

Billing for split (shared) E/M services**Date of origin: 06/26****Review dates: None yet recorded****DEFINITION**

A split or shared visit is an evaluation and management (E/M) visit that meets all the following criteria:

- Performed in a facility setting AND
- Performed in part by both a physician and a non-physician practitioner (NPP) AND
- Physician and NPP are part of the same group practice.

Split or shared services can be reported for new patients, established patients, initial services, or subsequent services.

Payment is made to the practitioner who performs the substantive portion (see below) of the visit.

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 (MDM) per the CPT E/M Guidelines. See the 2024 CPT Codebook.

For critical care visits and prolonged services which don't use MDM and only use time, substantive portion still means more than half of the total time spent by the practitioner performing the split or shared visit.

For prolonged visits, the substantive portion is more than half of the practitioners' total time. Only bill prolonged services when time is used to select visit level, and determination of who performed the substantive portion is based on time.

FOR MEDICARE

For indications that don't meet criteria of NCD, local LCD or specific medical policy a Pre-Service Organization Determination (PSOD) will need to be completed. Get more information on PSOD [in our Provider Manual](#).

POLICY SPECIFIC INFORMATION**Coding specifics**

Both the physician and NPP, each with their own assigned NPI, must be part of the same practice group.

- When entities have separate tax identification numbers, payment arrangements are defined by the group agreement as Priority Health will send payment to the billing practitioner. (Follows Medicare guidelines).
- Each practitioner must be able to show how they're a group when performing services under a split or shared billing arrangement. (Follows CMS guidelines).
- Don't submit separate claims. Only bill for the practitioner who provided the most substantive portion of the service (see below).
- Meet E/M coding requirements for billing at the specified level of service (see documentation requirements below under "Requirements to bill split / shared services").
- Rely on the substantive portion of the service to drive the billing provider. Reimbursement for services billed under a physician or non-physician practitioner may differ depending on contracted fees. However, this shouldn't drive the billing provider decision.

- Select E/M CPT codes based on MDM or time based on new E/M CPT guidelines. However, this may not drive which provider performed the substantive portion of the service as history and exam elements are considered.
- Services performed within a global period of 0, 10 or 90 days are still applicable.

E/M code families applicable to this policy:

- Other outpatient
- Inpatient / Observation / Hospital / Skilled Nursing Facility (SNF)
- Emergent Department
- Critical Care

Place of service

Coverage will be considered for services furnished in the appropriate setting to the patient's medical needs and condition. Authorization may be required. Get more information [in our Provider Manual](#).

E/M services can be allowed as a split or shared service in a facility setting which includes inpatient, outpatient, emergency room, observation services, and critical care services.

Office visits and nursing facility visits aren't billable as split or shared services.

Documentation requirements

Complete and thorough documentation to substantiate the procedure performed is the responsibility of the Provider. In addition, the Provider should consult any specific documentation requirements that are necessary for any applicable defined guidelines.

The practitioner providing the most substantive portion can bill for the E/M service. Select the E/M level based on documentation prepared by both the physician and NPP.

The documentation must support and define which practitioner is performing the substantive portion, including:

- E/M components, including history, exam, medical decision making (MDM) and time (if applicable, see below for examples)
- Elements performed by both practitioners
- Face-to-face services provided by at least one of the practitioners (doesn't have to be the billing provider)

According to the Centers for Medicare & Medicaid Services (CMS) Correct Billing of Split (Shared) Services, below are examples of elements for qualifying time:

- Preparing to see the patient (i.e., review of tests)
- Obtaining and/or reviewing separately obtained history
- Performing a medically necessary exam or evaluation
- Counseling and educating 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 patient / family / caregiver
- Care coordination (not separately reported*)

*" Not separately reported" means neither practitioner submits a separate charge for the activity. When submitting a separate charge, carve out the time spent from the remainder of the E/M service.

Modifiers

Priority Health follows standard billing and coding guidelines which include CMS NCCI. Modifiers should be applied when applicable based on this guidance and only when supported by documentation.

Incorrect application of modifiers will result in denials. Please see our provider manual page for modifier use here.

Append modifier FS, Split or shared E/M visit, to the E/M service billed under the practitioner providing the substantive portion of the service. This can be either the physician or NPP.

Resources

<https://www.priorityhealth.com/provider/manual/billing/split-billing>

DISCLAIMER

CMS and/or MDHHS guidelines apply unless otherwise specified in this policy or provider manual. Where such guidance is absent, this policy applies. Priority Health's billing policies outline our guidelines to assist providers in accurate claim submissions and define reimbursement or coding requirements if the service is covered by a Priority Health member's benefit plan. The determination of visits, procedures, DME, supplies and other services or items for coverage under a member's benefit plan or authorization isn't being determined for reimbursement. Authorization requirements and medical necessity requirements appropriate to procedure, diagnosis and frequency are still required. We use Current Procedural Terminology (CPT), Centers for Medicare and Medicaid Services (CMS), Michigan Department of Health and Human Services (MDHHS) and other defined medical coding guidelines for coding accuracy.

An authorization isn't a guarantee of payment when proper billing and coding requirements or adherence to our policies aren't followed. Proper billing and submission guidelines must be followed. We require industry standard, compliant codes defined by CPT, HCPCS and revenue codes for all claim submissions. CPT, HCPCS, revenue codes, etc., can be reported only when the service has been performed and fully documented in the medical record to the highest level of specificity. Failure to document for services rendered or items supplied will result in a denial. To validate billing and coding accuracy, payment integrity pre- or post-claim reviews may be performed to prevent fraud, waste and abuse. Unless otherwise detailed in the policy, our billing policies apply to both participating and non-participating providers and facilities.

If guidelines detailed in government program regulations, defined in policies and contractual requirements aren't followed, Priority Health may:

- Reject or deny the claim
- Recover or recoup claim payment

An authorization on file for an item or services doesn't supersede coding, billing or reimbursement requirements.

These policies may be superseded by mandates defined in provider contracts or state, federal or CMS contracts or requirements. We make every effort to update our policies in a timely manner to align to these requirements or contracts. If there's a delay in implementation of a policy or requirement defined by state or federal law, as well as contract language, we reserve the right to recoup and/or recover claim payments to the effective dates per our policy. We reserve the right to update policies when necessary. Our most current policy will be made available [in our Provider Manual](#).

CHANGE / REVIEW HISTORY

Date	Revisions made
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06/26	Provider manual page formatted to billing policy
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