TITLE: Split/Shared Billing between Advanced Practice Professionals and Physicians

POLICY/PURPOSE: To explain the Medicare Part B rules for performing, documenting and billing Evaluation and Management Services ("E/M Services") that are split (or shared) between an Advanced Practice Professional ("APP") and a physician.

There are different rules for calendar year 2022, calendar year 2023, for critical care, and for skilled nursing facilities and nursing facilities. This policy is applicable to non-critical care services rendered in a Facility setting during calendar year 2022. A revised policy will be issued for non-critical care services rendered in calendar year 2023.

Refer to policy # 2022-02-001 (Billing Medicare Part B for Critical Care Services) for instructions billing critical care services beginning with calendar year 2022.

For E/M services rendered in a Skilled Nursing Facility or Nursing Facility, refer to policy # AA-04-10-001 (Nursing Facility E/M Services and the Use of Advanced Practice Professionals).

This policy is applicable to Medicare Part B only. Commercial and managed care payors may have different requirements. Refer to the payor contract and/or policy manual for specific payor instructions.

DEFINITIONS:

Advanced Practice Professional ("APP") – An individual qualified by education, training, licensure/regulation and facility privileging who performs a professional service within his/her state scope of practice and may independently report that professional service. APPs may be supervised by a physician or collaborate with a physician.

Medicare recognizes the following APPs who may report E/M Services:

- Certified Nurse Midwife
- Clinical Nurse Specialist
- Nurse Practitioner
- Physician Assistant

Distinct Time – time spent separately on patient care by the physician or APP.

Facility Setting – For purposes of this section means institutional settings in which payment for services and supplies furnished incident to a physician or practitioner's professional services is prohibited and Medicare benefits are assigned to the patient. A physician office (Place of Service code 11) and an Urgent Care Center (Place of Service code 20) are not considered Facility settings.

Joint Time – time spent by the physician/APP discussing/assessing the patient together.

Note: Joint physician/APP time may also be added to arrive at the time reported, but when physicians and APPs jointly meet with or discuss the patient, only the time of one of the practitioners may be counted.

Example: If the APP first spent 10 minutes with the patient and the physician then spent another 15 minutes on the same calendar day, their individual time spent would be summed to equal a total of 25 minutes. If, in the same situation, the physician and APP met together for five additional minutes (beyond the 25 minutes) to discuss the patient's treatment plan, that overlapping time could only be counted once for purposes of establishing total time and who provided the Substantive Portion of the visit. The total time would be 30 minutes, and the physician would bill for the visit, since the physician spent more than half of the total time (20 of 30 total minutes).

Key Component – History, physical examination and medical decision-making portions of an E/M Service.

Qualifying Time – Drawing on the CPT E/M Guidelines, the following listing of activities can be counted toward total time for purposes of determining the Substantive Portion, when performed and whether or not the activities involve direct patient contact:

- 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.
- Independently interpreting results (not separately reported) and communicating results to the patient/family/caregiver.

• Care coordination (not separately reported).

Practitioners cannot count time spent on the following:
• The performance of other services that are reported separately.
• Travel.
• Teaching that is general and not limited to discussion that is required for the management of a specific patient.

Split (or shared) visit: An E/M visit in the facility setting that is performed in part by both a physician and an APP, who are in the same group, in accordance with applicable law and regulations such that the service could be billed by either the physician or APP if furnished independently by one of them.

Substantive Portion – A substantive portion of an E/M Service involves all of either the history, the exam or the medical decision making component or more than half of the total time spent by the physician and APP performing the split (or shared) visit.

Note: The role of the physician in the service extends further than providing general oversight-of/agreement-with the APP's work (e.g., reviewing/co-signing the APP's note) but instead consists of active, shared participation in the service with the APP.

In order to bill the E/M service under the physician's provider number, the physician must personally perform the Substantive Portion of the E/M service that supports the level of service billed. The physician's contributions should generally consist of visit work not already performed by the APP (i.e., a physician should not routinely bill shared/split visits based on the repetition of visit elements already performed by the APP).

PROCEDURE:
For E/M services rendered in a Skilled Nursing Facility or Nursing Facility, refer to policy # AA-04-10-001 (Nursing Facility E/M Services and the Use of Advanced Practice Professionals).

PROCEDURE:

I. Applicable and Inapplicable Services

The split/shared billing concept is applicable only to E/M Services performed in a Facility Setting. The split/shared billing concept is applicable to new and established patients as well as initial and subsequent encounters.

II. E/M Modifier

Append the ***"FS"*** *modifier* [Split (or shared) Evaluation and Management service] when E/M services are split (or shared) between a physician and an APP. The ***"FS"*** modifier must be entered regardless of whether the charge is billed under the physician's or the APP's provider number.

