

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 11288	Date: March 4, 2022
	Change Request 12543

Transmittal 11181, dated January 2022, is being rescinded and replaced by Transmittal 11288, dated March 4, 2022, to revise the long descriptor for FT Modifier in various sections throughout chapter 12 in Publication (Pub.) 100-04 for Split-Shared Critical Care Teaching Phys PAs. This correction does not make any revisions to the companion Pub. 100-02; all revisions are associated with Pub. 100-04. All other information remains the same.

SUBJECT: Internet-Only Manual Updates (IOM) for Critical Care, Split/Shared Evaluation and Management Services, Teaching Physicians, and Physician Assistants

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 "CY 2022 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies" final rule (CMS-1751-F) for critical care services, split/shared evaluation and management services, teaching physicians, and physician assistants. This is a companion CR that updates manual instructions in Chapter 12 of Pub. 100-04 and Chapter 15 of Publication (Pub.) 100-02.

EFFECTIVE DATE: January 1, 2022

**Unless otherwise specified, the effective date is the date of service.*

IMPLEMENTATION DATE: February 15, 2022

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/Table of Contents
R	12/30/30.6.1/Selection of Level of Evaluation and Management Service
R	12/30/30.6.9/Payment for Inpatient Hospital Visits - General
R	12/30/30.6.12/Critical Care Visits and Neonatal Intensive Care (CPT Codes 99291-99292)
N	12/30/30.6.12.1/Definition
N	12/30/30.6.12.2/Critical Care by a Single Physician or NPP
N	12/30/30.6.12.3/Critical Care Visits Furnished Concurrently by Different Specialties
N	12/30/30.6.12.4/Critical Care Furnished Concurrently by Practitioners in the Same Specialty and Same Group (Follow-Up Care)
N	12/30/30.6.12.5/Split (or Shared) Critical Care Visits
N	12/30/30.6.12.6/Critical Care and Other Same-Day Evaluation and Management (E/M) Visits
N	12/30/30.6.12.7/Critical Care Visits and Global Surgery
N	12/30/30.6.12.8/Medical Record Documentation
R	12/30/30.6.13/Nursing Facility Services
R	12/30/30.6.15/Prolonged Services and Standby Services (Codes 99354-99360), and Evaluation and Management service for Power Mobility Devices (PMDs) (G0372)
N	12/30/30.6.18/Split (or Shared) Visits
R	12/100/100.1.1/Evaluation and Management (E/M) Services
R	12/100/100.1.4/Time-Based Codes
R	12/110/110.4/PA Billing to the A/B MAC (B)

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: 11288	Date: March 4, 2022	Change Request: 12543
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EFFECTIVE DATE: January 1, 2022

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IMPLEMENTATION DATE: February 15, 2022

I. GENERAL INFORMATION

A. Background: This CR will update the IOM to conform with the updated policies published in the "CY 2022 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies" final rule (CMS-1751-F) for critical care services, split/shared evaluation and management services, teaching physicians, and physician assistants. This is a companion CR that updates manual instructions in Chapter 15 of Publication (Pub.) 100-02 and Chapter 12 of Pub. 100-04.

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

1. Split/shared E/M visit information previously referenced in sections 30.6.1, 30.6.12., and 30.6.13 has been updated or moved to new section 30.6.18 where noted.
2. Critical care services have been updated and/or added in sections 30.6.9, and 30.6.12 through 30.6.12.8.
3. The title of section 30.6.15 has been revised, and a reference to section 30.6.18 has been added regarding split/shared E/M visits involving prolonged services.
4. E/M visit billing information for Teaching physicians has been updated in sections 100.1.1 and 100.1.4.
5. Physician assistant billing information has been updated in section 110.4.

B. Policy: Consolidated Appropriations Act, 2021 and CY 2022 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 MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
12543 - 04.1	Contractors shall be aware of the updates listed in	X	X	X						

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
	this CR to Chapter 12 in Pub. 100-04.									

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
12543 - 04.2	Medicare Learning Network® (MLN): CMS will market provider education content through the MLN Connects® newsletter shortly after CMS releases the CR. MACs shall follow IOM Pub. No. 100-09 Chapter 6, Section 50.2.4.1 instructions for distributing the MLN Connects newsletter information to providers and link to relevant information on your website. You may supplement MLN content with your local information after we release the MLN Connects newsletter. Subscribe to the “MLN Connects” listserv to get MLN content notifications. You don’t need to separately track and report MLN content releases when you distribute MLN Connects newsletter content per the manual section referenced above.	X	X	X		

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

Pre-Implementation Contact(s): Liane Grayson, 410-786-6583 or liane.grayson@cms.hhs.gov (Payment Policy) , Regina Walker-Wren, 410-786-9160 or regina.walkerwren@cms.hhs.gov (Teaching Physicians and Physician Assistant policy contact) , Ann Marshall, 410-786-3059 or ann.marshall@cms.hhs.gov (Payment Policy)

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

VI. FUNDING

Section A: 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.

ATTACHMENTS: 0

Medicare Claims Processing Manual

Chapter 12 - Physicians/Nonphysician Practitioners

Table of Contents
(Rev. 11288; Issued:03-04-22)

Transmittals for Chapter 12

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- 30.6.12.3 - Critical Care Visits Furnished Concurrently by Different Specialties*
- 30.6.12.4 - Critical Care Furnished Concurrently by Practitioners in the Same Specialty and Same Group (Follow-Up Care)*
- 30.6.12.5 - Split (or Shared) Critical Care Visits*
- 30.6.12.6 - Critical Care and Other Same-Day Evaluation and Management (E/M) Visits*
- 30.6.12.7 - Critical Care Visits and Global Surgery*
- 30.6.12.8 - Medical Record Documentation*
- 30.6.15 - Prolonged Services and Standby Services (Codes 99354 - 99360), and Evaluation and Management service for Power Mobility Devices (PMDs) (G0372)**
- 30.6.18 - Split (or Shared) Visits*

30.6.1 - Selection of Level of Evaluation and Management Service *(Rev. 11288; Issued: 03-04-22; Effective: 01-01-22; Implementation: 02-15-22)*

A. Use of CPT Codes

Advise physicians to use CPT codes (level 1 of HCPCS) to code physician services, including evaluation and management services. Medicare will pay for E/M services for specific non-physician practitioners (i.e., nurse practitioner (NP), clinical nurse specialist (CNS) and certified nurse midwife (CNM)) whose Medicare benefit permits them to bill these services. A physician assistant (PA) may also provide a physician service, however, the physician collaboration and general supervision rules as well as all billing rules apply to all the above non-physician practitioners. The service provided must be medically necessary and the service must be within the scope of practice for a non-physician practitioner in the State in which he/she practices. Do not pay for CPT evaluation and management codes billed by physical therapists in independent practice or by occupational therapists in independent practice.

Medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of a CPT code. It would not be medically necessary or appropriate to bill a higher level of evaluation and management service when a lower level of service is warranted. The volume of documentation should not be the primary influence upon which a specific level of service is billed. Documentation should support the level of service reported. The service should be documented during, or as soon as practicable after it is provided in order to maintain an accurate medical record.

B. Selection of Level of Evaluation and Management Service

Instruct physicians to select the code for the service based upon the content of the service. The duration of the visit is an ancillary factor and does not control the level of the service to be billed unless more than 50 percent of the face-to-face time (for non-inpatient services) or more than 50 percent of the floor time (for inpatient services) is spent providing counseling or coordination of care as described in subsection C.

Any physician or non-physician practitioner (NPP) authorized to bill Medicare services will be paid by the Medicare Administrative Contractor (MAC) at the appropriate physician fee schedule amount based on the rendering *national provider identifier (NPI) number*.

"Incident to" Medicare Part B payment policy is applicable for office visits when the requirements for "incident to" are met (refer to sections 60.1, 60.2, and 60.3, chapter 15 in IOM 100-02).

SPLIT/SHARED E/M SERVICE

See section 30.6.18 for rules regarding billing of E/M visits that are split (or shared).

C. Selection of Level of Evaluation and Management Service Based On Duration of Coordination of Care and/or Counseling

Advise physicians that when counseling and/or coordination of care dominates (more than 50 percent) the face-to-face physician/patient encounter or the floor time (in the case of inpatient services), time is the key or controlling factor in selecting the level of service. In general, to bill an E/M code, the physician must complete at least 2 out of 3 criteria applicable to the type/level of service provided. However, the physician may document time spent with the patient in conjunction with the medical decision-making involved and a description of the

coordination of care or counseling provided. Documentation must be in sufficient detail to support the claim.

EXAMPLE: A cancer patient has had all preliminary studies completed and a medical decision to implement chemotherapy. At an office visit the physician discusses the treatment options and subsequent lifestyle effects of treatment the patient may encounter or is experiencing. The physician need not complete a history and physical examination in order to select the level of service. The time spent in counseling/coordination of care and medical decision-making will determine the level of service billed.

The code selection is based on the total time of the face-to-face encounter or floor time, not just the counseling time. The medical record must be documented in sufficient detail to justify the selection of the specific code if time is the basis for selection of the code.

In the office and other outpatient setting, counseling and/or coordination of care must be provided in the presence of the patient if the time spent providing those services is used to determine the level of service reported. Face-to-face time refers to the time with the physician only. Counseling by other staff is not considered to be part of the face-to-face physician/patient encounter time. Therefore, the time spent by the other staff is not considered in selecting the appropriate level of service. The code used depends upon the physician service provided.

In an inpatient setting, the counseling and/or coordination of care must be provided at the bedside or on the patient's hospital floor or unit that is associated with an individual patient. Time spent counseling the patient or coordinating the patient's care after the patient has left the office or the physician has left the patient's floor or begun to care for another patient on the floor is not considered when selecting the level of service to be reported.

The duration of counseling or coordination of care that is provided face-to-face or on the floor may be estimated but that estimate, along with the total duration of the visit, must be recorded when time is used for the selection of the level of a service that involves predominantly coordination of care or counseling.

D. Use of Highest Levels of Evaluation and Management Codes

A/B MACs (B) must advise physicians that to bill the highest levels of visit codes, the services furnished must meet the definition of the code (e.g., to bill a Level 5 new patient visit, the history must meet CPT's definition of a comprehensive history).

The comprehensive history must include a review of all the systems and a complete past (medical and surgical) family and social history obtained at that visit. In the case of an established patient, it is acceptable for a physician to review the existing record and update it to reflect only changes in the patient's medical, family, and social history from the last encounter, but the physician must review the entire history for it to be considered a comprehensive history.

The comprehensive examination may be a complete single system exam such as cardiac, respiratory, psychiatric, or a complete multi-system examination.

30.6.9 - Payment for Inpatient Hospital Visits - General

(Rev. 11288; Issued: 03-04-22; Effective: 01-01-22; Implementation: 02-15-22)

A. Hospital Visit and Critical Care on Same Day

Hospital evaluation and management (E/M) visits may be billed the same day as critical care services in certain circumstances discussed in section 30.6.12. Documentation must support the claims as indicated in that section.

During critical care management of a patient those services that do not meet the level of critical care shall be reported using an inpatient hospital care service with CPT Subsequent Hospital Care using a code from CPT code range 99231 - 99233.

Both Initial Hospital Care (CPT codes 99221 - 99223) and Subsequent Hospital Care codes are “per diem” services and may be reported only once per day by the same physician or physicians of the same specialty from the same group practice.

B. Two Hospital Visits Same Day

A/B MACs (B) pay a physician for only one hospital visit per day for the same patient, whether the problems seen during the encounters are related or not. The inpatient hospital visit descriptors contain the phrase “per day” which means that the code and the payment established for the code represent all services provided on that date. The physician should select a code that reflects all services provided during the date of the service.

C. Hospital Visits Same Day But by Different Physicians

In a hospital inpatient situation involving one physician covering for another, if physician A sees the patient in the morning and physician B, who is covering for A, sees the same patient in the evening, A/B MACs (B) do not pay physician B for the second visit. The hospital visit descriptors include the phrase “per day” meaning care for the day.

