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

Reference Number: LA.PP.071
Date of Last Revision: 01/2026

Coding Implications
Revision Log

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:
Type of Bill 130x

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 2025, 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
99202-99499	Evaluation and Management Services
G0380-G0384	Procedures and Professional Services
G0463-G0463	Procedures and Professional Services
G2212-G2212	Procedures and Professional Services

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®)*, 2025
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	Revision Date	Approval Date	Effective Date
Initial Policy Draft	09/28/21		
Removed overlap in CPT code ranges 99202-99499, G0380-G0384 G0463 and G2212	01/19/22		
Rebranded from Corp Policy	2/22		
Annual review, updated policy dates, updated Important Reminder section.	4/23	7/10/23	
Annual review, no updates	3/24	3/26/24	
Annual review; copyright date updated	2/25	2/25/25	2/25/25
Annual review; no updates	1/26	2/3/26	

Important Reminder
This payment policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this payment policy; and other available clinical information. LHCC makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This payment policy is consistent with standards of medical practice current at the time that this payment policy was approved.

The purpose of this payment policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions 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 LHCC administrative policies and procedures.

This payment policy is effective as of the date determined by LHCC. The date of posting may not be the effective date of this clinical 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. LHCC 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/enrollees. This payment policy is not intended to recommend treatment for members/enrollees. Members/enrollees should consult with their treating physician in connection with diagnosis and treatment decisions.

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

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