American Society of Clinical Oncology Position Statement: Medicare Policy on Billing for Split/Shared Evaluation and Management Visits

Approved by the ASCO Board of Directors August 19, 2022

Overview

On November 2, 2021, the Centers for Medicare & Medicaid Services (CMS) released the CY 2022 Medicare Physician Fee Schedule (MPFS) final rule which, among other policy and regulatory changes, updated and codified longstanding CMS policy on billing for split (or shared) evaluation and management (E/M) visits under the MPFS.[1] The finalized policies generally reflected and clarified prior CMS guidance for billing these visits, but also included changes from the historical guidance that updated conditions of payment and expanded the clinical scenarios under which a health care provider may bill services as split or shared. Split (or shared) services are evaluation and management services performed jointly between a physician and a non-physician practitioner (NPP) in the same group, in a facility setting. Throughout this position statement, we will use the term "split/shared" to describe these services. Either the physician or the NPP may bill for a split/shared E/M visit, as long as the billing practitioner performs the "substantive portion" of the visit.

Policy makers have focused increasing attention on the potential for NPPs (also referred to as advance practice providers, or APPs) to expand the capacity of the health care workforce. In recent years, the number of APPs billing Medicare has grown rapidly. State governments also have expanded scope of practice laws, enabling APPs—nurse practitioners (NPs) and physician assistants (PAs)—to practice with more authority and autonomy. Between 2010 and 2017, the number of NPs and PAs that billed Medicare more than doubled, reaching 212,000 in 2017.[2] And, while APPs have historically been concentrated in primary care, they are increasingly practicing in specialty fields.

ASCO connects more than 45,000 members from the United States and abroad who set the standard for patient care worldwide. As the leading resource for best practices in academic and community oncology practice, ASCO understands the increasingly important role that APPs are playing in the cancer care team. Evidence has shown that the employment of APPs in oncology practices contributes greatly to cancer care, and, as such, ASCO believes that APPs providing care in oncology

[1] Department of Health and Human Services. Medicare Program; CY 2022 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Provider Enrollment Regulation Updates; and Provider and Supplier Prepayment and Post-Payment Medical Review Requirements. https://www.govinfo.gov/content/pkg/FR-2021-11-19/pdf/2021-23972.pdf.

[2] Medicare Payment Advisory Commission (MedPAC). Report to the Congress: Medicare and the Health Care Delivery System, June 2019. https://www.medpac.gov/reports/jun19_ch5_medpac_reporttocongress_sec.pdf

should work to the level permitted by their state practice laws.[3,4] For two decades—following the creation of the Quality Oncology Practice Initiative (QOPI®) in 2002—ASCO has dedicated significant resources to help oncology practices across the United States provide high-quality, high-value cancer care. Continuing this work, ASCO and the Community Oncology Alliance (COA) recently developed an Oncology Medical Home (OMH) certification program, built on evidence-based standards that emphasize the equitable team-based care that will be central to the future of the health care system. Team-based practice in oncology requires careful planning and execution to enhance patient safety and quality of care, and well-implemented team-based care has the potential to improve the comprehensiveness, coordination, efficiency, effectiveness, and value of care, as well as the satisfaction of patients and providers.

ASCO is committed to supporting and promoting practical policy solutions that ensure patients with cancer have access to the most effective team-based care. We agree with policymakers that a rapidly changing workforce—and new policies relating to evaluation and management (E/M) billing—drive the need for greater integration and accommodation of interprofessional practice arrangements. ASCO is concerned that CMS' policies regarding split/shared visits may lead to a significant misalignment of clinical resources, including a potential major limitation on the utilization of APPs in clinical practice, which may negatively impact patient care. Prohibiting the determination of a split/shared visit's "substantive portion" by any method other than the majority of total time spent is not an accurate reflection of the complicated practice of medicine, especially in oncology. Consequences of this policy may include lost productivity and loss of efficiency, struggles to maintain quality and patient safety, and heightened financial pressure that may impact the pace of consolidation.