If the physicians are each responsible for a different aspect of the patient’s care, pay both visits if the physicians are in different specialties and the visits are billed with different diagnoses. There are circumstances where concurrent care may be billed by physicians of the same specialty.

D. Visits to Patients in Swing Beds

If the inpatient care is being billed by the hospital as inpatient hospital care, the hospital care codes apply. If the inpatient care is being billed by the hospital as nursing facility care, then the nursing facility codes apply.

30.6.12 - Critical Care Visits and Neonatal Intensive Care (CPT Codes 99291-99292)

(Rev. 11288; Issued:03-04-22; Effective: 01-01-22; Implementation: 02-15-22)

30.6.12.1 – Definition

(Rev. 11288; Issued: 03-04-22; Effective: 01-01-22; Implementation: 02-15-22)

For payment under the Medicare Physician Fee Schedule (PFS), Medicare adopts the definition of critical care services in the CPT Codebook, and the CPT listing of bundled services, unless otherwise specified. This includes the CPT prefatory language stating that critical care is the direct delivery by a physician(s) or other qualified healthcare professional (QHP) of medical care for a critically ill/injured patient in which there is acute impairment of one or more vital organ systems, such that there is a probability of imminent or life-threatening deterioration of the patient’s condition. It involves high complexity decision-making to treat single or multiple vital organ system failure and/or to prevent further life-threatening deterioration of the patient’s condition.

Bundled services that are included by CPT in critical care services and therefore not separately payable include interpretation of cardiac output measurements, chest X rays, pulse oximetry, blood gases and collection and interpretation of physiologic data (for example, ECGs, blood pressures, hematologic data), gastric intubation, temporary transcutaneous pacing, ventilator management, and vascular access procedures. As a result, these codes are not separately billable by a practitioner during the time-period when the practitioner is providing critical care for a given patient. Time spent performing separately reportable procedures or services should be reported separately and should not be included in the time reported as critical care time.

Because critical care services are delivered by a physician(s) or QHP(s), critical care may be reported by physicians and other practitioners who are qualified by education, training, licensure/regulation (when applicable), facility privileging (when applicable), and the applicable Medicare benefit category to perform critical care services and independently report them, referred to in this manual section as physicians and non-physician practitioners (NPPs).

As specified in CPT prefatory language, critical care may be furnished on multiple days, and is typically furnished in a critical care area, which can include an intensive care unit or emergency care facility. Critical care requires the full attention of the physician or NPP and therefore, for any given time period spent providing critical care services, the practitioner cannot provide services to any other patient during the same period of time.

30.6.12.2 - Critical Care by a Single Physician or NPP **(Rev. 11288; Issued: 03-04-22; Effective: 01-01-22; Implementation: 02-15-22)**

For payment of critical care by a single physician or NPP, we are adopting CPT's reporting rules. When a single physician or NPP furnishes 30 -74 minutes of critical care services to a patient on a given date, the physician or NPP will report CPT code 99291. CPT code 99291 will be used only once per date even if the time spent by the practitioner is not continuous on that date. Thereafter, the physician or NPP will report CPT code 99292 for additional 30-minute time increments provided to the same patient.

CPT codes 99291 and 99292 will be used to report the total duration of time spent by the physician or NPP providing critical care services to a critically ill or critically injured patient, even if the time spent by the practitioner on that date is not continuous. Non-continuous time for medically necessary critical care services may be aggregated.

Regarding critical care services crossing midnight, CPT guidance defines how a service is to be billed when the service extends across calendar dates. For continuous services that extend beyond midnight, the physician or NPP will report the total units of time provided continuously. Any disruption in the service, however, creates a new initial service. We are adopting this rule for critical care being furnished by a single physician or NPP when the critical care crosses midnight.

30.6.12.3 - Critical Care Visits Furnished Concurrently by Different Specialties **(Rev. 11288; Issued: 03-04-22; Effective: 01-01-22; Implementation: 02-15-22)**

Concurrent care is when more than one physician renders services that are more extensive than consultative services during a period of time. The reasonable and necessary services of each physician furnishing concurrent care is covered when each plays an active role in the patient's treatment. In the context of critical care services, a critically ill patient may have more than one medical condition requiring diverse, specialized medical services and

requiring more than one practitioner, each having a different specialty, playing an active role in the patient's treatment.

Medicare policy allows critical care visits furnished as concurrent care (or concurrently) to the same patient on the same date by more than one practitioner in more than one specialty (for example, an internist and a surgeon, allergist and a cardiologist, neurosurgeon and NPP), regardless of group affiliation, if the service meets the definition of critical care and is not duplicative of other services. Additionally, these critical care visits need to be medically reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.

30.6.12.4 - Critical Care Furnished Concurrently by Practitioners in the Same Specialty and Same Group (Follow-Up Care) ***(Rev. 11288; Issued: 03-04-22; Effective: 01-01-22; Implementation: 02-15-22)***

Physician(s) or NPP(s) in the same specialty and in the same group may provide concurrent follow-up care, such as a critical care visit subsequent to another practitioner's critical care visit. This may be as part of continuous staff coverage or follow-up care to critical care services furnished earlier in the day on the same calendar date.

In the situation where a practitioner furnishes the initial critical care service in its entirety and reports CPT code 99291, any additional practitioner(s) in the same specialty and the same group furnishing care concurrently to the same patient on the same date report their time using the code for subsequent time intervals (CPT code 99292). CPT code 99291 will not be reported more than once for the same patient on the same date by these practitioners. This policy recognizes that multiple practitioners in the same specialty and the same group can maintain continuity of care by providing follow-up care for the same patient on a single date.

When one practitioner begins furnishing the initial critical care service, but does not meet the time required to report CPT code 99291, another practitioner in the same specialty and group can continue to deliver critical care to the same patient on the same date. The total time spent by the practitioners is aggregated to meet the time requirement to bill CPT code 99291. Once the cumulative required critical care service time is met to report CPT code 99291, CPT code 99292 can only be reported by a practitioner in the same specialty and group when an additional 30 minutes of critical care services have been furnished to the same patient on the same date (74 minutes + 30 minutes = 104 total minutes).

