Welcome to the Indiana-ACC Virtual Meeting

Solving the Mysteries of Split-Shared:

How Groups Have Adapted & What 2023 Holds

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Agenda

7:00-7:05 p.m. Introductions, Vijay Rao, MD, FACC

7:05- 7:10 p.m. Background on the Rule, Linda Gates-Striby, CCS-P, ACS-CA

7:10-7:15 p.m. Peer Data, Joel Sauer, MBA

7:15-7:40 p.m. How Organizations Have Responded to the Split-Shared Model

- **7:15-7:23 p.m. Ascension St. Vincent Experience, Sandeep Joshi, MD, FACC**
- **7:23-7:31 p.m. Parkview Experience, Michael GeRue, MSN, RN**
- **7:31-7:40 p.m. Franciscan Experience, Atul Chugh, MD, FACC**

7:40-7:50 p.m. Critical Care Change, Linda Gates-Striby, CCS-P, ACS-CA

7:50-8:00 p.m. Q&A

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7:05- 7:10 p.m.
Background on the Rule
Linda Gates-Striby, CCS-P, ACS-CA

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“Split/Shared” Services in a Hospital Setting

“Split/Shared” – What are they?

- A split (or shared) visit refers to an E/M visit that is performed (“split” or “shared”) by both a physician and an NPP who are in the same group.
- Medicare pays a higher rate for a physician service as compared to a NPP (85%) and “needs to address whether and when the physician can bill”.
- These new guidelines apply to a facility setting (i.e. hospital).
- **As a reminder “Incident to” are the guidelines followed in an office setting and are not impacted by these new guidelines.**

CMS standing position, proposed & Finalized

- **STANDING** - The CMS longstanding policy allows a physician to bill for an E/M that is split/shared when both clinicians in the same group perform portions of the visit, but only if the physician performs a “*Substantive portion*” of the visit.
- **PROPOSED** - Take time spent by each clinician into consideration and “substantive” to be defined by the greater amount of time.

Finalized in 2022

- New and established patients can be split/shared
- CMS finalized as proposed to use time spent as the deciding factor. They did acknowledge the need for an adjustment period and states this will go into effect January 1, 2023. SEE BELOW- DELAYED To **2024**
- CMS made changes to how they will view “substantive” portion that DOES go into effect January 1, 22 and will also require an “FS” modifier on split/shared services

Finalized For 2023 – Pg 672 Final rule.

“we are finalizing our proposed policy to delay implementation of our definition of the substantive portion as more than half of the total practitioner time until January 1, 2024”

Counting time –

Not Critical care visits

- Distinct time of service spent by each clinician would be summed to determine total time and who bills.
- For any time spent jointly meeting with and or discussing the pt, only the time of one would be counted

This only applies if you are using time to select your level of service. As previously discussed, if you use the "Key elements" of HX, EX, and MDM this is not a deciding factor now, but CMS says it will be in 2024 Per CMS 2023 Final Rule.

E/M visit level, specifically the following activities, when performed and regardless

of whether or not they involve direct patient contact:

- 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).

Practitioners would not count time spent on the following:

- The performance of other services that are reported separately., ● Travel.
- Teaching that is general and not limited to discussion that is required for the management of a specific patient

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Take Away Thoughts

- Beginning January 1, 2022, the **modifier "FS"** is to be added to all Traditional Medicare split/share visits – **Clinicians must ensure a method to communicate this to billing.**
- Many organizations are submitting the modifier to other payors as well.
- **CMS expressed they will be monitoring claims – this could represent new and increased risk if not documented correctly**
- Know how your team determines who will be billing each day and if any changes need to be made
- Use a designed template, if possible, for split/shared to assist with documentation compliance
- What is the organizational and or individual physician impact as to who bills the split/shared service? Should the APP bill more frequently or should the MD?
- Determine what the changes to Critical Care coding means to your team
  - Adding time spent by both the APP and the MD is now required – the one who spends greater than half of the total time is now the billing clinician. How will you document this?
  - Adding the modifier "FS" to a split/shared critical care service is also required

7:10-7:15 p.m.
Peer Data
Joel Sauer, MBA

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Split Share Billing

November 2022

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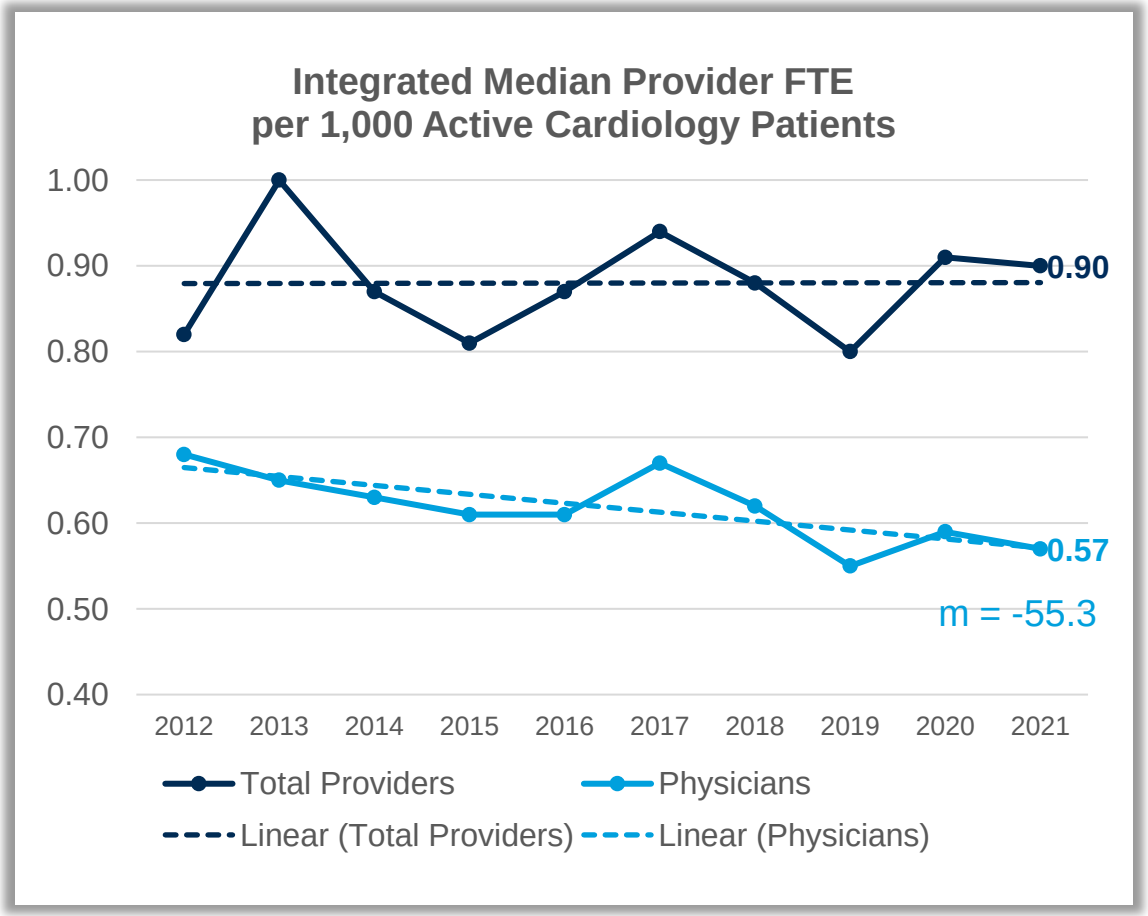
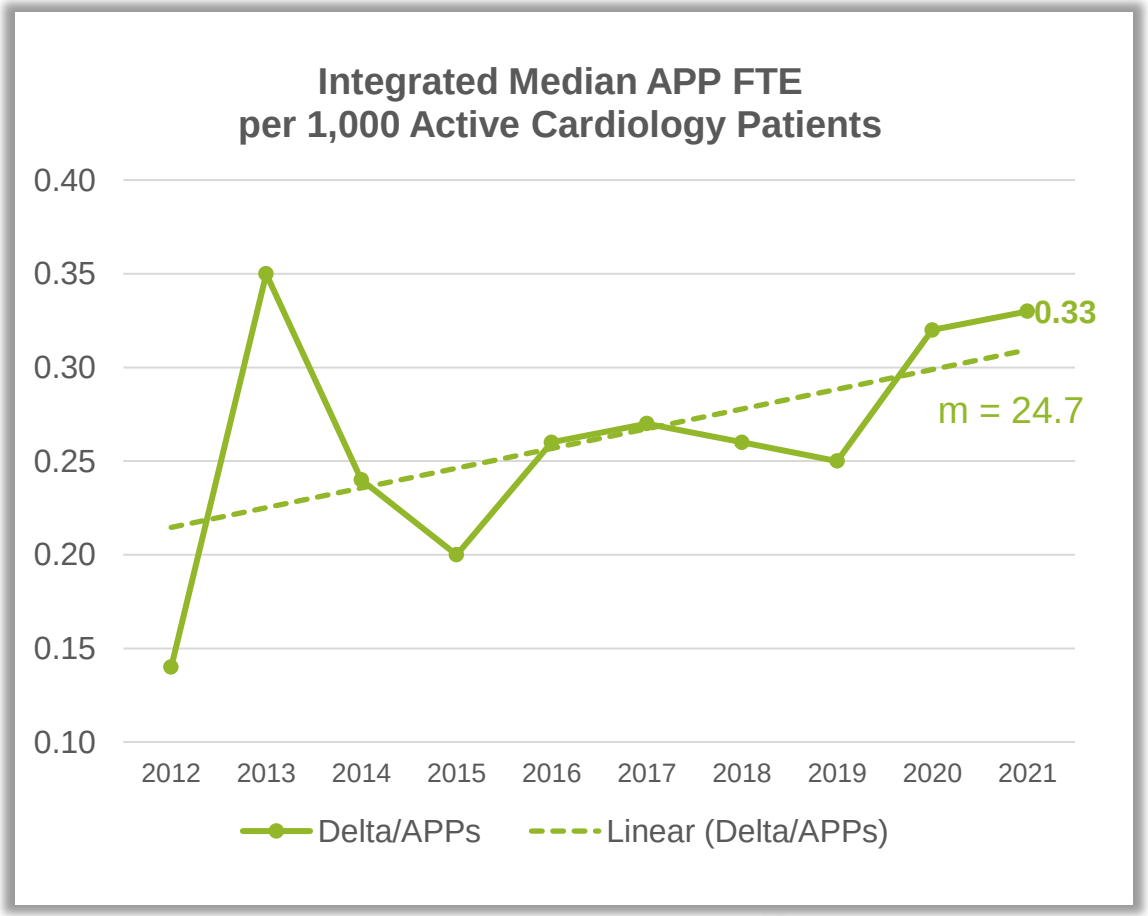
PROVIDER CHANGES





