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Successful split/shared implementation for your organization

by Maya Turner, CPC

If your healthcare organization utilizes split/shared billing, your organization could be at risk without proper training and attestation to support services billed correctly. If you are unfamiliar with split/shared services, it's the practice of two providers: a physician and a qualified healthcare professional (QHP) see a patient on the same day, and one of them decides to bill based on a "discussion" with the QHP as well as attestation of the QHP note. As such, the Centers for Medicare & Medicaid Services (CMS) has modified guidelines with documentation requirements as well as the elements of medical decision-making related to the care provided. The Final Rule was published in the November 18, 2022, *Federal Register*—an annual publication of confirmed regulatory requirements to bill these and other types of services to CMS.[1] It explained how the proper documentation requirements to bill for split/shared services would be granted another year extension from calendar year (CY) 2023 to CY 2024. This means that when split/shared services are billed, documentation requires—per CMS—the physician or the QHP to detail a substantive portion through history, examination, *or* medical decision-making (MDM) more than half of the total time. CMS intends to change the documentation from history, examination, or MDM to only total time beginning in CY 2023. With this additional year in place, organizations have more time to train their providers of services to meet these regulatory requirements.

What exactly is split/shared billing?

CMS finalized a major change regarding services performed in a facility setting when both the QHP and physician make rounds with the same patient on the same calendar date—otherwise known as a split/shared visit. This occurs when a physician and a QHP of the same specialty/subspecialty perform an evaluation and management (E/M) service on the same calendar date; if these services are performed on a different date, it is not considered split/shared. This is demonstrated by who is performing the most work while rounding (greater than 50%); according to CMS's definition of substantive portion, the greater than 50% must be in the form of MDM or time, which must be explicitly documented via the attestation written by the physician. The QHP typically does not bill for the work they performed, and the physician, in turn, bills for the service based on the appropriate attestation for their participation in patient care.

What has CMS changed when I bill split/shared services?

CMS changed how split/shared services are used effective January 1, 2022, and will change how the physician attests as well as what is supported when documented.[2] CMS uses the term "substantive portion" to specify what should be documented when determining the substantive portion (greater than 50%), which is much different from years prior as it only required an attestation for the physician to receive a credit to bill. Now, CMS has changed its requirements dramatically.

Here is the breakdown of how split/shared services are reimbursed when billed by an medical doctor or QHP:

When a physician bills

- When a physician bills for split/shared services, the bill is paid at 100% of the Medicare Physician Fee Schedule (MPFS)

When a QHP bills

- When a QHP bills for split/shared services, the bill is paid at 85% of the MPFS

Other items to consider when split/shared services are billed

- An encounter is shared between a physician and QHP from the same group specialty/subspecialty
- The same employer employs both QHP and doctor (note that this would not apply to medical students or residents)
- When encounters are submitted to the bill, they are submitted with the modifier FS when performed in one of the following places of service:
    - Hospital inpatient
    - Hospital observation
    - Outpatient hospital outpatient departments
    - Hospital discharge services
    - Emergency department
    - Critical care services
    - Prolonged services

Examples of split/shared billing scenarios

Example 1: A nurse practitioner sees a patient at noon and writes a note to explain her findings and recommendations discussed with her collaborative physician; the physician then attests his note, documents his discussion and to the extent of MDM related to the patient as well as sign and date the attestation on the same day.

Rationale: In this instance, this example would be appropriate and does not demonstrate risk as the services and the requirements were documented correctly with the attestation signed by the physician on the same calendar date of the nurse practitioner's note.

Example 2: Physician and physician assistant see the patient. The documentation of the care was discussed and detailed; however, the physician had to leave early for another patient and forgot to attest the note on the same calendar date they saw the patient. Here is what the physician wrote:

Attestation by the physician: I saw the patient on the (same calendar date); I agree with what was documented by the physician assistant.

Signed and dated by the physician.