The aggregated time spent on critical care visits must be medically necessary and each visit must meet the definition of critical care in order to add the times for purposes of meeting the time requirement to bill CPT code 99291.

For purposes of payment under the Physician Fee Schedule, Medicare classifies NPPs in a specialty that is not the same as a physician with whom the NPP is working, so the policies above would not apply to the situation where an NPP provides the follow-up care to a physician, or vice versa. Instead, see the section below regarding split (or shared) critical care services.

30.6.12.5 - Split (or Shared) Critical Care Visits ***(Rev. 11288; Issued: 03-04-22; Effective: 01-01-22; Implementation: 02-15-22)***

Critical care visits may be furnished as split (or shared) visits, defined in section 30.6.18. The rules described in section 30.6.18 for other types of split (or shared) visits apply (except for the listing of qualifying activities for determining the substantive portion, discussed below),

and service time is counted for CPT code 99292 in the same way as for prolonged E/M services. Specifically, the billing practitioner bills the initial service (CPT 99291) and any add-on codes(s) for additional time (CPT 99292). Also, the substantive portion for critical care services is defined as more than half of the total time spent by the physician and NPP beginning January 1, 2022. In the context of critical care, split (or shared) visits occur when the total critical care service time furnished by a physician and NPP in the same group on a given calendar date to a patient is summed, and the practitioner who furnishes the substantive portion of the cumulative critical care time reports the critical care service(s).

As stated earlier, when critical care services are furnished as a split (or shared) visit, the substantive portion is defined as more than half the cumulative total time in qualifying activities that are included in CPT codes 99291 and 99292. Since, unlike other types of E/M visits, critical care services can include additional activities that are bundled into the critical care visits code(s), there is a unique listing of qualifying activities for split (or shared) critical care. These qualifying activities are described in the prefatory language for critical care services in the CPT Codebook.

To bill split (or shared) critical care services, the billing practitioner first reports CPT code 99291 and, if 75 or more cumulative total minutes are spent providing critical care, the billing practitioner reports one or more units of CPT code 99292. Modifier -FS (split or shared E/M visit) must be appended to the critical care CPT code(s) on the claim.

The same documentation rules apply for split (or shared) critical care visits as for other types of split (or shared) E/M visits. Consistent with all split (or shared) visits, when two or more practitioners spend time jointly meeting with or discussing the patient as part of a critical care service, the time can be counted only once for purposes of reporting the split (or shared) critical care visit.

30.6.12.6 - Critical Care and Other Same-Day Evaluation and Management (E/M) Visits **(Rev. 11288; Issued: 03-04-22; Effective: 01-01-22; Implementation: 02-15-22)**

Our general policy, as described in section 30.6.5, states that physicians in the same group who are in the same specialty must bill and be paid for services under the PFS as though they were a single physician. If more than one E/M visit is provided on the same date to the same patient by the same physician, or by more than one physician in the same specialty in the same group, only one E/M service may be reported, unless the E/M services are for unrelated problems. Instead of billing separately, the physicians should select a level of service representative of the combined visits and submit the appropriate code for that level. This general policy is intended to ensure that multiple E/M visits for a patient on a single day are medically necessary and not duplicative.

However, in situations where a patient receives another E/M visit on the same calendar date as critical care services, both may be billed (regardless of practitioner specialty or group affiliation) as long as the medical record documentation supports: 1) that the other E/M visit was provided prior to the critical care services at a time when the patient did not require critical care, 2) that the services were medically necessary, and 3) that the services were separate and distinct, with no duplicative elements from the critical care services provided later in the day. Practitioners must use modifier -25 (same-day significant, separately identifiable evaluation and management service) on the claim when reporting these critical care services.

30.6.12.7 - Critical Care Visits and Global Surgery **(Rev. 11288; Issued: 03-04-22; Effective: 01-01-22; Implementation: 02-15-22)**

Critical care visits are sometimes needed during the global period of a procedure, whether pre-operatively, on the same day, or during the post-operative period. In some cases, preoperative and postoperative critical care visits are included in procedure codes that have a global surgical period.

In those cases where a critical care visit is unrelated to the procedure with a global surgical period, critical care visits may be paid separately in addition to the procedure. Preoperative and/or postoperative critical care may be paid in addition to the procedure if the patient is critically ill (meets the definition of critical care) and requires the full attention of the physician, and the critical care is above and beyond and unrelated to the specific anatomic injury or general surgical procedure performed (for example, trauma, burn cases). When the critical care service is unrelated to the procedure, append the modifier -FT ((unrelated evaluation and management (E/M) visit on the same day as another E/M visit or during a global procedure (preoperative, postoperative period, or on the same day as the procedure, as applicable). (Report when an E/M visit is furnished within the global period but is unrelated, or when one or more additional E/M visits furnished on the same day are unrelated.)) to the critical care CPT code(s).

If care is fully transferred from the surgeon to an intensivist (and the critical care is unrelated), modifiers -54 (surgical care only) and -55 (postoperative management only) must also be reported to indicate the transfer of care. The surgeon will report modifier -54. The intensivist accepting the transfer of care will report both modifier -55 and modifier -FT. As usual, medical record documentation must support the claims.

30.6.12.8 - Medical Record Documentation

(Rev. 11288; Issued: 03-04-22; Effective: 01-01-22; Implementation: 02-15-22)

Critical care is a time-based service, and therefore, practitioners must document in the medical record the total time (not necessarily start and stop times) that critical care services are furnished by each reporting practitioner. Documentation needs to indicate that the services furnished to the patient, including any concurrent care by the practitioners, are medically reasonable and necessary for the diagnosis and/or treatment of illness and/or injury or to improve the functioning of a malformed body member.

To support coverage and payment determinations regarding concurrent care, services must be sufficiently documented to allow a medical reviewer to determine the role each practitioner played in the patient's care (that is, the condition or conditions for which the practitioner treated the patient).

