Split/Shared Billing in Emergency Medicine: Why Attestation Matters More Than Ever

Emergency medicine is evolving—and so are the billing rules.

Emergency departments (ED) are built for urgency. Physicians and non-physician providers (NPP) often work side by side in fast-paced, overlapping workflows delivering timely, critical care. But as team-based care becomes the norm, Centers for Medicare & Medicaid Services (CMS) is taking a closer look at how these shared encounters are billed.

At the center of that scrutiny? **Split/shared billing.**

The challenge? **Documenting it the right way—consistently and in real time.**

The opportunity? **Protecting compliance and preserving revenue.**

Let's walk through what's changed, what matters most and how Coronis Health approaches this in the EDs we support nationwide.

From face-to-face to substantive portion: what the rule says now.

In the past, EDs could bill under a physician's National Provider Identifier (NPI) if there was some level of face-to-face interaction with the patient. That allowed for flexibility and especially helpful in the dynamic, high-volume world of emergency care.

Michael Jeffery
President of Emergency Medicine

Michael Jeffery's 37 years of revenue cycle management (RCM) experience includes 30 in emergency medicine. In 2021 after 22 years as owner of MRI (an RCM company), his firm was acquired by MMGS and later merged with Coronis Health. Now, Michael directs a seasoned team that focuses on accurate, timely reimbursements support, so providers can deliver high-quality patient care.

But CMS's **2024 guidance** introduced a major shift. **Now, the provider who performs the "substantive portion" of the visit must bill the service.**

That "substantive portion" can be determined in one of two ways:

- **More than 50% of the total time** spent with the patient
- **Performance of the key components of the medical decision making (MDM)**

This dual definition allows EDs some flexibility, but also raises new questions:

- How do we decide who did "most" of the work?
- Do we need to track time precisely?
- How do we document it efficiently without slowing down care?

Why attestation is the most practical answer.

Time tracking is nearly impossible in a typical ED setting. Providers manage multiple patients, shift between roles and rarely engage in linear, trackable encounters. CMS recognizes this reality, which is why **attestation** is not just allowed—it's encouraged.

You don't need a stopwatch.
You need a sentence.

An effective attestation:

- **Clearly identifies** the provider who performed the substantive portion
- **Specifies** the work completed (especially MDM)
- **Is documented** by the billing provider themselves

Example:

> *"I, Dr. [Name], have personally performed the substantive portion of this visit, including key components of the medical decision making."*

Without that sentence, coders are forced to make assumptions. Many will **default the claim to the NPP**, resulting in a **15% reduction in Medicare reimbursement.**

That's revenue leakage—not from missed services, but from missed documentation.

What attestation is—and what it isn't.

There's still confusion about what qualifies. To clarify:

- **A specific, provider-written statement** confirming who led the care? That's attestation.
- **A co-signature on an NPP note?** Not enough.
- **A general statement like "seen and agree?"** Doesn't meet the requirement.

Seen and agree? Not good enough. CMS wants more than a signature.

CMS expects to see **clear, active confirmation** the billing provider delivered the majority of care whether by time or by decision making. Without that, compliance risks rise—and reimbursement can fall.

Modifier FS: required for Medicare.

For split/shared services billed to **Medicare**, CMS now requires the **FS modifier** on the E/M code. This flag:

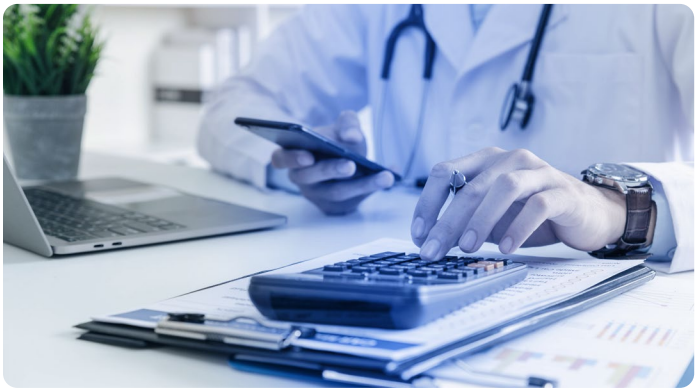
- Indicates both a physician and NPP participated in the service
- Enables CMS to track utilization of split/shared billing
- Does not affect reimbursement but supports claims integrity

