

## After-Hours Codes Coverage

**Policy** REIMB-028

**Origination Date:** 3/24/2021

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**Next Review Date:** 03/29/2024

**Current Effective Date:** 03/29/2023

### Disclaimer:

1. Policies are subject to change in accordance with State and Federal notice requirements.
2. Policies outline coverage determinations for U of U Health Plans Commercial and Healthy U (Medicaid) plans. Refer to the "Policy" section for more information.
3. Services requiring prior-authorization may not be covered, if prior-authorization is not obtained.
4. **This Medical Policy does not guarantee coverage or payment of the service. The service must be a benefit in the member's plan and the member must be eligible for coverage at the time of service. Additional payment guidelines may be applied that are not included in this policy.**

### Description:

After hours or weekend care Current Procedural Terminology (CPT®) codes represent services provided, when an individual physician or other health care professional is required to render the services outside of regular posted office hours to treat a patient's urgent illness or condition.

### Policy Statement and Criteria

#### 1. Commercial Plans

**U of U Health Plans COVERS CPT code 99050 for an after-hours charge when services are provided in an office/clinic setting consistent with the following guidelines:**

- A. After-hours services are provided in the office at times other than regularly posted office hours, or days when the office is closed (e.g., holidays, Saturday or Sunday) in addition to basic service.
- B. Providers will submit documentation to substantiate additional payment for after-hours upon request.
- C. Services are billed with a covered evaluation/management service CPT code but not a preventive service code
- D. The provider billing the service is a primary care provider practicing in one of the following areas:

- i. Adolescent Medicine
- ii. Pediatric-Adolescent
- iii. General Pediatrics
- iv. Family Nurse Practitioner
- v. Nurse Practitioner
- vi. Pediatric Nurse Practitioner
- vii. Advanced Registered Nurse Practitioner
- viii. Family Medicine
- ix. General Practice
- x. Geriatric Medicine
- xi. Obstetrics & Gynecology (*where the provider has indicated PCP status*)
- xii. General Internal Medicine (*where the provider has indicated PCP status*)
- xiii. Certified Nurse Midwife

**U of U Health does NOT separately reimburse CPT codes 99051, 99053, 99056, 99060 for an after-hours charge when a service is provided in an office/clinic setting during regularly scheduled evening, weekend, or holiday office hours or at a 24-hour facility.** These codes will be denied as a provider liability. Coverage for services rendered in an urgent care clinic or setting will be processed based on the procedure/service itself. Co-pays may differ based on member benefits.

**U of U Health Plans does NOT separately reimburse a charge for an after-hours CPT code for a service provided at the request of the patient for the patient's convenience.**

**U of U Health Plans does NOT separately reimburse a charge for an after-hours CPT code when submitted with Virtual Visits.**

## **2. Medicaid Plans**

**Coverage is determined by the State of Utah Medicaid program; if Utah State Medicaid has no published coverage position and InterQual criteria are not available, the U of U Health Plans Commercial criteria will apply. For the most up-to-date Medicaid policies and coverage, please visit their website at: <https://medicaid.utah.gov/utah-medicaid-official-publications/> or the [Utah Medicaid code Look-Up tool](#)**

**CPT/HCPCS codes covered by Utah State Medicaid may still require further evaluation to determine medical necessity for coverage.**

## Rationale

The Centers for Medicare and Medicaid Services (CMS) considers reimbursement for CPT codes 99050, 99051, 99053, 99056, 99058 and 99060 to be bundled into the payment for other services provided on the same day. U of U Health Plans aligns with CMS for after-hours services represented by CPT codes 99053– 99056 and 99060 which are assigned a status of “B”. CMS assigns a status of “B” (Bundled Code) to the denied procedure, which is defined, “Payment for covered services are always bundled into payment for other services not specified. There will be no RVUs or payment amount for these codes and no CMS 1500 separate payment is made. A Modifier will not over-ride the edit”.

In some instances providing services by providers in a clinic setting afterhours may reduce the use of higher cost services and warrants reimbursement. For that reason it is reasonable to consider coverage of 99050 and 99051 separately from the e/m bundling rules established by CMS.

## Applicable Coding

### CPT Codes

<b>99050</b>	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
<b>99051</b>	Service(s) provided in the office during regularly scheduled evening, weekend, or holiday office hours, in addition to basic service
<b>99053</b>	Service(s) provided between 10:00 PM and 8:00 AM at 24-hour facility, in addition to basic service
<b>99056</b>	Service(s) typically provided in the office, provided out of the office at request of patient, in addition to basic service
<b>99060</b>	Service(s) provided on an emergency basis, out of the office, which disrupts other scheduled office services, in addition to basic service

### HCPCS Codes

No applicable codes

### References:

1. American Medical Association (AMA). “Current Procedural Terminology (CPT)”. 2021.
2. Centers for Medicare and Medicaid Services (CMS) (2020) National Correct Coding Initiative Edits (NCCI). Accessed March 16, 2021. Available at: <https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html>

### Disclaimer:

This document is for informational purposes only and should not be relied on in the diagnosis and care of individual patients. Medical and Coding/Reimbursement policies do not constitute medical advice, plan preauthorization, certification, an explanation of benefits, or a contract. Members should consult with appropriate health care providers to obtain needed medical advice, care, and treatment. Benefits and eligibility are determined before medical guidelines and payment guidelines are applied. Benefits are determined by the member’s individual benefit plan that is in effect at the time services are rendered.

The codes for treatments and procedures applicable to this policy are included for informational purposes. Inclusion or exclusion of a procedure, diagnosis or device code(s) does not constitute or imply member coverage or provider reimbursement policy. Please refer to the member’s contract benefits in effect at the time of service to determine coverage or non-coverage of these services as it applies to an individual member.

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