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Documentation of 'Substantive Portion' for CMS, CPT May Not Align, Creating Audit Risk

By Nina Youngstrom

Although CMS has adopted the new CPT definition of "substantive portion" for a split/shared evaluation and management (E/M) visit—reportedly a welcome change for physicians and nonphysician practitioners (NPPs)—cracks are starting to show in terms of differences in documentation requirements for medical decision-making (MDM), an expert says.

The CPT Editorial Panel's 2024 definition of substantive portion seems to expect less in the way of documentation than CMS's for billing purposes, said Valerie Rock, a principal with PYA, P.C. Although CMS says it's aligning with CPT for 2024, the regulation "could be interpreted as requiring the physician to document the MDM independently in support of the E/M code," she noted. That may become a problem because "we continue to see minimal documentation by physicians in split/shared scenarios."

Medicare pays for an E/M service provided in part by a physician and in part by an NPP/advanced practice provider (APP)—such as a nurse practitioner—at an institution (e.g., hospital, skilled nursing facility). Split/shared visits are billed under the National Provider Identifier of the physician or NPP who provides the substantive portion of the visit. As CMS explained in the 2022 Medicare Physician Fee Schedule (MPFS) rule, "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." The 2022 MPFS rule phased out history, exam and MDM as a basis for determining the substantive portion, leaving time as the only option starting in 2023, but CMS delayed implementation until 2024, and then in the 2024 MPFS rule, it swapped out its definition of substantive portion for the CPT definition.

For billing purposes, the substantive portion means "more than half of the total time spent by the physician and NPP performing the split (or shared) visit or a substantive part of the medical decision making" except for critical care because it's a time-based service, according to the rule. And here's the heart of the new material: "For the purpose of reporting E/M services within the context of team-based care, performance of a substantive part of the MDM requires that the physician(s) or other QHP(s) [qualified health professionals] made or approved the management plan for the number and complexity of problems addressed at the encounter and takes responsibility for that plan with its inherent risk of complications and/or morbidity or mortality of patient management. By doing so, a physician or other QHP has performed two of the three elements used in the selection of the code level based on MDM. If the amount and/or complexity of data to be reviewed and analyzed is used by the physician or other QHP to determine the reported code level, assessing an independent historian's narrative and the ordering or review of tests or documents do not have to be personally performed by the physician or other QHP because the relevant items would be considered in formulating the management plan. Independent interpretation of tests and discussion of management plan or test interpretation must be personally performed by the physician or other QHP if these are used to determine the reported code level by the physician or other QHP (2024 CPT Codebook, pg. 6)."

Sentence in MPFS Rule Raises the Stakes

The new CPT guidelines should allow for less documentation, Rock said. "The physician only has to make or approve the management plan for the problems addressed and take responsibility for the plan—which is a reference to the risk portion of the MDM. It does not say how a physician should document that. However, one could assume that documentation such as 'reviewed and agree with plan at my direction' and physician signature would suffice," she said.

But CMS has superimposed its own requirements and that's complicating matters, Rock explained. The MPFS rule stated that "although we continue to believe there can be instances where MDM is not easily attributed to a single physician or NPP when the work is shared, we expect that whoever performs the MDM and subsequently bills the visit would appropriately document the MDM in the medical record to support billing of the visit."

In other words, "Medicare is saying a countersignature from a physician is not enough," added Colleen Ejak, a senior health care consultant with 3M Health Information Systems. "There has to be substance" in that note.

Rock said that's at odds with CPT, which is comfortable with physicians documenting that they've reviewed the NPP's notes and agree with them. "CMS is saying if you're going to be the billing provider, you need to document what you actually reviewed specifically and what plan you're approving so you can support medical decision making," Rock said. "It's possible CMS meant that the physician only has to summarize or refer to the MDM already documented by the NPP, along the lines of CPT, but my fear is that auditors will translate that the physician has to document medical decision-making independently in support of the code reported." She advises watching for updates to the Medicare manual and Medicare administrative contractor (MAC) guidance to get a better sense of expectations.

Other Themes to Focus On

Physicians should already be documenting something substantive although "you don't have to document the entire MDM over again," said Erica Remer, M.D, president of Erica Remer, M.D. Inc. in Ohio. "You need to have some sort of attestation that says, 'I saw the patient or my advanced practice provider saw the patient, and we went over the findings, and I take responsibility for the MDM as documented above.' You have to do something that says, 'I believe this is my patient and you should be paying me even if I didn't type it all out myself.'"

Instead of worrying so much about the documentation, Remer said physicians and NPPs/APPs should focus on two themes in the new definition of substantive portion:

1. There are three elements of medical decision-making: number and complexity of diagnoses to be addressed; the amount and/or complexity of data to be analyzed; and the risk of complications or morbidity from testing or treating. In the data element is the independent interpretation of tests, and only the practitioner who interprets the tests can take credit for it. "If my APP looked at the test, I can't take credit for it," Remer explained.

2. If physicians or NPPs decide to base the substantive portion on time, remember that "two people can't take credit for the same moment in time," she said. For example, if the physician and NPP are treating the patient together for 30 minutes—ordering lab tests, talking to consultants, discussing a treatment plan with the patient—only the physician or the NPP is allowed to take credit for the time or they can divvy it up. As Ejak put it: "Only distinct time should be summed, meaning when two individuals jointly meet and discuss the patient, only the time of one individual should be counted."

Ejak noted that the billing provider doesn't necessarily have to be the one who had face time with the patient. Maybe the physician saw the patient in person but the NPP did the substantive portion of the visit with non-face-to-face services. "MACs should not be requiring face-to-face visits to get the substantive portion of care," Rock

said. But if you have state requirements or hospital bylaws that say otherwise, they still stand, she noted.

Ejak added that "the documentation in the medical record must identify the physician and NPP who performed the visit." The physician or NPP who performed the substantive portion of the visit and therefore bills for the visit is required to sign and date the medical record," she said Dec. 4 on the *Talk Ten Tuesdays* webcast. And "don't forget the FS modifier" on claims for split/shared visits. Medicare is expected to identify claims to audit based on the presence of the FS modifier.

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