Keep in mind:

- Some **commercial payers do not recognize FS**
- Others still follow **older billing standards** (e.g., face-to-face models or NPP credentialing limitations)
- **Payer-specific guidelines must be reviewed regularly**

Top compliance risks we see

When working with EDs across multiple health systems, we consistently see two high-risk documentation gaps:



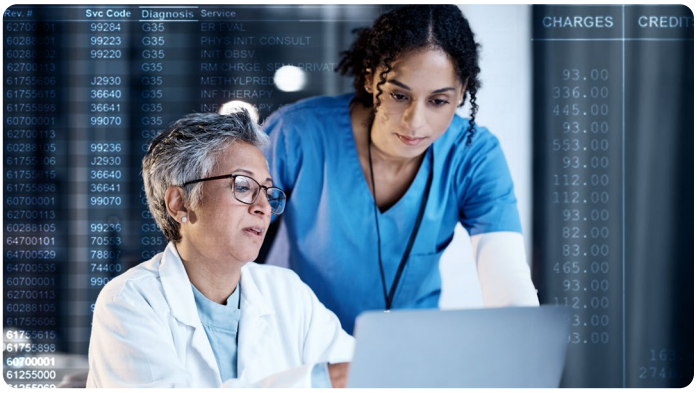
1. **Missing or conflicting attestations:**
    - The physician says they provided the majority of care
    - The NPP says the same
    - Neither supports this statement with specific notes or an attestation

This creates uncertainty for coders and potential exposure to payer audits.

2. **Inconsistent billing practices across payers:**
    - Medicare requires FS
    - Some commercial payers don't allow split/shared billing
    - Others won't credential NPPs, forcing to bill under the physician—whether they led care or not

Without an organized, payer-specific approach, billing can become noncompliant—without anyone realizing it.

How high-performing EDs are responding.



The most successful EDs we support don't leave this to chance. They do the following:

Use smart workflows

- EHRs flag when physician attestation is needed
- Policies define when physicians must lead care (e.g., high ESI levels, complex presentations)

Standardize attestation language

- Dot phrases or smart texts make attestation easy
- Providers use templates but customize them to their specific contribution

Generate operational reports

We help teams regularly review:

- The **volume of split/shared encounters**

- The **billing provider mix** (physician vs. NPP)
- The **financial difference** between physician- and NPP-billed services

These reports allow operational and clinical leaders to spot trends, address documentation gaps and reduce lost revenue.

Key misconceptions.

"If I wasn't at the bedside the longest, I can't bill it."

→ MDM counts. Reviewing results, consulting specialists and leading clinical decisions matter.

"Co-signing the NPP's note is enough."

→ CMS wants confirmation you performed the substantive portion. Not just agreement.

"This only affects Medicare billing."

→ Many commercial payers have adopted similar rules—or will soon. Payer diversity adds complexity.

Substantive portion means more than **50% of the time**—of the key MDM elements. It's not about the bedside anymore.

Final thoughts: make it easy to do the right thing.

Split/shared billing isn't new. But its enforcement is evolving—and it's now a top compliance focus for CMS and commercial payers alike.

This doesn't mean ED workflows need to slow down. With the right tools and structure, attestation can be low lift and high impact.

If you lead an emergency department, here's where to focus:

- **Clarifying the policy** for your teams
- **Standardizing attestation tools** to reduce friction
- **Auditing your billing trends** to identify gaps
- **Tailoring your approach** to your payer landscape

When documentation accurately, clearly and consistently reflects the care being delivered, everyone benefits.

- Your teams get credit for their work
- Your organization protects its revenue
- Your compliance risk stays exactly where it should be

Simplify split/shared billing in your ED—contact us today.

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