CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 12604	**Date: May 3, 2024**
	Change Request 13592

SUBJECT: Internet-Only Manual (IOM) Updates for Split (or Shared) Evaluation and Management Visits

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to update the IOM to conform with the updated policies published in the "Calendar Year (CY) 2024 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies" final rule (CMS-1784-F) for split (or shared) evaluation and management services. This CR updates manual instructions in Chapter 12 of Pub. 100-04.

EFFECTIVE DATE: January 1, 2024
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: August 1, 2024

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
R	12/30.6.18/ Split (or Shared) Visits

III. FUNDING:

For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

Attachment - Business Requirements

Pub. 100-04	Transmittal: 12604	Date: May 3, 2024	Change Request: 13592

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I. GENERAL INFORMATION

A. Background: The purpose of this Change Request (CR) is to update the IOM to conform with the updated policies published in the "CY 2024 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies" final rule (CMS-1784-F) for split/shared evaluation and management services. This CR updates manual instructions in Chapter 12 of Pub. 100-04.

The Medicare Claims Processing Manual, Pub. 100-04, Chapter 12, has been revised as follows:

- Split/shared E/M visit information has been updated in section 30.6.18, where noted.

B. Policy: CY 2024 PFS Final Rule

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME	Shared-System Maintainers				Other
		A	B	HHH	MAC	FISS	MCS	VMS	CWF	
13592.1	Contractors shall be aware of the updates listed in this CR to Chapter 12 in Pub. 100-04.	X	X	X						

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
13592.2	Medicare Learning Network® (MLN): CMS will develop and release national provider education content and market it through the MLN Connects® newsletter shortly after we issue	X	X	X		

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
	the CR. MACs shall link to relevant information on your website and follow IOM Pub. No. 100-09 Chapter 6, Section 50.2.4.1 for distributing the newsletter to providers. When you follow this manual section, you don't need to separately track and report MLN content releases. You may supplement with your local educational content after we release the newsletter.					

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
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ATTACHMENTS: 0

30.6.18 - Split (or Shared) Visits

(Rev. 12604; Issued:05-03-24; Effective:01-01-24; Implementation:08-01-24)

A. Definition of Split (or Shared) Visit

A split (or shared) visit is an evaluation and management (E/M) visit in the facility setting that is performed in part by both a physician and a nonphysician practitioner (NPP) who are in the same group, in accordance with applicable law and regulations such that the service could be could be billed by either the physician or NPP if furnished independently by only one of them. Payment is made to the practitioner who performs the substantive portion of the visit.

Facility setting means an institutional setting in which payment for services and supplies furnished incident to a physician or practitioner's professional services is prohibited under our regulations.

B. Definition of Substantive Portion

(1) More Than Half of the Total Time*, or a Substantive Part of the Medical Decision Making*

Beginning January 1, 2024, substantive portion means more than half of the total time spent by the physician and NPP performing the split (or shared) visit*, or a substantive part of the medical decision making (MDM) as defined in the CPT E/M Guidelines (see 2024 CPT Codebook). For critical care visits and prolonged services (which do not use MDM and only use time), "substantive portion" continues to mean more than half of the total time spent by the physician and NPP performing the split (or shared) visit.*

In other words, *beginning in* calendar year 202*4*, the practitioner who spends more than half of the total time, or performs the *substantive part of* MDM can be considered to have performed the substantive portion and can bill for the split (or shared) E/M visit. When MDM is used as the substantive portion, *we believe* each practitioner could perform certain aspects of MDM, but the billing practitioner must perform *the substantive part* of MDM *laid out in the CPT E/M Guidelines in order to bill the shared visit*.

For critical care visits, starting for services furnished in CY 2022, the substantive portion will be more than half of the total time. A unique listing of qualifying activities for purposes of determining the substantive portion of critical care visits applies (see below).

We summarize these policies in the following table.

Definition of Substantive Portion for E/M Visit Code Families

E/M Visit Code Family	2024 Definition of Substantive Portion
Other Outpatient*	More than half of total time *or a substantive part of the MDM*
Inpatient/Observation/ Hospital/SNF*	More than half of total time *or a substantive part of the MDM*
Emergency Department	More than half of total time *or a substantive part of the MDM*
Critical Care	More than half of total time

Acronyms: E/M (Evaluation and Management), MDM (medical decision-making), SNF (Skilled Nursing Facility)

*Office visits and Nursing Facility visits are not billable as split (or shared) services.

