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Part B News
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Special Issue

Coverage of the final 2022 Medicare physician fee schedule and Quality Payment Program

In this issue

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Billing

CMS widens scope of split/shared policy, firms up billing rules

Prepare for major changes to the way your practice bills original split/shared services — traditionally performed in the hospital setting — that will go into effect Jan. 1, 2022. CMS will implement the new guidelines it released in the proposed 2022 Medicare physician fee schedule, but it added a transitional plan designed to smooth the switch to the new billing policy (*PBN 7/26/21*).

Consider five main points in the new guidelines, which CMS confirmed in the final 2022 Medicare physician fee schedule released Nov. 2:

1. The treating provider who performs the "substantive portion" of the visit will bill the service.
2. Split/shared facility services may be billed for encounters in any facility setting, including the emergency department and skilled nursing facilities.
3. The service may be billed for initial and subsequent encounters, for new and established patients and for critical care services (**99291-99292**).
4. Prolonged services are allowed for codes that have a typical time in the descriptor.
5. The services must be reported with a new modifier — **FS** (Split [or shared] evaluation and management visit). CMS released the modifier in the latest quarterly HCPCS code update published Nov. 8.

Practices should focus on how to calculate the "substantive portion" of the visit because it is a unique approach to billing that will determine which practitioner bills the service and how much revenue the practice receives.

Get ready for 2022 E/M updates

CMS is unleashing big changes to E/M coding, billing and documentation policy starting Jan. 1, 2022. From revisions for split/shared billing policy to a wide-ranging update on critical care services, a flurry of new policies will hit medical practices in the new year. Prepare for the updates during the Nov. 23 webinar **E/M for 2022: Brace for Revised Medicare Policies, Code Updates**. Learn more: *https://codingbooks.com/ympda112321*.

Calculating 'substantive portion'

In 2022, you can calculate the substantive portion of the visit based on time or performance of a key component.

To calculate based on time, both practitioners will need to document the time they spent on the nine activities that are used for time-based coding of office and other outpatient visits (**99202**-**99215**) on the date of the encounter.

The encounter should be billed under the name and national provider identifier (NPI) of the person who spends the greatest amount of time — i.e., more than 50% — on the activities. Practices should not use the counseling/coordination of care rules to calculate time for billing facility split/shared services.

Time-based billing was the original proposal, but in response to negative comments about the plan CMS created a key component option: The practitioner who performs a key component of a visit — history, exam or medical decision-making — will bill the service. But note that the key component option is only available in 2022 (*see chart, p. 3*).

"We also 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," CMS says in the final rule.

The billing provider must fully document what's required for that element, says Betsy Nicoletti, CPC, president of Medical Practice Consulting in North Andover, Mass.

Time-based billing could free physician time

Even though CMS created the key component option in response to complaints about time-based billing, two statements in the final rule may make a focus on time more attractive:

- **A face-to-face encounter is not required**. The billing practitioner doesn't have to see the patient. "The substantive portion could be entirely with or without direct patient contact and will be determined by the proportion of total time, not whether the time involves direct or in-person patient contact," CMS said in response to several comments. That means that if a physician spends 20 minutes on activities that do not need to be performed face-to-face, such as ordering procedures, interpreting test results, conferring with other physicians or coordinating care, and the NPP spends 15 minutes with the patient getting a history, performing a physical exam and counseling the patient, the physician will bill the service.
- **Timekeeping is an individual choice**. CMS also received questions about how it wanted practices to track time. "We believe we should leave it to the discretion of individual practitioners and the groups they work in to decide how time will be tracked," the final rule states.

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