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NAVIGATING MEDICARE'S NEW BILLING RULES FOR SPLIT/SHARED VISITS

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OVERVIEW

On November 2, 2021, the Centers for Medicare & Medicaid Services (CMS) published the 2022 Medicare Physician Fee Schedule (MPFS) final rule (the "2022 Rule"), which included policy refinements for billing "split (or shared)" evaluation and management (E/M) visits in the facility setting "to better reflect the current practice of medicine, the evolving role of non-physician practitioners (NPPs) as members of the medical team, and to clarify conditions of payment that must be met to bill Medicare for these services."[1] Revisions include the following:

- Split (or shared) E/M visits are now defined as "E/M visits provided in the facility setting by a physician and a NPP in the same group."
- The visit is to be billed by the physician or NPP who provides the "substantive portion" of the visit, determined as follows.
  - For 2022, such determination is attributable to the physician or NPP providing either (i) one of three components of the visit (history, physical exam, or medical decision-making), or (ii) more than half of the total time spent by the physician or NPP performing the visit. For critical care E/M visits, the determination can only be time-based (more than half of the total time of the visit).
  - By 2023, such determination can only be time-based (more than half of the total time of the visit).
- Split (or shared) E/M visits can be reported for both new and established patients, initial and subsequent visits, and prolonged services.
- A modifier is required on the claim to identify split (or shared) visits to inform policy and help ensure program integrity.
- Documentation in the medical record must identify the two individual providers who performed the split (or shared) visit. The individual providing the substantive portion must sign and date the medical record.

Although CMS believes concerns related to the administrative burden of tracking time are exaggerated, the definition of a "substantive portion" was modified for 2022 to afford organizations "one transitional year" to establish provider time-tracking systems to facilitate compliance with the time-based billing requirements for split (or shared) E/M visits by January 1, 2023. Further, and to the extent the mix of billed

[1] CMS, Fact Sheet: Calendar Year (CY) 2022 Medicare Physician Fee schedule Final Rule (Nov. 2, 2021), available at https://www.cms.gov/newsroom/fact-sheets/calendar-year-cy-2022-medicare-physician-fee-schedule-final-rule.

split (or shared) E/M visits shifts from physicians to NPPs, organizations must prepare for the resulting adverse impact on both reimbursement (*i.e.*, a 15% MPFS reduction for NPP billings) and/or provider compensation tied to work relative value units ("wRVUs") and consider the need to adjust compensation plans for both physicians (and NPPs) accordingly.

We note that on July 7, 2022, CMS issued a proposed rule for the 2023 MPFS, which would further delay required application of the "substantive portion" determination until January 1, 2024. Given the current status of this proposed rule, we focus exclusively on the final 2022 Rule herein.

IMPACT TO WRVU-BASED PHYSICIAN COMPENSATION PLAN OUTCOMES

For those physicians subject to wRVU-based compensation plans that historically received full wRVU credit for split (or shared) visits, the new CMS policy under the 2022 Rule may impact prospective compensation results beginning no later than 2023, absent compensation plan modifications. Specifically, such plan modifications might be necessary to bridge any resulting "gaps" between split (or shared) E/M visit wRVU credit assigned (i) *for billing purposes* (*i.e.*, a binary determination resulting in exclusive wRVU credit assigned to one of the two underlying physician or NPP providers) and (ii) *for underlying professional services recognition and compensation purposes* (*i.e.*, an informed judgment determination resulting in an allocation of wRVU credit between the subject physician and NPP providers).

In determining potential compensation plan revisions, diligent consideration of the unique facts and circumstances of each subject arrangement is required, including assessment of the underlying compensation terms of the subject agreement, operating characteristics of the subject practice, patient care team and model(s) utilized, as well as the capabilities of the electronic medical record and billing system used by the practice. Given the unique nuances and variables affecting each provider, there is no single "best practice" answer, and solutions could range from precise visit-level determinations to an application of broader level proxy factors. Moreover, any adjustments to underlying professional services compensation plans should consider both the commercial reasonableness and fair market value of the allocated wRVU credit to the providers. HealthCare Appraisers has extensive experience in valuing provider compensation arrangements and assisting its clients in developing innovative, practical, and compliant solutions as provider compensation models and reimbursement policies continue to evolve.