When critical care services are reported the same date as another E/M visit, the medical record documentation must support: 1) that the other E/M visit was provided prior to the critical care services at a time when the patient did not require critical care, 2) that the services were medically necessary, and 3) that the services were separate and distinct, with no duplicative elements from the critical care services provided later on that date.

When critical care services are furnished in conjunction with a global procedure, the medical record documentation must support that the critical care was unrelated to the procedure, as discussed above.

To support coverage and payment determinations regarding split (or shared) critical care services, the documentation requirements for all split (or shared) E/M visits apply to critical care visits also (see section 30.6.18).

30.6.13 - Nursing Facility Services

A. Visits to Perform the Initial Comprehensive Assessment and Annual Assessments

The distinction made between the delegation of physician visits and tasks in a skilled nursing facility (SNF) and in a nursing facility (NF) is based on the Medicare Statute. Section 1819 (b) (6) (A) of the Social Security Act (the Act) governs SNFs while section 1919 (b) (6) (A) of the Act governs NFs. For further information refer to the Medicare Learning Network article SE0418 at: <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNGenInfo/index.html?redirect=/MLNGenInfo>

The federally mandated visits in a SNF and NF must be performed by the physician except as otherwise permitted (42 CFR 483.40 (c) (4) and (f)). The principal physician of record must append the modifier “-AI”, (Principal Physician of Record), to the initial nursing facility care code. This modifier will identify the physician who oversees the patient’s care from other physicians who may be furnishing specialty care. All other physicians or qualified NPPs who perform an initial evaluation in the NF or SNF may bill the initial nursing facility care code. The initial federally mandated visit is defined in S&C-04-08 (see <http://www.cms.gov/site-search/search-results.html?q=S%26C-04-08>) as the initial comprehensive visit during which the physician completes a thorough assessment, develops a plan of care, and writes or verifies admitting orders for the nursing facility resident. For Survey and Certification requirements, a visit must occur no later than 30 days after admission.

Further, per the Long Term Care regulations at 42 CFR 483.40 (c) (4) and (e) (2), in a SNF the physician may not delegate a task that the physician must personally perform. Therefore, as stated in S&C-04-08 the physician may not delegate the initial federally mandated comprehensive visit in a SNF.

The only exception, as to who performs the initial visit, relates to the NF setting. In the NF setting, a qualified NPP (i.e., a nurse practitioner (NP), physician assistant (PA), or a clinical nurse specialist (CNS)), who is not employed by the facility, may perform the initial visit when the State law permits. The evaluation and management (E/M) visit shall be within the State scope of practice and licensure requirements where the E/M visit is performed and the requirements for physician collaboration and physician supervision shall be met.

Under Medicare Part B payment policy, other medically necessary E/M visits may be performed and reported prior to and after the initial visit, if the medical needs of the patient require an E/M visit. A qualified NPP may perform medically necessary E/M visits prior to and after the initial visit if all the requirements for collaboration, general physician supervision, licensure, and billing are met.

The CPT Nursing Facility Services codes shall be used with place of service (POS) 31 (SNF) if the patient is in a Part A SNF stay. They shall be used with POS 32 (nursing facility) if the patient does not have Part A SNF benefits or if the patient is in a NF or in a non-covered SNF stay (e.g., there was no preceding 3-day hospital stay). The CPT Nursing Facility code definition also includes POS 54 (Intermediate Care Facility/Mentally Retarded) and POS 56 (Psychiatric Residential Treatment Center). For further guidance on POS codes and associated CPT codes refer to §30.6.14.

Effective January 1, 2006, the Initial Nursing Facility Care codes 99301- 99303 are deleted.

Beginning January 1, 2006, the new CPT codes, Initial Nursing Facility Care, per day, (99304 - 99306) shall be used to report the initial federally mandated visit. Only a physician may report these codes for an initial federally mandated visit performed in a SNF or NF (with

the exception of the qualified NPP in the NF setting who is not employed by the facility and when State law permits, as explained above).

A readmission to a SNF or NF shall have the same payment policy requirements as an initial admission in both the SNF and NF settings.

A physician who is employed by the SNF/NF may perform the E/M visits and bill independently to Medicare Part B for payment. An NPP who is employed by the SNF or NF may perform and bill Medicare Part B directly for those services where it is permitted as discussed above. The employer of the PA shall always report the visits performed by the PA. A physician, NP or CNS has the option to bill Medicare directly or to reassign payment for his/her professional service to the facility.

As with all E/M visits for Medicare Part B payment policy, the E/M documentation guidelines apply.

Medically Necessary Visits

Qualified NPPs may perform medically necessary E/M visits prior to and after the physician's initial federally mandated visit in both the SNF and NF. Medically necessary E/M visits for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed body member are payable under the physician fee schedule under Medicare Part B. A physician or NPP may bill the most appropriate initial nursing facility care code (CPT codes 99304-99306) or subsequent nursing facility care code (CPT codes 99307-99310), even if the E/M service is provided prior to the initial federally mandated visit.

SNF Setting--Place of Service Code 31

Following the initial federally mandated visit by the physician, the physician may delegate alternate federally mandated physician visits to a qualified NPP who meets collaboration and physician supervision requirements and is licensed as such by the State and performing within the scope of practice in that State.

NF Setting--Place of Service Code 32

Per the regulations at 42 CFR 483.40 (f), a qualified NPP, who meets the collaboration and physician supervision requirements, the State scope of practice and licensure requirements, and who is not employed by the NF, may at the option of the State, perform the initial federally mandated visit in a NF, and may perform any other federally mandated physician visit in a NF in addition to performing other medically necessary E/M visits.

Questions pertaining to writing orders or certification and recertification issues in the SNF and NF settings shall be addressed to the appropriate State Survey and Certification Agency departments for clarification.

B. Visits to Comply With Federal Regulations (42 CFR 483.40 (c) (1)) in the SNF and NF

Payment is made under the physician fee schedule by Medicare Part B for federally mandated visits. Following the initial federally mandated visit by the physician or qualified NPP where permitted, payment shall be made for federally mandated visits that monitor and evaluate residents at least once every 30 days for the first 90 days after admission and at least once every 60 days thereafter.

Effective January 1, 2006, the Subsequent Nursing Facility Care, per day, codes 99311-99313 are deleted.

