Select Health

CODING/REIMBURSEMENT POLICY

AFTER-HOURS AND URGENT CARE CHARGES

Policy # 02
Implementation Date: 4/1/05
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Disclaimer:
1. Policies are subject to change without notice.
2. Policies outline coverage determinations for Select Health Commercial, Select Health Advantage (Medicare/CMS), and Select Health Community Care (Medicaid/CHIP) plans. Refer to the "Policy" section for more information.

Description

Codes 99050–99060 and S9088 are services that are reported by Providers for After-Hours and Other Special Services, Procedures and Reports.

COMMERCIAL PLAN POLICY AND CHIP (CHILDREN'S HEALTH INSURANCE PROGRAM)

99050

Criteria for code *99050 Services provided in the office at times other than regularly scheduled office hours, or days when the office is normally closed (e.g., holidays, Saturday or Sunday), in addition to basic service*:

- Pay when code 99050 is reported in addition to the code for the basic service rendered when a service is provided at times other than the providers posted (regularly scheduled) office hours.
- Documentation in the medical record must support that services were rendered after posted, regularly scheduled office hours (including evenings, holidays, Saturdays, or Sundays). The date and time of the encounter must be documented, or code 99050 will not be considered for payment.
- Do not pay when code 99050 is reported for services rendered in any location other than in a physician's office/clinic (e.g., hospital, Laboratory, Radiology Department, Emergency Department, Urgent Care Center).
- Pay regardless of the provider's specialty as long as the service is provided in an office/clinic and the above criteria are met.

99051

Prior to 01/01/15 - Code *99051 Service(s) provided in the office during regularly scheduled evening, weekend, or holiday office hours, in addition to basic service* will be denied as included in the E/M or any basic service provided. Effective January 1, 2015, the provider may bill with the after-hours code 99051.

Effective January 1, 2015

Criteria for code 99051 *Service(s) provided in the office during regularly scheduled evening, weekend, or holiday office hours, in addition to basic service:*

- Pay when code 99051 is reported in addition to the code for the basic service rendered when a service is provided during regularly scheduled evening, weekend, or holiday office hours.
- Documentation in the medical record must support that services were rendered during regularly scheduled evening, weekend, or holiday office hours. The date and time of the encounter must be documented, or code 99051 will not be considered for payment.

- Do not pay when code 99051 is reported for services rendered in any location other than in a physician's office/clinic (e.g., hospital, Laboratory, Radiology Department, Emergency Department, Urgent Care Center).
- Pay regardless of the provider's specialty as long as the service is provided in an office/clinic and the above criteria are met.

99053

Criteria for code 99053 *Service(s) provided between 10:00 PM and 8:00 AM at a 24-hour facility, in addition to basic service*:

- Pay when code 99053 is reported with the initial inpatient or outpatient hospital visit at a 24-hour facility. Do not pay for code 99053 when it is reported with any subsequent service code.
- Pay code 99053 when the initial service is performed between the hours of 10:00 PM and 8:00 AM. (The documentation must specify the time the service is rendered.). This code will not be paid if the service is performed during any other time period.
- Pay when the service is requested, and do not pay when the provider is coincidentally at the service site. This determination should be based on available records and other information. If the documentation substantiates the services were provided within the specified time period in a 24-hour facility and the provider was not present at the service site prior to the service (e.g., trauma call, emergency department physician), the code can be paid.
- Pay regardless of the provider's specialty if the above criteria are met.

99056

Criteria for code 99056 *Service(s) typically provided in the office, provided out of the office at request of patient, in addition to basic services*

- Pay when code 99056 is reported in addition to the code for the basic service rendered as follows:
    - When medical record documentation supports the service was requested by a patient in a location other than the provider's office.
    - When the correct CPT code is used to report the service according to the documentation (e.g., a code for a home service, 99348 is reported, and documentation specifies the patient requested service in the home (a location other than the provider's office).
- Do not pay when code 99056 is reported for services rendered in any location that would be considered the provider's office.
- Do not pay if the provider is coincidentally in the non-office setting where a patient is being seen (e.g., the provider is already in the emergency department).
- Pay regardless of the provider's specialty as long as the service is provided in a setting other than the provider's office and the above criteria are met.

99058

Code 99058 *Service(s) provided on an emergency basis in the office, which disrupts other scheduled office services, in addition to basic service* is denied as included in an E/M service.