2021 SUBSPECIALTY MIX

Subspecialty	Integrated %	Private %
General/Non-Invasive	25%	25%
Interventional	19%	28%
EP	9%	8%
Invasive	8%	5%
Advanced Heart Failure	2%	
APPs	37%	33%
General Cardiology	31%	31%
EP	4%	2%
Heart Failure	3%	

PATIENT PANEL

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Applied to Programs Managing 15,000 Active Cardiology Patients

Subspecialty	Integrated	Private
General/Non-Invasive	3.4	2.8
Interventional	2.5	3.1
EP	1.1	0.9
Invasive	1.0	0.6
Advanced Heart Failure	0.3	
APPs	5.1	3.7
General Cardiology	4.2	3.4
EP	0.5	0.2
Heart Failure	0.4	
	13.5	**11.1**

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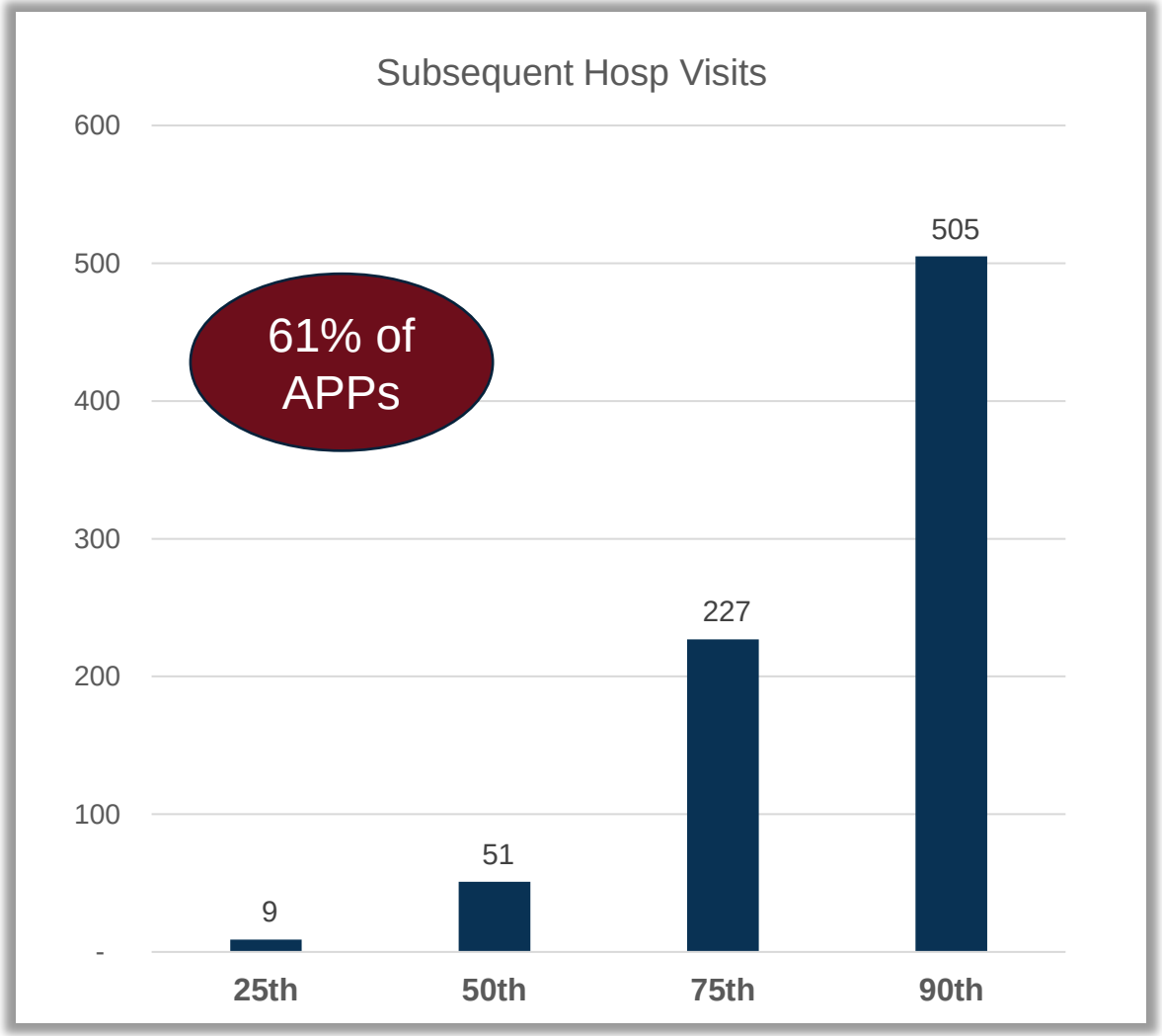
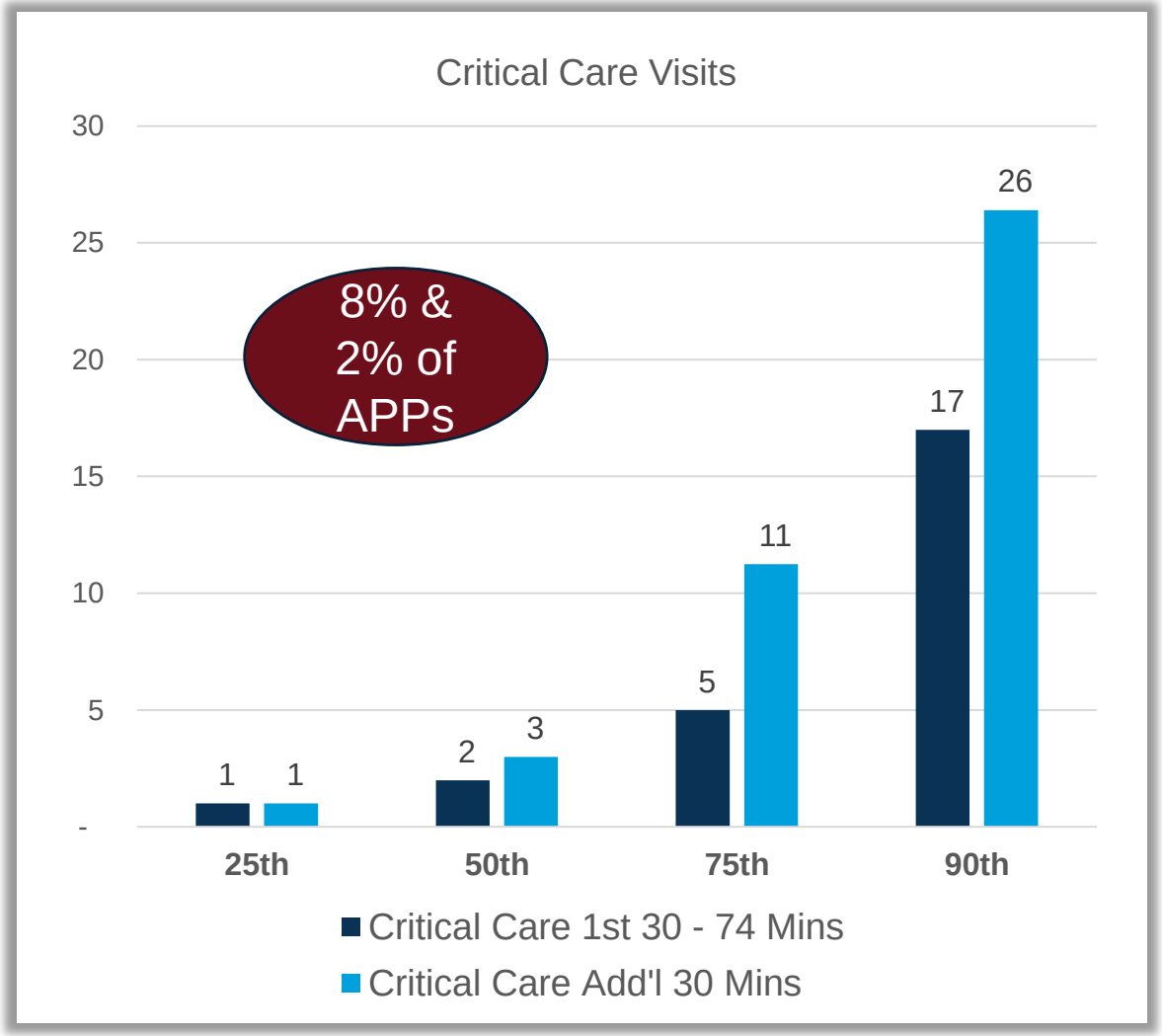
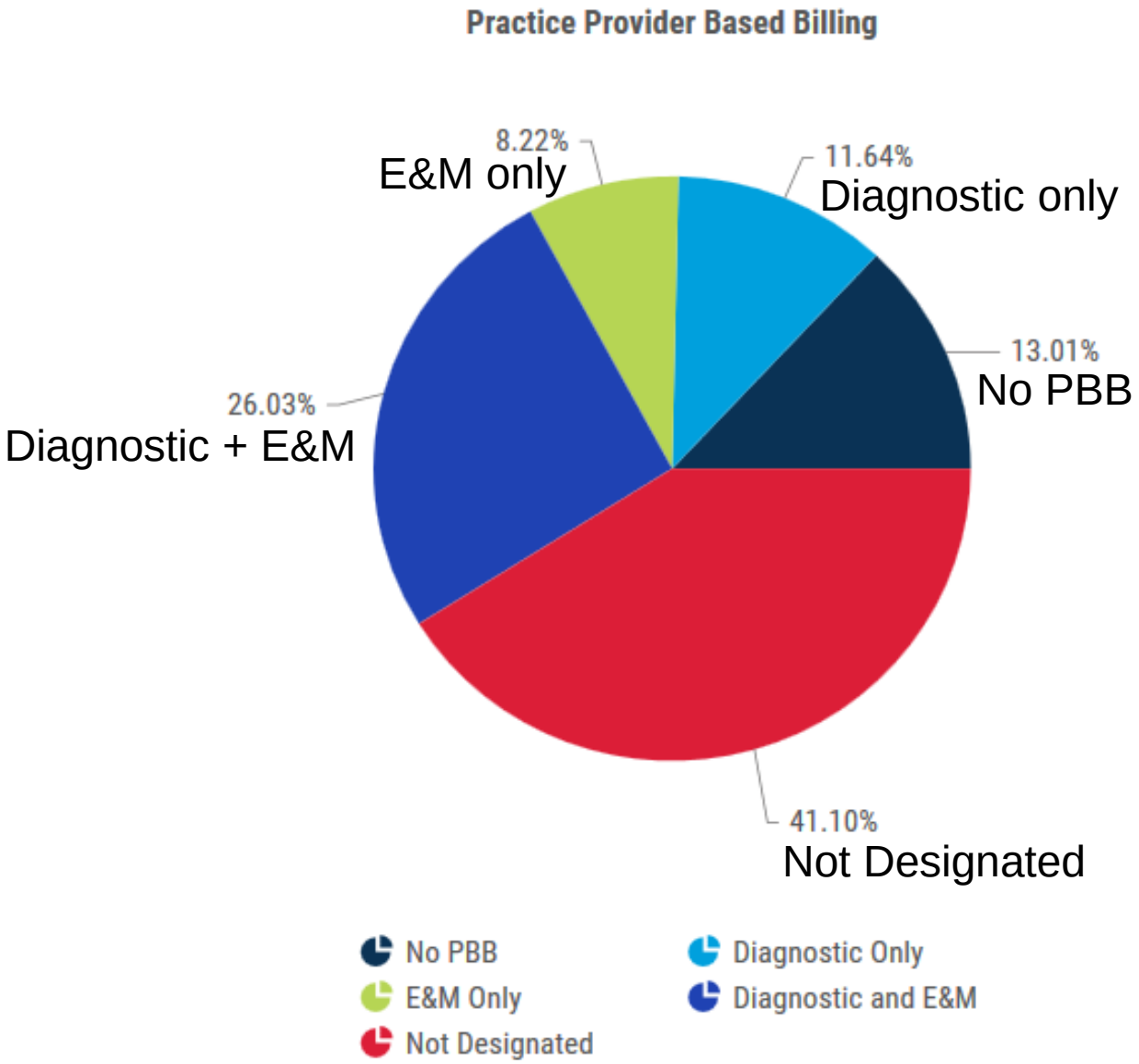
APPs IN THE HOSPITAL