Beginning January 1, 2006, the new CPT codes, Subsequent Nursing Facility Care, per day, (99307 - 99310) shall be used to report federally mandated physician E/M visits and medically necessary E/M visits.

A/B MACs (B) shall not pay for more than one E/M visit performed by the physician or qualified NPP for the same patient on the same date of service. The Nursing Facility Services codes represent a "per day" service.

The federally mandated E/M visit may serve also as a medically necessary E/M visit if the situation arises (i.e., the patient has health problems that need attention on the day the scheduled mandated physician E/M visit occurs). The physician/qualified NPP shall bill only one E/M visit.

Beginning January 1, 2006, the new CPT code, Other Nursing Facility Service (99318), may be used to report an annual nursing facility assessment visit on the required schedule of visits on an annual basis. For Medicare Part B payment policy, an annual nursing facility assessment visit code may substitute as meeting one of the federally mandated physician visits if the code requirements for CPT code 99318 are fully met and in lieu of reporting a Subsequent Nursing Facility Care, per day, service (codes 99307 - 99310). It shall not be performed in addition to the required number of federally mandated physician visits. The new CPT annual assessment code does not represent a new benefit service for Medicare Part B physician services.

Qualified NPPs, whether employed or not by the SNF, may perform alternating federally mandated physician visits, at the option of the physician, after the initial federally mandated visit by the physician in a SNF.

Qualified NPPs in the NF setting, who are not employed by the NF and who are working in collaboration with a physician, may perform federally mandated physician visits, at the option of the State.

Medicare Part B payment policy does not pay for additional E/M visits that may be required by State law for a facility admission or for other additional visits to satisfy facility or other administrative purposes. E/M visits, prior to and after the initial federally mandated physician visit, that are reasonable and medically necessary to meet the medical needs of the individual patient (unrelated to any State requirement or administrative purpose) are payable under Medicare Part B.

C. Visits by Qualified Nonphysician Practitioners

All E/M visits shall be within the State scope of practice and licensure requirements where the visit is performed and all the requirements for physician collaboration and physician supervision shall be met when performed and reported by qualified NPPs. General physician supervision and employer billing requirements shall be met for PA services in addition to the PA meeting the State scope of practice and licensure requirements where the E/M visit is performed.

Medically Necessary Visits

Qualified NPPs may perform medically necessary E/M visits prior to and after the physician's initial visit in both the SNF and NF. Medically necessary E/M visits for the diagnosis or treatment of an illness or injury or to improve the functioning of a malformed

body member are payable under the physician fee schedule under Medicare Part B. A physician or NPP may bill the most appropriate initial nursing facility care code (CPT codes 99304-99306) or subsequent nursing facility care code (CPT codes 99307-99310), even if the E/M service is provided prior to the initial federally mandated visit.

SNF Setting--Place of Service Code 31

Following the initial federally mandated visit by the physician, the physician may delegate alternate federally mandated physician visits to a qualified NPP who meets collaboration and physician supervision requirements and is licensed as such by the State and performing within the scope of practice in that State.

NF Setting--Place of Service Code 32

Per the regulations at 42 CFR 483.40 (f), a qualified NPP, who meets the collaboration and physician supervision requirements, the State scope of practice and licensure requirements, and who is not employed by the NF, may at the option of the State, perform the initial federally mandated visit in a NF, and may perform any other federally mandated physician visit in a NF in addition to performing other medically necessary E/M visits.

Questions pertaining to writing orders or certification and recertification issues in the SNF and NF settings shall be addressed to the appropriate State Survey and Certification Agency departments for clarification.

D. Medically Complex Care

Payment is made for E/M visits to patients in a SNF who are receiving services for medically complex care upon discharge from an acute care facility when the visits are reasonable and medically necessary and documented in the medical record. Physicians and qualified NPPs shall report initial nursing facility care codes for their first visit with the patient. The principal physician of record must append the modifier “-AI” (Principal Physician of Record), to the initial nursing facility care code when billed to identify the physician who oversees the patient’s care from other physicians who may be furnishing specialty care. Follow-up visits shall be billed as subsequent nursing facility care visits.

E. Incident to Services

Where a physician establishes an office in a SNF/NF, the “incident to” services and requirements are confined to this discrete part of the facility designated as his/her office. “Incident to” E/M visits, provided in a facility setting, are not payable under the Physician Fee Schedule for Medicare Part B. Thus, visits performed outside the designated “office” area in the SNF/NF would be subject to the coverage and payment rules applicable to the SNF/NF setting and shall not be reported using the CPT codes for office or other outpatient visits or use place of service code 11.

F. Use of the Prolonged Services Codes and Other Time-Related Services

Beginning January 1, 2008, typical/average time units for E/M visits in the SNF/NF settings are reestablished. Medically necessary prolonged services for E/M visits (codes 99356 and 99357) in a SNF or NF may be billed with the Nursing Facility Services in the code ranges (99304 - 99306, 99307 - 99310 and 99318).

Counseling and Coordination of Care Visits

With the reestablishment of typical/average time units, medically necessary E/M visits for counseling and coordination of care, for Nursing Facility Services in the code ranges (99304 - 99306, 99307 - 99310 and 99318) that are time-based services, may be billed with the appropriate prolonged services codes (99356 and 99357).

G. Multiple Visits

The complexity level of an E/M visit and the CPT code billed must be a covered and medically necessary visit for each patient (refer to §§1862 (a)(1)(A) of the Act). Claims for an unreasonable number of daily E/M visits by the same physician to multiple patients at a facility within a 24-hour period may result in medical review to determine medical necessity for the visits. The E/M visit (Nursing Facility Services) represents a “per day” service per patient as defined by the CPT code. The medical record must be personally documented by the physician or qualified NPP who performed the E/M visit and the documentation shall support the specific level of E/M visit to each individual patient.

H. *Split (or Shared) SNF/NF E/M Visit*

SNF E/M visits may be billed as split (or shared) visits if they meet the rules for split (or shared) visit billing, discussed in our other manual sections, except for SNF E/M visits that are required to be performed in their entirety by a physician. NF visits do not meet the definition of split (or shared) services, and therefore, are not billable as such. See section 30.6.18 for additional information.

