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# The past, present, and future of split/shared visits for Medicare and beyond

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Healthcare delivery has expanded in its utilization by nonphysician practitioners (NPPs), often working with physicians in similar specialty areas. In some healthcare settings, it is common for both an NPP and a physician to see a patient on the same day. As this delivery model became more common, providers sought mechanisms to ensure reimbursement was consistent with professional resources. The concept of a split/shared visit between physicians and NPPs eventually developed.

This article describes the inception of the split/shared visit concept as a billing rule, incremental revisions to the policy, and updates in both Medicare policy and Current Procedural Terminology (CPT) guidelines for 2024.

## History of the split/shared billing rule, definition, and implications on payment

In October 2022, the Centers for Medicare & Medicaid Services (CMS) announced an amendment to the *Medicare Carriers Manual* claims process provisions to address payment for evaluation and management (E/M) services shared between a physician and a nurse practitioner, physician assistant, clinical nurse specialist, or certified nurse midwife (collectively, NPPs) in the same group practice.[1] The split/shared billing rule is a payment policy developed by CMS to determine which of the providers involved in a split/shared service may bill for the visit. The policy has implications on the amount reimbursed; services billed by a physician may receive 15% greater reimbursement than those rendered by an NPP.

Initially, the split/shared billing policy was limited to the hospital inpatient, outpatient, and emergency department settings. If "the physician provides any face-to-face portion of the E/M encounter," the service could be billed under the physician's Provider Identification Number. Eventually, the policy expanded to other facility settings—such as encounters in skilled nursing facilities.[2], [3] CMS policy now defines the facility settings in which a split/shared visit may be rendered as "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." A group practice is described by CMS payment policy as a group of two or more physicians and NPPs legally organized in a partnership, professional corporation, foundation, not-for-profit corporation, faculty practice plan, or similar association.[4] The initial CMS policy for reporting split/shared services explained that in the nonfacility clinic setting, if a physician and NPP split or share a single E/M encounter, the physician could only bill the service as rendering provider if "incident-to" billing requirements were met.[5]

## The genesis of substantive portion

Soon after the initial split/shared policy was published, CMS converted its *Medicare Carriers Manual* to the new online-based, internet-only manuals where split/shared billing policies have lived since 2004. Then, the concept of a substantive portion of the visit dictating the billing provider appeared in the manual's policies. Interestingly, the term "substantive portion" was first used in an update to the *Medicare Claims Processing Manual*, Chapter 12, Section 30.6.13, Nursing Facility Services. This was prompted by the American Medical Association's (AMA) CPT changes to billing codes describing nursing facility services that took effect for calendar year 2006. At the time, new language was added to explain that split/shared visits could not be reported in the skilled or non-skilled nursing facility setting. Although eventually, this guidance was reversed to permit a split/shared E/M in a skilled nursing facility,[6], [7] 2006 *Medicare Claims Processing Manual* revisions continued to state, "A split/shared E/M visit is defined by Medicare Part B payment policy as a medically necessary encounter with a patient where the physician and a qualified NPP each personally perform a substantive portion of an E/M visit face-to-face with the same patient on the same date of service."[8] For the first time, we were given a definition of the term "substantive portion": A substantive portion of an E/M visit involves all or some portion of the history, exam or medical decision-making key components of an E/M service.[9]

The language change is notable because the concept of a substantive portion of a split/shared E/M visit has endured to this day, with considerable iterations throughout its evolution. Without going through the rulemaking process, policy defining a "substantive portion" appears to have potentially altered the policy regarding the decision of which practitioner reports a split/shared service. Even more, none of the Medicare Physician Fee Schedule *Federal Register* notices between 2003 and 2006 propose, consider, or finalize any language changes to CMS's split/shared visit billing rules. Recall that initially, a physician could report a split/shared E/M service if the physician provided any face-to-face services. However, the 2006 *Claims Processing Manual* updates appear to have created a heightened standard that the physician performs all or a portion of the history, examination, or medical decision-making components. At the time, these were the three key components that were used to select the evaluation and management service level. This birth of the term "substantive portion" is also curious, given its placement in the *Claims Processing Manual*. It was described as part of a section intended to highlight when split/shared billing *is not permitted*, yet the developed policy had the effect of dictating how split/shared billing would work in the permitted setting.