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CY 2022 Changes to Split (or Shared) Visit, Critical Care and Teaching Physician Billing

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In preparation for the beginning of calendar year 2022, we want to highlight several important policies in the CY 2022 Medicare Physician Fee Schedule (PFS) final rule (Final Rule) related to billing for teaching physician services, split (or shared) visits, and critical care. These include:

- Establishing guidelines for billing for teaching physician services based on time instead of medical decision making (MDM) and clarifying the circumstances in which "virtual" presence of the teaching physician is acceptable outside the current public health emergency (PHE).
- Addressing which practitioner should report the split (or shared) visit when elements are performed by different practitioners.
- Allowing for split (or shared) visits to be billed for: new patients, critical care visits in institutional settings, certain Skilled Nursing Facility (SNF/NF) evaluation and management (E/M) visits, and a prolonged E/M visit.
- Clarifying guidance related to how critical care services may be furnished and billed: by a single physician or non-physician practitioner (NPP), as concurrent care, as split (or shared) services, on the same day as an E/M service, and in addition to a procedure with a global surgical period.

These key billing policies are summarized in more detail below.

Teaching Physician Billing

Under general teaching physician billing rules (outside the COVID-19 PHE), if a resident participates in a service furnished in a teaching setting, a teaching physician only can bill for the service if s/he is present for the key or critical portion of the service. For residency training sites that are located outside a metropolitan statistical area (MSA), PFS payment also may be made if a teaching physician is virtually present through audio/video real-time communications technology. In the case of E/M services, the teaching physician must be present during the portion of the service that determines the level of service billed.

The Final Rule clarifies that when total time instead of MDM is used to determine the office/outpatient E/M visit level, only the time spent by the teaching physician in qualifying activities, including time that the teaching physician was present with the resident performing those activities, can be included for purposes of visit level selection. During the PHE, teaching physicians can count time that they are virtually present through real-time audio-video technology in the total time used for level selection. Outside the PHE, however, this "virtual" presence only may be counted toward time used for level selection in residency training sites located outside of an MSA. Despite public comments urging CMS to permanently permit a "virtual" presence beyond the COVID-19 pandemic, CMS declined to permanently extend this flexibility beyond the PHE outside of MSAs.

For services furnished under the primary care exception, CMS finalized that time cannot be used to select the office/outpatient E/M visit level – in other words, only MDM can be used to select the visit level. CMS decided

that MDM is a more accurate indicator of visit complexity than time in the context of care furnished by residents. This restriction also guards against the possibility of residents providing and billing for E/M visits that are more complex than lower and mid-level complexity when this is no longer permitted under the primary care exception after the PHE ends.

Split (or Shared) Visits

Existing rules around billing for split (or shared) visits have often been a source of confusion for practitioners, particularly given that prior Medicare Claims Processing Manual guidance was withdrawn effective May 9, 2021 (more information on this is in our prior article on the CY 2022 Medicare PFS Proposed Rule). Given that, "incident to" billing is not allowed in facility (*e.g.*, hospital) settings. The only way that a physician and an NPP in a facility can "share" a visit and have their combined work taken into account when billing for services is when split (or shared) visit requirements are satisfied.

When Split (or Shared) Visits Should Be Reported

CMS finalized a definition of split (or shared) visits in a new section of the regulations at 42 CFR § 415.140. The new regulation defines split (or shared) visits as E/M visits in the facility setting that are performed in part by both a physician and an NPP who are in the same group. To provide further detail, split (or shared) visits are those that:

- Are furnished in a facility setting by a physician and an NPP in the same group, where the facility setting is defined as an institutional setting in which payment for services and supplies furnished incident to a physician or practitioner's professional services is prohibited under the regulations on incident to billing (42 CFR § 410.26(b)(1)).

- Are furnished in accordance with applicable law and regulations, including conditions of coverage and payment, such that the E/M visit could be billed by either the physician or the NPP if it were furnished independently by only one of them in the facility setting (rather than as a split (or shared) visit).

How the "Substantive Portion" of the Split (or Shared) Visit Should Be Determined

The Final Rule establishes that only the physician or NPP who performs the substantive portion of the split (or shared) visit may bill for the visit. CMS finalized the definition of "substantive portion" to mean, as of January 1, 2023, more than half of the total time spent by the physician and NPP performing the visit. Except in the case of critical care visits, CMS is allowing an adjustment period for providers to establish systems that track and attribute time by defining "substantive portion" for one transitional year (CY 2022) as one of three key components of a visit – history, exam, or MDM – *or* more than half of the total time spent by the physician and NPP performing the split (or shared) visit. In other words, for CY 2022, the practitioner who spends more than half of the total time, or performs the history, exam, or MDM, can be considered to have performed the substantive portion and can bill for the split (or shared) E/M visit. For critical care visits, which are already timed, the "substantive portion" will have the initially proposed definition (i.e., more than half of the total time) beginning in CY 2022.

