moda HEALTH	Reimbursement Policy Manual	Policy #:	RPM004
Policy Title:	After Hours and Other Special Circumstances		
Section:	Administrative	Subsection:	None

Scope: This policy applies to the following Medical (including Pharmacy/Vision) plans:

Companies:	☒ All Companies: Moda Partners, Inc. and its subsidiaries & affiliates ☐ Moda Health Plan ☐ Moda Assurance Company ☐ Summit Health Plan ☐ Eastern Oregon Coordinated Care Organization (EOCCO) ☐ OHSU Health IDS
Types of Business:	☐ All Types ☒ Commercial Group ☒ Commercial Individual ☒ Commercial Marketplace/Exchange ☒ Commercial Self-funded ☐ Medicaid ☒ Medicare Advantage ☒ Short Term ☐ Other: _____
States:	☒ All States ☐ Alaska ☐ Idaho ☐ Oregon ☐ Texas ☐ Washington
Claim forms:	☒ CMS1500 ☒ CMS1450/UB (or the electronic equivalent or successor forms)
Date:	☒ All dates ☐ Specific date(s): _____ ☐ Date of Service; For Facilities: ☐ n/a ☐ Facility admission ☐ Facility discharge ☐ Date of processing
Provider Contract Status:	☒ Contracted directly, any/all networks ☒ Contracted with a secondary network ☒ Out of Network

Originally Effective:	5/1/2003	Initially Published:	7/6/2011
Last Updated:	12/14/2022	Last Reviewed:	12/14/2022
Last update payment policy changes, subject to 28 TAC §3.3703(a)(20)(D)?		No	
Last Update Effective Date for Texas:		12/14/2022	

Reimbursement Guidelines

A. Medicare Advantage

Medicare Advantage plans follow Original Medicare policy and do not allow separate reimbursement for any of these procedure codes.

B. Commercial Plans

1. Commercial plans follow the Medicare policy for after-hours codes, with a few limited exceptions listed below.

2. There is no separate reimbursement for after-hours codes for services provided during normal, posted operating hours.

   a. Services provided in the emergency room are never eligible for separate reimbursement for after-hours service codes since emergency rooms are open to provide services 24/7. The RVUs for emergency room E/M procedure codes are increased to reflect the unexpected, after-hours nature of the service involved.

   b. Services provided in the urgent care setting are not eligible for separate reimbursement for after-hours service codes, since urgent care centers are by definition open for walk-in

business and are scheduled to be open for extended and non-traditional hours. Urgent care clinics have established procedures for redirecting patients to the emergency room or other facilities for care when closing time approaches.

c. Any after-hours procedure codes billed with place of service 23 (Emergency room – hospital) or 20 (Urgent care facility) will be denied to provider responsibility as a bundled service.

3. There is no additional separate reimbursement due to the place of service for services provided at an urgent care center or an "Immediate Care" center, as mentioned above.

   a. Procedure code S9088 will be denied to provider responsibility as a bundled service.

   b. Services provided in an urgent care center are reimbursed at the contracted fee or the maximum plan allowable for the procedure codes billed.

   c. When an urgent care patient requires more complex services, those procedure codes have higher RVUs. The higher fee allowances connected to those RVUs will be fair compensation to the urgent care for the services rendered, including the practice expense involved in rendering more complex services.

4. Separate reimbursement is allowed for services provided in the office setting at times when the office is normally closed.

   a. Procedure code 99050 billed with place of service 11 (Office) is eligible for separate reimbursement.

   b. Procedure code 99050 billed with any other place of service code is not eligible for separate reimbursement.

   c. Procedure code 99050 is not eligible to be billed by hospitals, facilities, DME providers, or other non-office provider types, due to code definition ("services provided in the office…"). When identified, these charges will be denied to provider write-off as not eligible for separate reimbursement.

   d. Procedure code 99051 is not eligible for separate reimbursement.

5. Separate reimbursement is allowed for emergency services provided <u>in the office</u> that result in a disruption of other scheduled services.

   a. Procedure code 99058 billed with place of service 11 (Office) is eligible for separate reimbursement.

   b. Procedure code 99058 billed with any other place of service code is not eligible for separate reimbursement.

   c. Procedure code 99060 for out-of-office emergencies is not eligible for separate reimbursement.