(2) Distinct Time

In accordance with the CPT E/M Guidelines, only distinct time can be counted. When the practitioners jointly meet with or discuss the patient, only the time of one of the practitioners can be counted.

Example: If the NPP first spent 10 minutes with the patient and the physician then spent another 15 minutes, their individual time spent would be summed to equal a total of 25 minutes. The physician would bill for this visit, since they spent more than half of the total time (15 of 25 total minutes). If, in the same situation, the physician and NPP met together for five additional minutes (beyond the 25 minutes) to discuss the patient's treatment plan, that overlapping time could only be counted once for purposes of establishing total time and who provided the substantive portion of the visit. The total time would be 30 minutes, and the physician would bill for the visit, since they spent more than half of the total time (20 of 30 total minutes).

(3) Qualifying Time

Drawing on the CPT E/M Guidelines, except for critical care visits, the following listing of activities can be counted toward total time for purposes of determining the substantive portion, when performed and whether or not the activities 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 cannot 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.

See section 30.6.12 for a listing of qualifying activities for purposes of determining the substantive portion of critical care services.

For all split (or shared) visits, 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. The substantive portion can be entirely with or without direct patient contact, and is determined by the proportion of total time, not whether the time involves patient contact.

(4) Application to Prolonged Services

Starting in 2024, *for prolonged visits,* the substantive portion is more than half of the practitioners' total time*. Prolonged services are only billed when time is used to select visit level, and therefore determination of who performed the substantive portion is based on time. T*he physician or practitioner who spent more than half the total time (the substantive portion starting in 2024) will bill for the primary E/M visit and the prolonged service code(s) when the service is furnished as a split (or shared) visit, if all other requirements to bill for split (or shared) services are met. The physician and NPP will add their time together, and

whomever furnished more than half of the total time, including prolonged time, (that is, the substantive portion) will report both the primary service code and the prolonged services add-on code(s), assuming the time threshold for reporting prolonged services is met (see Prolonged Services section above).

- During the transitional calendar years 2022-2023, when practitioners use a key component as the substantive portion, Emergency department and critical care visits are not reported as prolonged services.

We summarize these policies in the following table.

Reporting Prolonged Services for Split (or Shared) Visits

E/M Visit Code Family	2022-2023		2024
	If Substantive Portion is a Key Component…	If Substantive Portion is Time…	Substantive Portion Must Be Time
Other Outpatient*	Combined time of both practitioners must meet the threshold for reporting prolonged services	Combined time of both practitioners must meet the threshold for reporting prolonged services	Combined time of both practitioners must meet the threshold for reporting prolonged services
Inpatient/Observation/Hospital/SNF*	Combined time of both practitioners must meet the threshold for reporting prolonged services	Combined time of both practitioners must meet the threshold for reporting prolonged services	Combined time of both practitioners must meet the threshold for reporting prolonged services
Emergency Department	N/A	N/A	N/A
Critical Care	N/A	N/A	N/A

Acronyms: E/M (Evaluation and Management); SNF (Skilled Nursing Facility)
*Office visits and Nursing Facility visits are not billable as split (or shared) services.

C. New and Established Patients, and Initial and Subsequent Visits

Split (or shared) visits may be billed for new and established patients, as well as for initial and subsequent visits, that otherwise meet the requirements for split (or shared) visit payment.

D. Settings of Care

Split (or shared) visits are furnished only in the facility setting, meaning institutional settings in which payment for services and supplies furnished incident to a physician or practitioner's professional services is prohibited under our regulations at 42 CFR § 410.26.

Accordingly, split (or shared) visits are billable for E/M visits furnished in hospital and skilled nursing facility (SNF) settings. Visits in these settings that are required by our regulations to be performed in their entirety by a physician are not billable as split (or shared) services. For example, our Conditions of Participation require certain SNF visits to be performed directly and solely by a physician; accordingly, those SNF visits cannot be billed as a split (or shared) visit (see Section 30.6.13).

E. Medical Record Documentation

Documentation in the medical record must identify the physician and NPP who performed the visit. The individual who performed the substantive portion of the visit (and therefore bills for the visit) must sign and date the medical record.

F. Claim Identification

Modifier -FS (Split or Shared E/M Visit) must be reported on claims for split (or shared) visits, to identify that the service was a split (or shared) visit.

The modifier identified by CPT for purposes of reporting partial services (modifier -52 (reduced services)) cannot be used to report partial E/M visits, including any partial services furnished as split (or shared) visits. Medicare does not pay for partial E/M visits.