Understanding Significant and Separately Identifiable E&M

These guidelines can prevent unfair denials.

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Significant and Separately Identifiable

Almost every service we provide is either a procedure or an evaluation and management (E&M). It is important to differentiate between the two so we know which one we provided, allowing us to code appropriately. Stated simply, a procedure occurs when we do something to a patient. Examples of procedures include cutting something, debriding something, injecting something, and performing an operation. Toenail debridement is a procedure. An E&M is when we evaluate a patient and medically manage their situation. Examples of E&Ms include writing a prescription, making a recommendation, suggesting an over-the-counter product, and referring a patient to another provider. With some exception, we cannot submit both an E&M and a procedure for the same patient during the same encounter.

Chapter I, Section D of the National Correct Coding Initiative Policy Manual for Medicare Services[1] informs, "An E&M service is separately reportable on the same date of service as a procedure under limited circumstances." That limited circumstance is when the E&M is significant and separately identifiable from the procedure.

What Does That Mean?

It is easy to answer the question of, "when can we submit an E&M at the same time as a procedure?" with, "if the E&M is significant and separately identifiable from the procedure." However, that does not help very much without an explanation of what "significant and separately identifiable" means. To summarize that explanation in one sentence, an E&M is significant and separately identifiable from a procedure if the work related to the E&M can be separated from the work related to the procedure and there is no overlap between the two. Chapter I, Section D of the National Correct Coding Initiative Policy Manual For Medicare Services informs a significant and separately identifiable E&M exists if it does not "include any work inherent in the procedure, supervision of others performing the procedure, or time for interpreting the result of the procedure."[1] There cannot be any overlap of work between the E&M and the procedure. "The decision to perform a minor surgical procedure is included in the payment for the minor surgical procedure, and shall not be reported separately as an E&M service."[1]

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What About a New Patient?

There is a common misconception that we can automatically submit an E&M for all new patients, even those that have a procedure performed, just because they are new. That is not correct. The National Correct Coding Initiative Policy Manual for Medicare Services makes this very clear in Chapter I, Section D by stating, "The fact that the patient is "new" to the provider is not sufficient alone to justify reporting an E&M service on the same date of service as a minor surgical procedure."[1] Often, this misconception arises from the thinking that we have performed a History and Physical (H&P) on a new patient and that warrants an E&M. H&P does not equal E&M! An H&P involves taking a patient's history and performing a physical exam. What is missing there is the "M" of E&M. There is no management in an H&P. An E&M requires some form of management. There is no CPT® code for performing an H&P. An H&P is not a billable service. Given all of the above, the rules of "significant and separately identifiable" apply to new patient encounters just as they apply to established patient encounters.

Documentation

When a significant and separately identifiable E&M and a procedure are both performed, it is essential that the documentation clearly reflects

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two separate services with no overlap in work between the E&M and the procedure. This is an area where errors are commonly made and audits fail, especially when it comes to new patients. Too often the provider actually did perform a significant and separately identifiable E&M, but the documentation does not reflect what was performed. The documentation must relate the work that was involved with the E&M and separately relate the work that was involved with the procedure, with a clear distinction that there is no overlap between the two.

Example

An example of incomplete documentation is often seen when a new patient receives an injection. The progress note may have a complete "subjective" section with chief complaint, history of present illness, past medical history, surgical history, social history, allergies, medications, and a review of systems. The "objective" section of the progress note may be complete as well. The problem occurs when the "plan" section of the note only describes the injection. While a significant and separately identifiable E&M may have been performed at this encounter, if the "plan" section of the note does not clearly outline the work that was involved with the E&M and that there was no overlap in this work and the work related to the procedure, then the note does not substantiate a significant and separately identifiable E&M.

This problem can be avoided by separating the "plan" section of the progress note into two sections: one that describes the work involved with the E&M and one that describes the work involved with the procedure, and there should be no overlap between these two sections. The description of the work involved with the E&M may include the description of the diagnosis to the patient, and the discussion of potential etiologies, potential treatment options, potential advantages and disadvantages of these treatment options, potential risks and complications of the treatment options, how something like this may be prevented in the future, and all of the patient's questions that were answered.

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Then the second section of the "plan" can include the decision for the procedure that was selected and a detailed description of the procedure performed. When documented in this manner, there is no overlap in work among the two sections of the "plan", and the note fully describes the encounter that took place. Not only is this thorough documentation that supports a significant and separately identifiable E&M, it is also a good form of risk management as the documentation does an excellent job of capturing all that took place during the encounter.

Conclusion

An understanding of what a significant and separately identifiable E&M is and how to substantiate its performance in a progress note are essential elements of ensuring proper coding, payment accuracy, and avoiding unfair denials. The documentation needs to be excellent when contesting denials for significant and separately identifiable E&M services that were actually performed and should be recognized. Following the guidelines illustrated here should help to accomplish these goals. **PM**

Reference

[1] National Correct Coding Initiative Policy Manual for Medicare Services https://www.cms.gov/Medicare/Coding/National-CorrectCodInitEd.

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