ASCO's intent with the release of this statement is to provide a summary of issues our members have raised about time-based billing for split/shared E/M visits and to make the following recommendations:

- **CMS should propose an alternative policy that allows physicians or APPs to bill split or shared visits based on either time or medical decision-making, following the 2023 changes to E/M services, to mitigate the negative impact that the time-only option will likely have on patient care.**
- **CMS should work with specialties to ensure a smooth transition to updated billing practices and adequate and appropriate reimbursement. This policy, as it stands, will require education and significant changes to day-to-day workflow.**
- **CMS should work with stakeholders to ensure that resources are allocated in a manner that: emphasizes team-based, evidence-supported care; reimburses physicians at adequate rates; and implements future reforms in a way that reduces administrative burdens encountered by patients, physicians, and other health care professionals.**

---

[3] Association of American Medical Colleges Center for Workforce Studies. Forecasting the supply of and demand of oncologists: A report to the American Society of Clinical Oncology. March 2007. https://www.asco.org/research-and-progress/documents/Forecasting-the-Supply-of-and-Demand-for-Oncologists.pdf

[4] Towle EL, Barr TR, Hanley A, Kosty M, Williams S, Goldstein MA. Results of the ASCO Study of Collaborative Practice Arrangements. J Oncol Pract. 2011;7(5):278-282. doi:10.1200/JOP.2011.000385

- **Congress should work with the physician community and other stakeholders to develop solutions to systematic problems in the prevailing models of health care delivery which discourage team-based approaches to care in both public and private systems.**

Background

Medicare pays 85 percent of the Medicare Physician Fee Schedule (PFS) rate when a service is furnished by an APP and billed under the APP's own National Provider Identifier (NPI). The same service, when furnished by a physician, is paid at 100 percent of the PFS rate. Under current Medicare policies, however, when an APP performs a patient visit in a physician office setting, the physician is permitted to bill for the visit under their own NPI and receive the higher Medicare payment rate, provided other Medicare requirements are met. This practice is known as "incident to" billing, as these services are considered "incident to" a physician's professional services.[5]

Medicare regulations have not previously addressed services furnished in part by a physician and in part by an APP in the facility setting (e.g., hospitals, outpatient departments, and skilled nursing facilities). Instead, CMS's policy for billing these visits historically has been reflected solely in instructions found in the Medicare Claims Processing Manual. In May 2021, in response to a petition submitted under HHS's Good Guidance Practices Regulation, CMS withdrew the manual sections specifically addressing split/shared visits, indicating that the agency would address these visits in future rulemaking.[6]

Accordingly, in the CY 2022 PFS Final Rule, CMS addressed split/shared visits by codifying the following:

- CMS finalized the definition of split/shared visits. The regulation defined split/shared visits as E/M visits in the facility setting that are performed in part by both a physician and a non-physician practitioner who are in the same group. The visit is billed by the physician or practitioner who provides the "substantive portion" of the visit.
    - For 2022, the substantive portion can be history, physical exam, medical decision-making, or more than half of the total time (except for critical care, which can only be more than half of the total time). In subsequent rulemaking, this definition of the substantive portion was extended through 2023.
    - By 2023, CMS intended to redefine the substantive portion of the visit as more than half of the total time spent (i.e., limiting the billing practitioner to the individual who performed more than 50% of the visit). In subsequent rulemaking, this redefinition was delayed to 2024.
- Split/shared visits can now be reported for new as well as established patients, in addition to initial and subsequent visits, as well as prolonged services (previously limited to established patients, only).

[5] Thus, when a service is billed "incident to," Medicare cannot know who actually delivered care to the beneficiary.
[6] Department of Health and Human Services. Revisions of Sections 30.6.1(B), 30.6.12, and 30.6.13(H) of Chapter 12 of the Medicare Claims Policy Manual. May 3, 2021. https://www.cms.gov/files/document/r10742cp.pdf

- A new claims modifier (FS) is required to identify these services to inform policy and "help ensure program integrity."[7]
- Documentation in the medical record must identify the two individuals who performed the visit. The individual providing the substantive portion must sign and date the medical record.[8]

Acknowledging the disruption these changes would bring, CMS has twice delayed its implementation of the definition of the substantive portion as more than half of the total time. In the CY 2022 PFS final rule, CMS provided a one-year transitional period until full implementation, permitting either time or the provision of one of three key components of the visit (history, exam, or MDM) to be considered a "substantive portion" of the visit through 2022. This transitional period was extended an additional year, through 2023, in the CY 2023 PFS final rule.[9] After January 1, 2024, CMS will utilize only time as the key factor in determining whether the physician or the APP performed the substantive portion of the visit.

