



Billing Integrity in Urgent Care: How to Manage Risk

■ Phyllis Dobberstein, CPC, CPMA, CPCO, CEMC, CCC

The financial and reputational health of an urgent care practice depends on one simple principle: Bill accurately and compliantly. Yet as reimbursement rules evolve and staffing models shift toward greater reliance on non-physician practitioners (NPPs), many centers find themselves at risk for costly missteps. From billing under the wrong provider to out-of-network (OON) complications and False Claims Act (FCA) violations, administrators are navigating an increasingly complex compliance landscape.

Understanding how these issues intersect—and building proactive strategies to mitigate them—is no longer optional. It’s a leadership imperative.

NPPs, such as nurse practitioners and physician assistants, have become essential to urgent care staffing. They enable clinics to meet rising patient volumes and manage physician shortages. But their expanding autonomy has outpaced billing clarity.

Common Misconceptions

One of the most persistent misconceptions is that NPPs can freely bill under supervising physicians. In reality, this is largely dictated by payer contract terms and government program rules. Government payers such as Medicare, Medicaid, and TRICARE require that all claims be billed under the rendering provider—the individual who performed the face-to-face service. There is no flexibility in these cases. Nongovernment payers may allow group-level billing, but only if the contract specifically provides for it.

When a contract requires full credentialing, every provider, whether temporary or permanent, must be cre-

denial before billing. Unlike physicians, NPPs cannot use fee-for-time or “locum tenens” arrangements to fill coverage gaps. Even if a physician reviews or signs off on the chart, this fulfills supervisory obligations but does not alter billing responsibility.

“Incident-to” billing, reporting services under a physician when performed by a nonphysician, is rarely appropriate in urgent care, as it applies only to established patients following an existing treatment plan under direct supervision. Many urgent care encounters involve new or worsening conditions, excluding them from “incident-to” eligibility.

Administrators should also note that while government payers prohibit billing under another provider except in narrow conditions, commercial payers vary widely. The safest course is to credential all NPPs as rendering providers and ensure payer contracts reflect this structure.

Out of Network Billing

Even when providers are credentialed correctly, urgent care centers can face revenue risk when operating with OON providers.

The process of credentialing and contracting remains largely archaic, often taking 9–12 months for new clinics and up to 120 days for new providers. Billing before credentialing is complete can lead to 1 of 3 outcomes: payment issued directly to the patient; application to the patient’s deductible; or outright claim denial. Each carries financial and patient-satisfaction consequences. Practices sometimes attempt to bridge the gap with cash-pay options, but this strategy can reduce patient volume and delay profitability.

Planning is the most effective preventive measure. Contracting should begin early, well before opening or adding a site. Onboarding of new providers should include collection of all credentialing data before a provider’s start date. In other words, do not wait until you



Phyllis Dobberstein, CPC, CPMA, CPCO, CEMC, CCC, is Revenue Integrity Manager at Experity.

are ready to open your doors.

Furthermore, urgent care centers should train front office staff to recognize when a patient is scheduled with a nonparticipating provider. Transparent communication prevents surprise billing and reduces reputational risk. Finally, customer service staff should have clear, legally vetted scripts for responding to patient inquiries regarding OON charges.

When Do Errors Become Violations?

The most serious billing errors carry not just financial risk but federal liability. Under the FCA, any person or entity that “knowingly submits false claims to the government” is subject to damages and per-claim penalties, which can add up quickly.

In recent years, urgent care settlements under the FCA have totaled \$44.4 million. The common thread in these cases is billing for services not rendered, or billing under the wrong provider. Examples include:

- A New York practice that billed for higher-level visits than performed and submitted claims under non-credentialed providers
- A South Carolina practice and management company fined \$22.5 million for billing noncredentialed providers under credentialed physicians
- A Missouri center that submitted claims for non-physician practitioners under physicians and paid bonuses tied to referral volume

While some violations stemmed from deliberate misconduct, others likely resulted from weak oversight, lack of training, or misunderstanding of credentialing and supervision rules. Regardless of intent, liability under the FCA extends to any organization that “knowingly” submits a false claim, a term encompassing reckless disregard or willful ignorance.

Integrating Compliance Across Billing Functions

These 3 domains—NPP billing, OON processes, and FCA exposure—are interconnected. Failures in one often cascade into the others. For instance, billing an uncredentialed NPP under a supervising physician to avoid OON denials can inadvertently create the basis for a false claim. Similarly, inconsistent documentation of who performed a service can violate payer contracts and federal law simultaneously.

To prevent this, administrators should establish a unified billing compliance framework built on 5 principles:

1. **Credential diligently**—Maintain a centralized credentialing calendar tracking application status and renewal deadlines. Credential all rendering providers whenever possible, regardless of payer type.

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2. **Audit regularly**—Conduct internal audits at least quarterly. Verify that each claim is billed under the correct provider, that services match documentation, and that payer rules are applied consistently.
3. **Educate continuously**—Provide ongoing education for clinicians and front office staff. Ensure everyone understands that “incident-to” and shared-visit billing are rarely applicable in urgent care settings.
4. **Plan ahead for OON scenarios**—Initiate payer contracting early and develop a policy for handling claims while credentialing is pending. This includes deciding whether to hold, bill out-of-network, or defer services.
5. **Empower compliance leadership**—Designate a compliance officer or manager (often within revenue cycle management) responsible for monitoring FCA risk, reviewing payer updates, and coordinating corrective actions.

Billing compliance in urgent care is no longer the exclusive domain of coders and billers. It’s an organizational responsibility led from the top. The consequences of noncompliance, including lost contracts, payer recoupments, FCA settlements, and reputational harm, are too great to ignore.

Administrators can protect their centers by fostering a culture of billing integrity. That means aligning operational processes with payer requirements, credentialing every rendering provider, and ensuring staff understand not just *what* to bill, but *why* accuracy matters.

As Experity’s revenue cycle experts consistently emphasize, “If you aren’t measuring it, you can’t manage it.” In today’s urgent care environment, that maxim applies as much to compliance as to collections. The reward for diligence is not just avoiding penalties, it’s sustaining the financial and ethical integrity of your practice. ■