Healthy Blue

Louisiana | Healthy Blue | Dual Advantage

Reimbursement Policy
Treatment Rooms

Policy Number: **G-26001**
Policy Section: **Facilities**
Last Approval Date: **02/17/2026**
Effective Date: **07/01/2026**

Visit our provider website for the most current version of the reimbursement policies. If you are using a printed version of this policy, please verify the information by going to **https://provider.healthybluela.com**.

Policy

The health plan requires the reporting of CPT® or HCPCS codes for treatment room revenue codes 0760, 0761, and 0769 on an outpatient facility claim unless provider, state, and federal contracts and/or mandates indicate otherwise.

The health plan does not allow reimbursement for:

- New or established evaluation and management (E/M) services when reported along with revenue codes 0760, 0761, or 0769.
- HCPCS code G0463 hospital clinic services when reported along with revenue codes 0760, 0761, or 0769.
- Revenue codes 0760, 0761, and 0769, when billed on the same claim with these revenue codes:
  - Emergency room (045X)
  - Outpatient surgery (036X)
  - Recovery room (071X)
  - Observation (0762)
  - Clinic (051X)
  - Freestanding clinic (052X)

This policy applies regardless of reimbursement methodology.

Related Coding

Standard correct coding applies.

Definitions

- General Reimbursement Policy Definitions

LA-HB-CR-RP-006457-26-GRP2030 March 2026

Related Policies and Materials

- Claims Submission – Required Information for Facilities
- Code and Clinical Editing Guidelines
- Eligible Billed Charges

References and Research Materials

This policy has been developed through consideration of the following:

- CMS
- National Uniform Billing Committee (NUBC)
- Optum EncoderPro 2026

Policy History

- **02/17/2026** - Initial approval 02/17/2026 and effective 07/01/2026

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 a member's benefit plan. The determination that a service, procedure, or item is covered under a member's benefit plan is not a determination that you will be reimbursed. Services must also meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis, as well as to the member's state of residence.

Ensure that you use proper billing and submission guidelines, including industry-standard, compliant codes on all claim submissions. Services should be billed with Current Procedural 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 participating providers and facilities; a noncontracting provider who accepts Medicare assignment will be reimbursed for services according to the original Medicare reimbursement rates.

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

- Reject or deny the claim.
- Recover and/or recoup claim payment.
- Adjust the reimbursement to reflect the appropriate services and/or procedures performed.

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, we will publish the most current policy to the website.