

**Release Date: May 26, 2021**

**Release: CMS Notice Regarding Split (or Shared) Evaluation and Management Visits and Critical Care Services from May 26, 2021 through December 31, 2021**

On January 19, 2021, the U.S. Department of Health and Human Services (“HHS” or “the Department”) received a petition pursuant to the HHS Good Guidance Practices Regulation, 85 Fed. Reg. 78,770 (Dec. 7, 2020). *See also* 45 C.F.R. § 1.5(a)(1). The petition challenged the following sections of the Centers for Medicare & Medicaid Services (“CMS”) Claims Processing Manual (MCPM) (Pub. 100-04), Chapter 12:

- Section 30.6.1 Selection of Level of Evaluation and Management Service, B. Selection of Level of Evaluation and Management Service; Split/Shared E/M Service.
- Section 30.6.12 Critical Care Visits and Neonatal Intensive Care (Codes 99291 - 99292), Critical Care Services (Codes 99291-99292).
- Section 30.6.13 Nursing Facility Services, H. Split/Shared E/M Visit.

CMS is responding to the petition by withdrawing these manual sections, and plans to address the topics therein through notice-and-comment rulemaking. In the absence of manual provisions, claims involving Evaluation and Management services performed in part by both a physician and non-physician practitioner, and claims relating to critical care services will remain subject to the requirements of Medicare law and duly promulgated regulations including the following:

- Sections 1861(s)(1) and 1861(s)(2)(A) of the Social Security Act (the Act), respectively, establish Medicare Part B benefit categories for physicians’ services and “services and supplies furnished as an incident to a physician’s professional service [hereinafter, “incident to” services].” *See also* 42 C.F.R. § 410.20.
- Section 1861(s)(2)(K) of the Act establishes a Medicare Part B benefit category for services “which would be physicians’ services [] if furnished by a physician (as defined in section 1861(r)(1)),” and services furnished incident to those services, which are performed by a physician assistant under the supervision of a physician, or by a nurse practitioner or clinical nurse specialist working in collaboration with a physician. *See also* 42 C.F.R. §§ 410.74, 410.75, 410.76.
- Section 1833(a)(1)(N) of the Act provides that the payment amount for physicians’ services as defined in section 1848(j)(3) of the Act is “80 percent of the payment basis determined under section 1848(a)(1) [the lesser of the actual charge or fee schedule amount under the Medicare physician fee schedule (PFS)].”
- Section 1833(a)(1)(O) of the Act provides that the payment amount for “services described in section 1861(s)(2)(K) (relating to services furnished by physicians assistants, nurse practitioners, or clinical nurse specialists)” is “80 percent of [] the lesser of the actual charge or 85 percent of the fee schedule amount provided under section 1848.” *See also* 42 C.F.R. §§ 414.52(d), 414.56(c).
- The regulation at 42 C.F.R. § 410.26 provides the conditions under which Medicare Part B payment is made for “incident to” services furnished by physicians and other practitioners.

- Section 1848(b)(1) of the Act requires the Secretary to establish, by regulation, fee schedules that establish payment amounts for all physicians' services furnished in all fee schedule areas for each year by November 1 of the preceding year; and that each such payment amount for a service is equal to the product of: 1) the resource-based relative value for the service, 2) the dollar-value conversion factor for the year, and 3) the geographic adjustment factor for the fee schedule area, determined in accordance with other provisions of section 1848 of the Act.
- The regulation at 45 C.F.R. §162.1002(c)(1) establishes as the Health Insurance Portability and Accountability Act of 1996 (HIPAA, Pub. L. 104-191) standard medical data code sets the combination of the Healthcare Common Procedure Coding System (HCPCS) maintained by and distributed by HHS, and the Current Procedural Terminology (CPT) codes maintained by the American Medical Association, for physicians' services and other health care services.
- Through annual notice-and-comment rulemaking to establish the PFS for the coming year, including in the CY 2021 PFS final rule (85 Fed. Reg. 84472-85377 (Dec. 28, 2020)), CMS adopts for purposes of PFS payment CPT or other HCPCS codes that describe each discrete physicians' service, and sets fee schedule amounts and other PFS payment policies for those services.
- In the CY 2020 PFS final rule (84 Fed. Reg. 62844-62860), CMS generally adopted the new CPT codes for office/outpatient E/M services, and the associated prefatory language and interpretive guidance framework for the codes, issued by the American Medical Association's CPT Editorial Panel (available at the following website: <https://www.ama-assn.org/practice-management/cpt/cpt-evaluation-and-management>). *See also* 85 Fed. Reg. 84549.

Until such time as CMS promulgates a final rule regarding split (or shared) E/M visits and critical care services, the agency will limit review to the applicable statutory and regulatory requirements for purposes of assessing payment compliance.