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Distinguishing Between a Pre-Anesthesia Evaluation and a Separately Reportable Evaluation and Management Service

ASA Committee on Economics

When providing anesthesia care, the anesthesiologist provides medical services before, during and after the actual administration of anesthesia to the patient. In the pre-anesthesia period, an essential part of the anesthesiologist's work is performing a pre-anesthesia evaluation to assess risks and develop an anesthetic plan. The value and payment for this work are included in the anesthesia base units and cannot be separately reported. However, the anesthesiologist may separately provide evaluation and management (E/M) services to a complex patient that are distinct from the pre-anesthesia evaluation as well as from the surgeon's pre-operative history and physical examination. In this case, the E/M service may be reported and paid in addition to the anesthetic service. **A distinct, preoperative E/M service must be supported by individual circumstances, including medical necessity, and would not be expected to be performed on a routine basis.**

Pre-Anesthesia Evaluation

To distinguish work included in the anesthesia base units from work done separately, one must understand what is included in the standard pre-anesthesia evaluation, when it is to be completed, and who can perform it.

Services included in a pre-anesthesia evaluation

A pre-anesthesia evaluation is conducted to assess the potential risks associated with the administration of anesthesia and performance of surgery and to develop the anesthetic plan. This evaluation specifically identifies the risks associated with anesthesia and is the sole purview of a qualified anesthesia professional. Elements of the pre-anesthesia evaluation include:

1) reviewing the patient's medical history, including anesthesia, drug, and allergy history, interviewing (as applicable based on the patient's ability to participate) and performing a physical examination;
2) formally assessing anesthesia risks and identifying potential anesthesia problems, particularly those that may suggest potential complications or contraindications to the planned procedure (e.g., difficult airway, ongoing infection or coagulopathy, limited intravascular access);
3) collecting additional pre-anesthesia data or information (e.g., stress tests, additional specialist consultations based on results of the evaluation of laboratory tests);
4) discussing risks and benefits and obtaining informed consent; and
5) developing a plan for the patient's anesthesia care as described in ASA's Basic Standards for Preanesthesia Care.

Timing of the pre-anesthesia evaluation

The pre-anesthesia evaluation should be conducted within 48 hours prior to the day of surgery. It can be conducted up to 30 days before surgery but must then be updated within 48 hours prior to surgery [CFR §482.52(b)(1)]. NOTE: Anesthesia practices should also review any applicable state law.

Providers who can perform the pre-anesthesia evaluation

Although the pre-anesthesia evaluation may include a review of medical history and medical information collected by non-anesthesia clinicians, the ability to assess the risks of anesthesia care, develop an anesthesia plan to provide the most appropriate care for the patient, and communicate the risks and the plan is an essential part of anesthesia training. The Centers for Medicare & Medicaid Services (CMS) recognizes this fact in federal regulations: "Only individuals qualified to administer anesthesia can perform the elements of a preoperative anesthesia evaluation as described above and this evaluation cannot be delegated to others" [CFR 482.52(b)(1)].

Compensation for the pre-anesthesia evaluation

Compensation for pre-anesthesia evaluation, including the immediate pre-anesthesia assessment (history, physical exam with airway assessment, NPO status, and other pertinent elements), is incorporated into the anesthesia base units and is not separately billable. Anesthesia services are usually paid based on the "base value + time" methodology, which is well described in the ASA Relative Value Guide®.

Pre-Operative or Pre-Procedural History and Physical Examination

In addition to the pre-anesthesia evaluation, state and federal regulations may require other evaluations in the pre-procedure/peri-operative period including the pre-operative history and physical (H&P) examination. These serve different purposes than the pre-anesthesia evaluation and do not assess anesthesia-related processes, e.g., risk, management, and consent.

Pre-operative history and physical examination

This is separate and distinct from a pre-anesthesia evaluation. The pre-operative history and physical examination includes a review of medical history, the current medical condition requiring surgery or procedure, a physical examination, and the development of a surgical or procedural plan.

