2022 CMS Changes Pertinent to APP Services

UCI Health Compliance & Privacy Office

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Conversion Factor

- Conversion factor decreased 3.75% in 2022, which means some services on the PFS will be decreased

Shared/Split Services

- Modifier FS
  - New HCPCS modifier effective 1-1-2022
  - Split (or shared) Evaluation and Management service

Shared/Split Services

- Shared or split services are Evaluation and Management (E/M) services performed jointly between a physician and a non-physician practitioner (NPP), in the same group, in a facility setting.
- Services may include both face-to-face and non-face-to-face activities, as defined by CPT.
- Services billed using the physician's NPI are paid at a higher rate than those billed by a non-physician practitioner.
- CMS states that the service should be reported by the clinician who performs a substantive portion of the visit.

Shared/Split Services

- Shared services will be allowed for nursing facility services, except for those services that are mandated to be done by a physician. Only a physician may bill the initial nursing facility visits 99304-99306 in a skilled nursing facility or nursing facility.

Shared/Split Services

- Specifically, office and other outpatient codes 99202–99215 can be billed as shared services in a facility setting, that is, an outpatient department. Also, inpatient hospital services, observation services and emergency department visits can be billed as shared services.
- Beginning in 2022, nursing facility services can be billed as shared services, except for the mandated visits which must be performed by a physician in the nursing facilities participation of care rules.
- Beginning in 2022, critical care services can be billed as shared or split services.

Shared/Split Services

- E/M services may be billed as shared or split services when provided in a facility setting.
- Prior to 2022, they could be provided in an office setting if they also met the requirements for incident-to billing. CMS is no longer allowing shared services in an office setting, although incident-to services are still allowed.
- Starting in 2022, shared services will no longer be allowed in place of service 11, even if they meet incident-to rules.

Shared/Split Services

- CMS's Final Rule uses the term "nonfacility" and "noninstutional" to describe place of service. However, it is really helpful to consider CPT place of service codes.
- Office and other outpatient services reported in place of service 11 may not be reported as shared services. Office and other outpatient codes in place of service 19 or 22 may be reported as shared services.

Shared/Split Services

- CMS is requiring that the shared visit be reported under the provider number of the physician or non-physician practitioner who has performed a substantive portion of the visit. If the physician is not performing a substantive portion of the service, then CMS believes the rate of payment should be at the 85% rate, paid for NPP services.

Shared/Split Services

- Office visits in an outpatient department use either time or MDM.
  - If the physician performs and documents all of the assessment and plan, then consider that the substantive portion.
  - If the physician spends more than 50% of the time, consider that the substantive portion. If neither of those is true, bill under the NPP provider number.

Shared/Split Services

- Emergency department visits
  - You must select the level of service based on the three key components. But you can determine the substantive portion either by the practitioner who spent to the most time, or the key components.
  - If the physician documents in its entirety either the history, exam or MDM, bill under the physician's NPI.

Shared/Split Services

- Inpatient, Observation and Nursing facility services
  - If billing under the physician's NPI, use either time or one of the key components to support the substantive portion.
  - Either the physician must have spent greater than 50% of the time, and time must be documented, or the physician must have documented one of the key components in its entirety.
  - If using time, both clinicians will need to document their time, so that it is clear which practitioner spent more than 50%. Use the current activities listed in CPT.

Shared/Split Services

- In 2022 a transitional year
  - They are defining a substantive portion of the service as the practitioner who performed more than 50% of the time of the visit, or the practitioner who performed and documented in its entirety either the history, exam, or medical decision-making portion of the note.
  - They seem to have forgotten here, that office and other outpatient services billed in outpatient departments use codes 99202—99215, and these do not anymore have a specific requirement for history and exam.
    - "We are clarifying that when one of the three key components 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. For example, if history is used as the substantive portion and both practitioners take part of the history, the billing practitioner must perform the level of history required to select the visit level billed."

Shared/Split Services

- In 2023
  - CMS will require that shared services be reported by the provider who provides more than half of the time of the service. They are proposing that all of the activities that are listed in the current CPT book as activities that can be included in the time of the visit can be counted in this calculation.

Shared/Split Services

- If billing shared services, the documentation must identify the two individuals who performed the service. CMS points out that in prior years, they finalized a rule that

  "any individual who is authorized under Medicare law to furnish and bill for their professional services, whether or not they are acting in a teaching role, may review and verify (sign and date) the medical record for the services they bill, rather than re-document notes in the medical record…"

- They say it may be helpful for each individual to document their own participation in the record, in order to determine the substantive time. They state that the record must identify the two individuals who performed the services, and "The individual who performed the substantive portion (and therefore, bills the visit) must sign and date the medical record."

