Centers for Medicare & Medicaid Services

Questions and Answers from Open Door Forum: Physicians, Nurses and Allied Health Professionals

November 9, 2021

1. I have a question about the shared E&M services rule. In one of the tables on Table 26, it says that outpatient visits can be billed as shared services but office visits cannot and that outpatient visits can be built based on history, exam, medical decision-making or time. Do you mean that Office and Outpatient Visit Codes 99202 to 99215 may be billed as shared in place of Service 19 and 21? And if so, since these codes don't have a required level of history and exam anymore, how can a clinician meet the criteria based on history and exam?
    a. I'll take the second part of it first. Those codes still have a history and exam as medically appropriate and the way that you decide your visit level selection is independent of how the substantive portion is determined. So, you should still use the regular CPT guidance, the new guidance for office and outpatient visits, to select your visit level. However, when you're deciding who performs a substantive portion for purposes of billing, what we're saying is that for a transitional year we will still allow for that code that for you to consider the substantive portion to be the history and - a full history, an exam or medical decision-making or more than half of the time. On the first part of your question, the reason we said that the office visits are not billable is because there's an incident to benefit there. And split and shared visits have now been defined as visits for which incidents through payment is not available because it's not needed where the incident to benefit provides an alternative mechanism. You are right that for certain places of service you would be able to build that code set. And for others, you would not as with our shared services.
2. You discussed the two new modifiers, one for split/shared and one for global critical care E&Ms global period. Are those effective calendar year '22 or '23?
    a. 2022. Sometimes we don't have the actual alphanumeric code assigned by the time the rule goes into publication but we'll be putting out some manual changes that have the letter in it and we've since gotten the actual alphanumeric and I just wanted to verbally mention it for anyone looking for that information. We have been getting some e-mails already on that.
3. I would like clarification on what kind of services can and cannot be built with chronic care management. We seem to be finding some conflicting statements regarding what can and cannot be billed to the CCM during the same service period or the billing month

and this is one of those services. In the CMS CCM booklet dated July 2019, it says that CCM cannot be billed during the same service period by the same practitioner's hospice. But a 2016 CCM frequently asked document didn't include the qualifier about the same or different physicians. So, what we're asking is if CCM can be billed by a different physician that is billing hospice during the same billing period.

   a. I think that if it is a different practitioner, you should be able to bill it and the prohibition shouldn't be for a patient receiving hospice services but rather the G codes for hospice supervision.

4. When should we anticipate guidance coming out regarding the critical care modifier and where should we be looking for that?
   a. It will be coming out through manual updates between now and the end of the year under our regular schedule. We can't update the manual until the rule is published. But we're working on that right now.