Timing of the pre-operative history and physical examination

If the procedure is being done in a hospital, the history and physical examination must be conducted no more than 30 days before a procedure. If the pre-operative history and physical was performed more than 24 hours before the procedure, an updated examination of the patient must be performed and any changes in the patient's condition documented prior to surgery. Medicare also allows a lower-level assessment to substitute for a history and physical examination prior to specific procedures in a hospital setting. However, procedures for which an assessment may be substituted must be clearly identified in the institution's Medical Staff Bylaws [482.22(C)(5)(i)]

[482.22(C)(5)(ii)] [482.22(C)(5)(iii)]. NOTE: there are varying rules in different settings (e.g., hospital inpatient, hospital outpatient, ASC).

Providers who can perform the pre-operative history and physical examination
Any physician or other qualified healthcare professional, in accordance with institutional medical staff bylaws and state law, may be deemed to be qualified to conduct a history and physical examination.

Compensation for the pre-operative history and physical examination
Compensation for the preoperative History and Physical is included in the surgical bundle, and as such is not separately billable during the global period [NCCI Chapter 1, I-16]. The Updated History & Physical Evaluation is likewise a routine E/M service performed during the global period and, as such, would also be considered a component of the surgeon's global bundle and not separately billable. [NCCI Chapter 1, I-16]. The provider performing the procedure is therefore typically responsible for performing, or making arrangements for others to perform, these evaluations.

Anesthesiologist Performing Surgical H&P
In an ambulatory surgery center (ASC), the institution's policies will determine which patients must have a comprehensive medical history and physical assessment completed by a physician or other qualified practitioner (as defined above). [42 CFR 416.52(a)(1)]]

The purpose of a comprehensive medical history and physical assessment (H&P) is to determine whether there is anything in the patient's overall condition that would affect the planned surgery, such as a medication allergy, or a new or existing co-morbid condition that requires additional interventions to reduce risk to the patient, or which may even indicate that an ASC might not be the appropriate setting for the patient's surgery. [Interpretive Guidelines 42 CFR §416.52(a)(1)].

In some circumstances, state regulations or facility policy may require a physician to perform the H&P, even though the operating proceduralist is a qualified and licensed non-physician (e.g., podiatrist, dentist). In these circumstances an anesthesiologist may be asked to perform the H&P. When completed on other than the day of surgery, this service may be separately reported. When performed on the day of surgery, some payers including Medicare may preclude payment based upon edits from the National Correct Coding Initiative (NCCI). On the rare occasion when an anesthesiologist performs a separate Surgical H&P for a non-physician proceduralist s/he could submit a claim for the appropriate level of Evaluation and Management service with modifier 25 (Significant, Separately Identifiable Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional on the Same Day of the Procedure or Other Service). The anesthesiologist should document the specific circumstances that necessitated that they perform this service.

Complex Patient Evaluation and Management Service

For some patients undergoing surgery or procedures requiring anesthesia care, it may be medically necessary to optimize underlying medical conditions, perform care coordination, and/or develop medical optimization transition or bridging orders for patient safety and optimal outcomes. These services for patients with complex medical co-morbidities may fall outside the scope of the pre-anesthesia evaluation and the pre-operative history and physical examination. In these circumstances, when the work is separate and distinct, the anesthesiologist can report this work with the appropriate Evaluation and Management (E/M) code. Selecting the correct level of E/M service to report a patient visit can seem complex. CPT® and CMS provide extensive guidance for selecting the code to report. ***This service must be distinct and separate from the pre-anesthetic evaluation.***

Telehealth Considerations

Some anesthesiologists may use phone calls to contact patients and conduct some portions of the pre-anesthesia evaluation. Many of the components of a pre-anesthesia evaluation can be accomplished in this manner but patients require some face-to-face time to complete the remaining important components of pre-anesthesia assessment. The telephone call is part of the pre-anesthesia evaluation and not a separately reportable event.

