



MASSACHUSETTS

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Medical Policy

Monitored Anesthesia Care (MAC)

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Policy Number: 154

BCBSA Reference Number: 7.02.01

NCD/LCD: N/A

Related Policies

Manipulation under Anesthesia, #483

Policy

Commercial Members: Managed Care (HMO and POS), PPO, and Indemnity Medicare HMO BlueSM and Medicare PPO BlueSM Members

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 co-morbidity (American Society of Anesthesiologists class III, IV, or V [see Table PG1])
 - Morbid obesity (BMI [body mass index] >40kg/m²)
- Documented sleep apnea
- Inability to follow simple commands (cognitive dysfunction, intoxication, or psychological impairment)
- Spasticity or movement disorder complicating procedure
- History or anticipated intolerance to standard sedatives, such as
 - Chronic opioid use, or
 - Chronic benzodiazepine use
- Patients with active medical problems related to drug or alcohol abuse
- 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
 - Dysmorphic facial features
 - Oral abnormalities (eg, macroglossia)
 - Neck abnormalities (eg, neck mass)

- Jaw abnormalities (eg, micrognathia)
- Acutely agitated, uncooperative patients, or
- Prolonged or therapeutic gastrointestinal endoscopy procedures requiring deep sedation.

*Examples of prolonged endoscopy procedures that may require deep sedation include the following: endoscopy in patients with adhesions after abdominal surgery, endoscopic retrograde cholangiopancreatography, stent placement in the upper gastrointestinal tract, and complex therapeutic procedures such as plication of the cardioesophageal junction.

Table PG1. ASA's Physical Status Classification System

Class	Definition
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

ASA: American Society of Anesthesiologists.

The 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.

Prior Authorization Information

Inpatient

- For services described in this policy, precertification/preauthorization **IS REQUIRED** for all products if the procedure is performed **inpatient**.

Outpatient

- For services described in this policy, see below for products where prior authorization **might be required** if the procedure is performed **outpatient**.

	Outpatient
Commercial Managed Care (HMO and POS)	Prior authorization is not required .
Commercial PPO and Indemnity	Prior authorization is not required .
Medicare HMO BlueSM	Prior authorization is not required .
Medicare PPO BlueSM	Prior authorization is not required .

CPT Codes / HCPCS Codes / ICD Codes

Inclusion or exclusion of a code does not constitute or imply member coverage or provider reimbursement. Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage as it applies to an individual member.

Providers should report all services using the most up-to-date industry-standard procedure, revenue, and diagnosis codes, including modifiers where applicable.

CPT Codes

CPT codes:	Code Description
00520	Anesthesia for closed chest procedures (including bronchoscopy)

00635	Anesthesia for procedures in lumbar region; diagnostic or therapeutic lumbar puncture
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
01936	Anesthesia for percutaneous image guided procedures on the spine and spinal cord; therapeutic
01991	Anesthesia for diagnostic or therapeutic nerve blocks and injections (when block or injection is performed by a different provider); other than prone position
01992	Anesthesia for diagnostic or therapeutic nerve blocks and injections (when block or injection is performed by a different provider); prone position

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,^{1,2} 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 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 visit, 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:

- 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 patient 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 patient 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
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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).³

ASA: American Society of Anesthesiologists.

Because sedation is a continuum, it is not always possible to predict how a 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 or analgesia (conscious sedation) should be able to rescue patients who enter a state of deep sedation or analgesia, while those administering deep sedation or analgesia should be able to rescue patients who enter a state of general anesthesia.

Sedation for Diagnostic and Therapeutic Procedures

Multiple diagnostic and therapeutic procedures performed in the outpatient setting (eg, 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.² By this standard, the personnel must be, in addition to the proceduralist, 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.

Moderate sedation can be achieved using pharmacologic agents for sedation, anxiolysis, and analgesia. A frequently used combination is an opioid and benzodiazepine (eg, 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 nonanesthesiologists. 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 nonanesthesiologists, stating that personnel must be prepared to respond to deep sedation and loss of airway protection should these complications inadvertently occur during sedation.⁴

Summary

Adequate sedation and analgesia are important parts of many diagnostic and therapeutic procedures. Various levels of sedation and analgesia (anesthesia) may be used, depending on the patient's condition and the procedure being performed. 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 a patient's airway becomes compromised.

For individuals who have planned endoscopy and certain risk factors or significant medical conditions who receive MAC, the evidence includes systematic reviews, a randomized controlled trial (RCT), and observational studies. Relevant outcomes are overall survival, 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. However, the evidence from RCTs is sparse. The single RCT comparing propofol administration by anesthesiologists for the purpose of anesthesia with propofol administered by nonanesthesiologists for sedation during colonoscopy reported that patients 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 patient satisfaction and reported a higher rate of hypoxia in patients treated by anesthesiologists with propofol. However, this trial may have been underpowered to detect differences in complication rates. The evidence is insufficient to determine the effects of the technology on health outcomes.

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 overall survival, morbid events, hospitalizations, 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 the effects of the technology on health outcomes.

For individuals who have a 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 overall survival, morbid events, hospitalizations, 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 the effects of the technology on health outcomes.

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

Policy History

Date	Action
1/2019	BCBSA National medical policy review. Description, summary and references updated. Policy statements unchanged.
2/2018	Clarified coding information.
1/2018	New references added from BCBSA National medical policy.
1/2018	Clarified coding information.
12/2016	New references added from BCBSA National medical policy.
3/2015	New references added from BCBSA National medical policy.
8/2013	BCBSA National medical policy review. Policy statement clarified. Effective 8/1/2013.
11/2011-4/2012	Medical policy ICD 10 remediation: Formatting, editing and coding updates. No changes to policy statements.
10/2011	Reviewed - Medical Policy Group - Gastroenterology, Nutrition and Organ Transplantation. No changes to policy statements.
11/2010	Reviewed - Medical Policy Group - Gastroenterology, Nutrition and Organ Transplantation. No changes to policy statements.
2/1/2010	Medical Policy 154 effective 2/1/2010.

Information Pertaining to All Blue Cross Blue Shield Medical Policies

Click on any of the following terms to access the relevant information:

[Medical Policy Terms of Use](#)

[Managed Care Guidelines](#)

[Indemnity/PPO Guidelines](#)

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