III. Hospital-based Inpatient/Hospital-Based Outpatient/Emergency Department Settings

A. When an E/M Service rendered in a *Facility Setting* is split/shared between a physician and an APP from the same group practice, the E/M encounter may be billed under the physician's name and provider number if and only if:

1. The physician personally performs one of the key components of an E/M Service; i.e., History, Exam, or Medical Decision- Making to the degree that it is medically necessary and supports the level of service billed. The APP would personally perform and personally document the other key components of the E/M Service. The documentation in the medical record must identify the physician and APP who performed the visit. When the physician personally performs one of the key components of an E/M Service, the physician's work shall be considered the Substantive Portion. The individual who performed the Substantive Portion of the visit (and therefore bills for the visit) must sign and date the medical record;. In lieu of personally documenting the Substantive Portion, the physician may use an attestation statement to indicate that he or she performed the Substantive Portion of the service, what the Substantive Portion of thservice was, whether or not face-to-face contact was made with the patient, and a reference to the APP's note for details. *****
Physician Attestation Example: *"I saw and evaluated the patient [only include if a face-to-face interaction was made with the patient]. I personally performed the Substantive Portion of this service, which was [choose between history, exam, or medical decision making]. Refer to the APP's note for details."*

or

2. The physician personally spends more than half of the total time spent by the physician and APP individually contributing to the split/shared visit. When the physician spends more than half of the total time, the physician's time shall be considered the Substantive Portion. Both the physician and the APP must document the time spent performing the E/M Service and how the time was spent. The individual who performed the Substantive Portion of the visit (and therefore bills for the visit) must sign and date the medical record.* Refer to definitions above for "Distinct Time" and "Qualifying Time." Joint time spent by the APP and physician together must be documented by either the APP or the physician. Either the physician or the APP must document that face-to-face contact was made with the patient.

   Example:
   The APP documents a note indicating 30 minutes of encounter time, "of which 10 minutes were spent with the physician assessing/discussing the patient."

   The Physician still documents a note indicating 20 minutes of encounter time, and mentioning that he/she saw/discussed the patient with the APP.

   Because of the APP's note, we know to only deduct 10 minutes from the physician's documented time, it being joint assessment/discussion time already being represented within the APP's documented 30 minutes. We can then confidently conclude that the total encounter time is 40 minute

*** Note: Regardless of billing requirements, physician signatures or cosignatures may be required for medical/legal reasons or to satisfy hospital policies. The Office of Compliance urges the author of each note to sign their respective note.**

B. If the physician does not personally perform he Substantive Portion of the E/M Service, the E/M Service shall not be billed under the physician's name and provider number but may only be billed only under the APP's name and provider number.

C. Brief, teaching physician-type attestation statements that one would write when a resident is involved in the service is not sufficient to support the Substantive

Portion. For example, the statement "I saw and examined the patient with the APP and agree with the APP's assessment and plan" would not be sufficient because it is not clear whether or not the physician performed the Substantive Portion of the service to the degree that supports the level of service billed.

When one of the three key components is used as the Substantive Portion, the practitioner who bills the visit must perform that component in its entirety to the level that supports the billable service. For example, if history is used as the Substantive Portion and both the physician and the APP take part of the history, the billing practitioner must perform the level of history required to select the level of service billed. Likewise, if physical exam is used as the Substantive Portion and both the physician and the APP examine the patient, the billing practitioner must perform the level of exam to select the level of service billed. If MDM is used as the Substantive Portion, the physician and the APP each could perform certain aspects of MDM, but the billing practitioner must perform all portions or aspects of MDM that are required to select the level of service billed.

D. For all split (or shared) visits, either the physician or the APP must have face-to-face (in-person) contact with the patient, but it does not necessarily have to be the physician, nor the practitioner who performs the substantive portion and bills for the visit. One of the clinicians must document that face-to-face contact was made with the patient.

E. When a shared/split visit is billed based on History, Exam, or Medical Decision Making being the Substantive Portion of the service, and each clinician has a separate note for their portion of the encounter, it may be advantageous to bill an E/M Service at a lower level but bill the service under the physician's provider number. Billers or Coders will need to compare the Medicare allowed amounts for the level supported when billing based on the level of service supported by the components performed by the APP or the level of service supported by the component completed by the physician (i.e., the Substantive Portion). E/M Services billed under the APP's provider number will incur a 15% reduction in payment.

For example, the APP performs and documents a level 3 History and level 3 Exam for a subsequent inpatient hospital visit. The level of service billed for established patient visits or subsequent visits is based on the highest two of the three key components (i.e., History, Exam, and Medical Decision Making).

The physician performs and documents the Medical Decision Making but it only supports a level 2 E/M Service. In order to bill as a physician service (i.e., under the physician's provider number), the level of service would be based on the Substantive Portion performed by the physician. In this case, a level 2 visit could be billed under the physician's provider number since the physician only performed and documented Medical Decision Making to support a level 2.

