Commercial Reimbursement Policy

Subject: **Treatment Rooms with Office Evaluation and Management Services - Facility**	
Policy Number: **C-20005**	Policy Section: **Facilities**
Last Approval Date: **10/01/2023**	Effective Date: **01/01/2024**

Disclaimer

These reimbursement policies serve as a guide to assist you in accurate claims submissions and to outline the basis for reimbursement if the service is covered by an Anthem Blue Cross (Anthem) member's benefit plan. The determination that a service, procedure, item, etc. is covered under a member's benefit plan is not a determination that you will be reimbursed. Services must meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis, as well as to the member's state of residence.

You must follow proper billing and submission guidelines. You are required to use industry standard, compliant codes on all claim submissions. Services should be billed with Current Procedure Terminology (CPT) codes, Healthcare Common Procedure Coding System (HCPCS) codes and/or revenue codes. These codes denote the services and/or procedures performed and when billed, must be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our reimbursement policies apply to both participating and non-participating professional providers and facilities.

If appropriate coding/billing guidelines or current reimbursement policies are not followed, Anthem may:

- Reject or deny the claim.
- Recover and/or recoup claim payment.

These reimbursement policies may be superseded by mandates in provider, state, federal, or Centers for Medicare & Medicaid Services (CMS) contracts and/or requirements. We strive to minimize delays in policy implementation. If there is a delay, we reserve the right to recoup and/or recover claims payment to the effective date, in accordance with the policy. We reserve the right to review and revise these policies when necessary. When there is an update, Anthem will publish the most current policy to the website.

Policy

The Health Plan requires the reporting of CPT® or HCPCS codes for treatment room revenue codes in an outpatient facility setting. The Health Plan does not allow reimbursement for office evaluation and management services when reported along with revenue codes 760, 761 or 769 unless provider contract language or state or federal contracts and/or mandates indicate otherwise.

Related Coding

Office evaluation and management and office consultation codes	Office evaluation and management and office consultation codes

Policy History

10/01/2023	Review approved 10/01/2023 and effective 01/01/2024: added HCPCS code G0463 to Related Coding section; Policy language updated to expand to revenue codes 760 and 769 when billed with office E/M codes; deny a facility claim line if revenue codes 760, 761 or 769 is not billed with an accompanying CPT® or HCPCS code on a UB-04
10/01/2021	Initial approval 10/01/2021 and effective 01/01/2022

References and Research Materials

This policy has been developed through consideration of the following:

- AMA Current Procedural Terminology (CPT®) 2020 Professional
- CMS
- Optum Encoder Pro 2022

Definitions

General Reimbursement Policy Definitions

Related Policies and Materials

Place of Service and Evaluation and Management – Facility
Clinic Charges - Facility

Use of Reimbursement Policy

State and federal law, as well as contract language, including definitions and specific inclusions/exclusions, take precedence over Reimbursement Policy and must be considered first in determining eligibility for coverage. The member's contract benefits in effect on the date that services are rendered must be used. Reimbursement Policy is constantly evolving and we reserve the right to review and update these policies periodically.