



<b>Policy</b>	<b>REIMB-003</b>
<b>Effective Date</b>	<b>09/01/2024</b>
Reviewed/Revised Date	07/11/2024
Next Review Date	10/01/2026
Origination Date	07/01/2024
Originated Department	Medical Management

### After-Hours Codes Coverage

<b>Audience</b>
Medical Management, Claims

<b>Purpose</b>
<p>Medical policies provide general support for applying Mountain Health Co-Op member policy document coverage decisions, and the member-specific benefit plan document must be referenced. The terms of the member-specific Policy document may differ from the standard benefit plan based on this medical policy. If there is a conflict between a member-specific policy document and the Mountain Health Co-Op medical policy, the document supersedes this policy. Any person(s) applying this medical policy must identify member eligibility, the member-specific policy document, and related policies or guidelines before applying this medical policy, including the existence of any state or federal guidance. Mountain Health Co-Op medical policies are designed for informational purposes only and are not an authorization, explanation of benefits, or contract. Receipt of benefits is subject to the satisfaction of all terms and conditions of the member-specific policy document coverage. Mountain Health Co-Op reserves the sole discretionary right to modify all policies and guidelines at any time.</p>

<b>Definition</b>
<p>After-hours or weekend care Current Procedural Terminology (CPT®) codes represent services provided when an individual physician or other health care professional must render the services outside of regular posted office hours to treat a patient's urgent illness or condition.</p>

<b>Policy/Procedure</b>
<p><b>Mountain Health Co-Op Health Plans COVERS CPT code 99050 for an after-hours charge when services are provided in an office/clinic setting when ALL of following guidelines are met:</b></p>

- A. In addition to basic service, after-hours services are provided in the office at times other than regularly posted office hours or on days when the office is closed (e.g., holidays, Saturdays, or Sundays)
- B. Providers must submit documentation to substantiate additional payment for after-hours charges
- 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:
  - Adolescent Medicine
  - Pediatric-Adolescent
  - General Pediatrics
  - Family Nurse Practitioner
  - Nurse Practitioner
  - Pediatric Nurse Practitioner
  - Advanced Registered Nurse Practitioner
  - Family Medicine
  - General Practice
  - Geriatric Medicine
  - Obstetrics & Gynecology (where the provider has indicated PCP status)
  - General Internal Medicine (where the provider has indicated PCP status)
  - Certified Nurse Midwife

**Mountain Health Co-Op Health does NOT separately reimburse CPT codes 99051, 99053, 99056, or 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. Copays may differ based on member benefits.

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

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

#### **Clinical 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 as “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 override the edit”.

In some instances, providers providing services in a clinic setting after hours may reduce the use of higher-cost services and warrant reimbursement. Therefore, 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)”. 2024.
2. Centers for Medicare and Medicaid Services (CMS) National Correct Coding Initiative Edits (NCCI).

<https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/index.html>

## Vendors

- Health Plan Services (HPS)

## Review/Revision/Approval History

Date	Description
<b>07/01/2024</b>	<b>NEW</b>

## 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 appropriate healthcare providers for 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 benefit plan, effective when services are rendered.

The codes for treatments and procedures applicable to this policy are included for informational purposes. Including or excluding 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 they apply to an individual member.

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