

Corporate Payment Policy 12

URGENT CARE CLINICS

Origination: May 2016

Last Review: December 2020

Next Review: December 2022

Effective Date: January 1, 2021

Document Precedence

The BCBSVT Payment Policy Manual was developed to provide guidance for providers regarding BCBSVT payment practices and facilitates the systematic application of BCBSVT member/employer contracts, provider contracts, BCBSVT corporate medical policies, and McKesson's ClaimCheck logic. Document precedence is as follows:

- 1) To the extent that there may be any conflict between the BCBSVT Payment Policy Manual and the member contracts or employer benefit documents, the member contract/employer benefit document language takes precedence.
- 2) To the extent that there may be any conflict between the BCBSVT Payment Policy Manual and provider contract language, the provider contract language takes precedence.
- 3) To the extent that there may be any conflict between the BCBSVT Payment Policy Manual and corporate medical policy, the corporate medical policy takes precedence.
- 4) To the extent that there may be any conflict between the BCBSVT Payment Policy Manual and the McKesson's ClaimCheck audit solution, the McKesson's ClaimCheck audit solution takes precedence.

Payment Policy

Description

This policy applies to Urgent Care Services provided at Urgent Care Clinics (which may be free-standing or hospital-based).

Urgent Care Services (also referred to as "Urgently-needed care" or "urgent care") means those health care services that are necessary to treat a condition or illness of an individual that if not provided promptly (within twenty-four hours or a time frame consistent with the medical exigencies of the case) presents a serious risk of harm.

An Urgent Care Clinic:

- Offers unscheduled health care services seven days per week, including holidays, for at least 10 hours per day, or, if the clinic's normal business day is shorter than 10 hours, the clinic can show evidence of availability to provide care outside of the clinic's normal business hours;
- Delivers health care services that do not constitute emergency services but rather are health care services that are necessary to treat a condition or illness of an individual that if not

provided promptly (within 24 hours or a time frame consistent with the medical exigencies of the case) presents a serious risk of harm;

- In the case of a non-free-standing clinic, that is located in a distinct area outside of a hospital emergency room or primary care office;
- Offers medical, laboratory and radiology services on site; and
- Is accredited by an organization approved by Blue Cross and Blue Shield of Vermont (including, but not limited to, the Joint Commission, the American Academy of Urgent Care Medicine, the Urgent Care Association or the National Association for Ambulatory Care).

A seasonal urgent care clinic is a clinic that operates during a specified period during the year and meets all requirements of an urgent care clinic except that it may not provide laboratory services. The period during which the clinic operates corresponds to when the population of the area served by the clinic is higher than during the other periods due to seasonal patterns (e.g., ski areas).

Urgent care clinics are intended to be a complement to, not a replacement for, our members' ongoing relationships with their primary care providers (PCPs). The urgent care clinic will send all medical records to the members' PCPs. All members should contact their PCPs for appropriate follow-up care.

Policy & Provider Billing Guidelines and Documentation

The following payment policy applies to Urgent Care Services provided at Urgent Care Clinics. Urgent Care Services provided in settings other than Urgent Care Clinics are outside the scope of this policy and should be billed in accordance with applicable industry standards and BCBSVT policies.

Claims for Urgent Care Services provided at Urgent Care Clinics should be billed on a professional claim format (CMS-1500/837P) under the place of service (POS) 20. The POS code 20 will apply urgent care benefits to the services if submitted.

Non-Urgent Care Services (including, but not limited to, physicals and immunizations) provided at an Urgent Care Clinic should not be billed with the POS 20 and should be billed as a regular office visit (using POS 11).

BCBSVT will not accept separate claims for "facility" urgent care services billed on a UB-04. See BCBSVT Corporate Payment Policy 11: Provider Based Billing for more details. There may, however, be a need in the case of a hospital-based urgent care clinic, to submit claims for certain laboratory or radiology services provided as part of the urgent care visit – that are provided outside of the urgent care clinic setting – on a UB-04, these should also be billed with POS 20 (Urgent Care).