Impact on Current Practice Patterns and the Adoption of Team-based Care Models

As previously noted, APPs have increasingly become integral members of the oncology care delivery team, with 81 percent of US oncology practices reporting employment of APPs in 2017. A majority of APPs in oncology report conducting both independent and shared visits, according to recent ASCO surveys.[10,11] Several studies have demonstrated that integrating APPs into care results in reduced length of stay and improved physician and nursing satisfaction. [12] For many years, ASCO has collaborated on projects to identify and survey the oncology APP workforce, enhance team interactions in oncology care, and apply the science of team-based care to help oncology professionals improve cancer care delivery.[13,14]

ASCO is particularly concerned that CMS's time-based split/shared visit billing policy could discourage investment in clinical teams and prevent team-based care from reaching its potential; practices that rely on teams that include APPs due to a large volume of patients may be

---

[7] CPT® modifier -52 (reduced service) should not be used to indicate the service was split or shared.

[8] CMS codified these revised policies in a new regulation at 42 CFR 415.140.

[9] Department of Health and Human Services. Medicare and Medicaid Programs; CY 2023 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; Implementing Requirements for Manufacturers of Certain Single-dose Container or Single-use Package Drugs to Provide Refunds with Respect to Discarded Amounts; and COVID-19 Interim Final Rules. https://public-inspection.federalregister.gov/2022-23873.pdf

[10] American Society of Clinical Oncology. The State of Cancer Care in America, 2017: A Report by the American Society of Clinical Oncology. J Oncol Pract. 2017;13(4):e353-e394. doi:10.1200/JOP.2016.020743

[11] Bruinooge SS, Pickard TA, Vogel W, et al. Understanding the Role of Advanced Practice Providers in Oncology in the United States [published correction appears in J Oncol Pract. 2019 Jan;15(1):60]. J Oncol Pract. 2018;14(9):e518-e532. doi:10.1200/JOP.18.00181

[12] Kleinpell RM, Grabenkort WR, Kapu AN, Constantine R, Sicoutris C. Nurse Practitioners and Physician Assistants in Acute and Critical Care: A Concise Review of the Literature and Data 2008-2018. Crit Care Med. 2019;47(10):1442-1449. doi:10.1097/CCM.0000000000003925

[13] Yang W, Williams JH, Hogan PF, et al. Projected supply of and demand for oncologists and radiation oncologists through 2025: an aging, better-insured population will result in shortage. J Oncol Pract. 2014;10(1):39-45. doi:10.1200/JOP.2013.001319

[14] Kosty MP, Hanley A, Chollette V, Bruinooge SS, Taplin SH. National Cancer Institute-American Society of Clinical Oncology Teams in Cancer Care Project. J Oncol Pract. 2016;12(11):955-958. doi:10.1200/JOP.2016.018127

disproportionately affected. Until now, Medicare documentation requirements have not required a claims modifier to be reported for split/shared visits, and there has been no evaluation to determine the extent to which a time-based billing requirement may disrupt collaborative patient care.

In a team-based model of care, many elements of a patient visit are performed by APP members of the care team, and the tasks for which a physician is not necessary may make up the bulk of the time of a patient visit. Highly effective team-based care requires clear roles and responsibilities and building a high-performance, collaborative team, with a goal of having team members practice to the maximum level permitted by their state practice laws. This model optimizes available time for physician expertise in medical decision-making, which is particularly valuable in the care of patients with cancer. As the field of oncology progresses via precision medicine, immunotherapy, and other innovative therapies, the number and type of cancer treatment options have increased, meaning that patients and providers face increasingly complex treatment decisions. Medical decision-making in oncology can be particularly multi-layered, involving the consideration of an intricate set of diagnostic, therapeutic, and prognostic uncertainties, patient preferences and values. Therefore, in cancer care, billing based on medical decision-making may be more appropriate for split/shared visits than billing based only on time.

Impact on Administrative Burden

ASCO is also concerned that CMS's split/shared billing policies could contribute to administrative burden, as CMS's claims modifier and medical record documentation requirements may require changes to existing documentation and billing practices for physicians and APPs who furnish services in facility settings.

One problematic consequence of CMS's policy is the potential burden of precise tracking of physician and APP time spent on a visit, including when it is spent simultaneously. In a team-based approach to care, this change would require time tracking in virtually every E/M visit. A typical oncology practice is balancing multiple patients, working with many different health care professionals and providers, and seeing patients at many points throughout a day, often throughout the course of an entire day, making it extremely challenging for time to be accurately and consistently tracked for billing purposes. For those physicians that have deeply integrated APPs into their care teams, this change will be especially burdensome and problematic. This requirement adds significant administrative burden to an already unacceptable level of time dedicated to such requirements.