If the anesthesiologist provides care that is separate and distinct from the pre-anesthesia evaluation / examination as described above, a telehealth visit may be an alternative to a face - to-face encounter. The rules, criteria, and payment for telehealth services have been revised to adapt to conditions under the COVID pandemic and those flexibilities are to remain in place throughout the declared public health emergency (PHE). Some commercial payers are following Medicare's lead and others are implementing their own policies on telehealth. If providing care via telehealth, be sure to check your commercial payers' policies frequently as they are subject to change. ASA will continue to monitor and inform our members when CMS issues additional information about use of telehealth for Medicare beneficiaries during and after the PHE.

Documentation Required for Evaluation and Management Services

E/M documentation is substantially different from anesthesia documentation. Simply stated, if it is not documented it has not been done. This topic is beyond the scope of this document. CMS and CPT provide reference tools for understanding E/M documentation.

These vignettes are offered for illustrative purposes only. They are intended to assist anesthesiologists and others in determining whether a specific encounter is included in the preanesthetic evaluation or may be separately reportable.

Vignettes

1. A 77-year-old man presents to the pre-anesthesia clinic five days prior to his scheduled total knee arthroplasty. The anesthesiologist completes a medical history and finds the patient has diabetes mellitus, hypertension, and COPD. He had tested positive for a COVID-19 infection and was admitted for management of respiratory failure three months ago. He required mechanical ventilation for three days but has made a complete recovery and is now COVID negative. He still has some shortness

of breath but no dyspnea on exertion. He is back to his pre-COVID activity level. On physical examination, the only significant finding is that the patient is obese. Chest examination is clear to auscultation. The anesthesiologist orders no pulmonary function testing (PFT).
Disposition: This is a pre-operative anesthesia evaluation. A follow-up evaluation would need to be documented within 48 hours prior to surgery.

2. The same patient from Example 1 above had PFTs that demonstrated an obstructive pattern that was concerning to the anesthesiologist. When seen in clinic the patient reports a cough that worsens when supine and some dyspnea on exertion and persistent fatigue. The anesthesiologist requests a pulmonary consultation for a plan to improve ventilation and manage cough and dyspnea. After consulting with the pulmonologist following the patient's appointment, the anesthesiologist amends the plan to include intravenous corticosteroids and bronchodilators per the pulmonologist and forwards the plan to both the anesthesiology team and surgical team for execution.
Disposition: The pre-operative anesthesia evaluation **exceeds** the typical preanesthetic evaluation. This would constitute an evaluation and management service based on medical decision making.

3. A 34-year-old woman with history of chronic pelvic pain for six months is sent for abdominal MRI identifying multiple fibroids, ovarian entrapment in the pouch of Douglas, and a mass on the right ovary. Laparoscopic hysterectomy with possible oophorectomy and other related procedures is scheduled. The patient is referred to the pre-operative clinic and seen by the anesthesiologist for assessment one week prior to surgery. A history of heavy menstrual bleeding requiring an iron infusion in the past is elicited. She does not have any bleeding at this time and is taking PO iron, however the anesthesiologist feels it is appropriate to order a complete blood count and iron study. The patient is sent to the lab, and the results come back later that day. Based on the results, the anesthesiologist determines that the patient would benefit from erythropoietin administration and an iron infusion prior to surgery. The patient is contacted by phone, the test results are communicated and a plan to get an iron infusion is discussed and scheduled. The patient is referred to the anemia clinic for the infusion.
Disposition: The initial visit represents a complex evaluation that **exceeds** the typical preanesthetic evaluation. The anesthesiologist addresses anemia and implements a plan to increase the patient's oxygen carrying capacity. This would constitute an evaluation and management service based on medical decision making.