Total Practices **146**



BILLING TYPE

Q&A

7:15-7:23 p.m.
Ascension St. Vincent Experience
Sandeep Joshi, MD, FACC

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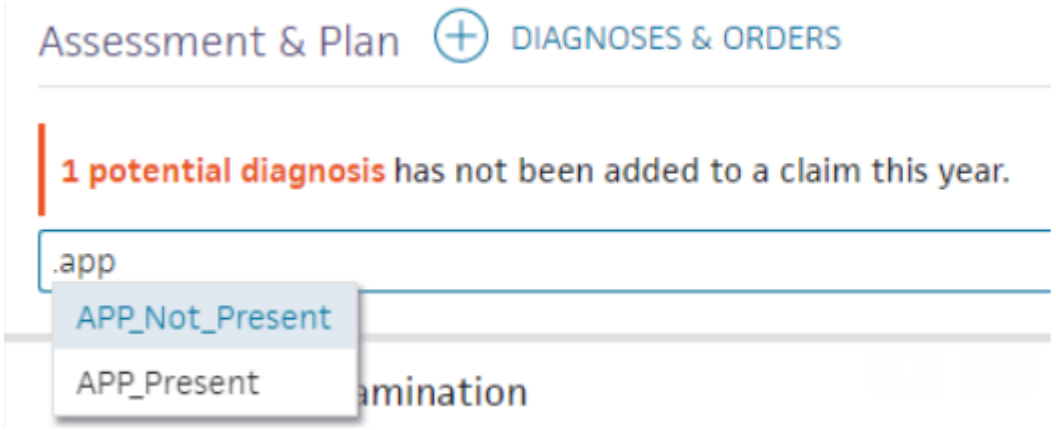
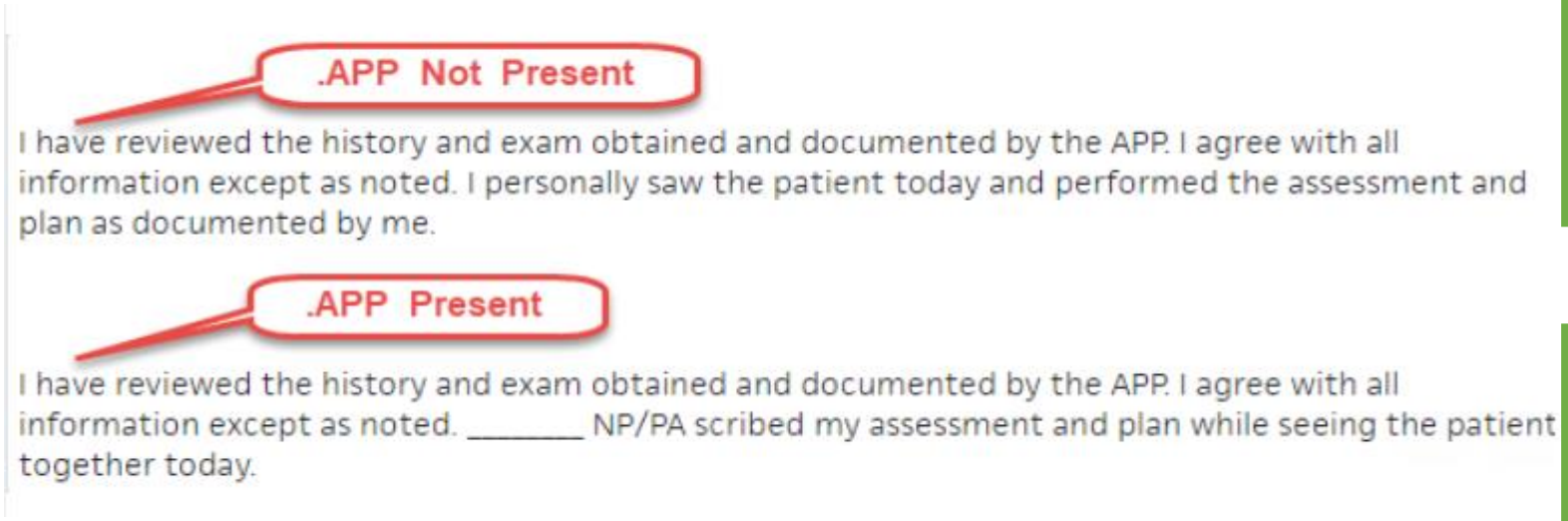
Split/Shared Visits In PBB Location



Visits that do not fit into one of the two options below can ONLY be submitted under the name of the APP
WHEN USING THE TEMPLATE - CLINICIAN MUST ATTACH THE MODIFIER



Select this option for the MD following the APP.