Critical Care Services

- A physician and NPP in a group may share critical care services.
  - You can add together the time of the physician and NPP (win) but you must bill it under the practitioner who has spent the most time (lose, if it's an NPP, because it's paid at 85% of the physician fee schedule.)
- CMS says it is adopting the same list of bundled procedures as in the CPT book.
- For services that cross midnight, CMS says it will follow the CPT® rule in the introduction section that if the service is continuous past midnight, it does not reset at midnight and create a new hour. If there is a disruption, then when the service resumes after midnight, it starts a new hour.

Critical Care Services

- CMS will now allow physicians/NPPs of different specialties to both provide critical care during the same time period.

Critical Care Services

- Critical care may be billed as a shared visit between a physician and NPP but must be reported by the practitioner who provides >50% of the time.
- Prior to 1/1/2022, one physician or NPP must have met the entire 74 minute time frame to bill 99291 before a second practitioner in the same group could report 99292 for an additional 30 minutes. So, if one pulmonologist spent 30 minutes and the second 50 minutes, the times could not be added together to report 99291 and 99292. Now, two practitioners of the same specialty can add together their time to meet 99291, and additional units of 99292.

Critical Care Services

- CMS will continue to allow an E/M service to be performed on the same day as critical care, if the E/M service occurred before the patient was critically ill, the patient later became ill later on the same calendar day. They removed the restriction that did not allow an ED visit and critical care to be billed on the same day by the same physician.

Q&A

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Q&A – Shared/Split Services

Question:

For Split/Shared changes for 2022, we know that the billing provider will be the one with the substantive portion of the service, but can we use the other clinician's documentation to support the documentation requirement?

Example Substantive Clinician documentation supports 99214, non-substantive clinician documentation supports 99215. Bill under substantive portion clinician's name but use non- substantive clinician's documentation and bill 99215?

Answer:

The physician or NPP who performs the substantive portion of the split (or shared) visit would bill for the visit. Beginning January 1, 2023 “substantive” portion is defined as more than half of total time spent by the physician and NPP performing the split (or shared) visit. The billing practitioner, who performs the substantive portion of the visit, could select the level for the split (or shared) visit based on medical decision-making. The physician and NPP should document the services they perform. If the documentation of the physician and the NPP involved in the split/shared visit includes all the elements of a level 99215 (when looked at it total), then it would be appropriate to bill for that level of service (99215). If the documentation only supports the elements of 99214, then 99214 should be billed.

Q&A – Shared/Split Services

Question:

For 2022 split/shared Evaluation and Management services, how do we differentiate between time spent to select E/M level versus time spent determining which practitioner performed the substantive portion?

Example: New patient Office Outpatient example: APP documents 30 distinct minutes spent performing clinical services on the date of the encounter. Physician documents 10 distinct minutes spent performing clinical services on the date of the encounter. 99203 is billed based on total time spent on the date of the encounter. If the physician also spent 20 minutes of pre-work the day before the encounter and 15 minutes of post-work on the day after, can the claim be billed under the physician's name since they spent the substantive amount of time (45 minutes total on all three days) on the E/M service?

Answer:

For visits that are not critical care visits, the CPT listing of activities that can count when time is used to select an E/M visit level. For E/M visits this would only include time on the date of the patient encounter. Specifically, the following activities, when performed and regardless of whether or not they involve direct patient contact would count:

- 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 electronic or other health record.
- Independently interpreting results (not separately reported) and communicating results to the patient/family/caregiver.'
- Care coordination (not separately reported)

In this scenario, the 20 minutes of pre-work the day before the encounter and the 15 minutes of post-work on the day after, would not be counted in determining the time. Also, the split (shared visits) may only be billed when provided in institutional (facility) settings. So split (shared) visits would not be billed by outpatient physician offices.

Q&A – Shared/Split Services

Question:

Office Outpatient E/M level is determined solely by medical decision making. For split/shared E/M services in 2022, can the history and exam be utilized as the substantive portion for purposes of selecting billing provider"

Answer:

In 2022, history or exam or medical decision-making, or more than half the total time can be used to determine who provided the substantive portion for purposes of selecting the billing provider. When one of the three key components 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. For example, if history is used as the substantive portion and both practitioners take part of the history, the bill practitioner must perform the level of history required to select the visit level billed. If physical exam is used as the substantive portion and both practitioners examine the patient, the billing practitioner must perform the level of exam required to select the visit level billed. If MDM is used as the substantive portion, each practitioner could perform certain aspects of MDM, but the billing practitioner must perform all portions of aspects of MDM that are required to select the visit level billed.

