow operating physician or the anesthesiologist to provide documentation about higher risk situations. Updated References.
Revised	11/08/2012	MPTAC review. Updated Description and Index. Title change to “Monitored Anesthesia Care for Gastrointestinal Endoscopic Procedures.” Updated Clinical Indications to remove statement for moderate sedation. Added medically necessary statement for anesthesiologist and CRNA. Added not medically necessary statement for when criteria are not met. Updated Coding section; removed 99143, 99144, 99145, 99148, 99149, 99150 no longer applicable.
Reviewed	08/09/2012	MPTAC review. Updated Discussion/General Information and References. Added Definitions section. Updated Coding section to remove anesthesia modifiers, and non-specific CPT codes related to epidural anesthesia, nerve blocks and risk factors.
Revised	08/18/2011	MPTAC review. Updated Clinical Indications to define “pediatric age group” as those individuals under the age of 18. Updated Discussion/General Information and References.
Reviewed	08/19/2010	MPTAC review. Updated Discussion/General Information and References.
Reviewed	08/27/2009	MPTAC review. Removed “Place of Service” section. Updated References.
Reviewed	08/28/2008	MPTAC review. Updated References and Web Sites.
Revised	08/23/2007	MPTAC review. Clarification of medically necessary criteria documentation. References updated.
Reviewed	05/17/2007	MPTAC review. References updated.
New	06/08/2006	MPTAC initial document development. Original document part of CG-MED-21 Anesthesia Services and Moderate Sedation.

Appendix

American Society of Anesthesiology Physical Status Classifications:

Class I: A normal healthy patient
Class II: A patient with mild systemic disease
Class III: A patient with severe systemic disease
Class IV: A patient with severe systemic disease that is a constant threat to life
Class V: A moribund patient who is not expected to survive without the operation
Class VI: A declared brain-dead patient whose organs are being removed for donor purposes