On appeal if the following criteria are met, 99058 may be reimbursed:

- Pay when code 99058 is reported in addition to the code for the basic service rendered as follows:
    - When the medical record documentation supports services were provided in the office for an unscheduled patient on an emergent basis whose condition, in the clinical judgment of the provider, warrants the provider's "hands-on personal care" and interrupts the care of other patients.
    - Do not reimburse for this service when the provider directs other healthcare personnel to treat and/or manage the "emergency" patient.
    - Do not reimburse for this service if the provider does not document that while providing emergent care, other patients were left, and their care was delayed or deferred.

- When the provider documents the patient requiring emergent care did not utilize an appointment or urgent care slot purposely left unfilled to accommodate time during the day to treat potential emergent/urgent patients.

99060

Criteria for code 99060 *Service(s) provided on an emergency basis, out of the office, which disrupts other scheduled office services, in addition to basic service*:

- Pay code 99060 when reported in addition to the code for the basic service rendered as follows:
  - When the medical record documentation supports the service was provided outside of the office for a patient on an emergency basis (unscheduled), whose condition, in the clinical judgment of the provider warrants the provider's "hands-on personal care" and interrupts the care of another patient to treat and/or manage the "emergency" patient.
  - Do not reimburse for this service when the provider directs other healthcare personnel to treat and/or manage the "emergency" patient.
  - Do not reimburse for this service if the provider does not document that while providing emergent care, they left scheduled patients in the office to provide the emergent care out of the office. If "scheduled office services" were for reasons other than patient care, the circumstances must be documented by the provider. The documentation must include the date and time they were called to care for a patient outside of the office on an emergent basis.
  - When the service is performed at a site other than the provider's office, according to Medicare Place of Service (POS) designations and descriptions.
  - When the provider is not coincidentally in the location where the emergent care is provided (other than the office).
  - When the service is not performed as part of a scheduled emergency department shift at a 24-hour facility, or as part of scheduled trauma call service.

S9088

Code S9088 *Services provided in an urgent care center (list in addition to code for service)* is denied as included in the E/M or basic service provided in any location (effective January 1, 2009).

Only one of the after-hours office codes can be used per visit in addition to the E/M or service code.

SELECT HEALTH ADVANTAGE (MEDICARE/CMS)

All after hour codes are 'B'-Status codes and they are not paid separately. Reimbursement is bundled into the primary procedure.

SELECT HEALTH COMMUNITY CARE (MEDICAID)

Select Health Community Care will cover after-hours add-on codes 99050 and 99058 when added to the basic evaluation and management office visit for a new patient (codes 99201–99205) and an established patient (codes 99212–99215).

When the services are provided during regularly scheduled office hours in the evenings, weekends, or holidays, the provider may bill with the after-hours code 99051. "Evening" is defined as after 6:00 PM and "Holiday" is defined as any federal or state-recognized holiday.

Only one of the after-hours office codes can be used per visit in addition to the E/M or service code.

99053, 99056, 99060, S9088

Not separately reimbursable as payment is included in the primary procedure

Applicable Codes

Codes	Descriptions
99050	Services provided in the office at times other than regularly scheduled office hours, or days when the office is normally closed (eg, holidays, Saturday or Sunday), in addition to basic service
99051	Service(s) provided in the office during regularly scheduled evening, weekend, or holiday office hours, or in addition to basic service
99053	Service(s) provided between 10:00 PM and 8:00 AM at 24-hour facility, in addition to basic service
99056	Service(s) typically provided in the office, provided out of the office at request of patient, in addition to basic service
99058	Service(s) provided on an emergency basis in the office, which disrupts other scheduled office services, in addition to basic service
99060	Service(s) provided on an emergency basis, out of the office, which disrupts other scheduled office services, in addition to basic service.
S9088	Services provided in an urgent care center (list in addition to code for service)

Sources

1. Current Procedural Terminology (CPT®), (2014) – American Medical Association.
2. ICD-9-CM Coding Guidelines. (2013, January 1). Retrieved July 8, 2014, from https://www.encoderpro.com/epro/physicianDoc/pdf/i9v1/i9_guidelines.pdf
3. Utah Department of Health. (2014, July 1). PHYSICIAN SERVICES. Retrieved August 27, 2014, from https://medicaid.utah.gov/Documents/manuals/pdfs/Medicaid Provider Manuals/Physician And Anesthesiology/SECTION 2 - Physician Services/Physician7-14.pdf
4. *Code 99056*, *CPT Assistant* Winter 1994 Special Services, Procedures, and Reports (99000–99090) p. 26.
5. *Coding Communications: Special Services, Procedures and Reports* - CPT® Assistant – August 2006 Volume 16, Issue 8 – MedAssets (2009), pp. 6–8.

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