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Last Review: December 05, 2024
Next Review: December 05, 2025
Effective Date: April 01, 2025

Description

Provide a policy statement for billing urgent care services provided at Urgent Care Clinics.

Policy Statement

Effective with dates of service on or after May 2016 Blue Cross and Blue Shield of Vermont (Blue Cross VT) will consider benefit for services associated and provided at urgent care clinics based on the guidelines set forth in this payment policy.

Definitions

Urgent Care

As defined by Vermont Rule H-2009-03

> 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.

Urgent Care Clinic

- Is a location, distinct from a hospital emergency room, an office, or a clinic, whose purpose is to diagnose and treat illness or injury for unscheduled, ambulatory members seeking immediate medical attention;

- 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;

- Offers medical, laboratory and radiology services on site; AND

- Is accredited by an organization approved by Blue Cross VT (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).

Seasonal Urgent Care Clinic

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' PCP's. All members are responsible to contact their PCP's for appropriate follow-up care.

Policy & Guidelines

Eligible

Procedure Codes **99202 - 99205** [office/other outpatient visit for evaluation and management of new patient] are eligible for benefit.

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

Laboratory services, radiology services, medical care and surgical supplies are eligible for benefits subject to the terms and conditions of the member's benefit plan.

Not Eligible

Procedure Code S9083 [global fee urgent care centers] and **S9088** [services provided in an urgent care center] are NOT eligible for benefit and will be denied as not eligible to bill, provider liability.

Procedure Codes **99050 - 99091** [adjunct codes] are not eligible for benefit and will be denied as not eligible to bill, provider liability.

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 Blue Cross VT policies.

Claims for Urgent Care Services provided at Urgent Care Clinics must be billed on a professional claim format CMS-1500/837P under the Place of Service (POS) 20.

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.

We will not accept separate claims for "facility" urgent care services billed on a UB-04. Laboratory and radiology services provided as part of the urgent care visit rendered outside of the urgent care clinical setting may be billed on a UB-04/837, with at the appropriate type of bill on the submitted claim."

Radiology/laboratory services that require a professional component modifier -26, when the rendering provider is not part of the urgent care clinic, the claim must be billed on a professional claim CMS-1500/837P using POS 20.

Documentation

Documentation must identify and describe the services and or procedures performed in the urgent care setting.

Benefit Determination Guidance

Payment for services 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 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 (Blue Cross VT 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.

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

Blue Cross VT reserves the right to conduct audits on any provider and/or facility to ensure adherence with the guidelines stated in the payment policy. If an audit identifies instances of non-adherence with this payment policy, Blue Cross VT reserves the right to recover all non-adherence payments.

Legislative and Regulatory Guidelines

Vermont Rule H2009-03 (Definition of Urgent Care)

Related Policies

Corporate Payment Policy CPP_11: Provider Based Billing

Document Precedence

The Blue Cross VT Payment Policy Manual was developed to provide guidance for providers regarding Blue Cross VT payment practices and facilitates the systematic application of Blue Cross VT member contracts and employer benefit documents, provider contracts, Blue Cross VT corporate medical policies, and Plan's claim editing logic. Document precedence is as follows:

1) To the extent that there may be any conflict between the Blue Cross VT Payment Policy Manual and the member contracts or employer benefit documents, the member contract or employer benefit document language takes precedence.
2) To the extent that there may be any conflict between the Blue Cross VT 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 Blue Cross VT 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 Blue Cross VT Payment Policy Manual and the Plan's claim editing solutions, the Plan's claim editing solution takes precedence.

Reference

Centers for Medicare & Medicaid Services (CMS). Place of Service Code Set. Retrieved from: https://www.cms.gov/medicare/coding-billing/place-of-service-codes/code-sets. November 25, 2024.

Policy Implementation/Update Information

This policy was originally implemented in May 2016.

Date of Change	Effective Date	Overview of Change
January 1, 2021	January 1, 2021	Code 99201 was deleted.
December 05, 2024	April 1, 2025	Payment policy updated new template format, reference added. Minor editorial refinements to policy statements; intent unchanged.

Approved by **Update Approved: 12/05/2024**

Tom Weigel, MD, Chief Medical Officer

Addendum 1

Coding Tables

The 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 (HCPS Level II) are eligible for benefits.

Code Type	Code	Description
CPT®	**99202-99205**	Office or other outpatient visit for the evaluation and management of a new patient.
CPT®	**99211-99215**	Office or other outpatient visit for the evaluation and management of an established patient.

The industry codes listed below are **NOT Eligible** for separate or additional benefit, provider liability.

Code Type	Code	Description
HCPCS	**S9083**	Global fee urgent care centers
HCPCS	**S9088**	Services provided in an urgent care center (list in addition to code for service)
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., 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.
CPT®	**99053**	Service(s) provided between 10:00 PM and 8:00 AM at 24-hour facility, in addition to basic service
CPT®	**99056**	Service(s) typically provided in the office, provided out of the office at request of patient, in addition to basic service
CPT®	**99060**	Service(s) provided on an emergency basis, out of the office, which disrupts other scheduled office services, in addition to basic service
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, 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
CPT®	**99075**	Medical testimony
CPT®	**99078**	Physician or other qualified health care professional qualified by education, training, licensure/regulation (when applicable) education services rendered to patients in a group setting (e.g., prenatal, obesity, or diabetic instructions)
CPT®	**99080**	Special reports such as insurance forms, more than the information conveyed in the usual medical communications or standard reporting form
CPT®	**99082**	Unusual travel (e.g., transportation and escort of patient)
CPT®	**99090**	Analysis of clinical data stored in computers (e.g., ECGs, blood pressures, hematologic data)
CPT®	**99091**	Collection and interpretation of physiologic data (e.g., 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