Rationale: This example would *not* be accepted if CMS reviewed the note. Why, you ask? The attestation does not elaborate on what was discussed with the physician assistant, nor does it explain what was done to arrive at the plan of care documented.

Example 3: Nurse practitioner (NP), Amy Jones, sees a patient on Wednesday, October 9, at 10 p.m., and Dr. Smith sees the same patient the next morning and attests to the note the next day.

Rationale: This encounter, if sent on as split/shared billing, is *not* acceptable as it was not attested on the same calendar date as the nurse Jones's note. To meet documentation requirements acceptable to CMS, the note must be attested on the day the patient was seen as well as on the same calendar date. If not, this would not be considered a split/shared service, and when reviewed, this would be recouped if any monies were paid post-review.

Example 4: The physician and the NP see the patient on the same calendar date, and the note is attested as the following: "I reviewed the QHP's note and spent more than 50% of the time." The encounter is billed out to CMS.

Rationale: This example would be questioned by CMS as it does not state specifically hhow much time was spent by each practitioner to demonstrate the substantive portion. When reviewed, this would require more scrutiny and could very well be recouped by CMS as this may not be supported. Whether MDM or time (which should be greater than 50% for the substantive portion), the activities associated with the time and the exact time need to be documented.

What does CMS mean by substantive portion?

CMS has determined the substantive portion for split/shared as more than half of the total time spent by the physician and QHP performing the split/shared visit beginning January 1, 2023.https://www.federalregister.gov/d/2021-23972/p-1260 In other words, for CY 2022, the practitioner who spends more than half of the total time or performs—in its entirety for that level—the history or exam, or MDM, can also be considered to have performed the substantive portion and can bill for the split/shared E/M visit. (See Table 1.)

Table 1: Table of Substantive Portion for E/M Portion Code Families in Split/Shared Billing

EM Code Visit Family	2022 Definition of Substantive Portion	2023 Definition of Substantive Portion
Other Outpatient Services*	MDM or more than half the total time	More than half the total time
Inpatient/Observation/Hospital/Nursing Facility**	MDM or more than half the total time	More than half the total time
Emergency Department	MDM or more than half the total time	More than half the total time
Critical Care Services	MDM*** with more than half the total time	MDM with more than half the total time

EM Code Visit Family	2022 Definition of Substantive Portion	2023 Definition of Substantive Portion

*Office visits will not be billable as split/shared services

**Some services in NF/SNF are mandated for physician participation, in these instances (POST PHE) this would be the exception

***MDM should be supported when billing critical care services

Documentation requirements

Documentation to support substantive portion by MDM for inpatient/facility setting

When logging the MDM in support of your documentation to determine the substantive portion, the note should demonstrate the elements of MDM in its entirety to bill for the level of service. If not using MDM to support the substantive portion, you may alternatively use the time to determine your substantive portion as well as the level of service. Since our organization, Franciscan Alliance, is endorsing the MDM, we've included the MDM and the time for each level of service in the most common facility setting types of service performed in the tables below.

Documentation to support substantive portion by time for inpatient/facility setting

When billing by time, the provider who has spent more than half the total time can bill by substantive portion; however, when choosing the level, the total time of both QHP and physician may be combined, as demonstrated in the table below.

Note: In instances where time exceeds the level associated with time, the provider may choose to bill prolonged services in addition to the level of service billed. Time-qualifying activities are noted after these tables.

Substantive portion MDM/time levels of service tables – facility (initial/subsequent)

Table 2, titled "Hospital Billing Tables for Full Admission and Observation Services," demonstrates the two types of visits in the inpatient setting (as well as time and MDM). The initial and subsequent visits for the categories of service performed in the facility. Keep in mind that the documentation requirements for such are related to split/shared services *only*. Any other type of billing related to professional inpatient services outside of split/shared services will still be billed as per CMS.*

When reviewing the billing of split/shared services, Table 2 explains what should be billed and how the split/shared services would be viewed by CMS* based on the inpatient service but not limited to.