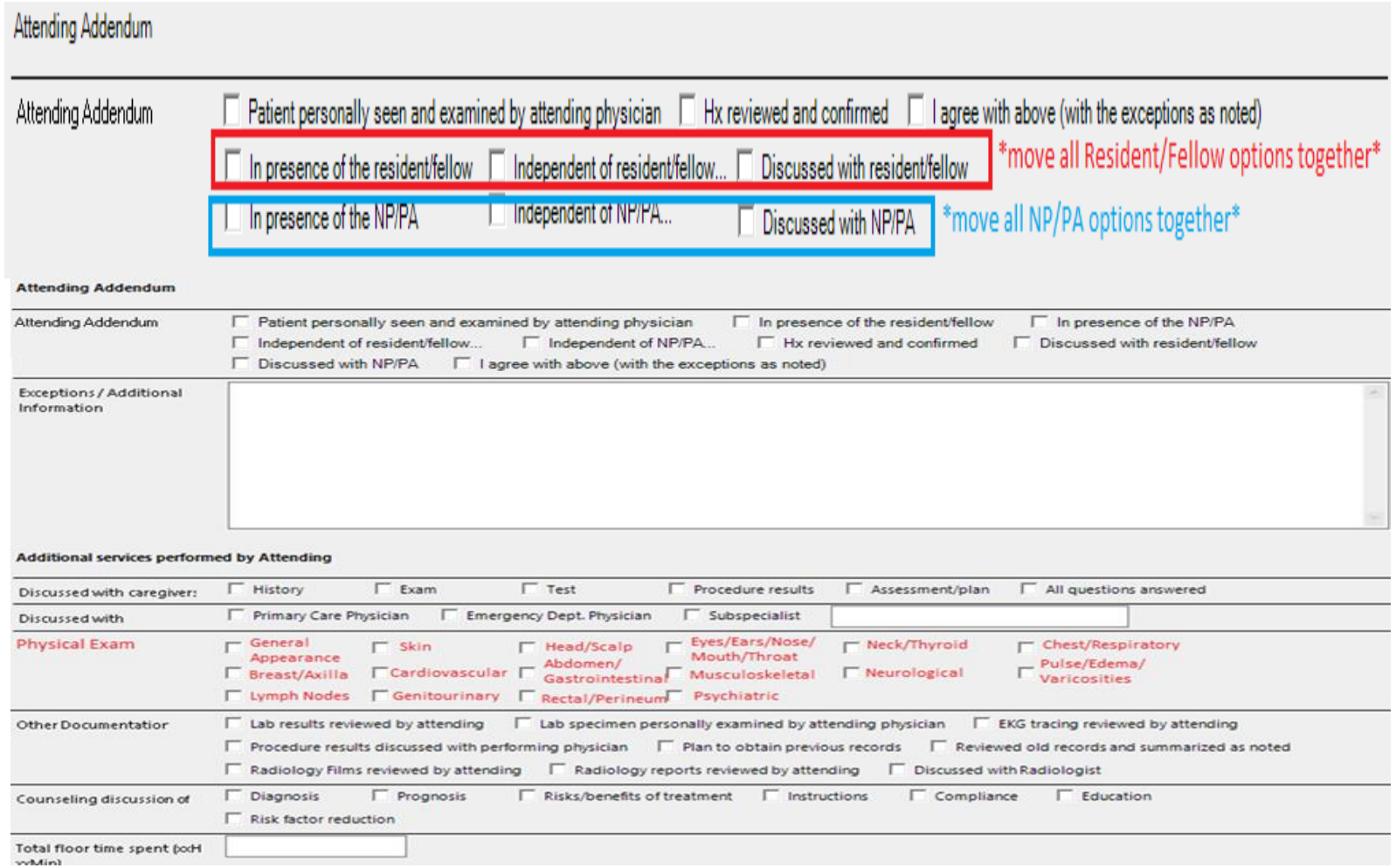
The MD then documents the A/P in its entirety

Select this option if the APP is with the MD and APP scribes the MD's A/P

Documenting Split/Shared In the Inpt Hospital Setting

Requirements in a Nutshell

- MDM can still be used to select the level
- When one of the three Key elements (HX, EX, MDM) is used as the substantive portion – *"the practitioner who bills the visit must perform that component in it's entirety in order to bill".*
  - If Hx or Ex is used and both take part of the info the billing practitioner must perform the level of history or exam required to select level of visit.
  - If MDM is used – each could participate, but billing must perform all aspects required for that level of visit



Physician completion of the attending addendum supports the bill under the MD. Physician can also document their review only and the APP submits the charge

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7:23-7:31 p.m.
Parkview Heart Institute Experience
Michael GeRue, MSN, RN

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Split-shared strategy

“When most heart programs look at the amount of inpatient-based professional revenue (removing professional fees for procedures and just focusing on rounding and consults during times when the APPs are doing team-based work in the hospital such as weekdays and potentially weekends during the day), the percentage of overall practice revenue associated with such activity can be as low as 10% or less.

If that is the case in your organizations, as it is in ours, I suggest that you carefully consider whether the trade-offs of physician productivity and increased frustration associated with having to do the work currently done by an APP is worth the loss of 15% of 10% of revenue. ”

Larry Sobal, MBA, MHA, FACMPE

CEO, Heart and Vascular Institute of Wisconsin

Internal Review

- For 2023, Critical Care split/shared visits must be billed under the NPI of the individual who provides more than 50% of total visit time. APPs are reimbursed at 85% of the physician rate.
  - 50% rule was not finalized as previously stated by CMS – delayed until 2024

- The APP/physician rounding platform has put us in the best position to succeed under this proposed model.
  - APPs in the hospital support our rounding teams with Interventional, CVS, and EP to facilitate post procedure management
  - Support HF & General Cardiology teams with a super-scribe approach to consults that would be at risk based on split billing proposals.
  - Same holds true for consults by the APPs across CVS and Cardiology.
  - Heart Failure team also is supported by APP in both inpatient and outpatient locations for follow up care, medication titration, etc.
  - Allowed us to align physician time with new patients in the office and increase procedure volume in the cath lab, CVOR

- APPs in the OP setting will continue to be optimized to expand access by having them see patients for risk-stratified “simple” follow ups.

Data Review

Lob Description	IN HEART INSTITUTE					
Procedure AMA Section	Evaluation and Management					
Service Month	(Multiple Items)	<<<---- *May 2021 through April 2022*				
Charge Amount	Rendering Provider Type:					
Procedure Code & Description	**Physician**	**Nurse Practitioner**	**Physician Assistant**	**Registered Nurse**	**Pharmacist**	**MA - Credentialed**
99217 - PR OBSERVATION CARE DISCHARGE MANAGEMENT						
99218 - PR INITIAL OBSERVATION CARE/DAY 30 MINUTES						
99219 - PR INITIAL OBSERVATION CARE/DAY 50 MINUTES						
99220 - PR INITIAL OBSERVATION CARE/DAY 70 MINUTES						
99221 - PR INITIAL HOSPITAL CARE,LEVL I						
99222 - PR INITIAL HOSPITAL CARE,LEVL II						
99223 - PR INITIAL HOSPITAL CARE,LEVL III						
99224 - PR SUBSEQUENT OBSERVATION CARE,LEVEL I						
99225 - PR SUBSEQUENT OBSERVATION CARE,LEVEL II						
99226 - PR SUBSEQUENT OBSERVATION CARE,LEVEL III						
99231 - PR SUBSEQUENT HOSPITAL CARE,LEVL I						
99232 - PR SUBSEQUENT HOSPITAL CARE,LEVL II						
99233 - PR SUBSEQUENT HOSPITAL CARE,LEVL III						
99234 - PR OBSERV/HOSP SAME DATE,LEVL III						
99235 - PR OBSERV/HOSP SAME DATE,LEVL IV						
99236 - PR OBSERV/HOSP SAME DATE,LEVL V						
99238 - PR HOSPITAL DISCHARGE DAY,<30 MIN						
99239 - PR HOSPITAL DISCHARGE DAY,>30 MIN						
99252 - PR INITIAL INPATIENT CONSULT,LEVL II						
99253 - PR INITIAL INPATIENT CONSULT,LEVL III						
99254 - PR INITIAL INPATIENT CONSULT,LEVL IV						
99255 - PR INITIAL INPATIENT CONSULT,LEVL V						
99281 - PR EMERGENCY DEPT VISIT,LEVEL I						
99282 - PR EMERGENCY DEPT VISIT,LEVEL II						
99283 - PR EMERGENCY DEPT VISIT,LEVEL III						
99284 - PR EMERGENCY DEPT VISIT,LEVEL IV						
99285 - PR EMERGENCY DEPT VISIT,LEVEL V						
99291 - PR CRITICAL CARE, E/M 30-74 MINUTES						
99292 - PR CRITICAL CARE, ADDL 30 MIN						

