Payment Policy: E&M Services Billed with Treatment Room Revenue Codes

Reference Number: CC.PP.071
Date of Last Revision: 09/28/21

Revision Log
Coding Implications

See Important Reminder at the end of this policy for important regulatory and legal information.

Description
Treatment Room and Specialty Services revenue codes characterize services performed in a facility setting that are represented by a specific procedure reportable in a treatment room setting. The patient receiving these services must be registered through the hospital business office for outpatient services on a hospital campus.

Treatment room services are outpatient services, furnished on hospital premises, which require the use of a bed, and periodic monitoring for a relatively brief episode of time in order to carry out certain procedures. The use of the treatment room is an expected part of a minor procedure and replaces the charge for the operating room and recovery room as patients can also recover in the treatment room. Operating rooms are procedure rooms within a sterile corridor and are used for open or major surgical procedures usually involving general anesthesia.

Policy/Criteria
The health Plan does not reimburse for facility evaluation and management (E/M) charges billed in conjunction with a treatment room revenue code as these services do not represent a ***specific procedure*** performed in a treatment room. Billing treatment room revenue codes is incorrect coding when reported for office-based evaluation and management services.

The health plan 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.

Applies to:
E/M services billed on a UB04 or CMS-1450 claim form
Revenue codes billed on a UB04 or CMS-1450 claim form

Reimbursement Guidelines
The health plan's code editing software will evaluate claims billed with revenue codes 760, 761 and 769 that are billed in conjunction with an evaluation and management service according to the application criteria mentioned in this policy.

Any service line reported incorrectly will be denied for reimbursement.

Coding and Modifier Information
This payment policy references Current Procedural Terminology (CPT®). CPT® is a registered trademark of the American Medical Association. All CPT® codes and descriptions are copyrighted 2020, American Medical Association. All rights reserved. CPT codes and CPT descriptions are from current manuals and those included herein are not intended to be all-inclusive and are included for informational purposes only. Codes referenced in this payment

policy are for informational purposes only. Inclusion or exclusion of any codes does not guarantee coverage. Providers should reference the most up-to-date sources of professional coding guidance prior to the submission of claims for reimbursement of covered services.

Revenue Code	Descriptor
0760	Specialty Services General
0761	Treatment Room
0769	Other Specialty Services

CPT/HCPCS Codes	Descriptor
99202-99215	Office Or Other Outpatient Services
99217-99226	Hospital Observation Services
99221-99239	Hospital Inpatient Services
99241-99255	Consultation Services
99281-99288	Emergency Department Services
99291-99292	Critical Care Services
99304-99318	Nursing Facility Services
99304-99318	Nursing Facility Services
99324-99340	Domiciliary, Rest Home or Custodial Care Services or Home Care Plan Services
99341-99350	Home Services
99354-99417	Prolonged Services
99366-99368	Case Management Services
99374-99380	Care Plan Oversight Services
99381-99429	Preventative Medicine Services
99439-99491	Care Management E/M Services
99450-99456	Special Evaluation and Management Services
99460-99463	Newborn Care Services
99464-99465	Delivery/Birthing Room Attendance and Resuscitation Services
99466-99486	Inpatient neonatal Intensive Care Services and Pediatric and Neonatal Care Services
99483-99483	Cognitive Assessment and Care Plan Services
99492-99494	General Behavioral Health Integration Care Management
99495-99496	Transitional Care E/M Services
99497-99498	Advance Care Planning E/M Services
99499-99499	Other E/M Services
G0380-G0384	Level 1-5 Hospital Emergency Department Visit
G0463	Hospital outpatient clinic visit for assessment and management of a patient
G2212	Prolonged office or other outpatient E/M service(s) beyond the maximum required time of the primary procedure which has been

	selected using total time on the date of the primary service; each additional 15 minutes by the physician or qualified health professional with or without direct patient contact (list separately in addition to CPT codes 99205, 99215 for office or other outpatient evaluation and management services) (do not report G2212 on the same date of service as 99354, 99355, 99358, 99359, 99415, 99416. (do not report G2212 for any time unit less than 15 minutes)

Modifier	Descriptor
Not Applicable	Not Applicable

ICD-10 Codes	Descriptor
Not Applicable	Not Applicable

Definitions

Revenue Code
A 4-digit number that is used on hospital bills to tell the insurance companies either where the patient was when they received treatment, or what type of item a patient might have received as a patient.

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 are biopsies, repairs of cuts or small wounds, removal of warts, lesions, hemorrhoids or abscesses. Minor procedures are performed over a brief period of time.

Revenue Code
A revenue code is a four-digit code that affects reimbursement. Revenue codes are used on hospital bills to inform insurance companies either where the patient was located when they received the treatment or the type of item a patient might have received while a patient.

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 insurance provider.

References

1. *Current Procedural Terminology (CPT®)*, 2020
2. *Centers for Medicare and Medicaid Services,* CMS Manual System and other CMS publications and services.
3. *American Medical Association, http:://www.amaassn.org/ama*

Revision History	
09/28/21	Initial Policy Draft

Important Reminder

For the purposes of this payment policy, "Health Plan" means a health plan that has adopted this payment policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any other of such health plan's affiliates, as applicable.

The purpose of this payment policy is to provide a guide to payment, which is a component of the guidelines used to assist in making coverage and payment determinations and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage and payment determinations and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable plan-level administrative policies and procedures.

This payment policy is effective as of the date determined by Health Plan. The date of posting may not be the effective date of this payment policy. This payment policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this payment policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. Health Plan retains the right to change, amend or withdraw this payment policy, and additional payment policies may be developed and adopted as needed, at any time.

This payment policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This payment policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this policy are independent contractors who exercise independent judgment and over whom Health Plan has no control or right of control. Providers are not agents or employees of Health Plan.

Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this payment policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this payment policy.

Note: For Medicare members, to ensure consistency with the Medicare National Coverage Determinations (NCD) and Local Coverage Determinations (LCD), all applicable NCDs and LCDs should be reviewed prior to applying the criteria set forth in this payment policy. Refer to the CMS website at http://www.cms.gov for additional information.