Table 2: Hospital Billing Tables for Full Admission and Observation Services

Level of Service Category of Service	Medical Decision-Making
IP/OBS H and P Level 1 99221 40 minutes Same Day/Adm-Disch 99234 45 minutes	Straight Forward/Low (2 of 3) • min #dx & mgt option(s) • No to min data to review • min risk
IP/OBS H and P Level 2 99222 55 minutes Same Day/Adm-Disch 99235 70 minutes	Moderate Complexity (2 of 3) • mult #dx & mgt option(s) • mod amt/complex data to review • mod risk
IP/OBS H and P Level 3 99223 75 minutes Same Day/Adm-Disch 99236 85 minutes	High Complexity (2 of 3) • ext #dx & mgt option(s) • ext amt/complex data to review • high risk

Inpatient Facility Levels 1–3

Level of Service Category of Service	Medical Decision-Making
IP/OBS Subsequent Visit Level 1 99231 25 minutes	Straight Forward/Low (2 of 3) • min #dx & mgt option(s) • No to min data to review • min risk

Level of Service Category of Service	Medical Decision-Making
IP/OBS Subsequent Visit Level 2 99232 35 minutes	Moderate Complexity (2 of 3) • mult #dx & mgt option(s) • mod amt/complex data to review • mod risk
IP/OBS Subsequent Visit Level 3 99233 50 minutes	High Complexity (2 of 3) • ext #dx & mgt option(s) • ext amt/complex data to review • high risk

Subsequent Facility Levels 1–3

Qualifying time-based activities to bill split/shared services per CMS

- Physician/other QHP time includes the following activities (when performed):
    - Preparing to see the patient (e.g., review of tests)
    - Obtaining and/or reviewing separately obtained history
    - Performing a medically necessary QHP-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 reported separately)
    - Documenting clinical information in the electronic or other health record
    - Independently interpreting results (not reported separately) and communicating results to the patient/family/caregiver
    - Care coordination (not reported separately)

What language is used for the attestation?

When notes are attested, they should include who performed the substantive portion and by which means (time or MDM). If the note determines the substantive portion by MDM, then the note should demonstrate by which means by way of the assessment and plan. If it's by more than half the total time, then it would need to say by how much and the qualifying activities used to bill based on time, as noted above. You should be monitoring very

closely, and the query should the attestation be insufficient in determining the substantive portion.

Allow time to implement workflows

As CMS has revised split/shared services, you should allow workflow implementation. Work with your IT team to create attention and training on usage. After the attestation has been determined, the bill should go out with the newly created FS modifier to identify split/shared services used to bill. CMS has noted that they will monitor split/shared services closely and may pull medical records for additional review to ensure proper documentation related to reimbursement.

Takeaways

- Gage the documentation requirements and evaluate risk within your organization.
- Continually educate providers, so they clearly understand how to document their substantive portion.
- Query when the substantive portion is not clear upon review.
- Keep a close watch for likely offenders and reeducate when needed.
- Implement workflows for departments that practice split/shared services more frequently; this may prove effective for coders and communication when there are issues.

**Documentation requirements have changed based on the final rule Medicare Physician Fee Schedule published on November 1 for CY 2023 from CMS via the* Federal Register *(which is updated annually). Keep in mind that as these rules are produced, so may documentation requirements as of the date of this publication which may be effective the following year they are introduced and/or modified.*

1 Medicare and Medicaid Programs; CY 2023 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Implementing Requirements for Manufacturers of Certain Single-dose Container or Single-use Package Drugs To Provide Refunds With Respect to Discarded Amounts; and COVID-19 Interim Final Rules, 87 Fed. Reg. 69,404 (Nov. 18, 2022), https://www.federalregister.gov/d/2022-23873.
2 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 Fed. Reg. 64,996, 65,153 (Nov. 19, 2021), https://www.federalregister.gov/d/2021-23972/p-1260.