BlueCross BlueShield Minnesota

MEDICARE REIMBURSEMENT POLICY

Urgent Care / After Hours Care / Extended Hours

Active

Section: General Coding
Policy Number: 011
Effective Date: 07/01/24

Description

This policy addresses coding and reimbursement for urgent care, after-hours care, and extended hours charges on a professional (837P) or outpatient facility (837I) claim.

Definitions

Urgent Care: an urgent care clinic's purpose is to diagnose and treat illness or injury for unscheduled, ambulatory patients seeking immediate medical attention. An urgent care is distinct from a hospital emergency room, an office, or a clinic.

Primary Care Clinics (PCC): may offer after-hours services or alternative/extended scheduling. A PCC that offers extended or after hours is not considered an urgent care clinic.

Policy Statement

Urgent Care

Codes S9083 (global fee urgent care centers) and S9088 (services provided in an urgent care center) have a CMS Status Code assignment of "I" (Not Valid for Medicare Purposes), and therefore will be denied.

Billing

- Clinic-based urgent care services should be billed on a professional claim format (837P) with place of service (POS) code 20.
- Hospital-based urgent care should be billed on an institutional health care claim (837I) with revenue code 0456. A professional claim with a facility POS should be submitted for the professional portion of the service.

Extended/After-hours Clinics

Consistent with Current Procedural Terminology (CPT®) and the Centers for Medicare and Medicaid Services (CMS), Blue Cross will not allow reimbursement for codes 99050, 99051, 99053, 99056, 99058 and 99060 whether submitted alone or with an associated service. According to CPT these codes are to be reported "in addition to basic service". Per the National Physician Fee Schedule (NPFS) Relative Value File, they have been assigned a Status B indicator and are, therefore, considered to be bundled into the payment for other services provided on the same day.

Documentation Submission

Documentation must identify and describe the services performed. If a denial is appealed, this documentation must be submitted with the appeal.

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Coverage

Eligible services will be subject to the subscriber benefits, applicable fee schedule amount and any coding edits

The following applies to all claim submissions.

All coding and reimbursement is subject to all terms of the Provider Service Agreement and subject to changes, updates, or other requirements of coding rules and guidelines. All codes are subject to federal HIPAA rules, and in the case of medical code sets (HCPCS, CPT, ICD), only codes valid for the date of service may be submitted or accepted. Reimbursement for all Health Services is subject to current Blue Cross Medical Policy criteria, policies found in the Provider Policy and Procedure Manual sections, Reimbursement Policies and all other provisions of the Provider Service Agreement (Agreement).

In the event that any new codes are developed during the course of Provider's Agreement, such new codes will be paid according to the standard or applicable Blue Cross fee schedule until such time as a new agreement is reached and supersedes the Provider's current Agreement.

All payment for codes based on Relative Value Units (RVU) will include a site of service differential and will be calculated using the appropriate facility or non-facility components, based on the site of service identified, as submitted by Provider.

Coding

The following codes are included below for informational purposes only and are subject to change without notice. Inclusion or exclusion of a code does not constitute or imply subscriber coverage or provider reimbursement.

CPT/HCPCS Modifier:	N/A
ICD-10 Diagnosis:	N/A
ICD-10 Procedure:	N/A
CPT/HCPCS:	S9083 S9088 99050 99051 99053 99056 99058 99060
Revenue Codes:	0456

Resources

Current Procedural Terminology (CPT®)
Healthcare Common Procedure Coding System (HCPCS)
National Physician Fee Schedule (NPFS)
National Uniform Claim Committee (NUCC)

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Policy History	
03/24/2015	Initial Committee Approval
01/07/2019	Annual Policy Review and Coding Update
01/26/2021	Annual Policy Review
07/27/2021	Annual Policy Review
04/25/2023	Revised
11/28/2023	Revised: Created separate Medicare policy
04/23/2024	Annual Policy Review