ASCO is committed to providing support in the recognition of burnout and promotion of well-being in oncology. The realities of the COVID-19 cancer care era resulted in a multifold increase in oncologist distress because of numerous practice changes, heightened moral distress, and personal challenges produced by the pandemic.[15] More than half of health workers now report symptoms of burnout ,and administrative burden is widely acknowledged as a key contributor to this trend.[16] Acknowledging the systemic roots of burnout in the health care system, United States Surgeon

[15] Hlubocky FJ, Symington BE, McFarland DC, et al. Impact of the COVID-19 Pandemic on Oncologist Burnout, Emotional Well-Being, and Moral Distress: Considerations for the Cancer Organization's Response for Readiness, Mitigation, and Resilience. JCO Oncol Pract. 2021;17(7):365-374. doi:10.1200/OP.20.00937

[16] Murthy VH. Confronting Health Worker Burnout and Well-Being. N Engl J Med. 2022;387:577-579. doi:10.1056/NEJMp2207252

General Dr. Vivek Murthy issued a Surgeon General's Advisory in May 2022 highlighting the urgent need to address this crisis across the country; In August 2022, Dr. Murthy authored a perspective in *The New England Journal of Medicine* which cited reduction of administrative burden as a key priority. Explicit in the perspective was a call to health insurers to streamline paperwork requirements.[17] Plainly, CMS's new split/shared visit billing requirements defy this call, instead adding to already unacceptable administrative load by requiring documentation requirements that do not accurately reflect the balance of complexity and related decision making that providers face.

Conclusion

In the interest of supporting high-value, high-quality care, ASCO supports policies that promote full access to the most effective team-based care. ASCO recognizes that it would be inappropriate to permit a physician to bill for a visit if they do not substantially participate in the visit. However, CMS's policy to require split/shared visits to be billed based only on time fails to ensure appropriate compensation for physicians when they make a substantive contribution to team-based care for a patient. E/M code selection and levels of service continue to be based on MDM or time spent. Therefore, prohibiting the determination of the substantive portion of a split/shared E/M visit by any method other than the majority of total time is unnecessarily restrictive and detrimental. We are concerned that the new split/shared billing rules would disrupt the way care is delivered, disincentivize high-value team-based care, and could lead to reduced utilization of the nation's essential APP workforce. Advanced practice providers are integral members of oncology teams, and significant advances to team-based care in recent years has been shown to be associated with such outcomes as decreased adverse events for hospitalized patients and decreased length of stay in the hospital.[18]

Given our concerns on the impact that CMS's split/shared visit policy will have on current practice patterns, the adoption of team-based care, administrative burden, and burnout, we strongly urge the agency to revisit and change the split/shared billing policy finalized in the CY 2022 Physician Fee Schedule final rule. **As policymakers consider options for how best to promote team-based care as well as accurate coding and billing, ASCO recommends the following:**

- **CMS should propose an alternative policy that allows physicians or APPs to bill split or shared visits based on either time or medical decision-making, following the 2023 changes to E/M services, to mitigate the negative impact that the time-only option will likely have on patient care.**
- **CMS should work with specialties to ensure a smooth transition to updated billing practices and adequate and appropriate reimbursement. This policy, as it stands, will require education and significant changes to day-to-day workflow.**
- **CMS should work with stakeholders to ensure that resources are allocated in a manner that: emphasizes team-based, evidence-supported care; reimburses physicians at adequate rates; and implements future reforms in a way that reduces**

[17] Department of Health and Human Services. New Surgeon General Advisory Sounds Alarm on Health Worker Burnout and Resignation. May 23, 2022. https://www.hhs.gov/about/news/2022/05/23/new-surgeon-general-advisory-sounds-alarm-on-health-worker-burnout-and-resignation.html

[18] Will KK, Johnson ML, Lamb G. Team-Based Care and Patient Satisfaction in the Hospital Setting: A Systematic Review. J Patient Cent Res Rev. 2019;6(2):158-171. Published 2019 Apr 29. doi:10.17294/2330-0698.1695

administrative burdens encountered by patients, physicians, and other health care professionals.

- **Congress should work with the physician community and other stakeholders to develop solutions to systematic problems in the prevailing models of health care delivery which discourage team-based approaches to care in both public and private systems.**

Questions? Contact Allyn Moushey at Allyn.Moushey@asco.org or 571-483- 1738.