4. The same patient from Example 3 above is seen one month after iron infusion therapy. Surgery is scheduled for the following week. The Hgb is now 12.9 and considered acceptable. There are no other interval changes.
Disposition: This second visit is a pre-operative anesthesia evaluation.

5. A 28-year-old woman who is five months pregnant (G1P0) and had scoliosis repair as a teenager is seen by the anesthesiologist for evaluation and counseling about labor analgesia and possible surgical (c-section) anesthesia. The anesthesiologist meets with the patient and her husband to review her surgical procedure report, examine the patient, and discuss the possible anesthesia options for labor and vaginal delivery as well as possible cesarean section delivery.
   Disposition: This would not constitute a pre-anesthesia visit, as it occurs more than 30 days prior to the planned anesthesia services. This would constitute an evaluation and management service based on medical decision making.

6. A 66-year-old man with a history of coronary artery disease and aortic stenosis, s/p CABG and AVR with metal prosthesis presents to the pre-operative clinic prior to scheduled prostatectomy for benign prostatic hypertrophy causing severe obstructive uropathy. At the time of the visit, the patient is on multiple medications for hypertension and anticoagulation (warfarin) for his prosthetic valve. The patient is evaluated in person by the anesthesiologist staffing the pre-operative clinic and a thorough history and physical examination are performed. The surgery team has already requested the patient to schedule an appointment with his cardiologist to determine appropriate medication management for his blood pressure. The anesthesiologist identifies the need for a plan to address his anticoagulation and withdrawing his warfarin. The anesthesiologist spends significant time explaining the concerns related to his anticoagulation and clarifies that a plan will be generated agreeable to his cardiology and surgical teams so that his procedure can occur safely. In the pre-operative assessment, the anesthesiologist writes a detailed note regarding the plan for bridging and sends the note to both the surgeon and the cardiologist the patient is planning to see the following week. After consulting with the cardiologist following the patient's appointment, the anesthesiologist amends the plan to include admission and heparin infusion per the request of the cardiologist and forwards the plan to both the anesthesiology and surgical teams for execution.
   Disposition: The pre-operative anesthesia evaluation **exceeds** the typical preanesthetic evaluation. This would constitute an evaluation and management service based on medical decision making.

7. A 47-year-old man is scheduled to undergo lumbar spinal fusion surgery in six weeks. He is currently taking Morphine ER 60mg bid and oxycodone 30mg PO q4 hours to manage his low back pain. The surgeon is concerned that the patient will have difficulty with pain management and recovery post operatively given the high doses of opioids he is consuming. The surgeon refers the patient to the perioperative pain clinic to help optimize the patient's pain medication regimen prior to surgery. At the perioperative pain clinic, the anesthesiologist screens the patient to assess his risk for opioid abuse, with the pain catastrophizing scale and screen for depression with PHQ-9. The anesthesiologist evaluates the medications and treatments the patient has received for pain in the past, creates a multimodal regimen for the perioperative

period, and formulates a weaning strategy to reduce preoperative opioid use while managing pain with agreement from the patient's chronic pain physician if involved. The anesthesiologist counsels the patient on optimal diet, music therapy, and the role of exercise.

Disposition: The pre-operative anesthesia evaluation **exceeds** the typical preanesthetic evaluation. The approach to optimization and pain management for the perioperative period requires unique evaluation and management separate from chronic pain management and includes the elements of evaluation of the patient's current pain, past history of treatments, and formulation of a plan to reduce risk by weaning opioids, if applicable, and introducing a multimodal opioid sparing strategy to manage pain in the perioperative period. This would constitute an evaluation and management service based on medical decision making.

This committee work product has not been approved by ASA's Board of Directors or House of Delegates and does not represent an ASA Policy, Statement, or Guideline.

This Timely Topic is intended to serve as a preliminary source of information and may be updated as it undergoes further review. It is meant to help advise anesthesiologists on billing and CMS Conditions of Participation requirements, rather than other areas of compliance that may overlap.

References/Resources:

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