

## Documentation of Time and Split/Share Encounters

Medicare's definition of split (or shared) visit is an E/M visit in the facility setting that is performed in part by **both a physician and an APP** who are in the **same group**, in accordance with applicable laws and regulations. For split/share visits:

- At least one of the providers must have face-to-face contact with the patient (physician or APP)
- Physicians and APPs must each document the portion of the encounter that he/she personally provided (e.g. history, physical exam, medical decision making), and must each sign the medical record to verify his/her involvement in the patient's care. It is not sufficient for the physician to simply document "seen and agree" or simply countersign .
- Physicians and APPs must each document the total unit/floor time he/she spent on the E/M encounter. Physicians should specify if that time was spent independently and/or jointly with the APP .
- The distinct time spent by the Physician and APP furnishing a split/shared visit will be summed to determine total time for the encounter; when the physician and APP jointly meet with or discuss the patient, only the time of one individual should be counted .
  - Unit/floor time includes the time present on the patient's hospital unit and at the bedside rendering services for that patient.
  - Do not include time spent on procedures or services that are separately reported.

# Physician Attest Section

The Attest Section has been updated in all PDoc templates.

Document: Discharge Summary - Attestations

DEMO, K

General | Med Rec | Objective | Tx & Proc | DC Instruc | Quality | Attest

Attestation need... **Physician Attestation**

Agree w/findings...

Reviewed finding...

**Time spent on pa...**

Time spent on patient care:  
I spent [] TOTAL minutes on patient care, including [] minutes spent jointly with [].  
> 50% time spent on counseling/coordination of care [yes/no]

THE KYA (QAA) NETWORK  
ONE PARK PLAZA  
Nashville CA  
37202

Discharge Summary

Patient Name: KAREN DEMO  
Date of Birth: 05/24/86  
Attending Doctor: GREER, SHERRY

Unit Number: J000446179  
Patient Status: ADM INo  
Account Number: J00021314707

**Physician Attestation**  
Time spent on patient care:  
Time spent on patient care:  
I spent 25 TOTAL minutes on patient care, including 10 minutes spent jointly with Suzi Greer, APP.  
> 50% time spent on counseling/coordination of care [yes]

*Time spent on patient care is a new field.*

A new canned text is available to address the total (distinct) time spent on patient care which includes the time spent jointly with APP and time spent counseling.

**Note: Avoid entering time ranges such as >, <. Enter time as a whole number.**

# Discharge Instruction Section

The verbiage in the Discharge Instruction → Diagnosis, Assessment & Plan, has been modified to reflect enhanced documentation for shared visits between Physicians and Advanced Practice Providers (APPs). All Inpatient DC summary templates have this update.

Time spent:		
Time spent on pa...		
>50% spent on co...		

Time spent on patient care (minutes):		
7	8	9
4	5	6
1	2	3
+/-	0	
←		Clear
<<	<	Ref
>	>>	

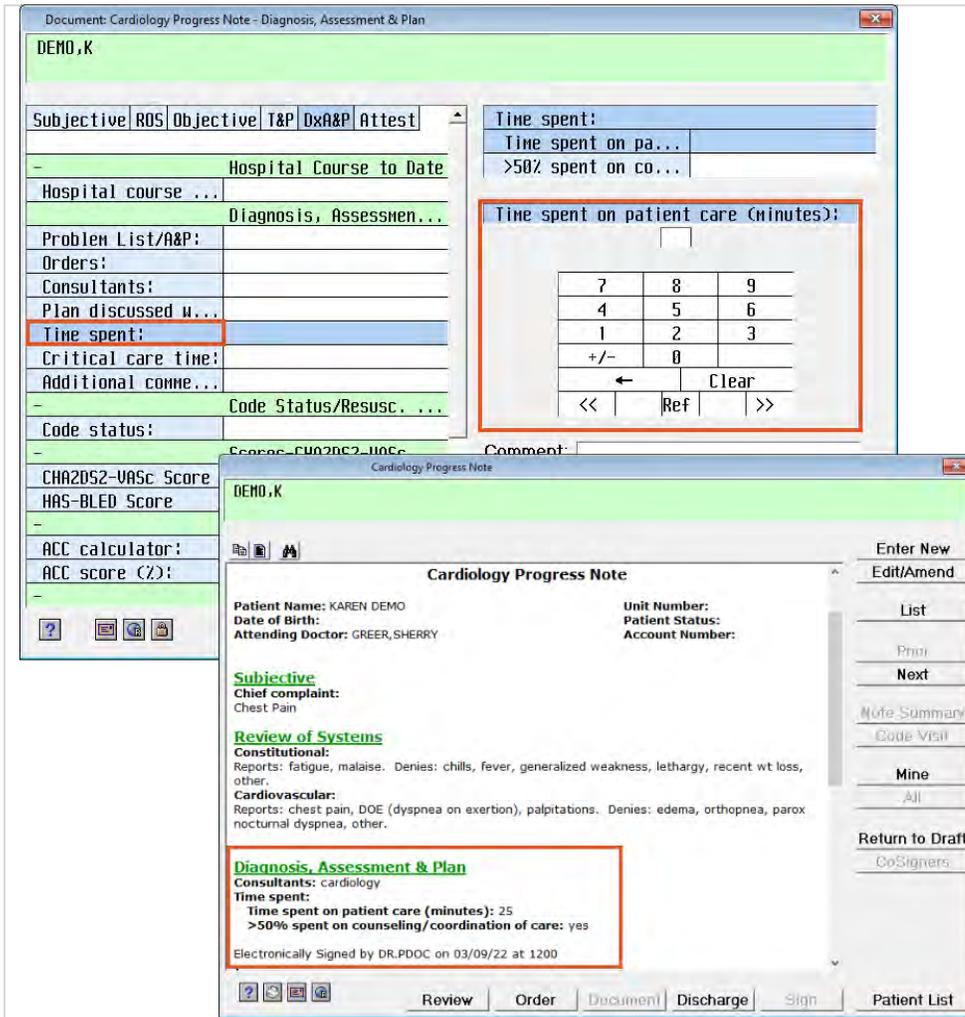
*Time spent in minutes* has been changed to *Time spent on patient care* to account for both face-to-face and non-face-to-face time with the patient.

**Note:** Physicians who participate in discharge services as a split/share visit with an APP should utilize the new *Time spent* field in the Physician Attest Section.

# Dx A&P Section

New time spent query has been added in Dx A&P has been updated on ALL Inpatient templates.

On the templates that this query already existed, the verbiage for time spent (in minutes) has been modified to time spent on patient care (minutes)



*Time spent on patient care (in minutes) accounts for both face to face and non-face-to-face time with the patient.*

**Note:** Critical Care notes and other Inpatient notes will continue to have a “critical care time” field under the Diagnosis, Assessment and Plan section.

This is unique to critical care and accounts for time specifically spent on critical care activities, documentation that supports why the patient is considered critically ill and the critical care management that was provided.

***Time spent counseling/ coordinating care does not apply to critical care notes.***