Review of charge codes shared by Physicians, APPs and PAs on IP services:

2.6% of Heart Division E&M charges are generated by an APP

2.8% of wRVU are aligned to the APP

7:31-7:40 p.m.
Franciscan Experience
Atul Chugh, MD, FACC

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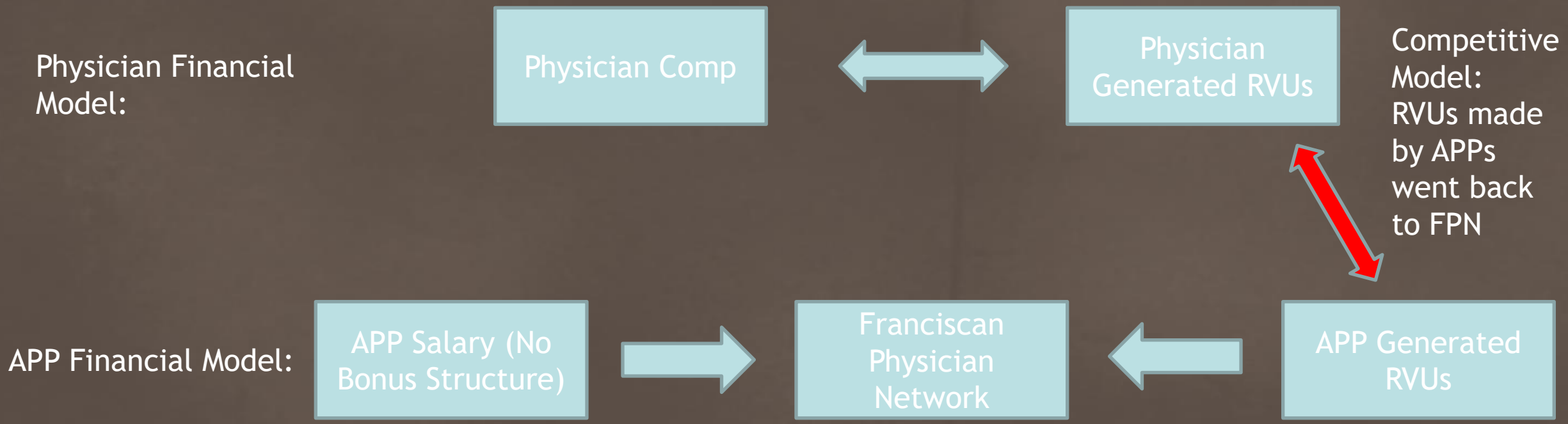
Franciscan Physician Network-Indiana Heart Physicians: Split-Shared Model, Our Experience

Atul R. Chugh, MD, FACC
Managing Partner, FPN: Indiana Heart Physicians
November 16, 2022

Franciscan ALLIANCE

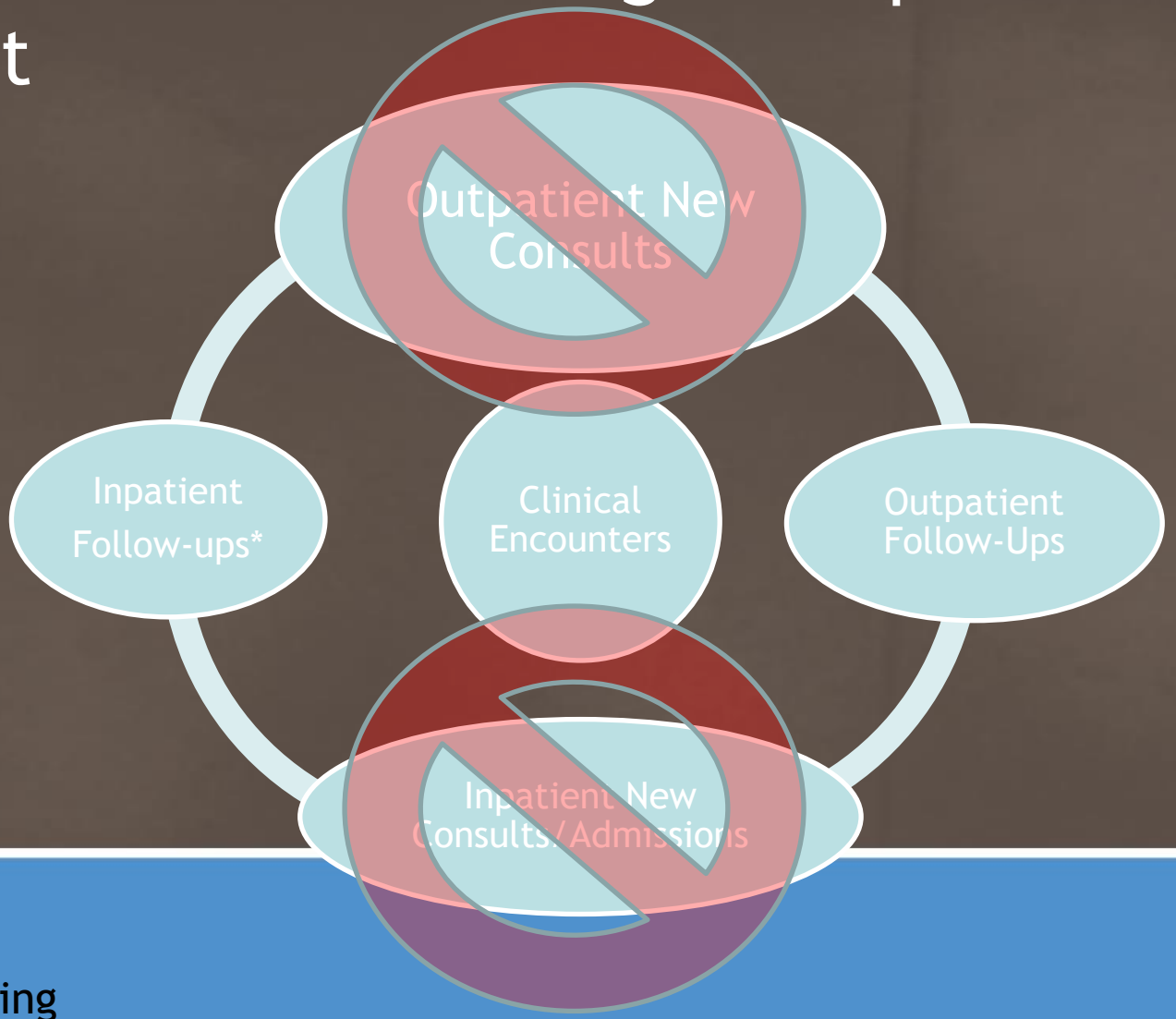
Pre-Shared Split Model: Challenges

- APP/Physician: Parallel Compensation Models



Pre-Shared Split Model: Challenges

- Lack of More Autonomous/Higher Impact APP Involvement



*-No independent APP billing

Required Changes prior to Split Sharing

- Need to put all RVUs (APP and Physician-derived) into a shared bucket to prevent internal competition and to promote more autonomous use of APPs

- Broaden the scope of APP practice (include new inpatient/outpatient encounters)

Phases of Transition

Phase 1 (July 2022)

1. Take on APP cost from physicians' bucket while accruing APP-derived RVUs into the common pool*
2. EP-associated APPs to start seeing appropriate inpatient consults and follow-ups independently with independent billing

Phase 2 (August 2022)

1. Greater outpatient APP autonomy in the outpatient setting (to see new consults)

Phase 3 (Ongoing)

1. Broader Inpatient APP autonomy with more independent billing
2. Greater APP utilization for outreach sites

*-Applies only to APPs making more than base salary

Physician Run Consult Board (Physicians See New Patients)

Total Tally:
70-80 patients

IC	EP	HF	Clinical
• 15 Patients	• 15 Patients	• 16 – 20 Patients • 1 MD, 1 APP	• 20 – 30 Patients • 2 MDs, 1 APP

- APPs rotate pager (no "call pager person")
- APPs see clinical inpatients not in unit ≤ 20, independently

Board Work/
New Consults
(14 – 18 Patients; 25 has been our max)

- 4 – 6 to IC/EP
- 3 – 4 from Short Call - assigned to a service
- 7 – 8 (approx) from Overnight - assigned 2 per service

- HF MD sees 8-10 Patients (sicker)
- HF APP 8-10 Patients

- Clinical MDs see 5 – 10 patients each
  - 4-5 New
  - 2-3 Overnight
  - 3-4 in unit
  - Shared work
- Clinical APP sees 15 – 20 Patients

Clinical MD runs list with APP every afternoon
Vs. Multi-disciplinary rounds

APP Run Consult Board (APPs see new patients)

Total Tally:
70-80 patients

IC	EP	HF	Clinical
• 15 Patients	• 15 Patients	• 16 – 20 Patients • 1 MD, 1 APP	• 20 – 30 Patients • 2 MDs, 1 APP