I. SNF/NF Discharge Day Management Service

Medicare Part B payment policy requires a face-to-face visit with the patient provided by the physician or the qualified NPP to meet the SNF/NF discharge day management service as defined by the CPT code. The E/M discharge day management visit shall be reported for the date of the actual visit by the physician or qualified NPP even if the patient is discharged from the facility on a different calendar date. The CPT codes 99315 - 99316 shall be reported for this visit. The Discharge Day Management Service may be reported using CPT code 99315 or 99316, depending on the code requirement, for a patient who has expired, but only if the physician or qualified NPP personally performed the death pronouncement.

30.6.15 - Prolonged Services and Standby Services (Codes 99354 - 99360), and Evaluation and Management service for Power Mobility Devices (PMDs) (G0372)

(Rev. 11288; Issued: 03-04-22; Effective: 01-01-22; Implementation: 02-15-22)

See section 30.6.18 for rules regarding billing of E/M visits that are split (or shared) and involve prolonged service time.

30.6.18 - Split (or Shared) Visits

(Rev. 11288; Issued: 03-04-22; Effective: 01-01-22; Implementation: 02-15-22)

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 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

Beginning January 1, 2023, substantive portion means more than half of the total time spent by the physician and NPP performing the split (or shared) visit.

During a transitional year from January 1, 2022 through December 31, 2022, except for critical care visits, the substantive portion can be one of the three key E/M visit components (history, exam, or medical decision-making (MDM)), or more than half of the total time spent by the physician and NPP performing the split (or shared) visit. In other words, for calendar year 2022, the practitioner who spends more than half of the total time, or performs the history, exam, or MDM can be considered to have performed the substantive portion and can bill for the split (or shared) E/M visit. 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. For example, if history is used as the substantive portion and both practitioners take part of the history, the billing practitioner must perform the level of history required to select the visit level billed. If physical exam is used as the substantive portion and both practitioners examine the patient, the billing practitioner must perform the level of exam required to select the visit level billed. If MDM is used as the substantive portion, each practitioner could perform certain aspects of MDM, but the billing practitioner must perform all portions or aspects of MDM that are required to select the visit level billed.

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	2022 Definition of Substantive Portion	2023 Definition of Substantive Portion
Other Outpatient*	History, or exam, or MDM, or more than half of total time	More than half of total time
Inpatient/Observation/Hospital/SNF	History, or exam, or MDM, or more than half of total time	More than half of total time
Emergency Department	History, or exam, or MDM, or more than half of total time	More than half of total time
Critical Care	More than half of total time	More than half of total time

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

*Office 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

Beginning January 1, 2023, the physician or practitioner who spent more than half the total time (the substantive portion starting in 2023) 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.

During the transitional calendar year 2022, when practitioners use a key component as the substantive portion, there will need to be different approaches for hospital outpatient E/M visits than other kinds of E/M visits:

- For shared hospital outpatient visits where practitioners use a key component as the substantive portion, prolonged services can be reported by the practitioner who reports the primary service, when the combined time of both practitioners meets the threshold for reporting prolonged hospital outpatient services (HCPCS code G2212).*
- For all other types of E/M visits (except emergency department and critical care visits), prolonged services can be reported by the practitioner who reports the primary service, when the combined time of both practitioners meets the threshold for reporting prolonged E/M services other than office/outpatient E/M visits (60 or more minutes beyond the typical time in the CPT code descriptor of the primary service). (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

<i>E/M Visit Code Family</i>	<i>2022</i>		<i>2023</i>
	<i>If Substantive Portion is a Key Component...</i>	<i>If Substantive Portion is Time...</i>	<i>Substantive Portion Must Be Time</i>
<i>Other Outpatient*</i>	<i>Combined time of both practitioners must meet the threshold for reporting HCPCS G2212</i>	<i>Combined time of both practitioners must meet the threshold for reporting HCPCS G2212</i>	<i>Combined time of both practitioners must meet the threshold for reporting HCPCS G2212</i>
<i>Inpatient/Observation/Hospital/SNF</i>	<i>Combined time of both practitioners must meet the threshold for reporting CPT 99354-9 (60+ minutes > typical)</i>	<i>Combined time of both practitioners must meet the threshold for reporting CPT 99354-9 (60+ minutes > typical)</i>	<i>Combined time of both practitioners must meet the threshold for reporting prolonged services</i>
<i>Emergency Department</i>	<i>N/A</i>	<i>N/A</i>	<i>N/A</i>
<i>Critical Care</i>	<i>N/A</i>	<i>N/A</i>	<i>N/A</i>

Acronyms: E/M (Evaluation and Management); SNF (Skilled Nursing Facility)

**Office 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.

100.1.1 - Evaluation and Management (E/M) Services

(Rev. 11288; Issued: 03-04-22; Effective: 01-01-22; Implementation: 02-15-22)

A. General Documentation Requirements

Evaluation and Management (E/M) Services -- For a given encounter, the selection of the appropriate level of E/M service should be determined according to the code definitions in the American Medical Association's Current Procedural Terminology (CPT) book and any applicable documentation guidelines.

For purposes of payment, E/M services billed by teaching physicians require that the medical records must demonstrate:

- That the teaching physician performed the service or was physically present during the key or critical portions of the service when performed by the resident; and
- The participation of the teaching physician in the management of the patient.

The presence of the teaching physician during E/M services may be demonstrated by the notes in the medical records made by physicians, residents, or nurses.

B. E/M Service Documentation Provided By Students

Any contribution and participation of students to the performance of a billable service (other than the review of systems and/or past family/social history which are not separately billable, but are taken as part of an E/M service) must be performed in the physical presence of a teaching physician or physical presence of a resident in a service

meeting the requirements set forth in this section for teaching physician billing.

Students may document services in the medical record. However, the teaching physician must verify in the medical record all student documentation or findings, including history, physical exam and/or medical decision making. The teaching physician must personally perform (or re-perform) the physical exam and medical decision making activities of the E/M service being billed, but may verify any student documentation of them in the medical record, rather than re-documenting this work.