If the radiology and/or lab services require a professional component (modifier -26), and the provider rendering this is not part of the urgent care clinic, the claim should be billed on a professional claim

format (CMS-1500/837P) under the place of service (POS) 20. The POS code 20 will apply urgent care benefits to the services if submitted.

Documentation must identify and describe the procedures performed.

All coding and reimbursement is subject to all terms of the provider's 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-10-CM), only codes valid for the date of service may be submitted or accepted.

Claims are subject to payment edits that are updated at regular intervals and generally based on Current Procedural Terminology (CPT®), Health Care Procedural Coding System (HCPCS), Internal Classification of Diseases, CMS National Correct Coding Initiative Edits, Specialty Society guidelines, etc.

Not Eligible for Payment

S9083 (global fee urgent care centers) and S9088 (services provided in an urgent care center) are **not eligible** for payment and will be denied as not eligible to bill, provider liability.

Codes 99050 - 99091 (adjunct codes) are **not eligible** for payment and will be denied as not eligible to bill, provider liability.

Eligible Services

Codes 99202 - 99205 (office/other outpatient visit for evaluation and management of new patient) are **eligible** for payment.

Codes 99211 - 99215 (office/other outpatient visit for evaluation and management of established patient) are **eligible** for payment.

BCBSVT will also provide coverage for Medically Necessary laboratory services, radiology services, and medical and surgical supplies (HCPCS Level II codes) that are covered by the terms and conditions of the member's benefit program.

Benefit Determination Guidance

Payment for urgent care services provided in an urgent care clinic setting is determined by the member's benefits. It is important to verify the member's benefits **prior** to providing the service to determine if benefits are available or if there is a specific exclusion in the member's benefit.

Eligible urgent care services are subject to applicable member cost sharing such as co-payments, co-insurance, and deductible.

Federal Employee Program (FEP): Members may have different benefits that apply. For further information please contact FEP customer service or refer to the FEP Service Benefit Plan Brochure. It is important to verify the member's benefits **prior** to providing the service to determine if benefits are available or if there is a specific exclusion in the member's benefit.

Inter Plan Programs (IPP): In accordance with the Blue Cross and Blue Shield Association's Inter-Plan Programs Policies and Provisions, this payment policy governs billing procedures for goods or services rendered by a Vermont-based provider (BCBSVT is the local Plan), including services rendered to out-of-state Blue members. Provider billing practices, payment policy and pricing are a local Plan responsibility that a member's Blue Plan must honor. A member's Blue Plan cannot dictate the type of claim form upon which services must be billed, codes and/or modifiers, place of service or provider type, unless it has its own direct contract with the provider (permitted only in limited situations). A member's Blue Plan cannot apply its local billing practices on claims rendered in another Plan's service area. A member's Blue Plan can only determine whether services rendered to their members are eligible for benefits. To understand if a service is eligible for payment it is important to verify the member's benefits **prior** to providing services. In certain circumstances, the member may be financially responsible for services beyond the benefit provided for eligible services.

Claims are subject to payment edits that are updated at regular intervals and generally based on Current Procedural Terminology (CPT®), Health Care Procedural Coding System (HCPCS), Internal Classification of Diseases, CMS National Correct Coding Initiative Edits, Specialty Society guidelines, etc.

National Drug Code(s)

Health Care Procedure Coding System (HCPCS) codes related to chemotherapy drugs, drugs administered other than oral method, and enteral/parenteral formulas may be subject to National Drug Code (NDC) processing and pricing. The use of NDC on medical claims helps facilitate more accurate payment and better management of drug costs based on what was dispensed and may be required for payment. For more information on BCBSVT requirements for billing of NDC please refer to the provider portal at <http://www.bcbsvt.com/provider-home> for the latest news and communications.

Eligible Providers

This policy applies to all providers/facilities contracted with the Plan's Network (participating/in-network) and any non-participating/out-of-network providers/facilities.