APPs carry pager

DAY 1

Routine → IC, EP, HF LARGELY UNCHANGED-
physician does not need to see the patient and will NOT drop a charge)

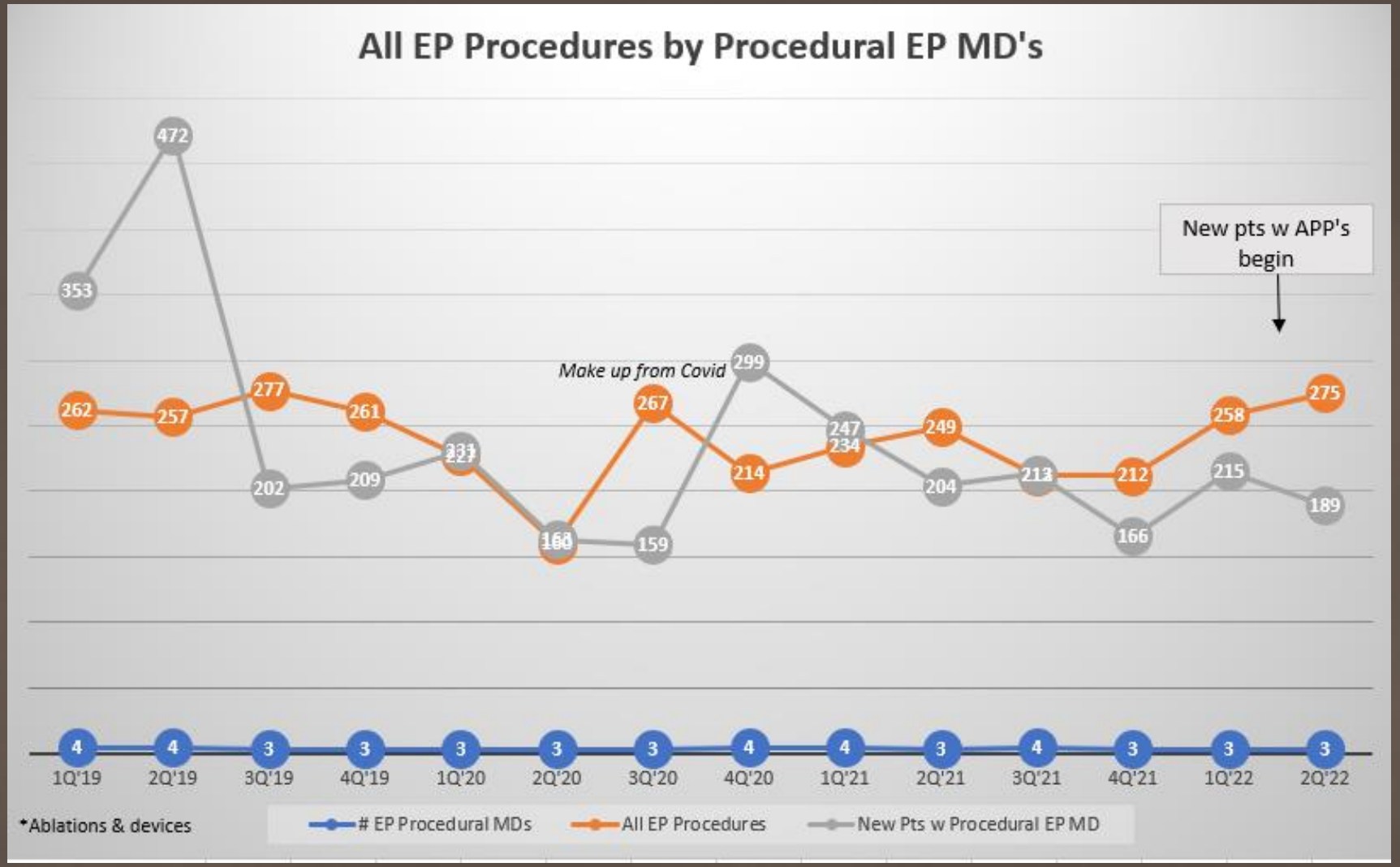
SICK → MD bills full consult/Critical Care bill (involved > 50%) → Combined critical care and hence, APP originates note for ongoing quality documentation

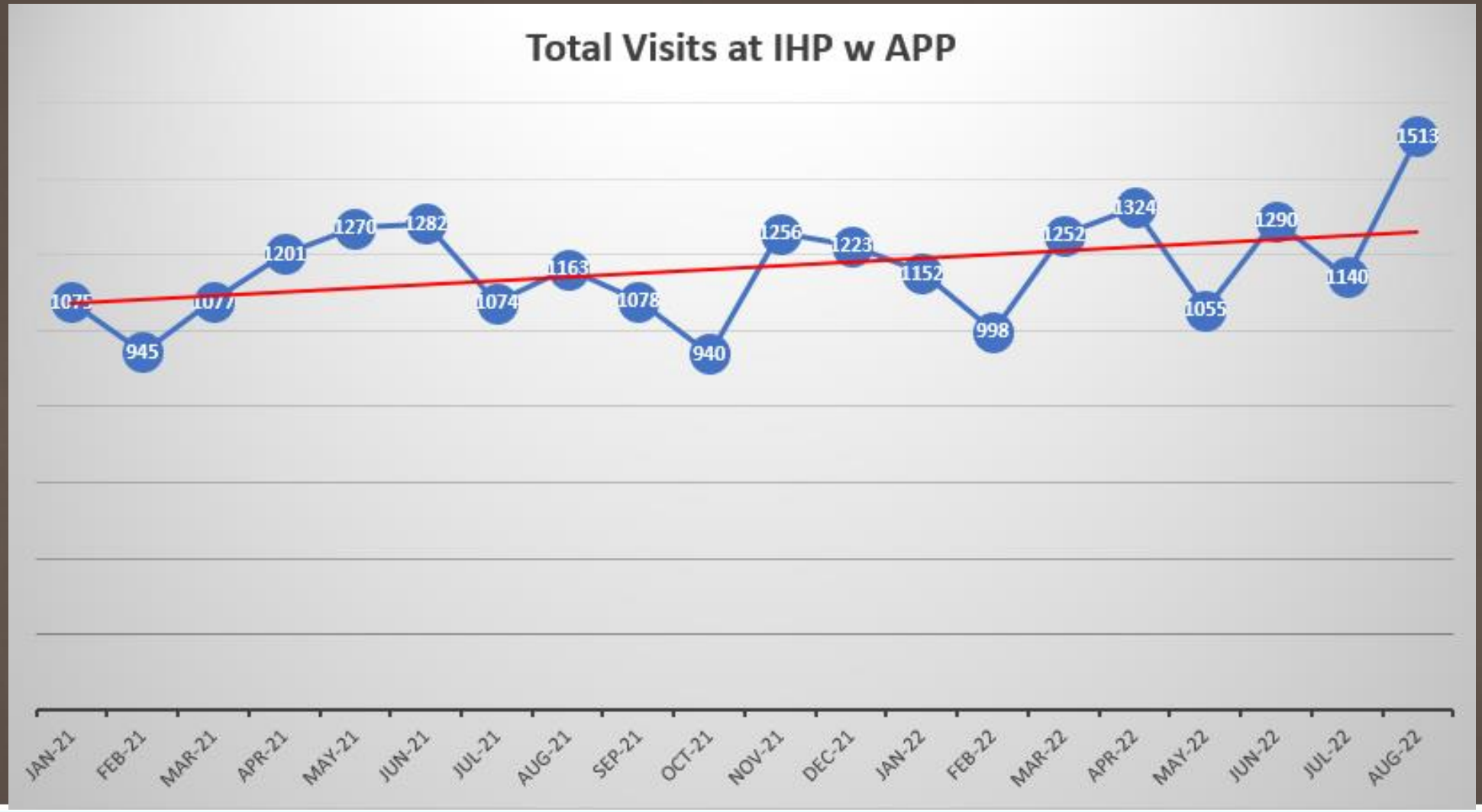
DAY 2 → **Physician** evaluates/adjusts/manages