C. Exception for E/M Services Furnished in Certain Primary Care Centers

Teaching physicians providing E/M services with a GME program granted a primary care exception may bill Medicare for lower and mid-level E/M services provided by residents. *Effective January 1, 2022, teaching physicians may use only medical decision making (MDM) for purposes of E/M visit level selection when billing the Medicare program under the physician fee schedule for office/outpatient E/M visits under this primary care exception.* For the E/M codes listed below, teaching physicians may submit claims for services furnished by residents in the absence of a teaching physician:

New Patient	Established Patient
99201	99211
99202	99212
99203	99213

Effective January 1, 2005, the following code is included under the primary care exception: HCPCS code G0402 (Initial preventive physical examination; face-to-face visit services limited to new beneficiary during the first 12 months of Medicare enrollment).

Effective January 1, 2011, the following codes are included under the primary care exception: HCPCS codes G0438 (Annual wellness visit, including personal preventive plan service, first visit) and G0439 (Annual wellness visit, including personal preventive plan service, subsequent visit).

If a service other than those listed above needs to be furnished, then the general teaching physician policy set forth in §100.1 applies. For this exception to apply, a center must attest in writing that all the following conditions are met for a particular residency program. Prior approval is not necessary, but centers exercising the primary care exception must maintain records demonstrating that they qualify for the exception.

The services must be furnished in a center located in the outpatient department of a hospital or another ambulatory care entity in which the time spent by residents in patient care activities is included in determining direct GME payments to a teaching hospital by the hospital's A/B MAC (A). This requirement is not met when the resident is assigned to a physician's office away from the center or makes home visits. In the case of a nonhospital entity, verify with the A/B MAC (A) that the entity meets the requirements of a written agreement between the hospital and the entity set forth at 42 CFR 413.78(e)(3)(ii).

Under this exception, residents providing the billable patient care service without the physical presence of a teaching physician must have completed at least 6 months of a GME approved residency program. Centers must maintain information under the provisions at 42 CFR 413.79(a)(6).

Teaching physicians submitting claims under this exception may not supervise more than

four residents at any given time and must direct the care from such proximity as to constitute immediate availability. Teaching physicians may include residents with less than 6 months in a GME approved residency program in the mix of four residents under the teaching physician's supervision. However, the teaching physician must be physically present for the critical or key portions of services furnished by the residents with less than 6 months in a GME approved residency program. That is, the primary care exception does not apply in the case of residents with less than 6 months in a GME approved residency program.

Teaching physicians submitting claims under this exception must:

- Not have other responsibilities (including the supervision of other personnel) at the time the service was provided by the residents;
- Have the primary medical responsibility for patients cared for by the residents;
- Ensure that the care provided was reasonable and necessary;
- Review the care provided by the residents during or immediately after each visit. This must include a review of the patient's medical history, the resident's findings on physical examination, the patient's diagnosis, and treatment plan (i.e., record of tests and therapies); and

Patients under this exception should consider the center to be their primary location for health care services. The residents must be expected to generally provide care to the same group of established patients during their residency training. The types of services furnished by residents under this exception include:

- Acute care for undifferentiated problems or chronic care for ongoing conditions including chronic mental illness;
- Coordination of care furnished by other physicians and providers; and,
- Comprehensive care not limited by organ system or diagnosis.

Residency programs most likely qualifying for this exception include family practice, general internal medicine, geriatric medicine, pediatrics, and obstetrics/gynecology.

Certain GME programs in psychiatry may qualify in special situations such as when the program furnishes comprehensive care for chronically mentally ill patients. These would be centers in which the range of services the residents are trained to furnish, and actually do furnish, include comprehensive medical care as well as psychiatric care. For example, antibiotics are being prescribed as well as psychotropic drugs.

The patient medical record must document the extent of the teaching physician's participation in the review and direction of the services furnished to each beneficiary. The extent of the teaching physician's participation may be demonstrated by the notes in the medical records made by physicians, residents, or nurses.

100.1.4 - Time-Based Codes

(Rev. 11288; Issued: 03-04-22; Effective: 01-01-22; Implementation: 02-15-22)

For procedure codes determined on the basis of time, the teaching physician must be present for the period of time for which the claim is made. For example, a code that specifically describes a service of from 20 to 30 minutes may be paid only if the teaching physician is physically present for 20 to 30 minutes. Do not add time spent by the resident in the absence

of the teaching physician to time spent by the resident and teaching physician with the beneficiary or time spent by the teaching physician alone with the beneficiary. Examples of codes falling into this category include:

- Individual medical psychotherapy (HCPCS codes 90804 - 90829);
- Critical care services (CPT codes 99291-99292);
- Hospital discharge day management (CPT codes 99238-99239);

E/M codes in which counseling and/or coordination of care dominates (more than 50 percent) of the encounter, and time is considered the key or controlling factor to qualify for a particular level of E/M service;

- *Office/outpatient E/M visit codes for which total time is used for the visit level selection. For purposes of selecting visit level, only count time spent by the teaching physician performing qualifying activities listed by CPT (with or without direct patient contact on the date of the encounter), including the time the teaching physician is present when the resident is performing such activities;*
- Prolonged services (CPT codes 99358-99359); and
- Care plan oversight (HCPCS codes G0181 - G0182).

110.4 - PA Billing to the A/B MAC (B)

(Rev. 11288; Issued: 03-04-22; Effective: 01-01-22; Implementation: 02-15-22)

A. PA Identification

Effective January 1, 2022, PAs must have their own “nonphysician practitioner” national provider identification (*NPI*) number *for billing purposes*. Specialty code 97 applies for PAs enrolled in Medicare.

B. Assignment Requirement

All claims for PA services must be made on an assignment basis. If any person or entity (PA employer or, a provider/supplier for whom the PA furnishes services as an independent contractor) knowingly and willfully bills the beneficiary an amount in excess of the appropriate coinsurance and deductible, the responsible party is subject to a civil monetary penalty not to exceed \$2,000 for each such bill or request for payment.