The distinct time of service spent by each physician or NPP furnishing a split (or shared) visit should be aggregated to determine total time and which practitioner provided the substantive portion (and therefore, bills for the visit). For visits that are not critical care services, CMS stated in the Final Rule that the same listing of activities that can count when time is used to select E/M visit level can count toward total time. (Critical care has a different listing of qualifying activities, as discussed below.)

Other Important Proposed Changes to Split (or Shared) Visit Billing Guidance

Additionally, the Final Rule established the following important changes to prior split (or shared) visit guidance. The Final Rule:

- Allows split (or shared) visits to be billed for **new** patients, as well as established patients, and for initial and subsequent split (or shared) visits.

- Allows split (or shared) visits for **critical care visits** when they are performed in any institutional setting. The Final Rule establishes rules specifically related to billing for critical care split (or shared) E/M Services, which are explained in further detail below.

- Allows split (or shared) visits for certain **SNF/NF** E/M visits that are not required to be performed in their entirety by a physician.

- 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.

Same Group Requirement for Split (or Shared) Visits

Consistent with longstanding CMS guidance, CMS finalized that a physician and NPP must be in the same group in order for them to bill a split (or shared) visit. If the physician and the NPP are in different groups, CMS expects that they will bill independently only for the services that they each specifically fully furnish. CMS did not offer a definition of "group" under its previous CY 2022 Medicare PFS proposed rule ("Proposed Rule") and instead sought comment as to whether it should further define "group" for purposes of split (or shared) visit billing. While many commenters proposed definitions of "group" for purposes of split (or shared) visits, CMS chose not to further define it in the Final Rule and instead intends to monitor claims data in consideration of potential future rulemaking.

Documentation and Coding

The Final Rule requires that for split (or shared) visits, documentation in the medical record must identify the individual practitioners who performed the visit, and the individual who performed the substantive portion (and therefore bills the visit) must sign and date the medical record.

Finally, CMS is creating a modifier for split (or shared) visits that must be appended to claims for these visits irrespective of whether the physician or NPP bills for the visits. The modifier will allow CMS to identify claims for split (or shared) visits more efficiently than previously, where the only way to identify such visits has been through medical record review.

Critical Care Services

CMS also updated critical care service policies to clarify guidance given that manual guidance had been withdrawn and to take into account recent revisions in E/M coding and payment. Specifically, CMS finalized the definitions of critical care services and qualified health professional (QHP) as proposed (further information on the proposed definitions is in our article on the CY 2022 Medicare PFS Proposed Rule).

Critical Care Services Furnished by a Single Physician or NPP

For critical care services furnished by a single physician or NPP, CMS finalized its proposal to adopt the rule that CPT code 99291 should be used to report the first 30-74 minutes of critical care services rendered on a given date (and that code should be used only once per date), and CPT code 99292 should be used for additional 30-minute time increments provided to the same patient. CPT codes 99291 and 99292 will be used

to report the total duration of time spent by the physician or NPP providing critical care services to a critically ill or critically injured patient, even if the time spent by the practitioner on that date is not continuous. Non-continuous time for medically necessary critical are services may be aggregated.

Finally, the Final Rule adopts the following language from the introduction to the CPT Codebook regarding when a critical care service furnished by a single physician or NPP extends beyond midnight the following calendar day: "Some services measured in units other than days extend across calendar dates. When this occurs, a continuous service does not reset and create a first hour. However, any disruption in the service does create a new initial service. For example, if intravenous hydration (96360, 96361) is given from 11 p.m. to 2 a.m., 96360 would be reported once and 96361 twice. For continuous services that last beyond midnight (that is, over a range of dates), report the total units of time provided continuously."

Critical Care Services Furnished as Concurrent Care

When critical care is furnished concurrently by two or more practitioners in the same specialty and the same group to the same patient on the same day, the individual physician(s) or NPP(s) providing the follow-up or subsequent care may report their time using CPT code 99292 (the code for subsequent time intervals), but should not report CPT code 99291 (the primary service code). CPT code 99291 should not be reported more than once for the same patient on the same day by practitioners in the same specialty in the same group.

Where one practitioner begins furnishing the initial critical care service but does not meet the time required to report CPT code 99291, and another practitioner in the same specialty and group continues to deliver critical care to the same patient on the same day, the time spent by those practitioners can be aggregated to meet the time requirement to bill CPT code 99291. Once the time threshold necessary to report CPT code 99291 is met, CPT code 99292 should not be reported by the practitioner or another practitioner in the same specialty and group unless and until the additional 20 minutes of critical care services are furnished to the same patient on the same day.