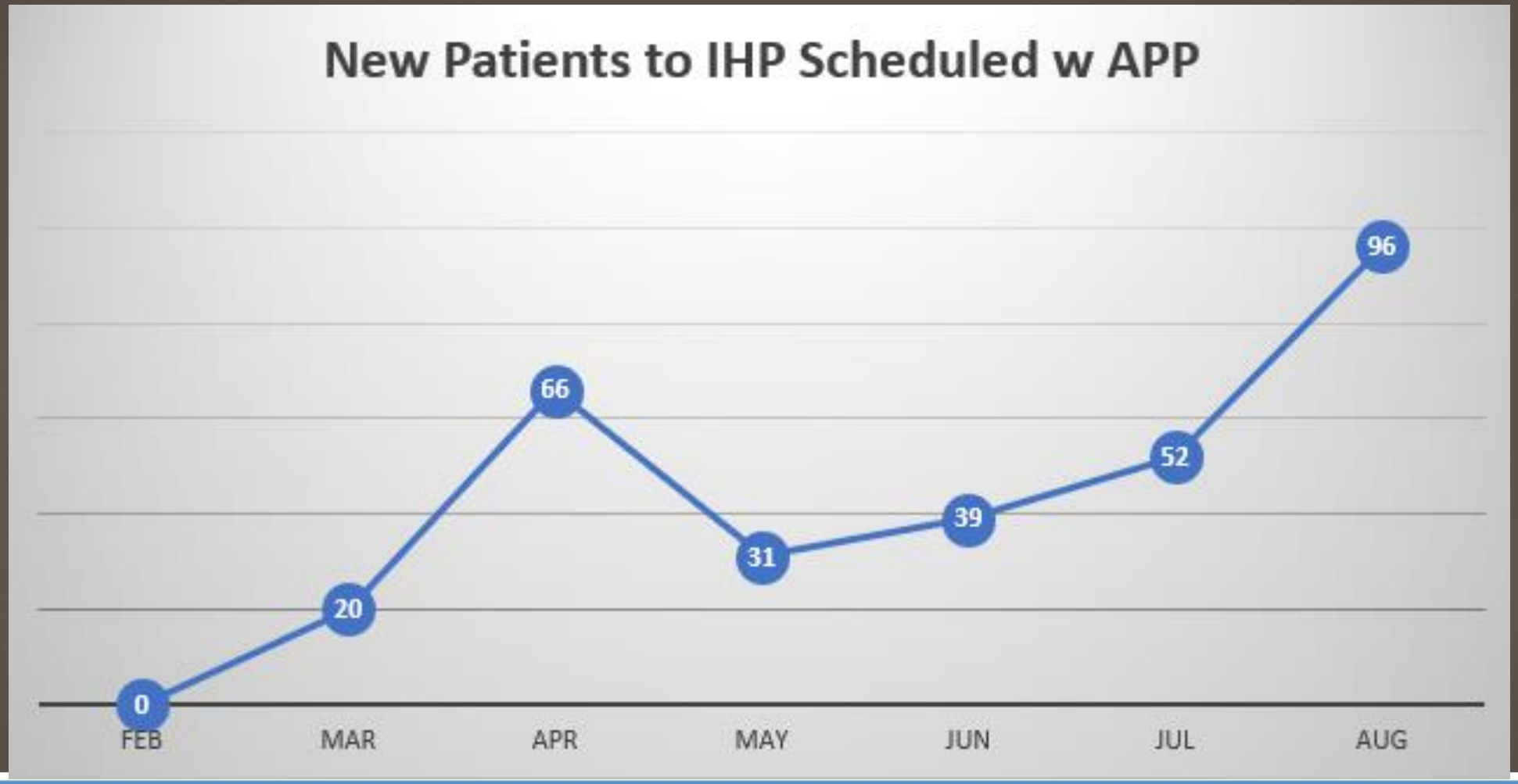
SPECIFICS (CLINICAL ROTATION):

- APP role limited for established inpatient encounters (done by physicians)
- 2 MDs do all inpatient rounding (12 – 15 ea)

Early Experiences


All EP Procedures by Procedural EP MD's
New pts w APP's begin
Make up from Covid
472
353
262
257
277
261
202
209
267
214
299
159
247
234
249
204
212
258
275
215
189
166
4
4
3
3
3
3
3
4
4
3
4
3
3
3
1Q'19
2Q'19
3Q'19
4Q'19
1Q'20
2Q'20
3Q'20
4Q'20
1Q'21
2Q'21
3Q'21
4Q'21
1Q'22
2Q'22
*Ablations & devices
EP Procedural MDs
All EP Procedures
New Pts w Procedural EP MD


Total Visits at IHP w APP
945
1201
1270
1282
1074
1163
1078
940
1256
1223
1152
998
1252
1324
1055
1290
1140
1513
JAN-21
FEB-21
MAR-21
APR-21
MAY-21
JUN-21
JUL-21
AUG-21
SEP-21
OCT-21
NOV-21
DEC-21
JAN-22
FEB-22
MAR-22
APR-22
MAY-22
JUN-22
JUL-22
AUG-22


New Patients to IHP Scheduled w APP
0
20
66
31
39
52
96
FEB
MAR
APR
MAY
JUN
JUL
AUG

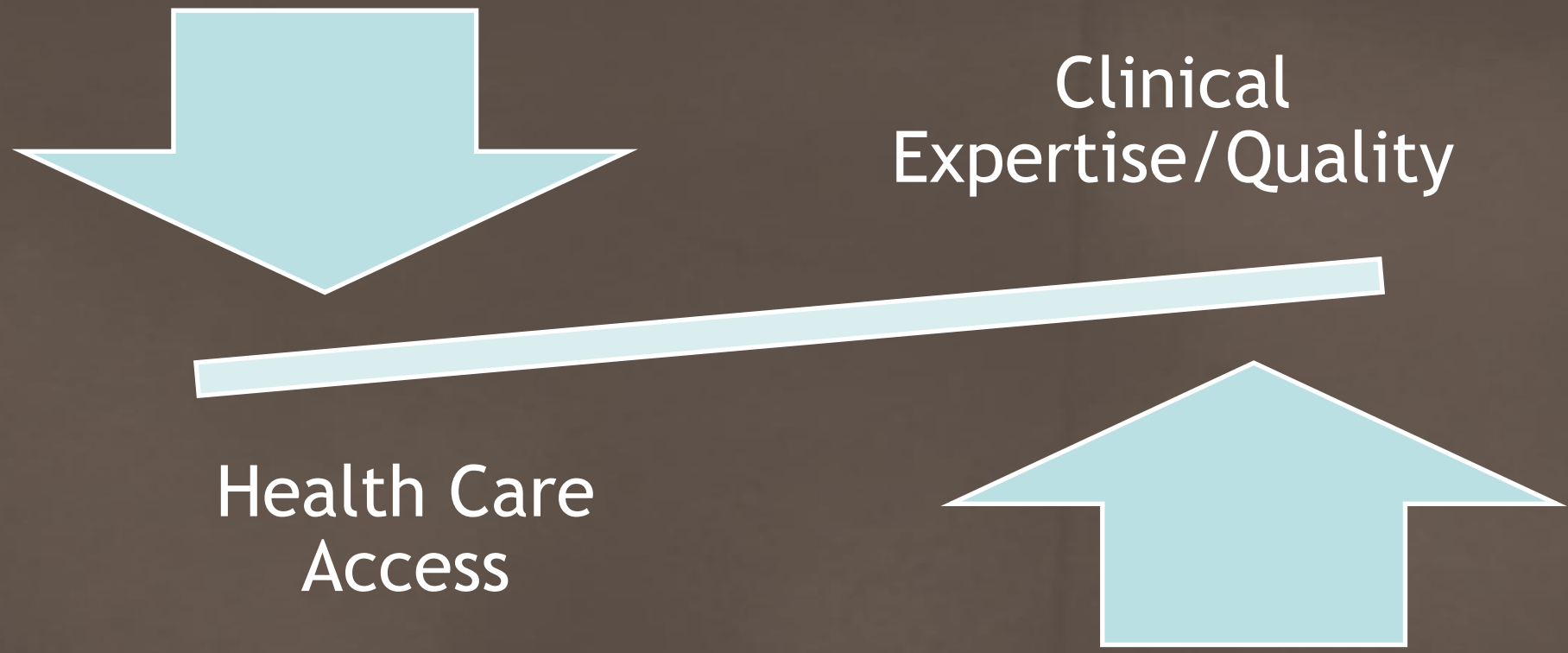
APP Experience Summary

- Greater EP procedural volumes with less physician FTEs
- Decrease in patient wait times for non-urgent new consultation by 74%
- Greater patient capacity (data pending)

Criticisms/Challenges

- More APP-derived RVUs makes physicians look less vital to the program (Counter-argument: Greater capacity increases RVU for everyone, not just APPs)
- The quality of care potentially decreases
- Patients may go months in the outpatient setting without seeing a physician (Requires more attention with patient clinic visit allocations)

The Crux of the Matter



Summary

- The more traditional APP utilization practice models at IHP made split-shared changes more challenging
- Rather than waiting for 2024, the decision was made by the group to forge ahead
- We continue to fine tune processes to ensure that our patients get the very best care while improving access

THANK YOU!

Franciscan ALLIANCE

7:40-7:50 p.m.
Critical Care Change
Linda Gates-Striby, CCS-P, ACS-CA

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Critical Care – Changes & Clarifications

Critical Care

- CMS has allowed APPs to bill critical care, now they can also *perform critical care as split shared*
- CMS acknowledged changes in the practice of medicine to a more team-based approach to care. They believe this creates close coordination and collaboration.
- CMS DID finalize who meets greater than half of the time as a deciding factor for billing critical care effective Jan 1, 2022
- CMS reasoned that these are already timed services so did not see an issue with implementing majority as a deciding factor now
- Starting Jan 1, 22 – "substantive portion will be more than half of the total time as proposed."

Team Impact

Now you will combine BOTH the APP and MD time spent rendering critical care services, total the time and bill under the one who rendered greater than half of the time. Attach the FS modifier.