The alternative would be to bill a level 3 visit under the APP's provider number because 2 of the 3 key components needed to support the overall level of service for a subsequent inpatient hospital visit support a level 3 visit.

Service Level Supported at Physician Rate	Allowance for Service Supported at Physician Rate	Service Level Supported at APP Rate	Allowance for Service at APP Rate (15% reduction)
99232	$71.59	99233	$87.39

According to the chart above, it would be financially advantageous to bill 99233 under the APP's provider number instead of 99232 under the physician's provider number. If the service is billed under the APP's provider number, the Relative Value Units would be assigned to the APP and not the physician. To assist Coders in making this decision, a chart containing facility visit codes and calendar year 2022 Medicare allowed amounts at both the physician and APP rates is included in *Appendix A*.

IV. Application to Prolonged Services

When practitioners use a Key Component as the Substantive Portion, there will need to be different approaches for hospital outpatient E/M Services than other kinds of E/M Services.

A. Outpatient Hospital Visits – For shared hospital outpatient visits where practitioners use a Key Component as the Substantive Portion, prolonged services can be reported by the practitioner who reports the primary service (i.e., the practitioner who performs the Substantive Portion) if the time threshold for reporting prolonged services is met.

In order to bill a prolonged service, the primary service billed would have to be either a level 5 new patient visit code 99205 or a level 5 established patient visit code 99215. Prolonged service code G2212 may be reported when the highest time in the range of time for the level five outpatient E/M visit (CPT code 99205 or 99215) is exceeded by at least 15 minutes on the date of the service.

The combined time of both the physician and the APP would need to meet the threshold for reporting a prolonged service code.

The units of service for the G2212 code may be adjusted for each additional 15 minutes of prolonged service time. Do not report G2212 for any time unit less than 15 minutes.

HCPCS Code & Units	Total Time Required for Reporting
99205	60-74 minutes
99205 x 1 and G2212 x 1	89-103 minutes
99205 x 1 and G2212 x 2	104-118 minutes
99205 x 1 and G2212 x 3 or more for each additional 15 minutes	119 or more minutes
99215	40-54 minutes
99215 x 1 and G2212 x 1	69-83 minutes

HCPCS Code & Units	Total Time Required for Reporting
99215 x 1 and G2212 x 2	84-98 minutes
99215 x 1 and G2212 x 3 or more for each additional 15 minutes	99 or more minutes

Note: Total time is the sum of all time, including prolonged time, spent by the reporting practitioner on the date of service of the visit.

B. Emergency Department and Critical Care Visits – Do not report prolonged services codes with these types of visits. .

C. All other types of E/M Services – Prolonged services can be reported by the practitioner who reports the primary service (i.e., the practitioner who performs the Substantive Portion) when the combined time of both practitioners meets the threshold for reporting prolonged E/M Services. Prolonged services codes 99354-99359 vary based on time, location, and whether or not there is direct patient contact. In all cases, a minimum of 60 minutes beyond the typical time listed for the primary service must be incurred before the initial prolonged services code may be billed.

E/M Visit Family	2022	2022	2023
	If Substantive Portion is a Key Component	If Substantive Portion is Time	Substantive Portion Must be Time
Inpatient/Observation/Hospital/SNF	Combined time of both practitioners must meet the threshold for reporting CPT 99354-99359 (60 + minutes > typical)	Combined time of both practitioners must meet the threshold for reporting CPT 99354-99359 (60 + minutes > typical)	Combined time of both practitioners must meet the threshold for reporting prolonged services
Emergency Department	N/A	N/A	N/A
Critical Care	N/A	N/A	N/A

V. Split (or Shared) Procedures

The split/shared billing concept is not applicable to procedures, regardless of setting. Procedures performed either in whole or in part by an APP may not be billed to Medicare as a "shared/split" procedure under a physician's number. No amount of physician involvement allows the procedure to be billed using the physician's provider number unless the physician personally performs the entire procedure. In which case, the physician must provide the documentation that supports his/her performance of the entire procedure.

All such procedures MUST be billed under the APP's own number, regardless of:

- the location of the physician (e.g., on campus, in the building, in the room);.
- the physician's participation in the procedure (e.g., instructing);
- the fact that an accompanying E/M service DID meet the requirements for split/shared billing; and

- who documents the procedure (A physician who witnesses the procedure must NOT document the procedure note on behalf of the APP, and conclude that his/her physician note somehow allows the service to be billed under his/her physician number).

REFERENCES:

CMS. Transmittal No. 11181. 01/14/2022.
CMS. Medicare Program; CY 2022 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Provider Enrollment Regulation Updates; and Provider and Supplier Prepayment and Post-Payment Medical Review Requirements. 86 FR 64996-66031.

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