AAMC Regulatory Resource

Medicare Policies Regarding Split (Shared) Visits - Effective January 1, 2022

Background

The Centers for Medicare and Medicaid Services (CMS) established new rules for split (shared) visits in the final 2022 physician fee schedule rule. These new rules will impact Medicare reimbursement for physician practices that use advanced practice providers (defined as nurse practitioner, physician assistant, certified nurse specialist, or certified nurse midwife) in facility settings.

Split (shared) Visit Defined

A split or shared visit refers to an evaluation/management (E/M) visit that is performed ("split" or shared") by both a physician and an Advanced Practice Provider (APP; referred to by Medicare as a Nonphysician Provider or NPP) who are in the same group. CMS clarifies that split (shared) visits are those that are furnished in a facility (institutional) setting (where "incident to" billing is not available. In the rule, CMS modifies its policy to allow split (shared) visits to be billed for "new" and "established" patients, and for critical care and skilled nursing facility/nursing facility E/M visits in addition to other E/M visits. Therefore, the split (shared) visit policy applies to the following E/M visit types: non-office outpatient, inpatient/observation/hospital, SNF; emergency department, and critical care.

Billing for Split (Shared) Visit: "Substantive" portion defined

Only the physician or APP who provides a "substantive" portion of the visit would bill for the "split (shared) visit. This is an important concept because a physician would be paid at 100% of the fee schedule rate while an APP would be paid at 85% of the rate. For 2022, the there is a choice about whether the split (shared) visit will be billed under the National Provider Identifier (NPI) of the physician or advanced practice provider (APP) depending on who either (1) provides one of the three key components of the visit (history, exam or medical decision-making) in its entirety or (2) provides more than 50% of the service time. Effective January 1, 2023, the billing practitioner must be the individual who performed more than 50% of service time for the visit. For critical care services, starting in January 2022, the substantive portion means more than half of the total time.

CMS identified a list of activities that would count toward the total time of the E/M visit when determining the provider who performed the substantive portion of the visit. These activities are:

- Preparing to see the patient (for example, review of tests).
- Obtaining and/or reviewing separately obtained history.
- Performing a medically appropriate examination and/or evaluation.
- Counseling and educating the patient/family/caregiver.
- Ordering medications, tests, or procedures.
- Referring and communicating with other health care professionals (when not separately reported).

- Documenting clinical information in the electronic or other health record (Note: CMS has stated it may be helpful for each practitioner to document their own participation in the medical record in order to determine the substantive time).
- Independently interpreting results (not separately reported).
- Communicating results to the patient/family/caregiver.
- Care coordination (not separately reported).

Only distinct services can be counted. When the practitioners jointly meet or discuss the patient, only the time of one of the practitioners can be counted. Practitioners cannot count time for performance of other separately reportable services, travel, and general teaching that is not limited to discussion about management of a specific patient.

A physician and APP have to be in the "same group" to bill for a split (or shared) visit. In the proposed rule, CMS solicited feedback on how "same group" would be defined; however, CMS did not adopt a definition of "same group" in its final rule.

Code Level Selection

Even though the practitioner who provides the substantive portion of the service is determined by time, the level of the code selected is not necessarily based on time. For example, an APP may spend 15 minutes on a split (shared) inpatient visit and the physician may spend 20 minutes to deliver the split (shared) visit. Since the physician spent more than 50% of the total time, the physician would bill the split (shared) visit. However, the physician can select the **level of code** to report using either medical-decision making or total time of both the physician and the APP.

Documentation in the medical record

Documentation in the medical record must identify both professionals who performed the visit. The individual who bills for the visit (performed the substantive portion) must sign and date the medical record. In the rule, CMS clarified that one of the practitioners must have face-to-face (in person) contact with the patient; however, face-to-face contact is not required of the practitioner who provides the substantive portion and bills for the visit.

CMS clarified that "when one of the three key components (history, exam, or medical decision-making) is used as the substantive portion in 2022, the practitioner who bills the visit must perform that component in its entirety in order to bill." If the practitioner billing is performing that component, it might be easiest for them to also document it. However, they can use a scribe, or APP to enter the information in the record about the component they performed. When the record is signed the billing provider attests that they performed the substantive portion in its entirety themselves. CMS has emphasized that although any member of the medical team may enter information into the medical record, only the reporting provider may review and verify notes made in the record by others for the services the reporting clinician furnishes and bills.

CMS established a claim modifier, - FS (split or shared e/m visit), that is mandatory for split (or shared) visits.

Below is a chart that summarizes the past guidance and the modifications to CMS policy for split (or shared) visits.

Topic	**Prior Guidance**	**New Guidance** **(Effective 1/1/2022 unless otherwise noted)**
Billing Practitioner (Definition of "Substantive" Portion)	Practitioner who performs a "substantive portion" of the E/M visit	For 2022, the split (shared) visit may be billed under the physician or APP who either (1) provided one of the three key components of the visit (history, exam or medical decision-making) in its entirety or (2) provides more than 50% of the service time. Effective **January 1, 2023**, the billing practitioner must be the individual who performed more than 50% of service time for the visit.
Same group	Practitioners must be in the same group to bill split (shared) services	Practitioners must be in the same group to bill split (shared) services. No definition of "same group."
Application to Prolonged Time	Not specified	Allows practitioners to bill for **a prolonged E/M visit** as a split (or shared) visit if the time threshold for reporting prolonged services is met
Settings of Care	Billable in institutional settings, not including skilled nursing facility (SNFs).	Billable for E/M visits in institutional settings (hospital and skilled nursing facility (SNF).
New and Established Patients, Initial and Subsequent visits	May be bill for established patients	Split (or shared) visits may be billed for new and established patients, as well as for initial and subsequent visits, that otherwise meet the

		requirements for split (or shared) visit payment
Medical Record Documentation	Not specified	Documentation in the medical record must identify the physician and APP who performed the visit. The individual who performed the substantive portion of the visit (and therefore bills for the visit) must sign and date the medical record
Claim Identification	None	Modifier -FS (Split or Shared E/M Visit) must be reported on claims for split (or shared) visits
Critical Care	No split (shared) visits may be billed	Split (shared) visits may be billed.

Implications

Teaching hospitals and physicians should be knowledgeable about these new policies regarding split (shared) visits because they will impact reimbursement for their facility-based E/M visits. This in turn may cause organizations to evaluate the ways in which they will use APPs while balancing the importance of APPs to team-based care and increasing patient access to services. In addition, appropriate documentation, a system for tracking time, and use of an attestation will be important to support the provision and billing for these services.

Given the challenges with implementation, AAMC has strongly urged CMS to rescind the policy related to split (shared) visits to allow the billing for the visit to be determined based on either the practitioner who performs the key medical decision-making component of the service or the practitioner who performed more than 50% of the time.

References

Medicare Program; CY 2022 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies. Published November 19, 2021. Retrieved from: **https://www.federalregister.gov/d/2021-23972**

Medicare Claims Processing Manual (Transmittal 11288), March 4, 2022. **https://www.cms.gov/files/document/r11288cp.pdf**

MLN Matters Number: MM12543 (March 4, 2022) **https://www.cms.gov/files/document/mm12543-internet-only-manual-updates-iom-critical-care-split-shared-evaluation-and-management-visits.pdf**

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