Urgent Care Billing Cheat Sheet

High-Volume Clinic Quick Reference

1. Core Billing Identifiers

Item	Required Code / Rule	Why It Matters
Place of Service	POS 20	Required for urgent care reimbursement
Claim Form	CMS-1500	Standard outpatient claim submission
Coding Systems	CPT, ICD-10-CM, HCPCS	Describe services, diagnoses, and supplies
Submission Method	Clearinghouse	Scrubs claims before payer review

2. Common E/M Codes in Urgent Care

Patient Type	Code Range	Selection Based On	Risk if Incorrect
New Patient	99202–99205	MDM or total time	Underpayment or audit risk
Established Patient	99212–99215	MDM or total time	Revenue loss or overcoding flag

Note: Documentation must support the level billed.

3. Modifier 25 Quick Reference

When to Use	Example Scenario	Documentation Requirement	Audit Risk
Same-day E/M + procedure	Visit + laceration repair	Separate E/M work clearly documented	High if overused
Same-day E/M + diagnostic test	Visit + rapid strep test	Medical necessity for both services	Moderate

Note: High usage rates may trigger payer review.

4. Urgent Care S-Codes and Add-On Codes

Code	Description	Payer Type	Important Note
S9083	Global urgent care fee	Commercial	Not accepted by all payers
S9088	Urgent care service add-on	Commercial	Often used to offset overhead

Note: Always verify payer contract rules before billing.

5. Top Claim Denial Triggers

Verification Item	Required Action	Risk If Missed
Member ID	Confirm accuracy	Claim rejection
Group Number	Verify correctly entered	Processing delay
Date of Birth	Match insurance record	Eligibility denial
Primary vs Secondary	Confirm payer order	Coordination of benefits denial
Self-Pay Status	Identify uninsured patients	Compliance issue

Note: Most urgent care denials originate at registration.

6. Front Desk Clean Claim Checklist

Verification Item	Required Action	Risk If Missed
Member ID	Confirm accuracy	Claim rejection
Group Number	Verify correctly entered	Processing delay
Date of Birth	Match insurance record	Eligibility denial
Primary vs Secondary	Confirm payer order	Coordination of benefits denial
Self-Pay Status	Identify uninsured patients	Compliance issue

Note: One incorrect digit can delay payment 30–60 days.

7. Documentation Essentials for Compliance

Documentation Element	Must Include	Why It Protects Revenue
Chief Complaint	Clear reason for visit	Supports medical necessity
Assessment	Diagnosis with ICD-10-CM	Justifies the CPT level
Medical Decision-Making	Risk, data, complexity	Supports E/M level
Procedure Note	Separate details	Justifies modifier use
Provider Signature	Signed and dated	Prevents rejections

Note: Cloned or repetitive notes increase audit exposure.

8. High-Volume Billing Control Benchmarks

Metric	Healthy Target	Warning Sign	Preventive Action
Clean Claim Rate	95%+	Under 90%	Weekly coding audits.
Denial Rate	Under 5–8%	Above 10%	Refresher training for the front desk.
Days in AR	Under 35 days	Over 45 days	Daily claim submission.
Charge Entry Lag	Under 48 hours	Over 3 days	Senior oversight during weekends.
Modifier 25 Usage	Case-dependent	Used on the majority of claims	Review for "cloned" documentation.

Note: Volume multiplies errors quickly. Monitor weekly, not monthly.

9. Peak Volume Risk Controls

High-Risk Period	Preventive Action	Expected Result
Flu Season	Refresher coding training	Fewer modifier errors
Weekends	Senior staff oversight	Reduced eligibility mistakes
Extended Hours	Daily claim submission	Improved cash flow

Note: Preparation prevents revenue leakage.