Codes, Terms, and Definitions

Acronyms & Abbreviations Defined

Acronym or Abbreviation		Definition
AMA	=	American Medical Association
CCI	=	Correct Coding Initiative (see "NCCI")
CMS	=	Centers for Medicare and Medicaid Services
CPT	=	Current Procedural Terminology
DRG	=	Diagnosis Related Group (also known as/see also MS DRG)
E/M E&M E & M	=	Evaluation and Management (services, visit) (Abbreviated as "E/M" in CPT book guidelines, sometimes also abbreviated as "E&M" or "E & M" in some CPT Assistant articles and by other sources.)
HCPCS	=	Healthcare Common Procedure Coding System (acronym often pronounced as "hick picks")
HIPAA	=	Health Insurance Portability and Accountability Act
MS DRG	=	Medicare Severity Diagnosis Related Group (also known as/see also DRG)
NCCI	=	National Correct Coding Initiative (aka "CCI")
RPM	=	Reimbursement Policy Manual (e.g., in context of "RPM052" policy number, etc.)
UB	=	Uniform Bill

Procedure codes (CPT & HCPCS):

Codes separately reimbursed for Commercial plans under limited circumstances:

Code	Code Description
99050	Services provided in the office at times other than regularly scheduled office hours, or days when the office is normally closed (eg, holidays, Saturday or Sunday), in addition to basic service
99058	Service(s) provided on an emergency basis in the office, which disrupts other scheduled office services, in addition to basic service

Codes never eligible for separate reimbursement:

Code	Code Description
99051	Service(s) provided in the office during regularly scheduled evening, weekend, or holiday office hours, in addition to basic service
99053	Service(s) provided between 10:00 PM and 8:00 AM at 24-hour facility, in addition to basic service

Code	Code Description
99056	Service(s) typically provided in the office, provided out of the office at request of patient, in addition to basic service
99060	Service(s) provided on an emergency basis, out of the office, which disrupts other scheduled office services, in addition to basic service
S9088	Services provided in an urgent care center (list in addition to code for service)

Coding Guidelines & Sources - (Key quotes, not all-inclusive)

Codes 99050 – 99060 are reported in addition to an associated basic service. Typically, only a single adjunct code from among 99050 – 99060 would be reported per patient encounter. However, there may be circumstances in which reporting multiple adjunct codes per patient encounter may be appropriate.

Cross References

None.

References & Resources

1. CMS, Medicare Claims Processing Manual, pub. 100-04, Chapter 12 – Physicians/Nonphysician Practitioners, §20.2, 20.3.

2. CMS, Medicare Claims Processing Manual, pub. 100-04, Chapter 23 – Fee Schedule Administration and Coding Requirements, §30.2.2.

Background Information

CPT has provided procedure codes 99050 through 99060 as adjunct codes to identify the special circumstances under which a basic procedure is performed. Moda Health allows separate reimbursement for some of these special circumstances, but not for others. See the Policy Statement below.

99050 – 99060 are all designated as status B (bundled) on the Medicare Physician Fee Schedule Database (MPFSDB). CMS indicates that the costs associated with these codes are bundled into the RVU (and thus the fee allowance) for the related primary service procedure code(s). No separate reimbursement is allowed for procedure codes designated as status B (bundled).

S9800 is another adjunct code to identify a special circumstance under which the basic procedure is performed. CMS does not recognize any HCPCS S-code, so S9800 is designated as status I (invalid) rather than status B (bundled) on the Medicare Physician Fee Schedule Database (MPFSDB). However, CMS does

clearly indicate that the costs associated with a special circumstance code such as this are already included in the RVU (and thus the fee allowance) for the related primary service procedure code(s).

IMPORTANT STATEMENT

The purpose of this Reimbursement Policy is to document our payment guidelines for those services covered by a member's medical benefit plan. Healthcare providers (facilities, physicians, and other professionals) are expected to exercise independent medical judgment in providing care to members. Our Reimbursement Policy is not intended to impact care decisions or medical practice.

Providers are responsible for submission of accurate claims using valid codes from HIPAA-approved code sets and for accurately, completely, and legibly documenting the services performed. Billed codes shall be fully supported in the medical record and/or office notes. Claims are to be coded appropriately according to industry standard coding guidelines (including but not limited to UB Editor, AMA, CPT, CPT Assistant, HCPCS, DRG guidelines, CMS' National Correct Coding Initiative [CCI] Policy Manual, CCI table edits and other CMS guidelines).

Benefit determinations will be based on the member's medical benefit plan. Should there be any conflicts between our Reimbursement Policy and the member's medical benefit plan, the member's medical benefit plan will prevail. Fee determinations will be based on the applicable provider fee schedule, whether out of network or participating provider's agreement, and our Reimbursement Policy.

Policies may not be implemented identically on every claim due to variations in routing requirements, dates of processing, or other constraints; we strive to minimize these variations.

***** The most current version of our reimbursement policies can be found on our provider website. If you are using a printed or saved electronic version of this policy, please verify the information by going to https://www.modahealth.com/medical/policies_reimburse.shtml *****

Policy History

Date	Summary of Update
12/14/2022	Formatting/Update Scope: Idaho added.
6/8/2022	Formatting & Clarification/Update: Change to new header. Procedure Code Table: "for Commercial plans" added to sub-header "Codes separately reimbursed under limited circumstances" for clarity. Policy History section: Added. Entries prior to 2022 omitted (in archive storage).
7/6/2011	Policy initially approved by the Reimbursement Administrative Policy Review Committee & initial publication.
5/1/2003	Original Effective Date (with or without formal documentation). Policy based on…