2022 Physician Fee Schedule: Understanding the Proposed Changes to Split/Shared Visits

Each year, the Centers for Medicare and Medicaid Services (CMS) incorporates changes in policy, regulations and requirements for billing under the Medicare Physician Fee Schedule (PFS). These changes are often adopted by commercial payers.

On November 2, 2021, CMS released the final rule for the 2022 PFS that included changes to split/shared visits scheduled to go into effect on January 1, 2022. The proposed changes included some important considerations related to the conditions for submitting split/shared visits for reimbursement and have the potential to alter the existing workflow of physicians and advanced practice providers (APPs) related to billing for split/shared encounters.

While some changes took effect in 2022, a number of the most impactful changes to split/shared billing were delayed to January 1, 2024. The 2023 PFS final rule indicates CMS' desire to make significant changes to split/shared visits while allowing organizations time to prepare.

Split/Shared Visits

According to the Medicare Claims Processing Manual Publication #100-04, a split/shared visit is defined as:

"A split/shared E/M visit is defined by Medicare Part B payment policy as a medically necessary encounter with a patient where the physician and a qualified non-physician provider each personally perform a substantive portion of an evaluation and management (E/M) visit face-to-face with the same patient on the same date of service. A substantive portion of an E/M visit involves all or some portion of the history, exam or medical decision making key components of an E/M service. The physician and the qualified NPP must be in the same group practice or be employed by the same employer."

Split/shared E/M visits are only applicable in the hospital inpatient and hospital outpatient departments using provider-based billing and emergency room sites of service for all

professional encounters currently except for critical care services, procedures, or time-based codes (e.g., prolonged service time).

What is Changing?

The 2022 final rule included several changes that are designed to reflect current clinical practice, recognize APPs' evolving role as members of the care team, reduce duplication of services and clarify the conditions of payment for these types of services.[1,2] These changes were implemented beginning in 2022 with additional changes identified for implementation in 2024. The most significant change is moving the split/shared visit from an E/M and medical decision-making based attribution to a time-based attribution. Under the current medical decision-making rubric, split/shared visits are typically billed by physicians, assuming specific conditions of collaboration have been met (e.g., face to face encounter, contributing to the evaluation, management or medical decision, employed by the same group or employer). In 2022, changes include the allowance of time-based accounting for a split/shared visit where "the practitioner who provides the substantive portion of the visit (more than ½ of the total time spent) would bill for the visit." In 2022 and 2023, split/shared visits can be submitted using the current medical decision-making methodology or the new time-based methodology. Other changes applicable in 2022 include the ability for critical care services to be reported as split/shared, and the requirement that a new billing modifier be added for all shared visits. A survey performed by SullivanCotter of National APP Advisory Council (NAAC) members found that 54% of organizations were still using split shared billing.[3]

The greatest impact on split/shared visit billing is set to occur in 2024 when all shared visits must be billed using the time-based methodology where the practitioner who provides the substantive portion of the visit ("more than ½ of the total time spent") bills for the visit[1]. In 2022 and 2023, the impact of the split/shared change will likely be modest but will allow organizations time to better understand the degree of split/shared billing that occurs within their organizations through the shared visit modifier requirement.

In 2024, the impact on attributed wRVUs for physicians and APPs providing services in the inpatient setting could be significant. The time-based methodology will require physicians to have greater than 50% of the time spent with a patient in order to bill and receive wRVU attribution. Because of this change, in 2024, the same patient volume using current split/shared workflows could result in an increase in reported APP wRVUs and a corresponding decrease in reported physician wRVUs. This change could also result in an overall decrease in professional collections (to account for the 15% difference in Medicare physician and APP

reimbursement levels for the same service).

When accounting for time, CMS identified these specific activities[2]:

- 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 individual 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).

Example

A hospitalized patient with a diagnosis of pneumonia is being cared for by the hospital medicine team composed of a physician and an APP. On hospital day 2, the APP sees the patient in the morning and spends 25 minutes with the patient performing a focused history and physical, reviewing the morning labs and providing patient education related to the course of treatment with the patient and their family. Based on a detected decrease in lung sounds during the lung exam, the APP orders a chest x-ray. Later in the day, the physician and the APP spend an additional 10 minutes together to make afternoon rounds and review the chest x-ray findings, make changes in treatment, and meet with the patient to review the chest x-ray results (35 minutes in total for the APP and 10 minutes total for the physician).

The hospital medicine team bills the encounter as 99233 (subsequent hospital care level 3). Under the historical medical decision-making approach, this could be billed by the physician as a split/shared visit (assuming all of the other criteria were met) or by the APP (paid at 85% of the allowed amount for Medicare patients).

Under the time-based billing approach, the visit could only be billed by the APP as the APP provided the majority of the encounter (35 out of 45 minutes or 78% of the total time spent in the encounter). As the physician would not receive wRVU or reimbursement credit for this visit using this methodology, this could impact credited physician productivity and, for organizations using productivity-based compensation models, both physician and APP compensation.

What Now?

Current care delivery models should be reevaluated when developing a strategy to transition to time-based billing for split/shared visits. It is important to design an effective and transparent workflow that allows for top-of-licensure operation and minimizes any competition for credit. With changes imminent, organizations can take the following steps to prepare:

- Assess the current state of split/shared billing at your organization.
- Evaluate current care team composition and work responsibilities to determine the optimal team composition and anticipated wRVU attribution impact to ensure that providers are efficient and optimally utilized.
- Assess the impact on specific patient workflows (e.g., new patients, established patients, discharges) where split/shared visits are utilized today.
- Identify types of encounters that could be performed solo by the APP thus allowing physician to see other patients.
- Consider if modifications to physician and APP compensation arrangements are needed to ensure financial sustainability and regulatory compliance. Be aware these changes may influence the reported wRVU and compensation per wRVU 2023 survey report data.

Sources

[1]*Calendar Year (CY) 2022 Medicare Physician Fee Schedule Final Rule*. Published November 2, 2021. Retrieved from https://www.cms.gov/newsroom/fact-sheets/calendar-year-cy-2022-medicare-physician-fee-schedule-final-rule

[2]*RIN 0938-AU42 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

[3]*National APP Advisory Council Fall 2022 Pulse Survey*