Keystone First
Community HealthChoices

Split or Shared Billing Guidelines

Reimbursement Policy ID: RPC.0092.72KF

Recent review date: 09/2026

Reimbursement policies and their resulting edits are based on guidelines from established industry sources, such as the Centers for Medicare and Medicaid Services (CMS), the American Medical Association (AMA), state and federal regulatory agencies, and medical specialty professional societies. Reimbursement policies are intended as a general reference and do not constitute a contract or other guarantee of payment. The health plan may use reasonable discretion in interpreting and applying its policies to services provided in a particular case and may modify its policies at any time.

In making claim payment determinations, the health plan also uses coding terminology and methodologies based on accepted industry standards, including Current Procedural Terminology (CPT®); the Healthcare Common Procedure Coding System (HCPCS); and the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM), and other relevant sources. Other factors that may affect payment include medical record documentation, legislative or regulatory mandates, a provider's contract, a member's eligibility in receiving covered services, submission of clean claims, other health plan policies, and other relevant factors. These factors may supplement, modify, or in some cases supersede reimbursement policies.

This reimbursement policy applies to all health care services billed on a CMS-1500 form or its electronic equivalent, and, when billed on a UB-04 form or its electronic equivalent.

To the extent that any procedure and/or diagnosis codes are specified in this policy, such inclusion is provided for reference purposes only, may not be all inclusive, and is not intended to serve as billing instructions. Listing of a code in this policy does not imply that the service described by the code is a covered or non-covered health service. Benefit coverage for health services is determined by federal, state, or contractual requirements and applicable laws that may require coverage for a specific service. The inclusion of a code does not imply any right to reimbursement or guarantee claim payment. Other Policies and Guidelines may apply.

Policy Overview

This policy addresses reimbursement of split billed outpatient and inpatient facility services as well as split or shared professional services.

Exceptions

Services subject to the 3-day payment window are an exception to this policy.
Office visits and nursing facility visits are not billable as split or shared services.

Reimbursement Guidelines

All separately payable, non-repetitive hospital outpatient services provided on the same date of service must be billed on the same claim. If an outpatient claim for services matches another claim with the same date, the claim is not reimbursable.

Split billing of an inpatient claim may be reimbursable when the admission and discharge dates cover two different calendar years. For example, if the patient is admitted on December 27 and discharged on January 3, a claim for each year may be submitted and separately reimbursable.

Physician Billing

CMS (Centers for Medicare & Medicaid Services) generally requires all physician services in the same specialty and the same group providing care concurrently to the same patient on the same day for the same patient to be billed on the same claim. There are exceptions and specific guidelines depending on the type of services and the setting where they are provided.

Physicians must bill charges performed on the same day on the same claim if the services are related and a single, comprehensive code is available. For instance, if a patient returns for follow-up on the same day for the same complaint, the work should be combined into a single E/M code. However, if there's a significant, separately identifiable E/M service, it can be billed separately.

- When a significant, separately identifiable E/M service is performed on the same day as a procedure, Modifier 25 can be used to indicate this.
- Modifier 25 clarifies that a separate E/M service was provided and is not part of the global period of the procedure.

Preventative Care

When billing Medicare, CMS requires that additional qualifying E/M services be billed separately from a preventive service. The CMS website states “When you provide an annual wellness visit and a significant, separately identifiable, medically necessary Evaluation and Management (E/M) service, Medicare may pay the additional service. Report the additional CPT code with Modifier-25. That portion of the visit must be medically necessary and reasonable to treat the patient’s illness or injury, or to improve the functioning of a malformed body part.”

Critical Care

Any provider in the same specialty and the same group providing care concurrently to the same patient on the same date should report their time using the code for additional time intervals (CPT code 99292).

- These providers may not report CPT code 99291 more than once for the same patient on the same date.
- When one provider begins the initial critical care service but doesn’t meet the time needed to report CPT code 99291, another provider in the same specialty and group can continue to deliver critical care to the same patient on the same date.

Combine the total time providers spent to meet the required time to bill CPT code 99291.

- Once the cumulative time is met to report critical care service CPT code 99291, only an individual in the same specialty and group can report CPT code 99292 when they provide an additional 30 minutes of critical care services to the same patient on the same date (74 minutes + 30 minutes = 104 total minutes).

Modifier 25 (same-day significant, separately identifiable E/M service) is used on the claim for critical care services unrelated to the service or procedure performed on the same day. Documentation in the medical record must include the relevant criteria for the respective E/M service being reported.

Critical care unrelated to the surgical procedure during a global surgical period may be eligible for separate payment. Medicare may pay for preoperative and postoperative critical care in addition to the procedure if:

- The patient is critically ill and requires the physician’s full attention.
- The critical care is above and beyond, and unrelated to the specific anatomic injury or general surgical procedure performed (like trauma or burn cases). When a critical care service is unrelated to the surgical procedure, use modifier FT on the claim. Modifier FT is used to describe an unrelated E/M visit:

- During a global procedure (preoperative period or postoperative period), or on the same day as the procedure.
- Report modifier FT if 1 or more unrelated E/M visits are provided on the same day as the critical care CPT code.

Observation

If a patient who is admitted to an inpatient hospital or observation care for 8 or more hours but less than 24 hours and is discharged on the same calendar date, a CPT code, 99234 – 99236 (includes admission and discharge services) is reported.

Definitions

Substantive Portion

A substantive portion is more than half of the total time, or a substantive part of the medical decision making (MDM).

Edit Sources

I. Current Procedural Terminology (CPT) and associated publications and services.
II. International Classification of Diseases,10th Revision, Clinical Modification (ICD-10-CM).
III. Healthcare Common Procedure Coding System (HCPCS).
IV. Centers for Medicare and Medicaid Services (CMS).
V. The National Correct Coding Initiative (NCCI).
VI. Updates for Split or Shared Evaluation & Management Visits

Attachments

N/A

Associated Policies

RPC.0091.72KF Three-Day Payment Window
RPC.0009.72KF Significant-Separately Identifiable Evaluation and Management Service (Modifier 25)

Policy History

09/2026	Reimbursement Policy Committee Approval
09/2026	• Removed the next review date • Replaced the plan name with “the health plan”
05/2026	Biennial review • No major changes
06/2025	Minor updates to formatting and syntax
05/2025	Reimbursement Policy Committee Approval