Q&A – Shared/Split Services

Question:

Attending provides the most substantive portion of the visit by stating 30 mins was spent with the established patient… 99214. But the NP, documents a High Complexity Medical decision making… 99215. With this in mind: The visit is billed by the physician or practitioner who provides the substantive portion of the visit. Would it be appropriate to bill under the Attending but use the NP's documentation for 99215.

Answer:

Both the attending and the NPP should document the services they provided and the elements of medical decision-making. If the attending provided the substantive portion of the visit, it is appropriate to bill under the attending. However, the documentation in the medical record from the attending and the NPP should include the elements of 99215 in order to bill 99215.

Q&A – Shared/Split Services

Question:

Must the billing provider (the one with the substantive portion) use their own documentation to support the level of service.

Answer:

Both the physician and the NPP should document in the medical record to support the level of the service. The documentation in the medical record in its entirety should support the level of the service. The billing provider should sign, but both the physician and NPP should document what they provided.

Q&A – Shared/Split Services

Question:

Must the billing provider (who has the substantive portion) use their own documentation, or can they use the APP (not the most substantive portion) but bill under their name?"

Answer:

Both the physician and the NPP should document in the medical record to support the level of the service. The documentation in the medical record in its entirety should support the level of the service. The billing provider should sign, but both the physician and NPP should document what they provided.

Q&A – Critical Care services

Question:

Critical care is not bundled if unrelated to the surgery. For neuro procedures, where a patient may end up with for ex. swelling how do we identify what is unrelated? Is the unrelated based on dx codes? The swelling would be a different dx code.

Answer:

Documentation the critical care was unrelated to the specific anatomic injury or surgical procedure must be submitted. Diagnosis codes that clearly indicate the reason for the encounter was unrelated to surgical postoperative care may provide sufficient documentation

Q&A – Critical Care services

Question:

The final rule provides guidance on how to bill when the service crosses over midnight for a single physician/NPP, with the date of service being the date critical care was initiated on day. How do we bill, for example, when 2 providers cross over midnight and their time is combined because the first provider did not meet the 99291 time?

Answer:

CPT coding principles require that when a time-dependent service is performed continuously and crosses over midnight the time should be accrued for, and reported as occurring, on the pre-midnight date. However, once the service is disrupted (i.e., becomes non-continuous), then that creates the need for a new initial service on the post-midnight date.

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. Then 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 pm to 2 am, 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.”

For example, if a patient presents in the emergency department at on day 1 and critical care services are continuously performed past midnight (12:15 am) on day 2 with no more services after 12:15 am, then critical care 99291 can be combined and reported for Day 1. In the same scenario, if the continuous critical care services are interrupted, they would be considered reinitiated on day 2.

Q&A – Critical Care services

Question:

How do we differentiate critical care that is being provided as split/shared vs continuous staff coverage/follow up care?

Answer:

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 could be aggregated to meet the time requirement to bill CPT code 99291. Once he cumulative required critical care service tie is met to report CPT code 99291, CPT cod 99292 would not be reported by the practitioner or another practitioner in the same specialty and group unless and until an additional 30 minutes of critical care services are furnished to the same patient on the same day. (104 total minutes). Critical care services can be billed as split (or shared) E/M visits. Service time would be counted for CPT code 99292 in the same way as for prolonged E/M Services. The total critical care service time provided by a physician and NPP in the same group on a given calendar date to a patient would be summed, and the practitioner who furnishes the substantive portion of the cumulative critical care time would report the critical care service (s).

Q&A – Critical Care services

Question:

Critical care is not bundled when unrelated to global surgery. How do we identify that this is unrelated to the procedure, based on diagnosis code?"

Answer:

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. An example would be trauma or burn cases. If care is fully transferred from a surgeon to an intensivist and the critical care is unrelated, modifiers must be reported to indicate the transfer of care and that the care is unrelated.

Documentation the critical care was unrelated to the specific anatomic injury or surgical procedure must be submitted. Diagnosis codes that clearly indicate the reason for the encounter was unrelated to surgical postoperative care may provide sufficient documentation.