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Reporting E&M Services and Anesthesia Services Together in the Pre-operative Period

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Over the years ASA has received a number of questions regarding the circumstances that allow separate payment for Evaluation & Management (E&M) services provided by anesthesiologists during the pre-operative period. This article is intended to provide some guidance on when such claims might be paid.

Payment for anesthesia services reported with CPT® codes 00100–01999 includes the pre-operative examination of the patient who will undergo the anesthetic. There is no separate payment available for that exam, even if it takes place at a time in advance of the day the anesthesia is provided or in a place separate from the surgical/procedure location, such as a pre-operative clinic.

E&M services that go beyond those provided as part of the "routine" preoperative evaluation and preparation of the patient for the planned surgery and anesthesia **may** meet the criteria for claiming separate payment in addition to payment for the underlying anesthesia service itself provided all relevant criteria are met and documented. The services must be separately identifiable and significant E&M services that are clearly beyond those necessary to evaluate the patient for anesthesia or necessary to safely provide anesthesia services. To qualify as a separate service, the anesthesiologist must provide services beyond the pre-operative anesthesia exam. In most cases this should include medical management of underlying diseases to optimize the patient for the surgical procedure and anesthesia. These could include a comprehensive evaluation of the patient's medical condition and management of those issues that need to be corrected or optimized prior to surgery and anesthesia, or managing the patient's medical conditions after the surgical procedure.

Separate charges for E&M services by anesthesiologists could raise red flags with Medicare, Medicaid, the Office of the Inspector General (OIG) or Recovery Audit

Contractor (RAC) auditors, especially if this occurs more often than as a rare event. When two services are reported together, the documentation should clearly indicate not just what was done as far as providing services necessary to qualify for the particular level of E&M code reported (history, physical exam, and medical decision

making), but also clearly demonstrate the medical necessity of the anesthesiologist providing E&M services beyond those provided by the surgeon or the patient's primary care physician. It is not enough to document what was done, but also that what was done was necessary for the treatment of that particular patient.

Claims for E&M services that are separate from the routine preoperative evaluation and preparation for the planned anesthetic should be identified with the CPT code that best describes the level of E&M services provided. To avoid RAC automated review processes, a modifier should be added to the E&M code to describe the particular circumstances surrounding the provision of those E&M services on the day of or day prior to the anesthetic when the clinical situation supports use of the modifier. The modifier most often used when reporting anesthesia services and a separate E&M service is modifier 25 (significant, separately identifiable E&M service by the same physician or other qualified health care professional on the same day of the procedure or other service). It is not appropriate to add a modifier to the E&M CPT code if the separate E&M service is provided prior to the day before surgery. However, a RAC may still review claims if both services are provided within a relatively short time period. In such cases even though no modifier is added to the code, it is necessary that the medical documentation clearly demonstrate that the E&M service was beyond the required preoperative anesthesia evaluation **and** that those additional services were medically necessary.

During the initial RAC operations, one of the RACs initiated automated processes to identify instances in which anesthesiologists submitted claims for an E&M service on the day of or the day prior to an anesthesia service. The RAC would then recoup the payment for the E&M service as part of its automated process without reviewing medical records to determine whether those services met criteria that would allow separate payment for the E&M services. The ASA successfully demonstrated that in many cases such payments could be proper and the combination of anesthesia services and E&M services should not be subject to automatic recoupment. The RACs may still review instances of claims for both anesthesia services and E&M services, but in most cases now conduct complex reviews, which require the RACs to notify the anesthesiologist of the review and allow them to submit medical records

to justify the separate reporting of the two services. Anesthesiologists receiving requests for such documentation must submit it within the required time frames or the RAC can proceed with its recoupment activities.

In summary, under rare conditions an anesthesiologist may submit claims for both an anesthesia service and an E&M service in the pre-operative period. However, the E&M service must be a significant, separately identifiable service that is medically necessary on its own in addition to the usual preoperative evaluation that is a part of every anesthesia service. Anesthesiologists submitting such claims should clearly document the extent of the services provided as part of the E&M service and the medical reasons that those services were necessary to care for the patient. Lastly, that documentation should be available to submit to payers, CMS, the OIG or RAC auditors if requested as part of a review of those services.