Additional Clarifications:

We clarify our definition of critical care visits, as well as requirements governing how critical care visits are reported under various circumstances, including when:

- A single practitioner furnishes critical care.
- More than one practitioner or specialty furnishes critical care visits.
- A critical care visit is furnished as a split (or shared) visit.
- A critical care visit and another E/M visit occur on the same day.
- Critical care is furnished in the context of global surgery.
- Documenting critical care visits

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Critical Care – What Did Not Change

Definition

- Critically ill or injured patient
- Acute impairment of one or more vital organ systems Probability of imminent or life-threatening deterioration of patient condition
- High complexity medical decision-making At the time of the service
- Full attention of practitioner
- Cannot provide service to other patients during the same time Face-to-face
- Floor or unit time

Counting Time

- Count time spent on bundled services
- Do not count time on procedures billed separately (carve out time)
- Count time spent directly providing care to the patient o When the patient is critically ill or injured
- Does not have to be continuous
- Going over midnight Count time toward the date started, If a break in care, start a new calendar date
- 99291 – first 30 to 74 minutes
- 99292 – each additional 30 minutes

Billable Vs Bundled Procedures

Procedures

Not Bundled	Bundled with Critical Care	
Do Not Count Procedure Time	Include procedure time in Critical Care Time	
Bill Procedure Separately	**Do not bill separately**	
Endotracheal Intubation	Cardiac output measurement	Gastric Intubation
Central Venous Access	Chest X-Ray Interpretation	Transcutaneous Pacing
Bronchoscopy	Pulse Oximetry	Ventilator Management
Cardioversion	ABG interpretation	Peripheral Venous Access
Chest tube placement	EKG Interpretation	
And other invasive procedures		

NOTE: CPR and Central Line placement are NOT included in critical care services

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For Your Reference: Medical Record Documentation Requirements

- **<u>In addition to documentation to support critical care in general:</u>**
  - Document total time that critical care services were provided by each reporting practitioner - *Stop and start times highly recommended*
  - Regarding concurrent care – sufficient documentation to allow a reviewer to determine the role each practitioner played in the pt care – "the condition or conditions for which the practitioner treated the patient".
  - For split/shared – all other requirements would also apply

- CMS requires that the billing clinician be the one to sign and date the medical record.
- CMS reminded that they do allow others to document the encounter, they suggested clinicians track their individual time – but left this piece "to the discretion of individual practitioners and the group they work in to decide how time will be tracked."
- CMS requires that the documentation needs to identify the two practitioners who split/shared the visit and the individual who performed the substantive portion and therefore bills the visit must sign and date the medical record.

Documentation Requirements – Recap of Essential Elements

- Patient's condition "acutely impairs one or more vital organ systems such that there is a high probability of imminent or life-threatening deterioration"
- High complexity decision making to assess, manipulate, and support vital systems to treat single or multiple system failure and or prevent further life-threatening deterioration."
- Total time spent by provider at bedside or on the unit that required their full attention
- If procedures are performed – notes must include a comment that time involved in separately billable procedures was not counted toward critical care time
- If family discussion was counted – document if pt was present and or why they were not as well as the decision that had a direct bearing on the patient's anticipated needs

Condition

Nature of services

Total time – minimum 30 minutes

No procedure time if billable

Family decision needed

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Thoughts From An Auditing Perspective

- Assume your documentation will be requested by the payor
- We LOVE TO SEE – **"I was called urgently to the bedside for _____"** This will cover your requirement to document the critical condition that qualifies for the service, as well as the fact that it required your immediate attention.
- **You MUST document your time – start and stop times are best** to show there was no overlap with another provider
- If your time includes running a code – note that time specifically as CPR is separately billable and you need to show that was carved out
- Note that any separately billable procedure was not counted towards critical care time
- Note nature of family discussion and why it was info you needed to know at that particular time

Critical Care Services

Change 1: Physicians or NPPs in the same specialty may bill concurrent critical care services

2022 Reimbursement Policy

In 2022, CMS is recognizing that critical care services may be provided concurrently by more than one practitioner in the same specialty if:

1. The Critical Care visit is medically necessary & 2. Each visit meets the definition of critical care

Same Specialty Critical Care 2022

A. Subsequent Care (i.e. 99292): CMS will allow each individual in the same specialty to report concurrent follow-up care for subsequent critical care time intervals. Each clinician will submit a charge under their NPI.

2022 Subsequent Care

Internist A = initial critical care ***75 min 99291 x 1 "Internist A"*** CPT 99291 is still only reported by one provider in same specialty per DOS

Internist B = subsequent critical care later in the day ***90 additional minutes 99292 x 3 "Internist B"***

Additional Clarifications:

Services that cross midnight – When 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."

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Critical Care Services

Change 2 : Critical Care Services May be Split Shared with New Modifier FS

Prior = Critical Care may not be Split Shared. Beginning in 2022, it may be Split Shared with an APP

Who Bills the Split Shared Critical Care Visit?

The practitioner who provided the **substantive portion** of the visit may bill.

- Substantive Portion = more than half the cumulative total time of both providers

Example: APP Lee ***20 mins Critical Care*** + Dr. Jones ***45 mins Critical Care*** || Total Time = ***65 minutes***
Dr. Jones may bill for the visit since more than half of the 65 total minutes was spent

NOTE: Count any overlapping or joint practitioner time only once ***i.e.*** an APP & Physician each separately spend 20 minutes, plus 10 mins of joint time discussing the patient = 40 + 10 (50 mins)

Documentation Requirements:

- ***Each*** practitioner documents a note for the medically necessary critical care they personally performed
- ***Each*** practitioner documents the time they spent in the medical record
- Document the visit was done in conjunction with the other practitioner

Split Shared Service Modifier Required: - Append Modifier FS to Split/Shared critical care

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Critical Care Services

Change 3: Critical Care + Other Visits are Payable on the Same Day with Modifier 25

2022 Change

1. Practitioners may bill for E/M services provided on the same day when there is supporting documentation.

New Documentation Requirements:
The practitioner must document that:

1. the E/M service was provided prior to the time when patient did not require critical care
2. the service is medically necessary
3. the service is separate and distinct with no duplicative elements from the critical care service later provided

Modifier 25 must also be appended to the Initial E/M service bill for this scenario

E/M First – then Critical care later

CMS Comments:
"As long as the physician documents E/M service was provided prior to the critical care service at a time when the pt did not require critical care, that the service is medically necessary, and that the service is separate and distinct, with no duplicative elements from critical care provided later in the day, practitioners may bill for both services."

Change 4: Critical Care Visits Separately Billable from Global Surgery with a New Modifier FT

Note: Providing medical care to a critically ill, injured, or post-operative patient qualifies as a critical care service only if both the illness/injury and the treatment being provided meet critical care requirements.

Current Critical Care Global Rules

Pre-operative and Post-operative Critical care is included in the surgical package of many procedures with a 10 or 90 day global period

- Critical Care visits may be separately paid in addition to a procedure with a global surgical period as long as the critical care service was ***unrelated*** to the procedure.

2022

Concept is essentially unchanged, but CMS is requesting a **new modifier FT** be used to report critical care unrelated to the procedure. There are also specific criteria that must be met.

Requirements to bill Critical Care **separate** from global package:

- Service provided meets the definition of critical care and requires the full attention of the physician/QHP
- Critical care is above and beyond the procedure performed
- Critical care is unrelated to the specific anatomic injury or general surgical procedure performed

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Critical Care Services Documentation Requirements

Change 5: Critical Care Medical Record Documentation Requirements

Medical Record Documentation Requirements

1. **Document Total Time:** each reporting practitioner must document the **total** critical care time they provided

2. **Services furnished to each patient & medical necessity:** documentation should indicate that the services furnished to the patient, including any concurrent care, were medically reasonable and necessary

3. **Role of Each Practitioner in Concurrent Care:** services should clearly identify the role each practitioner played in the patient's care:
   a) the condition(s) for which each concurrent care practitioner treated the patient
   b) document if critical care was subsequent to initial critical care by colleague (please note practitioner)

- **Split Shared Critical Care**

  The documentation requirements for all split shared E/M visits would also apply to critical care visits, such as:
  1. services should indicate both practitioners who provided care
  2. the record must be signed and dated by the billing provider
  3. Total time of each practitioner should be documented

CMS reminded that they do allow others to document the encounter, they suggested clinicians track their individual time – but left this piece "to the discretion of individual practitioners and the group they work in to decide how time will be tracked."

CMS requires that the documentation needs to identify the two practitioners who split/shared the visit and the individual who performed the substantive portion and therefore bills the visit must sign and date the medical record

Where To Learn More

Internet-Only Manual Updates (IOM) for Critical Care, Split/ Shared Evaluation and Management Visits, Teaching Physicians, and Physician Assistants

MLN Matters Number: MM12543

Related Change Request (CR) Number: 12543

Related CR Release Date: January 14, 2022

Effective Date: January 1, 2022

Related CR Transmittal Number: R11181CP and R11181BP

Implementation Date: February 15, 2022

REMINDER For January 1, 2023

AMA CPT now addressing the rest of the EM visit code families (except critical care) to match the general framework of the office codes.

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