



BILLING POLICY No. 009

E/M SERVICES BILLED WITH TREATMENT ROOM REVENUE CODES

Effective date: Nov. 11, 2024

Review dates: 2/2025, 2/2026

Date of origin: Sept. 2024

DEFINITION

Treatment room and specialty room services are outpatient services, furnished on hospital premises that require the use of a bed and periodic monitoring for a brief amount of time in order to carry out minor procedures and allow the patient to recover. The use of the treatment room is an expected part of the minor procedures, unlike major procedures that would require use of an operating room.

POLICY SPECIFIC INFORMATION

Reimbursement specifics

Priority Health doesn't reimburse facility evaluation and management (E/M) charges billed in conjunction with a treatment room revenue code (760, 761 and 769) as these services don't represent a specific procedure performed in a treatment room. Billing treatment room revenue codes is incorrect coding when reported for office-based E/M services. Priority Health will reimburse facility treatment room services directly related to the procedure(s) that are provided on the same day in which the treatment is rendered.

Coding specifics

Revenue code	Description
0760	Specialty Services General
0761	Treatment Room
0769	Other Specialty Services

CPT / HCPCS Codes	Description
99201-99215	Evaluation and Management Services
99221-99223	Evaluation and Management Services
99231-99233	Evaluation and Management Services
99238-99499	Evaluation and Management Services
G0380-G0384	Procedures and Professional Services
G0463	Procedures and Professional Services
G2212	Procedures and Professional Services

Definitions

- **Evaluation and Management service:** Services reported by physician and non-physician practitioners. E/M services include office and other outpatient services,

hospital inpatient services, consultations, emergency room visits, nursing facility services, domiciliary care services and home services.

- **Minor procedure:** Minor surgical procedures that are minimally invasive. Some procedures are performed laparoscopically or arthroscopically and consist of small incisions and surgical tools and cameras inserted into the body. Examples of minor surgeries include biopsies, repairs of cuts or small wounds, removal of warts, lesions, hemorrhoids or abscesses. Minor procedures are performed over a brief period.
- **Revenue code:** A revenue code is a four-digit code that affects reimbursement. Revenue codes are used on hospital bills to inform health plans either where the patient was located when they received the treatment or the type of item a patient might have received while a patient was in a hospital.
- **UB-04:** Forms used by hospitals and other providers to bill for institutional services. A valid procedure code must accompany a revenue code for it to be accepted by the health plan.

RESOURCES

- Current Procedural Terminology (CPT®), 2023
- Centers for Medicare and Medicaid Services, CMS Manual System and other CMS publications and services.
- [American Medical Association](#)
- [CC.PP.072 - E&M Services Billed with Treatment Room Revenue Codes \(biopolicy.s3.amazonaws.com\)](#)

DISCLAIMER

CMS and/or MDHHS guidelines apply unless otherwise specified in this policy or provider manual. Where such guidance is absent, this policy applies. 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, HCPCS, 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. 4, 2025	Added "Disclaimer" section
Feb. 23, 2026	Reviewed, no changes