healthfirst
Health Insurance for New Yorkers

Reimbursement Policy

Subject:	After Hours and Weekend Care		
Policy Number:	PO-RE-101v1		
Effective Date:	05/01/2024	Last Approval Date:	03/18/2024

I. Policy Description

After hours or weekend care (CPT®) codes represent services provided when a Healthcare Provider is required to render the services outside of regular posted office hours to treat a patient's urgent illness or condition.

The information below applies to the following lines of business.

- Child Health Plus
- Small/Individual Group (Commercial Plan)
- Essential Plan
- Medicaid Managed Care
- Medicare PPO
- Integrated Benefits Dual Connection Plan
- Health & Recovery Plan (HARP)
- Medicare Advantage
- Medicaid Advantage Plus/MAP (Complete Care)
- Qualified Health Plan (QHP)
- Managed Long Term Care Partial Capitation Plan (MLTCP)
- Senior Health Plan (SHP)- Coverage based on benefit plan.

Reimbursement Guidelines

Centers for Medicare & Medicaid Services (CMS) considers reimbursement for Current Procedural Terminology (CPT) codes 99050 and 99051 to be bundled into the payment for other services provided on the same day.

Consistent with the Centers for Medicare & Medicaid Services (CMS), Healthfirst will **NOT** separately reimburse after-hours services represented by CPT codes 99050 (after hours services when office is normally closed) and 99051 (services provided in the office during regularly scheduled evening, weekend, or holiday officer hours) which are assigned a status of “B”. Centers for Medicare & Medicaid Services (CMS) assigned a status “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 separate payment will be made. When these services are covered, payment for them is subsumed by the payment for the services to which they are incident”.

Adjudication and Appeal Process

- If Healthfirst receives claims billed with CPT codes 99050 and 99051, the claim lines will be denied.
- Corrected claim submissions will be subject to timely filing requirements, as set forth in the provider contract with Healthfirst and in the Healthfirst Provider Manual. Refer to: Healthfirst Provider Manual Subsection 17.6, “Claims Inquiries, Corrected Claims, Claim Reconsideration, and Appeal Process” in this section.

II. Applicable Codes

Code	Description	Comment
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.	
99051	Services provided in the office during regularly scheduled evening, weekend, or holiday office hours, in addition to basic service.	

III. Definitions

Term	Meaning
CMS	Centers for Medicare and Medicaid Services
CPT	Current Procedural Terminology

IV. Related Policies

Policy Number	Policy Description
N/A	N/A

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Procedure codes appearing in Reimbursement Policy documents are included only as a general reference tool for each policy. They may not be all-inclusive.

V. Reference Materials

VI. Revision History

Revision Date	Summary of Changes

Disclaimer

Healthfirst's claim edits follow national industry standards aligned with CMS standards that include, but are not limited to, the National Correct Coding Initiative (NCCI), the National and Local Coverage Determination (NCD/LCD) policies, appropriate modifier usage, global surgery and multiple procedure reduction rules, medically unlikely edits, duplicates, etc. In addition, Healthfirst's coding edits incorporate industry-accepted AMA and CMS CPT, HCPCS and ICD-10 coding principles, National Uniform Billing Editor's revenue coding guidelines, CPT Assistant guidelines, New York State-specific coding, billing, and payment policies, as well as national physician specialty academy guidelines (coding and clinical). Failure to follow proper coding, billing, and/or reimbursement policy guidelines could result in the denial and/or recoupment of the claim payment.

This policy is intended to serve as a resource for providers to use in understanding reimbursement guidelines for professional and institutional claims. This information is accurate and current as of the date of publication. It provides information from industry sources about proper coding practice. However, this document does not represent or guarantee that Healthfirst will cover and/or pay for services outlined. Reimbursement decisions are based on the terms of the applicable evidence of coverage, state and federal requirements or mandates, and the provider's participation agreement. This includes the determination of any amounts that Healthfirst or the member owes the provider.