Priority Health	BILLING POLICY No. 047
TREATMENT ROOMS	
Date of origin: Oct. 14, 2024	**Review dates: 2/2025**

APPLIES TO

- Commercial
- Medicare follows NCD, LCD or guidelines defined by CMS unless otherwise specified
- Medicaid follows guidelines defined by MDHHS unless otherwise specified

DEFINITION

Treatment Room services are outpatient services that are done on hospital premises, which require a bed and monitoring for minor procedures or services that wouldn't be performed in a specialized suite.

POLICY SPECIFIC INFORMATION

Treatment rooms can be utilized for minor procedure(s), and would replace any operating room, emergency room and recovery room charges. The reimbursement of treatment room services requires a physician order. Failure to have an order on file may result in a denial. Members transferred to an inpatient status would require notification. Treatment room services shouldn't be reported with a CPT/HCPCS code that's more appropriately reported with another revenue code as detailed below. These guidelines align to billing requirements outlined in the Uniform Billing Editor.

Coding specifics

- Revenue code 0760, 0761, 0769 should be used when reporting treatment room services
- Using the applicable CPT/HPCS code that was performed in the treatment room is required
- E&M codes will deny when billed with a treatment room revenue code
- Treatment rooms shouldn't be billed in association with the services detailed below:
    - Any service related to artificial limbs or other prosthetics
    - Diagnostic procedures- unless it's related to the surgical procedure
    - Observation services on TOB 013x
    - Durable medical equipment
    - Lab services
    - Radiology
    - Provider based clinic services

Revenue codes

- **0760**: Treatment/observation room - Not applicable for treatment room billing
- **0761**: Treatment room - Bill with applicable HCPCS/CPT codes when a specific procedure has been performed or a treatment rendered

RESOURCES

Uniform Billing Editor

RELATED POLICIES

- E/M services billed with treatment room revenue codes
- General coding policy

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 for 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 to 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. 14, 2025	Added "Disclaimer" section