Priority Health	BILLING POLICY No. 077
AFTER HOURS AND WEEKEND CARE (PROFESSIONAL)	
Date of origin: Feb. 18, 2025	**Review dates: 2/2025, 2/2026**

APPLIES TO

- Commercial group HMO, EPO, POS and PPO plans
- Commercial individual MyPriority® plans

DEFINITION

Priority Health reimburses primary care providers (PCPs) for after-hours services to commercial plan members for fee-for-service. No modifier is necessary to bill these codes.

FOR MEDICARE

For indications that don't meet criteria of NCD, local LCD or specific medical policy, a Pre-Service Organization Determination (PSOD) will need to be completed. Get more information on PSOD in our Provider Manual.

POLICY SPECIFIC INFORMATION

Payment will be made for members of employer-sponsored and MyPriority℠ HMO, POS and PPO plans for the codes listed below

These codes are **not payable** for members of Medicare, Medicaid or Healthy Michigan Plan plans.

Before billing for after-hours care for Priority Health **Medicare Advantage** plan members, refer to Correct Coding Initiative (CCI) edits.

Coding specifics

99050

- Applies to services supplied to a member by a PCP when the office is normally closed. Scheduled clinic hours or walk-in hours do not apply.
- Document the special circumstances of the visit to the medical record.
- Report CPT 99050 in addition to the basic service.

99051

- Applies to services supplied to a member by a PCP during regularly scheduled evening, weekend or holiday office hours.
- Priority Health considers "after hours" to be any scheduled appointment after 5:00pm EST and prior to 8 a.m. ET.
- Report CPT 99051 in addition to the basic service.

99053

- Applies when a PCP comes into the ER between 10 p.m. and 8 a.m. to treat a patient.
- Not billable for an on-duty ER physician.
- 99053 is incidental to any E&M service(s), surgical service(s), laboratory service(s), etc., when provided by emergency room physicians, anesthesiologists, radiologists, laboratory staff or any other provider scheduled to be onsite at the time the service was rendered.

- 99053 example:
    - A member refuses treatment from an ER physician and requests that his/her PCP come to the facility to treat the illness/injury. The rendering PCP is called the 24-hour facility to render unscheduled services.
    - Documentation within the medical record indicates the special circumstances of the visit.
    - The PCP reports CPT 99053 in addition to the basic service.

Payment for these services is bundled into payment for other services provided on the same day

Place of service

99050 & 99051

- 03: School
- 05: Indian Health Service Free-standing Facility
- 07: Tribal 638 Free-Standing Facility
- 11: Office
- 49: Independent Clinic
- 50: Federally Qualified Health Center
- 71: State or Local Public Health Clinic
- 72: Rural Health Clinic
- 20: After-hours care billed with POS 20 or a specialty of urgent care will be denied

99053

- Emergency room

Documentation requirements

Documentation within the medical record must indicate the special circumstances of the visit.

Modifiers

No modifier is necessary to bill these codes.

Resources

- After Hours and Weekend Care Policy, Professional – Reimbursement Policy (UnitedHealthcare Community Plan)

Related policies

- After-hours medical availability (Priority Health Provider Manual)

DISCLAIMER

Priority Health's billing policies outline our guidelines to assist providers in accurate claim submissions and define reimbursement or coding requirements if the service is covered by a Priority Health member's benefit plan. The determination of visits, procedures, DME, supplies and other services or items for coverage under a member's benefit plan or authorization isn't being determined for reimbursement. Authorization requirements and medical necessity requirements appropriate to procedure, diagnosis and frequency are still required. We use Current Procedural Terminology (CPT), Centers for Medicare and Medicaid Services (CMS), Michigan Department of Health and Human Services (MDHHS) and other defined medical coding guidelines for coding accuracy.

An authorization isn't a guarantee of payment when proper billing and coding requirements or adherence to our policies aren't followed. Proper billing and submission guidelines must be followed. We require industry standard, compliant codes defined by CPT, HCPCS and revenue codes for all claim submissions. CPT, HCPCPS, revenue codes, etc., can be reported only when the service has been

performed and fully documented in the medical record to the highest level of specificity. Failure to document services rendered or items supplied will result in a denial. To validate billing and coding accuracy, payment integrity pre- or post-claim reviews may be performed to prevent fraud, waste and abuse. Unless otherwise detailed in the policy, our billing policies apply to both participating and non-participating providers and facilities.

If guidelines detailed in government program regulations, defined in policies and contractual requirements aren't followed, Priority Health may:

- Reject or deny the claim
- Recover or recoup claim payment

An authorization on file for an item or services doesn't supersede coding, billing or reimbursement requirements.

These policies may be superseded by mandates defined in provider contracts or state, federal or CMS contracts or requirements. We make every effort to update our policies in a timely manner to align these requirements or contracts. If there's a delay in implementation of a policy or requirement defined by state or federal law, as well as contract language, we reserve the right to recoup and/or recover claim payments to the effective dates per our policy. We reserve the right to update policies when necessary. Our most current policy will be made available in our Provider Manual.

CHANGE / REVIEW HISTORY

Date	Revisions made
Feb. 18, 2025	• Transitioned policy from a webpage into this PDF document. • Added the place of service (POS) requirements for codes 90050 and 90051 for transparency into which settings are appropriate for these codes.
Feb. 20, 2026	• Added Place Of Service Requirements After-hours care billed with POS 20 or a specialty of urgent care will be denied