

FAQs: Split (or Shared) Visits and Critical Care Services

The following Frequently Asked Questions (FAQs) address frequent questions we received regarding recent policy revisions for payment of split (or shared) visits and critical care services under the Medicare Physician Fee Schedule (PFS).

Split (or Shared) Services

Q1. Under the new policies effective January 1, 2022, can a split (or shared) visit be billed for visits furnished in a Nursing Facility (NF) setting?

A1. No, a split (or shared) visit cannot be billed for visits furnished in a NF setting. We revised our regulation at 42 CFR § 415.140 to define a split (or shared) visit as an E/M visit in a facility setting in which payment for services and supplies furnished incident to a physician or practitioner's professional services is not available under § 410.26(b)(1).

Critical Care Services (CPT 99291 and 99292)

Q1. Under CMS policy, what is the time duration for the correct reporting of critical care services by a single physician or NPP (CPT codes 99291 and 99292)?

A1. Our CY 2022 final rule provides that the physician or NPP will report CPT code 99291 for the first 30–74 minutes of critical care services provided to a patient on a given date. Thereafter, the physician or NPP will report CPT code 99292 for additional 30-minute time increments provided to the same patient.

Q2. Does the CY 2022 final rule provide that a physician or NPP providing critical care services to a patient on a given date may report CPT code 99291 once 30 minutes has been reached?

A2. Yes, 99291 can be billed by a physician or NPP providing critical care services to a patient on a given date if between 30-74 minutes is spent.

Q3. Does the CY 2022 final rule provide that a physician or NPP spending more than 74 minutes providing critical care services to a patient on a given date may report CPT code 99292?

A3. No, as finalized in the CY 2022 rule a physician or NPP spending more than 74 minutes providing critical care services to a patient on a given date may report CPT code 99292 only when they have spent a whole additional 30-minute time increment (in other words, when 104 minutes have been spent), and may bill 99292 for each additional 30-minute time increment completed.

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Q4. Do I have to report modifier FT on a claim for critical care services when a decision for surgery is made?

A4. Yes, the modifier must be reported. Critical care must be unrelated to the surgery in order to be separately paid, even if a decision for surgery is made during the critical care visit.