Audit Information:

BCBSVT reserves the right to conduct audits on any provider and/or facility to ensure compliance with the guidelines stated in the payment policy. If an audit identifies instances of non-compliance with this payment policy, BCBSVT reserves the right to recoup all non-compliant payments.

Legislative Guidelines

Vermont Rule 09-03 (definition of urgent care)

Related Policies

Corporate Payment Policy 11: Provider Based Billing

Policy Implementation/Update Information

Effective January 01, 2021, code 99201 has been deleted.

Approved by

Date Approved: 12/21/2020



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Addendum

Coding Table¹²

The industry codes listed below are **eligible** for separate or additional payment. Also, as noted in the policy, laboratory and radiology codes as well as medical/surgical supply codes (HCPCS Level II) are eligible for payment.

Please Note: Codes may not be all inclusive as the AMA and CMS code updates may occur more frequently than policy updates.

Code Type	Code/Modifier	Description	Unit Designation (S = single / M = multiple)
CPT [®]	99202-99205	Office or other outpatient visit for the evaluation and management of a new patient.	S
CPT [®]	99211-99215	Office or other outpatient visit for the evaluation and management of an established patient.	S

¹Current Procedural Terminology CPT[™] codes and descriptions are the property of the American Medical Association.

²Healthcare Common Procedure Coding System (HCPCS) code set and descriptions are the property of CMS.

Coding Table¹²

The industry codes listed below are **not eligible** for separate or additional payment, provider liability.

Please Note: Codes may not be all inclusive as the AMA and CMS code updates may occur more frequently than policy updates.

Code Type	Code/Modifier	Description	Unit Designation (S = single / M = multiple)
HCPCS Level II	S9083	Global fee urgent care centers	S
HCPCS Level II	S9088	Services provided in an urgent care center (list in addition to code for service)	S
CPT [®]	99050	Services provided in the office at times other than regularly scheduled office hours, or days when the office is normally closed (e.g.,	S

Code Type	Code/Modifier	Description	Unit Designation (S = single / M = multiple)
		holidays, Saturday or Sunday), in addition to basic service.	
CPT®	99051	Service(s) provided in the office during regularly scheduled evening, weekend, or holiday office hours, in addition to basic service.	S
CPT®	99053	Service(s) provided between 10:00 PM and 8:00 AM at 24-hour facility, in addition to basic service.	S
CPT®	99056	Service(s) typically provided in the office, provided out of the office at request of patient, in addition to basic service.	S
CPT®	99058	Service(s) provided on an emergency basis in the office, which disrupts other scheduled office services, in addition to basic service.	S
CPT®	99060	Service(s) provided on an emergency basis, out of the office, which disrupts other scheduled office services, in addition to basic service	S
CPT®	99070	Supplies and materials (except spectacles), provided by the physician or other qualified health care professional over and above those usually included with the office visit or other services rendered (list drugs, trays,	S

Code Type	Code/Modifier	Description	Unit Designation (S = single / M = multiple)
		supplies, or materials provided)	
CPT®	99071	Educational supplies, such as books, tapes, and pamphlets, for the patient's education at cost to physician or other qualified health care professional	S
CPT®	99075	Medical testimony	S
CPT®	99078	Physician or other qualified health care professional qualified by education, training, licensure/regulation (when applicable) educational services rendered to patients in a group setting (eg, prenatal, obesity, or diabetic instructions)	S
CPT®	99080	Special reports such as insurance forms, more than the information conveyed in the usual medical communications or standard reporting form.	S
CPT®	99082	Unusual travel (eg, transportation and escort of patient)	S
CPT®	99090	Analysis of clinical data stored in computers (eg, ECGs, blood pressures, hematologic data)	S
CPT®	99091	Collection and interpretation of physiologic data	S

Code Type	Code/Modifier	Description	Unit Designation (S = single / M = multiple)
		(eg, ECG, blood pressure, glucose monitoring) digitally stored and/or transmitted by the patient and/or caregiver to the physician or other qualified health care professional, qualified by education, training, licensure/regulation (when applicable) requiring a minimum of 30 minutes of time	

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