McCarter & English

Healthcare Alert

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Slow and Steady Wins the Race

Hospitals Should Evaluate Their Split/Shared Services Notwithstanding the Delay Under CMS's 2024 Physician Fee Schedule Proposed Rule

In the CY 2024 Physician Fee Schedule Proposed Rule (the Proposed Rule), the Centers for Medicare & Medicaid Services (CMS) proposed a further delay in implementing its time-only definition for determining the "substantive portion" of a "split/shared" Evaluation and Management (E/M) visit in the facility setting until at least December 31, 2024. Although CMS continues to kick the can down the road on this specific issue, several key changes for split/shared services have been implemented over the past few years, and industry data has suggested a lack of compliance. Hospitals, and other facilities, should make sure they are complying with those changes and evaluate the impact of the anticipated implementation of the time-only definition as soon as January 1, 2025.

Definitions and conditions of payment that became effective on January 1, 2022, are primarily reflected in 42 C.F.R. § 415.140 and include the following:

- A split/shared visit is defined as an E/M service "in a facility setting that is performed in part by both a physician and a nonphysician practitioner [referred to herein as an advanced practice practitioner (APP)] who are in the same group";
- Documentation requirements for the claim and medical record; and
- For critical care visits, only the provider who spent more than half of the total time of a split/shared visit can be deemed to have performed the substantive portion of that visit and can bill for the visit.

As CMS explained in the Proposed Rule, it planned to phase in the time-only definition for non-critical care split/shared E/M visits by allowing the substantive portion of a visit to be performed by the provider who spent more than half the total time or who performed the history, physical exam, or medical decision-making of the visit in CY 2022, and then moving to a time-only definition on January 1, 2023. **CMS subsequently delayed implementing the time-only definition for CY 2023 and has proposed another delay for CY 2024, as it received numerous comments that a time-only definition will affect facilities and may disrupt current team-based practice and billing systems.** CMS also acknowledged that the American Medical Association's CPT Editorial Panel is considering changes related to these services, which CMS stated it will consider if they are available for the final rule.

CMS's delay in the implementation of the time-only definition would provide hospitals with at least another year with four definitions of "substantive portion," i.e., four options to bill the visit under the physician, instead of billing it under the APP at 85% of Medicare's physician fee schedule. They must, however, ensure that they are following all other conditions for payment and should evaluate how the time-only definition for critical care services has impacted their workflow and finances and be prepared for the anticipated additional changes in the final rule and future rulemaking.

Facilities should focus their efforts on:

(1) **Updating their policies and procedures for documenting and properly billing for split/shared E/M visits and training staff with respect to those policies and procedures;**

(2) **Determining the optimal care delivery teams for providing split/shared services within the various departments, using critical care services as a model; and**

(3) **Evaluating the financial ramifications of the existing change to critical care services and possible changes to other E/M services, including the estimated decrease in reimbursement to the facility resulting from billing more split/shared services as APP services, and the effect on physician and APP compensation models and pay.**

1. Updating Policies and Procedures and Training Staff for Documenting and Properly Billing Split/Shared E/M Visits

Facilities must ensure that they are following previously implemented documentation requirements for claims and medical records in order to meet CMS conditions of payment for split/shared visits, while considering how those policies would need to be further updated if the substantive portion were limited to a time-based definition for all split/shared E/M services, as is now the case for critical care visits. These conditions of payment under 42 C.F.R. § 415.140 include:

(1) Identifying in the medical record the physician and APP who performed the visit;

(2) Signing and dating of the medical record by the individual who performed the substantive portion of the visit; and

(3) Using the designated modifier FS on the claim to identify the visit as a split/shared service, which will stand out in audits.

CMS stated in the Proposed Rule that it intends, in part, to use the modifier to better quantify split/shared visits, understand billing patterns, ensure program integrity, and consider clarifications or revisions in future rulemaking.

2. Determining the Optimal Care Delivery Teams for Providing Split/Shared Services Within Various Departments

Facilities should determine (a) the type and number of split/shared E/M services provided by the facility and (b) the time spent and services currently provided by physicians and APPs, respectively, for each type of service. Using critical care services as a model, facilities should determine how to change their current care delivery models, if necessary, to maximize the capabilities of their physicians and APPs, which are likely to differ across departments. For example, some E/M visits might call for more physician involvement and time, while other E/M visits may be performed by APPs, giving physicians the opportunity to focus on more complex cases and to assume additional roles within the facility.

In determining the optimal care team composition and responsibilities for E/M visits, facilities should also consider which providers are best suited for performing qualifying time activities that can be counted in the total time spent in determining the substantive portion, as CMS identified in its final rule for CY 2022:

- 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)

Critical care services have a separate list of qualifying time activities, but all split/shared E/M visits provide that (1) qualifying time activities performed together can only be counted once in the total time spent; and (2) "one of the practitioners 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."

Even though these changes follow a decades-long trend to increase APP roles and responsibilities, facilities must ensure that all their providers are acting within their state's scope of practice laws and regulations and their medical staff bylaws and rules and regulations when performing qualifying time activities and billing for split/shared services.

3. Evaluating the Financial Ramifications of the Changes and the Effect on Physician and APP Compensation Models and Pay

In conjunction with determining optimal care teams and activities, hospitals must evaluate the financial ramifications of billing E/M visits more frequently under APPs, which are reimbursed at 85% of the Medicare fee schedule rate for physicians. Facilities should further identify potential goals of serving more patients, providing more services, or otherwise increasing revenue. As noted above, facilities can use the changes effective for critical care services as a model to consider the impact on other split/shared E/M visits.

If physicians are contributing to the care of patients in certain E/M visits, including through meaningful action in qualifying activities, but are not able to bill for these services because their time spent with patients is less than that of the APPs, their work may not be reflected in a work Relative Value Unit (wRVU) compensation system. In fact, APP wRVUs will likely increase with a time-only definition, while physician wRVUs will likely decrease, assuming the same number of visits and level of work. Facilities should consider future changes to compensation models that will fairly compensate all their providers, while being careful to avoid Anti-Kickback Statute, Stark Law, or other legal or regulatory issues.

Please contact George Kendall and Megan Nigro if you would like to discuss any of the above issues and to consider the impact of CMS's final rule when it becomes available later this year.

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