Critical Care Services Furnished as Split (or Shared Services)

As referenced above, the Final Rule allows critical care services to be reported when furnished as split (or shared) services. The aforementioned rules related to split (or shared) services will apply to critical care services with one exception (described below), and time would be counted for CPT code 99292 in the same way as for prolonged E/M services. In short, CMS has finalized that the total critical care service time provided by a physician and NPP in the same group on the same day can be aggregated, with the practitioner who furnishes the substantive portion of the total critical care time reporting the critical care services.

The only exception to the general split (or shared) visit rules that CMS has finalized for critical care services is that the qualifying activities that would be counted toward the total cumulative time are the qualifying activities included in CPT codes 99291 and 99292, rather than the qualifying activities for E/M code level selection. The billing practitioner should first report CPT 99291 and, if 75 or more cumulative total minutes were spent providing critical care, the billing practitioner should report one or more units of CPT code 99292, as applicable. For split (or shared) critical care services (unlike concurrent critical care services), when two or more practitioners spend time jointly meeting with or discussing the patient, the time may be counted only once.

Documentation Requirements for Critical Care Services

The Final Rule requires practitioners to document in the medical record the total time that critical care services were provided by each reporting practitioner (but does not necessarily require start and stop times). Services

need to be sufficiently documented to allow a medical reviewer to determine the role each practitioner played in the patient's care (*i.e.*, the condition or conditions for which each practitioner treated the patient). The documentation requirements included in the Final Rule for split (or shared) E/M visits also apply to split (or shared) critical care visits.

Critical Care Services and Same-Day E/M Services

In the Proposed Rule, CMS proposed that no other E/M visit should be billed for the same patient on the same date as a critical care service when the services are furnished by the same practitioner, or by practitioners in the same specialty in the same group, as such E/M visits would not typically be medically necessary.

Pursuant to the Final Rule, CMS will now permit payment for critical care services rendered on the same day as other E/M visits by the same practitioner or another practitioner in the same group of the same specialty, if the practitioner documents that the E/M visit was provided prior to the critical care service at a time when the patient did not require critical care, the visit was medically necessary, and the services are separate and distinct with no duplicative elements from the critical care service provided later that day. Practitioners must report modifier -25 on claims reporting these critical care services.

Critical Care Visits and Global Surgery

In the Proposed Rule, CMS proposed to bundle critical care visits with procedure codes that have a global surgical period. However, in response to public comments highlighting potentially negative impacts on the quality and safety of patient care, among other things, CMS has chosen not to finalize this proposal.

Instead, CMS maintains its current policy that critical care visits may be separately paid in addition to a procedure with a global surgical period, so long as the critical care service is unrelated to the procedure. Preoperative and/or postoperative critical care may be paid in addition to the procedure if the patient is critically ill and requires the full attention of the physician, and the critical care is above and beyond and unrelated to the specific anatomic injury or general surgical procedure performed (i.e., trauma or burn cases). CMS is creating new modifiers to identify that critical care is unrelated to a surgical procedure. If care is fully transferred from a surgeon to an intensivist (and the critical care is unrelated), modifiers -54 (surgical care only) and -55 (postoperative management only) must also be reported to indicate the transfer of care. The surgeon will report modifier -54, and the intensivist accepting the transfer of care will report both modifiers -55 and the new unrelated modifier.

Take-Aways

The provisions of the Final Rule summarized above reflect changes in care delivery arising from an ongoing evolution toward care that includes the services of NPPs and other QHPs. Especially in light of the recently withdrawn Medicare guidance related to split (or shared) visits and critical care services, the Final Rule provides needed clarity to practitioners working together or concurrently to provide medically necessary E/M, critical care, and other services to patients in a variety of settings. Moreover, CMS's clarifications regarding permissibly billing for teaching physician services provided virtually will be instructive when the PHE comes to an end. From a practical perspective, providers should begin to evaluate how current practices will need to be modified to comply with the new guidance. Providers will need to establish systems to track and document time spent by physicians and NPPs, especially with respect to split (or shared) visits for non-critical care services. Though CMS has provided a one-year transitional period for such services, it is advisable to evaluate existing billing and coding procedures as soon as possible, especially since other requirements in the Final Rule – like those related to new modifiers for split (or shared) visits and critical care services, as well as guidelines applicable to billing for teaching physician services – are not subject to the transition period.

For more information, please contact Allison Cohen, Heather Alleva, or any member of Baker Donelson's Reimbursement Team.